

# Supported Employment

## Research

# A Ten-Year Follow-Up of a Supported Employment Program

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**Objective:** Supported employment has steadily increased in prominence as an evidence-based mental health practice, and research shows that the service significantly improves employment outcomes over one to two years. The objective of this study was to examine the outcomes of supported employment ten years after an initial demonstration project.

**Methods:** The study group consisted of 36 clients who had participated in a supported employment program at one of two mental health centers in 1990 or 1992. Clients were interviewed ten years after program completion about their employment history, facilitators to their employment, and their perceptions of how working affected areas of their lives. **Results:** Seventy-five percent of the participants worked beyond the initial study period, with 33 percent who worked at least five years during the ten-year period. Current and recent jobs tended to be competitive and long term; the average job tenure was 32 months. However, few clients made the transition to full-time employment with health benefits. Clients reported that employment led to substantial benefits in diverse areas, such as improvements in self-esteem, hope, relationships, and control of substance abuse. **Conclusions:** On the basis of this small sample, supported employment seems to be more effective over the long term, with benefits lasting beyond the first one to two years. (*Psychiatric Services* 55:302-308, 2004)

Supported employment has steadily spawned greater interest within the mental health, rehabilitation, and advocacy communities and is considered to be an evidence-based mental health practice (1). Under the rubric of recovery, consumers have emphasized the importance of functional outcomes and quality of life (2). The ideological commitment to community integration focuses on adult roles in the com-

munity rather than dependent roles in segregated settings (3). The President's New Freedom Commission on Mental Health (4), the Surgeon General (5), the National Alliance for the Mentally Ill (6), and the National Institute of Mental Health (7) have identified the importance of employment as an outcome of mental health rehabilitation.

By definition, supported employment assists people with the most se-

vere disabilities so that they are able to obtain competitive employment directly—on the basis of the client's preferences, skills, and experiences—and provides the level of professional help that the client needs. Competitive employment includes jobs that have permanent status, pay at least minimum wage, and are not set aside for people with disabilities, that is, anyone can apply. Research has consistently shown that supported employment is more successful than previous approaches in helping persons with severe mental illnesses to attain competitive jobs (1,8-11). For example, according to the Cochrane Review, rates of competitive employment were three times as high in supported employment programs as in other programs (11,12). This systematic review found that clients who received supported employment were significantly more likely to be in competitive employment than those who received prevocational training; for example, at 12 months 34 percent of clients in supported employment programs were employed, compared with 12 percent of clients in prevocational training programs.

In addition to higher rates of competitive employment, clients in supported employment programs report high satisfaction with their jobs and their improved financial status (12). However, one limitation of existing follow-up studies is that nearly all the studies span one to two years, a relatively brief period (13). Other limitations of these follow-up studies are that many of the jobs obtained in supported employment last less than six

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months, and clients receive little subsequent follow-up after the study is completed (14).

A few supported employment studies that were followed up have examined the persistence of employment outcomes. McHugo and colleagues (15) followed a group of clients who participated in a supported employment study for two years beyond the original study, which lasted for 18 months. Despite the erosion of vocational services because of the loss of grant funds, the high rate of competitive employment in this group was maintained for two additional years. There was also some evidence that continued supports were related to continued success in employment. In another long-term study, Bond and colleagues (16) also found persistence of employment in a setting in which vocational supports continued three years after a supported employment grant was terminated. However, other studies found that employment rates decreased rapidly after grant funds were terminated (17,18).

We conducted a ten-year follow-up of former day treatment clients who were originally studied when two separate day treatment programs were converted to supported employment programs in the early 1990s. Our hypotheses were that clients who had participated in the original supported employment program would obtain jobs over the ten-year period that would be characterized by longer job tenure and high satisfaction. Given the limitations imposed by rules for benefits and federal health insurance, we also hypothesized that the majority of participants would remain on Social Security benefits and Medicaid insurance over the ten-year period.

## Methods

### Setting

Two rural rehabilitative day treatment centers in Lebanon, New Hampshire, and Claremont, New Hampshire, closed in 1990 and 1992, respectively. These centers then substituted supported employment programs based on the Individual Placement and Support model. This model emphasizes the integration of vocational and clinical services; rapid job search; matching jobs to clients' pref-

erences, skills, and experiences; and ongoing job supports (19). Both program conversions demonstrated increases in competitive employment outcomes without adverse effects (20–22). Importantly, both centers have maintained their focus on supported employment since the program conversion. Services are organized into multidisciplinary teams in which employment is supported by all team members. In the original study of the centers' supported employment programs, clients were followed for one year to determine how they were affected by program conversion and by the supported employment program (20). Clients of the original study, as well as new clients, share the

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mental health centers' view of the importance of work and community integration. Since the day treatment programs closed in the early 1990s, the agencies have shown no interest in reopening the program. However, an expansion of social opportunities for clients has occurred through the development of consumer-run recovery centers (23).

### Participants

For our ten-year follow-up study, we attempted to locate all participants who had been defined as regular users of day treatment services in 1990 or 1992. These clients were the primary focus of the original one-year follow-up study (20,24). We followed a standardized informed consent pro-

cedure, explaining the study and reading the consent statement to the participant. These procedures as well as the interview described below were reviewed and approved by the institutional review boards of both Dartmouth College and the state of New Hampshire.

### Measures

We developed a semistructured interview specifically for this study. (The interview is available from the second author.) The interview gathered information about demographic characteristics, including Social Security benefits, clients' work history for the ten-year period, facilitators of employment, and clients' perceived effects of working. To measure facilitators, we asked participants several open-ended questions about problems they had encountered when they tried to find or keep a job and things that helped them to find or keep a job. These open-ended questions were followed by rating scales that asked participants to rate the helpfulness of 20 different potential facilitators (1, not at all; 2, some; 3, a lot). Facilitators included having someone to encourage them to work and having someone to help them practice for a job interview. Perceived effects of working were assessed with two open-ended questions that asked the participant to identify the positive and negative aspects of working. We followed these questions with structured ratings of how work affected the frequency of services and the supports clients received. Specifically, participants were asked whether working affected how often they saw their case manager, psychiatrist, and family members; how often they went to the hospital; or how much medication they needed (1, less; 2, the same; 3, more). Finally, we asked participants to rate how working affected other areas of their lives, such as symptoms, medication side effects, and self-confidence (1, worse; 2, the same; or 3, better). Interviews were conducted by the authors in 1999 and 2000.

## Results

### Study group characteristics

Of the 62 clients who were regular day treatment users originally includ-

**Table 1**

Demographic and clinical characteristics at the time of the ten-year follow-up interview for 36 adults who participated in a supported employment program in 1990 or 1992

Characteristics	N	%
<b>Gender</b>		
Male	18	50
Female	18	50
Age (mean±SD years)	45.5±10	
<b>Race</b>		
White	33	92
American Indian	2	6
Hispanic	1	3
<b>Marital status</b>		
Never married	24	67
Married	4	11
Divorced or widowed	8	22
<b>Education status</b>		
Less than high school	10	28
High school or graduate equivalency diploma	12	33
Some college or technical school	10	28
A bachelor's degree or higher	4	11
Receiving Social Security benefits <sup>a,b</sup>	34	97
Supplemental Security Income	17	49
Social Security Disability Insurance	18	51
Other Social Security benefits	5	14
Any insurance benefits <sup>a,b</sup>	35	100
Private health insurance	2	6
Medicaid	32	91
Medicare	21	62
Department of Veterans Affairs benefits	1	3
<b>Primary diagnosis<sup>b</sup></b>		
Schizophrenia	16	46
Schizoaffective disorder	6	17
Major depression	5	14
Posttraumatic stress disorder	3	9
Bipolar disorder	3	9
Personality disorder	2	6

<sup>a</sup> Types of benefits are not mutually exclusive.

<sup>b</sup> Data were available for 35 participants.

ed in the one-year follow-up study, we were able to locate and interview 36 clients, or 58 percent. Seven clients had moved and could not be located, 12 declined to be interviewed, three were hospitalized or unable to give informed consent, and four were deceased. Participants in the ten-year follow-up study group were significantly younger than nonparticipants at the time of the original study; participants had a mean±SD age of 36.5±10 and nonparticipants had a mean age of 43.4±13.2 ( $t=2.32$ ,  $df=60$ ,  $p<.05$ ). Participants of the ten-year follow-up study did not differ significantly from nonparticipants in other available baseline characteristics for which data were available, such as gender, educational level, or diagnosis. In addition, at the time of the orig-

inal study, participants of the ten-year follow-up study did not differ from nonparticipants in employment outcomes in the categories of presence of community employment, hours worked, and wages earned. Of the 36 participants, 31 (86 percent) were still receiving services from the agency.

Demographic characteristics of the follow-up study group are shown in Table 1. Of note is the finding that 97 percent of the participants were receiving some form of Social Security benefits at the time of the interview. Similarly, 91 percent were receiving public health insurance through Medicaid.

#### **Employment history**

At the time of our study, the vast majority of clients (33 clients, or 92 per-

cent) reported having participated in work activity during the past ten years, including paid work, volunteer positions, sheltered work, and homemaking; 17 clients (47 percent) were currently employed at the time of the interview. We examined patterns of work over time based on the type, frequency, and duration of work reported. Five clients (14 percent) did not work for pay at all during the ten-year period, and an additional four clients (11 percent) worked in the initial years after program conversion. About a third of the study group (11 clients, or 31 percent) worked sporadically throughout the entire ten-year period; four (11 percent) were sporadic in their work initially, but by the time of the ten-year follow-up study, they had become workers with at least 12 months of continuous employment. Finally, 12 clients (33 percent) were consistently employed for at least five years of the ten-year follow-up period. For those who worked, the mean number of jobs held during the past ten years was 3.1±1.9, ranging from one to seven.

We compared workers who were consistently employed for at least five years of the ten-year follow-up period ( $N=16$ ) with the others ( $N=20$ ) on the background characteristics listed in Table 1. Workers who were consistently employed were more likely than the remainder to be male (69 percent compared with 35 percent;  $\chi^2=4.05$ ,  $df=1$ ,  $p<.05$ ) and were less likely to be insured through Medicaid (81 percent compared with 100 percent;  $\chi^2=3.99$ ,  $df=1$ ,  $p<.05$ ). The two groups did not differ significantly on the remaining variables.

Job descriptors for persons who were employed over the ten-year period are shown in Table 2. Data are given for persons with a recent job ( $N=33$ ) and for persons with a current job ( $N=17$ ). Of the clients who detailed their most recent job, 13 clients held a competitive job in the service industry, for example, a clerk at donut shop or a maintenance person (39 percent); five clients (15 percent) were employed competitively in a professional, technical, or managerial position, for example, a crisis respite worker or a peer counselor. The crisis respite and peer counselor

positions were classified as competitive even though the positions were designed for consumers, because the designation was based on their experiences and skills rather than on their mental disability. The mean length of time, number of hours worked per week, and rate of pay for the most recent and the current position are shown in Table 2.

We examined rates of employment in the original one-year follow-up study to see whether clients who were currently employed in our ten-year follow-up study were the same clients who were the most successful in the original study. Of the 17 participants who were currently employed, nine (53 percent) had also worked during the first year of the study, and of the 19 participants who were not currently employed, six (32 percent) had worked during the original one-year follow-up study, although the results were not significant. The two employment groups did not differ significantly in hours worked or wages earned during the original study. Clients who were currently employed at the time of our study had worked a mean of 126.3±249 hours during the original study period, compared with 117.4±300.3 hours for clients who were not currently employed. Clients who were currently employed at the time of our study had earned a mean of \$543.06±\$1,150.43 during the entire period of the original study, compared with \$738.37±\$1,880.49 during the original study for clients who were not currently employed.

#### Facilitators of work

As shown in Table 3, clients with work experience reported that several factors were very helpful. For example, working reduced schedules in terms of hours per day or number of days per week and knowing about disability benefits were the facilitators cited most frequently by clients.

#### Perceived effects of work

In terms of the support received, most participants reported that work generally did not have much effect on how often they were in contact with professional and nonprofessional supporters. Most clients responded

**Table 2**

Characteristics of jobs held by 33 adults during the ten years after they participated in a supported employment program<sup>a</sup>

Characteristics	Most recent job (N=33)		Current job (N=17)	
	N	%	N	%
<b>Job type</b>				
Competitive	23	70	15	88
Volunteer	5	15	1	6
Casual	43	9	1	6
Sheltered	1	3	0	0
Homemaking	1	3	0	0
<b>Job codes from the Dictionary of Occupational Titles</b>				
Professional, technical, or managerial	5	15	5	29
Clerical or sales	7	21	4	24
Service	13	39	6	35
Agricultural	4	12	1	6
Benchwork	1	3	0	0
Miscellaneous	3	9	1	6
Mean±SD number of months on the job	32.1±36.3		50.5±41.3	
Mean±SD hours per week <sup>b</sup>	14.4±12.1		13.7±9.2	
<b>Categorical hours per week</b>				
10 or fewer hours per week	16	50	8	50
11 to 20 hours per week	7	22	4	25
21 to 30 hours per week	6	19	4	25
31 to 40 hours per week	3	9	0	0
Mean±SD hourly wage	\$6.57±\$2.03		\$6.55±\$2.20	

<sup>a</sup> Three participants were never employed during the ten-year period.

<sup>b</sup> Data were missing for one participant.

“same” when asked whether work affected how often they saw their case manager (19 clients, or 63 percent), psychiatrist (20 clients, or 63 percent), and family members (23 clients, or 70 percent); how often they went to the hospital (13 clients, or 42 percent); and the amount of medication they needed (20 clients, or 63 percent). A substantial minority of participants reported that they saw their psychiatrist less (ten clients, or 31 percent) and went to the hospital less (12 clients, or 39 percent) because of working. (Ns vary because of missing data.)

Table 4 displays the impact of work on different aspects of the participants' lives. Notably, most participants reported that their symptoms and the side effects of their medications were the same whether they worked or not. On the remaining items, the majority of clients reported that work made these aspects better. The particular areas of improvement ranged from physical health (14 clients, or 42 percent) to “feelings

about yourself in general” (27 out of 32 clients, or 84 percent).

#### Discussion

Overall, the consumers in our study group demonstrated substantial employment rates during the ten years that followed the conversion from a day treatment program to a supported employment program. Almost all the consumers reported that they were employed at some point during the ten-year follow-up period, and 17 consumers (47 percent) were employed at the time of the ten-year follow-up interview. The majority of the jobs were competitive, with consumers making at least minimum wage in a community setting. These rates of employment are very high given the nature of the study group—high users of day treatment in the original conversion study. In the original study, which followed clients for one year, only 29 percent of day treatment participants were employed (24), and a recent survey of other day treatment participants found that

**Table 3**

Facilitators of employment cited by adults who had participated in a supported employment program and who were employed during the ten-year follow-up period (N=33)<sup>a</sup>

Description	Not applicable		Not at all		Some		A lot	
	N	%	N	%	N	%	N	%
Working a few hours at a time rather than a whole day	0	—	1	3	8	24	23	70
Working a few days a week rather than the whole week	2	6	2	6	8	24	20	61
Knowing more about your disability benefits (Social Security, Medicaid, or Medicare)	3	9	2	6	7	21	20	61
Getting help learning how to do the tasks of the job	2	6	3	9	9	27	18	55
Having someone encourage you to try working	2	6	3	9	12	36	16	49
Having someone help you choose a job that fits your needs and interests	6	18	3	9	7	21	16	49
Having your medications adjusted	8	24	5	15	3	9	16	49
Having someone be at work with you in the beginning while you are getting started	8	24	7	21	3	9	14	42
Working in a group with other people you know	9	27	3	9	6	18	13	39
Having someone help you find jobs that are available	4	12	3	9	13	39	12	36
Having someone help you get along better with people at work	10	30	5	15	6	18	11	33
Having someone to talk to about the stress of working	6	18	5	15	10	30	11	33
Working in a group with other consumers you know from the mental health center	8	24	6	18	8	24	10	30
Having someone take you to a job interview	11	33	2	6	11	33	8	24
Having someone take you to work regularly	16	49	2	6	6	18	8	24
Having someone help you fill out job applications	8	24	8	24	9	27	7	21
Having a trial period of work (for example, two weeks) to test it out	18	55	3	9	4	12	7	21
Getting more training or schooling	15	46	4	12	6	18	7	21
Talking to other consumers about their work experiences	9	27	5	15	13	39	6	18
Having someone help you practice for a job interview	13	39	9	27	4	12	6	18

<sup>a</sup> For some items responses were missing from one participant.

only 16 percent were employed (25). Thus the employment rates in our study group are strong.

Of the participants who did work over the ten-year period, many of the jobs they held were long term, with an average tenure of almost three years. In addition, participants noted many positive effects that working had on their lives, particularly in reference to their perceptions of self-worth. Thus supported employment seems to be more effective for the long term, with benefits that last beyond the first one to two years, the duration of most follow-up studies. Notably, 86 percent of participants in this study continued their involvement with a mental health center that included a focus on supported employment, a focus that continued throughout the ten-year follow-up period. These mental health centers provide a culture in which work is valued and consumers are expected to work. Thus the participants in our study likely had continued contact with supported em-

ployment services in the intervening years.

Interestingly, participants' success in the original one-year follow-up study appeared to have minimal impact on their later employment. Clients who were employed at the ten-year follow-up were not more likely than those who were not employed to have been employed, to have made more money, or to have worked more hours during the original study. Although the lack of statistical differences may result in part from the small sample size, of the 17 study participants currently employed, eight (47 percent) had not worked at all during the first year of the program. Some clients initially may not be interested in competitive work, but they still can become consistently employed. Thus some clients may need more than a year of supported employment before positive effects are seen. This result highlights the need for a long-term perspective when working with clients in supported employment programs. The result

also points to the need for longer follow-up periods in studies of supported employment.

Although the majority of participants were consistently employed by the end of the ten-year period, supported employment may not be appropriate for everyone: five participants (14 percent) did not work for pay at all over the course of our study, and an additional 11 percent worked a little early on, but not for very long. Because the original study examined all regular users of day treatment, not just those with stated vocational goals, all the participants may not have wanted to work. Supported employment is designed for consumers who want to work. Other clients may have tried working and then decided to pursue other goals. Thus we expect that some clients would not seek or try to maintain employment over the ten-year period.

Despite positive employment results, almost all the consumers continued to receive Social Security benefits, which is not surprising given the

real and perceived barriers to giving up of benefits (26,27). In our study, half of those who were employed worked ten hours a week or less. The average hourly wage was less than \$7, and the maximum reported wage did not exceed \$10. It would be nearly impossible to sustain independent living, for which many clients would require expensive medications, at this level of employment. On the other hand, it may be that some consumers choose to work at this low level so that they can keep their government benefits. Benefits counseling often includes discussions about the maximum pay a consumer can receive and still maintain current benefits (28). Policy changes, such as the Ticket to Work and Work Incentive Improvement Act, may remove some of these barriers by increasing the ability of consumers to make choices and reducing their concerns about benefit loss (29).

Consistent with the idea of community integration as a key factor in recovery, most of the consumers reported that working improved multiple areas of their lives, particularly feelings about themselves and life in general. Working made the participants feel less bored and lonely and more self-confident and hopeful about the future. These findings are even more interesting in light of the finding that most participants did not think that working improved their symptoms or medication side effects. Rehabilitation specialists have argued for years that rehabilitation can be successful for persons with mental illness, regardless of their symptoms (30).

This study has several limitations worth noting. First, the study group was small, and we conducted follow-up interviews with 58 percent of the original sample, or 62 percent of the living participants. Given the severity of illness of the participants in the original study and the ten-year follow-up period of our study, this participation rate is good. However, the combination of the small sample and the rural setting of the supported employment program leads to concern about the generalizability of our findings. We need further data from larger, more diverse samples. In addition, the interviews were based on self-re-

**Table 4**

Impact of employment on adults who had participated in a supported employment program and who were employed during the ten-year follow-up period (N=33)<sup>a</sup>

Item	Worse		Same		Better	
	N	%	N	%	N	%
How did work affect:						
Feelings about yourself in general	1	3	4	13	27	84
Self-confidence	2	6	6	18	25	76
Feelings about life in general	1	3	9	27	23	70
Hopefulness	0	0	10	30	23	70
Boredom	1	3	11	34	20	63
Loneliness	1	3	12	38	19	59
Relationships with other people	1	3	12	38	19	59
Drug use <sup>b</sup>	2	17	3	25	7	58
Alcohol use <sup>c</sup>	3	14	6	29	12	57
Energy level	4	13	11	34	17	53
Physical health	7	21	12	36	14	42
Symptoms	9	27	12	36	12	36
Medication side effects	5	17	22	73	3	10

<sup>a</sup> Mean±SD effect of work, 2.5±.4; range=1.4 to 3.0. Effect of work was measured on a 3-point scale developed by the authors, with higher numbers indicating greater effect.

<sup>b</sup> Question applied to 12 persons

<sup>c</sup> Question applied to 21 persons

port and were not validated by agency records or other informants. Finally, we had no method for controlling factors that may have contributed to outcomes, and as noted above, the large majority of participants were involved in a mental health program that emphasized supported employment consistently over many years. Thus it is impossible to make clear causal attributions for our study outcomes, for example, to determine the effects of initial intervention versus the effects of ongoing treatment. The most parsimonious interpretation of the data is that ongoing involvement in the mental health program, including supported employment, over ten years was likely related to the pattern of improved vocational outcome. Although this was not a controlled study, other interpretations, such as delayed effects, are plausible but unlikely and untestable.

Despite these limitations, our study represents a new perspective on the effectiveness of supported employment. Our study is the first look at the long-term impact of supported employment, with follow-up data ten years after the initial conversion from a day treatment program to a supported employment program. Our

findings are encouraging in terms of rates of employment, particularly competitive employment, and the benefits of working that clients perceived in other areas of their lives. Our findings also raise questions about whether self-sufficiency is a realistic goal for most mental health consumers. Given the current constraints of insurance and benefits, most consumers appear to focus on goals, such as increasing income, self-worth, and community integration, rather than on self-sufficiency. †

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## Psychiatric Services Invites Short Descriptions of Novel Programs

*Psychiatric Services* invites contributions for Frontline Reports, a column featuring short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings.

Text should be 350 to 750 words. A maximum of three authors, including the contact person, can be listed; one author is preferred. References, tables, and figures are not used. Any statements about program effectiveness must be accompanied by supporting data within the text.

Material to be considered for Frontline Reports should be sent to the column editor, Francine Cournois, M.D., at the New York State Psychiatric Institute, 1051 Riverside Drive, Unit 112, New York, New York 10032. Dr. Cournois is director of the institute's Washington Heights Community Service.

**Workforce Investment Act (WIA) - Certified Ohio One-Stop Centers by County**

<b>Adams</b>	<b>Workforce Connections of Adams and Brown Counties</b> 19221 State Route 136 , Winchester, OH 45697 (937) 695-0316
<b>Allen</b>	<b>ACCENT (Allen County Center for Employment and Training)</b> 1501 S. Dixie Highway, P.O. Box 4506, Lima, OH 45802-4506 (419) 999-0360
<b>Ashland</b>	<b>Employment and Training Connection</b> 15 W. Fourth St., Ashland, OH 44805 (419) 282-5052
<b>Ashtabula</b>	<b>Ashtabula Job Source</b> 2247 Lake Ave., Ashtabula, OH 44004 (440) 994-1234
<b>Athens</b>	<b>The Work Station</b> 70 N. Plains Rd., Suite C, The Plains, OH 45780 (740) 797-1405
<b>Auglaize</b>	<b>One Stop Employment &amp; Training Network - Auglaize County</b> 801 Middle St., Wapakoneta, OH 45895 (419) 739-7225
<b>Belmont</b>	<b>Belmont County Connections</b> 302 Walnut St., Martins Ferry, OH 43935 (740) 633-5627
<b>Brown</b>	<b>Workforce Connections of Adams and Brown Counties</b> 406 W. Plum St., Georgetown, OH 45121 (937) 378-6041
<b>Butler</b>	<b>Workforce One of Butler County</b> 4631 Dixie Highway, Fairfield, OH 45014 (513) 785-6500
<b>Carroll</b>	<b>Carroll County Connections</b> 55 E. Main St., Carrollton, OH 44615 (330) 627-3804
<b>Champaign</b>	<b>C-TEC (Champaign Technology and Employment Center)</b> 1512 South U.S. Hwy. 68, Bay 14, Urbana, OH 43078 (937) 484-1581
<b>Clark</b>	<b>WorkPlus Center</b> 1345 Lagonda Ave., Springfield, OH 45503 (937) 327-1961
<b>Clermont</b>	<b>Workforce One of Clermont County</b> 756 Old State Route 74, Cincinnati, OH 45245 (513) 943-3000
<b>Clinton</b>	<b>CC Works</b> 1025 S. South St., Suite 500, Wilmington, OH 45177 (937) 382-7762

**Workforce Investment Act (WIA) - Certified Ohio One-Stop Centers by County**

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<b>Columbiana</b>	<b>Columbiana County One-Stop</b> 7860 Lincole Place, Lisbon, OH 44432 (330) 420-9675
<b>Coshocton</b>	<b>Coshocton County Opportunity Links</b> 725 Pine St., Coshocton, OH 43812 (740) 622-1020
<b>Crawford</b>	<b>Crawford County Jobs Plus</b> 225 E. Mary St., Bucyrus, OH 44820 (419) 562-8066
<b>Cuyahoga</b>	<b>Employment Connection - Brookpark</b> 11699 Brookpark Rd., Parma, OH 44130 (216) 898-1366
<b>Cuyahoga/ Cleveland</b>	<b>Employment Connection - Downtown</b> 1020 Bolivar Rd., Cleveland, OH 44115 (216) 664-4673
<b>Darke</b>	<b>The Job Center Network of Darke County</b> 603 Wagner Ave., Greenville, OH 45331 (937) 548-4132
<b>Defiance</b>	<b>Northwest Ohio Job Center</b> 1300 E. Second St., Suite 202, Defiance, OH 43512 (419) 784-3777
<b>Delaware</b>	<b>Delaware Job Link</b> Delaware County Area Career Center, 4565 Columbus Pike, Delaware, OH 43015 (740) 548-6665
<b>Delaware</b>	<b>Delaware Job Network</b> Hayes Adiminstriation Building, 140 N. Sandusky St., Delaware, OH 43015 (740) 833-2300
<b>Erie</b>	<b>Your Job Store</b> 5500 Milan Road, Sandusky, OH 44870 (419) 624-6451
<b>Fairfield</b>	<b>WorkNet (JOBS One-Stop)</b> 239 W. Main St., Lancaster, OH 43130 (740) 689-2494
<b>Fayette</b>	<b>FayetteWorks</b> 1270 U.S. Route 62, S.W., Washington CH, OH 43160 (740) 333-5115 Ext. 5720
<b>Franklin</b>	<b>JOBLeaders</b> 1111 E. Broad St., Columbus, OH 43205 (614) 559-5052
<b>Fulton</b>	<b>Northwest Ohio Job Center</b> 604 S. Shoop Ave., Suite 110, Wauseon, OH 43567 (419) 337-9215
<b>Gallia</b>	<b>Gallia County Work Opportunity Center</b> 848 Third Avenue, Gallipolis, OH 45631 (740) 446-3222
<b>Geauga</b>	<b>Workplace</b> 12480 Ravenwood Dr., Chardon, OH 44024 (440) 285-9141

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**Workforce Investment Act (WIA) - Certified Ohio One-Stop Centers by County**

<b>Greene</b>	<b>GreeneWorks Employment and Training</b> 581 Ledbetter Rd., Xenia, OH 45385 (937) 562-6565
<b>Guernsey</b>	<b>Guernsey County Opportunity Center</b> 9900 Brick Church Rd., Cambridge, OH 43725 (740) 432-9317
<b>Hamilton</b>	<b>SuperJobs Center</b> 1916 Central Parkway, Cincinnati, OH 45214 (513) 731-9800
<b>Hancock</b>	<b>JOBSolutions of Hancock County</b> 7746 Hancock County Road 140, Findlay, OH 45839 (419) 422-3679
<b>Hardin</b>	<b>One Stop Employment &amp; Training Network - Hardin County</b> 1021 W. Lima St., Suite 103, Kenton, OH 43326 (419) 674-2312
<b>Harrison</b>	<b>Harrison County Connections</b> 520 N. Main St., Cadiz, OH 43907 (740) 942-2171
<b>Henry</b>	<b>Northwest Ohio Job Center of Henry County</b> 104 E. Washington St., Room 201, 203-215, P.O. Box 527, Napoleon, OH 43545 (419) 592-3862
<b>Highland</b>	<b>The Employment Center</b> 1575 N. High St., Hillsboro, OH 45133 (937) 393-1933
<b>Hocking</b>	<b>Hocking County Job Services Center</b> 389 W. Front St., Logan, OH 43138 (740) 380-1545
<b>Holmes</b>	<b>Employment and Training Connection</b> 85 N. Grant St., Millersburg, OH 44654 (330) 674-1111
<b>Huron</b>	<b>The Job Store</b> 185 Shady Lane Dr., Norwalk, OH 44857 (419) 668-8126, Ext. 3335
<b>Jackson</b>	<b>Jackson County One Stop Training and Technology Center</b> 25 E. South St., Jackson, OH 45640 (740) 286-4181
<b>Jefferson</b>	<b>Jefferson County Connections</b> 114 N. Fourth St., Steubenville, OH 43952 (740) 282-0971
<b>Knox</b>	<b>Opportunity Knox Employment Center</b> 17604 Coshocton Rd., Mount Vernon, OH 43050 (740) 392-9675
<b>Lake</b>	<b>Lake1Stop</b> 177 Main Street, Painesville, OH 44077 (440) 350-4000
<b>Lawrence</b>	<b>Workforce Development Resource Center</b> 120 N. 3rd St., Ironton, OH 45638 (740) 532-3140

## Workforce Investment Act (WIA) - Certified Ohio One-Stop Centers by County

<b>Licking</b>	<b>Opportunity Links</b> 998 E. Main St., Newark, OH 43055 (740) 670-8700
<b>Logan</b>	<b>WorkPlus of Logan County</b> 211 E. Columbus Ave., Bellefontaine, OH 43311 (937) 599-5165
<b>Lorain</b>	<b>The Employment netWork</b> 42495 North Ridge Rd., Elyria, OH 44035 (440) 324-5244
<b>Lucas</b>	<b>The Source Northwest Ohio</b> 1301 Monroe St., Toledo, OH 43604 (419) 213-5627
<b>Madison</b>	<b>MadisonWorks!</b> 200 Midway St., London, OH 43140 (740) 852-8801
<b>Mahoning</b>	<b>Mahoning County One-Stop</b> 149 Boardman-Canfield Rd., Boardman, OH 44512 (330) 965-1787
<b>Marion</b>	<b>Marion Connections Workforce Development Center</b> 622 Leader St., Marion, OH 43302 (740) 382-0076
<b>Medina</b>	<b>MedinaWorks</b> 3721 Pearl Rd., Medina, OH 44256 (330) 723-9675
<b>Meigs</b>	<b>Meigs County One-Stop Employment and Training Center</b> 175 Race St., Box 191, Middleport, OH 45760 (740) 992-2117
<b>Mercer</b>	<b>One Stop Employment &amp; Training Network - Mercer County</b> 220 Livingston St., B272 , Celina, OH 45822 (419) 586-6409
<b>Miami</b>	<b>The Job Center Network of Miami County</b> 2040 N. County Road 25A, Troy, OH 45373 (937) 440-3465
<b>Monroe</b>	<b>Jobs etc. - Your One Stop Employment Training Center</b> 100 Home Ave., Woodsfield, OH 43793 (740) 472-1602
<b>Montgomery</b>	<b>The Job Center</b> 1111 S. Edwin C. Moses Blvd., Dayton, OH 45408 (937) 225-5627
<b>Morgan</b>	<b>Jobs etc. - Your One Stop Employment Training Center</b> 155 E. Main St., Third Floor, McConnellsville, OH 43756 (740) 962-2519
<b>Morrow</b>	<b>Morrow County Job Training Office</b> 619 W. Marion Rd., Mt. Gilead, OH 43338 (419) 946-8480
<b>Muskingum</b>	<b>Muskingum County Opportunity Center</b> 503 Main St., Zanesville, OH 43701 (740) 454-6211

**Workforce Investment Act (WIA) - Certified Ohio One-Stop Centers by County**

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<b>Noble</b>	<b>Jobs etc. - Your One Stop Employment Training Center</b> 18065 State Route 78, P.O. Box 250, Caldwell, OH 43724 (740) 732-2392
<b>Ottawa</b>	<b>Ottawa County - The Job Store</b> 8043 W. State Route 163, Suite 200, Oak Harbor, OH 43449 (419) 898-3688, Ext. 270
<b>Paulding</b>	<b>ACCENT Paulding County Job Center</b> 250 Dooley Dr., Suite B, Paulding, OH 45879 (419) 399-3345
<b>Perry</b>	<b>Perry Co. One Stop</b> 212 S. Main St., P.O. Box 311, New Lexington, OH 43764 (740) 342-3551
<b>Pickaway</b>	<b>Jobs One-Stop</b> 160 Island Rd., Circleville, OH 43113 (740) 420-7339
<b>Pike</b>	<b>Workforce Connections of Pike County</b> 941 Market St., P.O. Box 799, Piketon, OH 45661 (740) 289-2371
<b>Portage</b>	<b>Portage Workforce Connection</b> 1081 W. Main St., Ravenna, OH 44266 (330) 296-2841
<b>Preble</b>	<b>The Job Center Network of Preble County</b> 1500 Park Ave., Eaton, OH 45320 (937) 456-6224
<b>Putnam</b>	<b>Putnam County ACCENT</b> 1225 E. Third St., Ottawa, OH 45875 (419) 523-4580
<b>Richland</b>	<b>Richland County OneStop Employment &amp; Training Center</b> 183 Park Ave. East, P.O. Box 188, Mansfield, OH 44901-0188 (419) 774-5300
<b>Ross</b>	<b>JOBS One-Stop</b> 150 E. Second St., P.O. Box 469, Chillicothe, OH 45601 (740) 779-2946
<b>Sandusky</b>	<b>The Job Store</b> 2511 Countryside Dr., Fremont, OH 43420 (419) 332-2169
<b>Scioto</b>	<b>Workforce Connections of Scioto County</b> 433 Third St., P.O. Box 1525, Portsmouth, OH 45662 (740) 354-4531
<b>Seneca</b>	<b>Seneca One-Stop Career and Resource Center</b> 3362 S. Twp. Road 151, Tiffin, OH 44883 (419) 447-5011 Ext. 443
<b>Shelby</b>	<b>The Job Center of Shelby County</b> 227 S. Ohio Avenue, Sidney, OH 45365 (937) 498-4981
<b>Stark</b>	<b>The Employment Source</b> 822 30th St., N.W., Canton, OH 44709 (330) 433-9675

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**Workforce Investment Act (WIA) - Certified Ohio One-Stop Centers by County**

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<b>Summit</b>	<b>The Job Center</b> 1040 E. Tallmadge Ave., Akron, OH 44310 (330) 633-1050
<b>Trumbull</b>	<b>Trumbull County One-Stop</b> 280 N. Park Ave., Suite 1, Warren, OH 44481 (330) 675-2179
<b>Tuscarawas</b>	<b>The Employment Source</b> 1260 Monroe St., Suite 35, New Philadelphia, OH 44663 (330) 364-9777
<b>Union</b>	<b>Employment Resource Center of Union County</b> 940 London Avenue, Suite 1500, Marysville, OH 43040 (937) 645-2018
<b>Van Wert</b>	<b>One Stop Employment &amp; Training Network - Van Wert County</b> 114 E. Main St., P.O. Box 595, Van Wert, OH 45891 (419) 238-4931
<b>Vinton</b>	<b>Vinton County Job and Family Services</b> 30975 Industrial Park Rd., McArthur, OH 45651 (740) 596-2584
<b>Warren</b>	<b>Workforce One of Warren County</b> 300 E. Silver St., Lebanon, OH 45036 (513) 695-1130
<b>Washington</b>	<b>Jobs etc. - Your One Stop Employment Training Center</b> 218 Putnam St., Marietta, OH 45750 (740) 373-3745
<b>Wayne</b>	<b>Employment and Training Connection</b> 358 W. North St., Wooster, OH 44691 (330) 264-5060
<b>Williams</b>	<b>Northwest Ohio Job Center of Williams County</b> 228 S. Main St., Bryan, OH 43506 (419) 636-0338
<b>Wood</b>	<b>JOBSolutions: Wood County Employment Resource Center</b> 1928 E. Gypsy Ln., P.O. Box 679, Bowling Green, OH 43402 (419) 352-4172
<b>Wyandot</b>	<b>JOBSolutions - Wyandot County Job &amp; Training Center</b> 120 E. Johnson St., Upper Sandusky, OH 43351 (419) 294-4977

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Ohio Rehabilitation Services Commission

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County	BVR	BSVI
ADAMS	<a href="#">Cincinnati East</a>	<a href="#">Cincinnati Centennial</a>
ALLEN	<a href="#">Lima</a>	<a href="#">Lima,Dayton</a>
ASHLAND	<a href="#">Mansfield</a>	<a href="#">Mansfield</a>
ASHTABULA	<a href="#">Ashtabula</a>	<a href="#">Youngstown</a>
ATHENS	<a href="#">Athens</a>	<a href="#">Athens</a>
AUGLAIZE	<a href="#">Lima</a>	<a href="#">Dayton</a>
BELMONT	<a href="#">St. Clairsville</a>	<a href="#">Canton</a>
BROWN	<a href="#">Cincinnati East</a>	<a href="#">Cincinnati Centennial</a>
BUTLER	<a href="#">Butler County</a>	<a href="#">Cincinnati Centennial</a>
CARROLL	<a href="#">St. Clairsville</a>	<a href="#">Canton</a>
CHAMPAIGN	<a href="#">Springfield</a>	<a href="#">Dayton</a>
CLARK	<a href="#">Springfield</a>	<a href="#">Dayton</a>
CLERMONT	<a href="#">Cincinnati East</a>	<a href="#">Cincinnati Centennial</a>
CLINTON	<a href="#">Cincinnati East</a>	<a href="#">Cincinnati Centennial</a>
COLUMBIANA	<a href="#">Trumbull/Columbiana</a>	<a href="#">Youngstown</a>
COSHOCTON	<a href="#">Zanesville</a>	<a href="#">Zanesville</a>
CRAWFORD	<a href="#">Tiffin</a>	<a href="#">Tiffin</a>
CUYAHOGA	<a href="#">Cleveland Metro</a>	<a href="#">Cleveland Metro</a>
DARKE	<a href="#">Dayton</a>	<a href="#">Dayton</a>
DEFIANCE	<a href="#">Defiance</a>	<a href="#">Defiance</a>
DELAWARE	<a href="#">Columbus Metro</a>	<a href="#">Columbus</a>
ERIE	<a href="#">Sandusky</a>	<a href="#">Tiffin</a>
<a href="#">Return to Top</a>		
FAIRFIELD	<a href="#">Columbus Metro</a>	<a href="#">Athens</a>
FAYETTE	<a href="#">Dayton</a>	<a href="#">Cincinnati Centennial</a>
FRANKLIN	<a href="#">Columbus Metro</a>	<a href="#">Columbus Metro</a>
FULTON	<a href="#">Defiance</a>	<a href="#">Defiance</a>
GALLIA	<a href="#">Portsmouth</a>	<a href="#">Portsmouth</a>
GEAUGA	<a href="#">Painesville</a>	<a href="#">Cleveland Area</a>
GREEN	<a href="#">Springfield</a>	<a href="#">Dayton</a>
GUERNSEY	<a href="#">St. Clairsville</a>	<a href="#">Zanesville</a>
HAMILTON	<a href="#">Cincinnati Centennial</a>	<a href="#">Cincinnati Centennial</a>
HANCOCK	<a href="#">Tiffin</a>	<a href="#">Lima</a>
HARDIN	<a href="#">Lima</a>	<a href="#">Lima,Dayton</a>

<b>HARRISON</b>	<b><u>Stuebenville</u></b>	<b><u>Canton</u></b>
<b>HENRY</b>	<b><u>Defiance</u></b>	<b><u>Defiance</u></b>
<b>HIGHLAND</b>	<b><u>Cincinnati East</u></b>	<b><u>Cincinnati Centennial</u></b>
<b>HOCKING</b>	<b><u>Athens</u></b>	<b><u>Athens</u></b>
<b>HOLMES</b>	<b><u>Wooster</u></b>	<b><u>Canton</u></b>
<b>HURON</b>	<b><u>Sandusky</u></b>	<b><u>Tiffin</u></b>
<b>JACKSON</b>	<b><u>Athens</u></b>	<b><u>Portsmouth</u></b>
<b>JEFFERSON</b>	<b><u>St. Clairsville</u></b>	<b><u>Canton</u></b>
<b>KNOX</b>	<b><u>Mansfield</u></b>	<b><u>Mansfield</u></b>
<b>LAKE</b>	<b><u>Painesville One Stop</u></b>	<b><u>Cleveland Area</u></b>
<b>LAWRENCE</b>	<b><u>Portsmouth</u></b>	<b><u>Portsmouth</u></b>
<b><u>Return to Top</u></b>		
<b>LICKING</b>	<b><u>Columbus Metro</u></b>	<b><u>Zanesville</u></b>
<b>LOGAN</b>	<b><u>Springfield</u></b>	<b><u>Lima,Dayton</u></b>
<b>LORAIN</b>	<b><u>Lorain</u></b>	<b><u>Mansfield</u></b>
<b>LUCAS</b>	<b><u>Toledo</u></b>	<b><u>Toledo</u></b>
<b>MADISON</b>	<b><u>Springfield</u></b>	<b><u>Dayton</u></b>
<b>MAHONING</b>	<b><u>Youngstown</u></b>	<b><u>Youngstown</u></b>
<b>MARION</b>	<b><u>Tiffin</u></b>	<b><u>Lima</u></b>
<b>MEDINA</b>	<b><u>Akron/Portage-Medina</u></b>	<b><u>Akron</u></b>
<b>MEIGS</b>	<b><u>Athens</u></b>	<b><u>Athens</u></b>
<b>MERCER</b>	<b><u>Lima</u></b>	<b><u>Lima,Dayton</u></b>
<b>MIAMI</b>	<b><u>Dayton</u></b>	<b><u>Dayton</u></b>
<b>MONROE</b>	<b><u>St. Clairsville</u></b>	<b><u>Athens</u></b>
<b>MONTGOMERY</b>	<b><u>Dayton</u></b>	<b><u>Dayton</u></b>
<b>MORGAN</b>	<b><u>Zanesville</u></b>	<b><u>Athens</u></b>
<b>MORROW</b>	<b><u>Mansfield</u></b>	<b><u>Mansfield</u></b>
<b>MUSKINGUM</b>	<b><u>Zanesville</u></b>	<b><u>Zanesville</u></b>
<b>NOBLE</b>	<b><u>Athens</u></b>	<b><u>Athens</u></b>
<b>OTTAWA</b>	<b><u>Sandusky</u></b>	<b><u>Toledo</u></b>
<b>PAULDING</b>	<b><u>Defiance</u></b>	<b><u>Defiance</u></b>
<b>PERRY</b>	<b><u>Zanesville</u></b>	<b><u>Zanesville</u></b>
<b>PICKAWAY</b>	<b><u>Columbus</u></b>	<b><u>Columbus</u></b>
<b>PIKE</b>	<b><u>Portsmouth</u></b>	<b><u>Portsmouth</u></b>
<b><u>Return to Top</u></b>		
<b>PORTAGE</b>	<b><u>Akron/Portage-Medina</u></b>	<b><u>Akron</u></b>
<b>PREBLE</b>	<b><u>Butler County</u></b>	<b><u>Dayton</u></b>
<b>PUTNAM</b>	<b><u>Defiance</u></b>	<b><u>Defiance</u></b>
<b>RICHLAND</b>	<b><u>Mansfield</u></b>	<b><u>Mansfield</u></b>
<b>ROSS</b>	<b><u>Columbus Metro</u></b>	<b><u>Portsmouth</u></b>
<b>SANDUSKY</b>	<b><u>Sandusky</u></b>	<b><u>Toledo</u></b>
<b>SCIOTO</b>	<b><u>Portsmouth</u></b>	<b><u>Portsmouth</u></b>
<b>SENECA</b>	<b><u>Tiffin</u></b>	<b><u>Tiffin</u></b>
<b>SHELBY</b>	<b><u>Lima, Dayton (8/1/09)</u></b>	<b><u>Dayton</u></b>
<b>STARK</b>	<b><u>Canton</u></b>	<b><u>Canton</u></b>
<b>SUMMIT</b>	<b><u>Akron/Portage-Medina</u></b>	<b><u>Akron</u></b>

<b>TRUMBULL</b>	<b>Trumbull/Columbiana</b>	<b>Youngstown</b>
<b>TUSCARAWAS</b>	<b>Dover</b>	<b>Canton</b>
<b>UNION</b>	<b>Cincinnati Centennial Springfield (8/1/09)</b>	<b>Lima,Dayton</b>
<b>VAN WERT</b>	<b>Defiance</b>	<b>Lima,Dayton</b>
<b>VINTON</b>	<b>Athens</b>	<b>Athens</b>
<b>WARREN</b>	<b>Butler County</b>	<b>Cincinnati Centennial</b>
<b>WASHINGTON</b>	<b>Athens</b>	<b>Athens</b>
<b>WAYNE</b>	<b>Wooster</b>	<b>Canton</b>
<b>WILLIAMS</b>	<b>Defiance</b>	<b>Defiance</b>
<b>WOOD</b>	<b>Toledo</b>	<b>Toledo</b>
<b>WYANDOT</b>	<b>Tiffin</b>	<b>Tiffin</b>

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**North**

**Administrative Offices**

<b>BSVI Area Manager: Jay Scerbak</b>	(216) FAX (216) Toll-free (866)
<b>North Area Office</b> 14650 Detroit Ave., Suite 300 Lakewood, OH 44107-4210	
<b>BVR Area Manager: Ann Okuley</b>	(419) FAX (419) Toll-free (800)
5241 Southwyck Blvd., Suite 300 Toledo, OH 43614-1586	

**Field Offices**

<b>Akron BSVI / BVR -Portage - Medina</b>	(330) TTY (330) FAX (330) Toll-free (800)
161 S. High St., Suite 103 Akron, OH 44308-1615	
<b>Ashtabula One Stop</b>	Voice/TTY (440) FAX (440) Toll-free (800)
2247 Lake Ave. Ashtabula, OH 44004-3437	
<b>Cleveland East BVR</b>	Voice (216) TTY (216) FAX (216) Toll-free (800)
27900 Euclid Ave. 1st Floor Cleveland, OH 44132-3520	
<b>Cleveland Metro BVR / BSVI</b>	(216) TTY (216) FAX (216) Toll-free (800)
113 St. Clair Ave., Suite 600 Cleveland, OH 44114-1502	
<a href="#">Return to Top</a>	
<b>Cleveland One-Stop</b>	(216) TTY (216) FAX (216)
11699 Brookpark Rd. Cleveland, OH 44130-1135	
<b>Cleveland West BVR</b>	(216) TTY (216) FAX (216) Toll-free (866)
14650 Detroit Ave., Ste. 300 Lakewood, OH 44107-2160	
<b>Painesville BVR</b>	(440) TTY (440) FAX (440) Toll-free (800)
1640 W. Jackson St., Painesville, OH 44077-1312	

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<p><b>Trumbull / Columbiana BVR</b>                  4076 Youngstown-Warren Rd., Suite 202                  Warren, OH 44484</p>	<p>Voice/TTY (330)                  FAX (330)                  Toll-free (800)</p>
<p><b>Youngstown BSVI/BVR</b>                  242 Federal Plaza W., Suite 403                  Youngstown, OH 44503-1210</p>	<p>(330)                  TTY (330)                  FAX (330)                  Toll-free (800)</p>
<p><b>Defiance BVR/BSVI</b>                  101 Clinton St., Suite 1100                  Defiance, OH 43512-2165</p>	<p>(419)                  TTY (419)                  FAX (419)                  Toll-free (800)</p>
<p><b>Lorain BVR</b>                  2173 N. Ridge Rd. E., Suite E                  Lorain, OH 44055-3412</p>	<p>Voice/TTY (440)                  FAX (440)                  Toll-free (800)</p>
<p><b>Mansfield BSVI</b>                  2281 Village Mall Dr., Suite A                  Mansfield, OH 44906-1159</p>	<p>Voice/TTY (419)                  FAX (419)                  Toll-free (800)</p>
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<p><b>Tiffin BVR/BSVI</b>                  2550 S. State Route 100                  Tiffin, OH 44883-9709</p>	<p>Voice/TTY (419)                  FAX (419)                  Toll-free (800)</p>
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<b>Administrative Offices</b>	
<p><b>BSVI Manager: Sharon Schmidt</b>  <b>BVR Manager: Rose Reed</b></p> <p><b>Southeast Area Office</b>                  2200 West 5th Avenue, 1st floor                  Columbus, OH 43215-1047</p>	<p>(614)                  TTY (614)                  FAX (614)                  Toll-free (800)</p>
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<p><b>Canton BVR/BSVI</b>  <b>Business Enterprise Program</b>                  401 Market Ave. N., Suite 200                  Canton, OH 44702-1543</p>	<p>(330)                  (BE) (330)                  TTY (330)                  FAX (330)                  Toll-free (800)</p>
<p><b>Columbus Central BVR/BSVI</b></p>	<p>BSVI (614)</p>

<p><b>Business Enterprise Program</b></p> <p>2200 West 5th Avenue, 1st floor Columbus, OH 43215-1047</p>	<p>BVR (614) (</p> <p>TTY (614)</p> <p>FAX (614)</p> <p>Toll-free (800)</p> <p>(BE) (614)</p> <p>BEP Toll-free (800) (</p>
<p><b>Columbus Metro BVR</b> <b>Columbus Tri-County BVR</b></p> <p>899 E. Broad St., Suite 200 Columbus, OH 43205-1191</p>	<p>(614)</p> <p>TTY (614)</p> <p>FAX (614)</p> <p>Toll-free (800)</p>
<p><b>Columbus South/Deaf BVR</b></p> <p>899 E. Broad St., Suite 201/202 Columbus, OH 43205-1191</p> <p><b>Return to Top</b></p>	<p>(614)</p> <p>TTY (614)</p> <p>FAX (614)</p> <p>Toll-free (800)</p>
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<p><b>Portsmouth BSVI</b></p> <p>4304-B Old Scioto Trail Portsmouth, OH 45662-6642</p>	<p>Voice/TTY (740)</p> <p>FAX (740)</p> <p>Toll-free (800)</p>
<p><b>Portsmouth BVR</b></p> <p>4304 Old Scioto Trail Portsmouth, OH 45662-6642</p>	<p>(740)</p> <p>TTY (740)</p> <p>FAX (740)</p> <p>Toll-free (800)</p>
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<p><b>BSVI Manager: Paula Shew</b> <b>BVR Manager: Mark Fay</b></p> <p><b>Southwest Area Office</b></p> <p>8050 Beckett Center Dr., Suite 216 West Chester, OH 45069-5001</p>	<p>Voice/TTY (513)</p> <p>FAX (513)</p> <p>Toll-free (800)</p>
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ARTICLE

**An Update on  
Randomized Controlled Trials  
of Evidence-Based  
Supported Employment**

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**Background:** *The Individual Placement and Support (IPS) model of supported employment for clients with severe mental illness has been described as a standardization of evidence-based supported employment. Although several reviews on the literature on its effectiveness have been conducted, the completion of several new studies suggests an updated review is warranted.*

**Methods:** *We conducted a comprehensive literature search for randomized controlled trials of IPS, limiting our review to programs with high-fidelity IPS programs, locating 11 studies. We examined the following competitive employment outcomes: employment rates, days to first job, annualized weeks worked, and job tenure in longest job held during the follow-up period.*

**Findings:** *Across the 11 studies, the competitive employment rate was 61% for IPS compared to 23% for controls. About two-thirds of those who obtained competitive employment worked 20 hours or more per week. Among those who obtained a competitive job, IPS participants obtained their first job nearly 10 weeks earlier than did controls. Among IPS participants who obtained competitive work, duration of employment after the start of the first job averaged 24.2 weeks per year, or 47% of the 52-week year.*

**Conclusions:** *The current review is consistent with earlier reviews, although the evidence for high-fidelity IPS appears to be somewhat stronger than reviews evaluating studies with more heterogeneity in the supported employment models examined. The number, consistency, and effect sizes of studies of evidence-based supported employment establish it as one of the most robust interventions available for persons with severe mental illness.*

**Keywords:** *supported employment, employment, evidence-based practices, randomized controlled trials*

## Introduction

The Individual Placement and Support (IPS) model of supported employment for clients with severe mental illness has been described as a standardization of evidence-based supported employment (Bond et al., 2001). It has been so described because it has been the best-described (Becker & Drake, 2003) and most extensively researched model of supported employment for this population. The core principles of this model are (1) a focus on competitive employment, (2) eligibility based on consumer choice, (3) rapid job search, (4) integration of mental health and employment services, (5) attention to consumer preference in the job search, (6) individualized job supports and (7) personalized benefits counseling (Bond, 2004).

Starting in the late 1990s, the literature on supported employment for individuals with severe mental illness has been reviewed on numerous occasions (Bond, 2004; Bond et al., 2001; Bond, Drake, Mueser, & Becker, 1997; Burns et al., 2007; Crowther, Marshall, Bond, & Huxley, 2001; Twamley, Jeste, & Lehman, 2003). The evidence from randomized controlled trials (RCTs) continues to accumulate quickly, and reviews from only a couple years ago are already obsolete. The purpose of the current review is to provide a comprehensive summary of competitive employment outcomes for RCTs evaluating evidence-based supported employment for this population. A second difference from earlier reviews is that we restricted our review to evaluations of programs with documented adherence to the aforementioned IPS principles. Our rationale was based on the literature suggesting that fidelity to IPS is associated with better competitive employment outcomes (Becker, Smith, Tanzman, Drake, & Tremblay, 2001; Becker, Xie, McHugo, Halliday, &

Martinez, 2006; Gowdy, Carlson, & Rapp, 2003; McGrew & Griss, 2005; McGrew, 2007).

## Methods

### Study Inclusion Criteria

To be included in this review, a study was required to be a randomized controlled trial design examining longitudinal competitive employment outcomes for individuals with severe mental illness in which participants were randomly assigned to two or more conditions, one of which used a high-fidelity IPS supported employment model. IPS has been well described in the literature (Becker & Drake, 2003), and a psychometrically validated fidelity scale has been developed to determine which programs achieve high fidelity (Bond, Becker, Drake, & Vogler, 1997). A further requirement for inclusion in the review was that the control group or groups must have received either services as usual or some other form of vocational rehabilitation besides IPS.

### Literature Search Strategies

Three main sources were used to identify studies. The first was to draw on published literature reviews (Bond, 2004; Bond et al., 2001; Crowther et al., 2001; Twamley et al., 2003). The second was to examine each of the studies in the Employment Intervention Demonstration Project (EIDP) (Cook et al., 2005). The third was through contacting principal investigators and continuous review of the published literature.

### Sample

The 11 studies included in the current review are shown in Table 1, sequenced according to date of publication or dissemination. Ten studies have been published in peer-reviewed journals, one is in press (Killackey, Jackson, & McGorry, in press). One study aimed at young

adults with schizophrenia comparing IPS to services as usual was not included because the results have not yet been reported (Nuechterlein et al., 2005; Nuechterlein, Subotnik, Turner, Ventura, Becker, & Drake, this issue).

Ten of the 11 studies used a 2-group design (IPS versus control); the Connecticut study compared IPS to 2 control groups (Mueser et al., 2004). The number of IPS sites ranged from one in 8 studies, two in 2 studies (Bond et al., 2007; Drake, McHugo, Becker, Anthony, & Clark, 1996), and six in 1 study (Burns et al., 2007). In terms of control groups, two studies used nonintegrated supported employment control groups (Drake et al., 1996; Mueser et al., 2004). Otherwise, all of the control groups consisted of either treatment as usual (typically referral to the state vocational system or equivalent) or alternative vocational models. In every study, the high fidelity to IPS was ensured through systematic monitoring using the IPS Fidelity Scale (Bond, Becker et al., 1997). Many other details of the study protocols, including sample inclusion criteria and measurement batteries, were the same or similar across studies. In all the studies, participants were adults who met each state's or province's criteria for severe mental illness, typically a *Diagnostic and Statistical Manual of Mental Disorders—4th Edition* (American Psychiatric Association, 1994) Axis I or II diagnosis plus severe and persistent impairment in psychosocial functioning. In most studies, participants were recruited from mental health centers. In all the studies, participants were unemployed at the time of study admission. In all but one study, the study inclusion criteria included an expressed desire to work; the single exception was the Maryland study (Lehman et al., 2002). Another eligibility criterion common across most studies was the absence of signif-

**TABLE 1—RANDOMIZED CONTROLLED TRIALS OF INDIVIDUAL PLACEMENT AND SUPPORT FOR INDIVIDUALS WITH SEVERE MENTAL ILLNESS**

Study	Control Condition	Study Population & Salient Eligibility Criteria	Study Site Location	Months of Follow-up	Label
Drake et al. (1996)	Skills training, nonintegrated	CMHC clients	NH	18	96 NH
Drake et al. (1999)	Sheltered workshop	Case management program clients	DC	18	99 DC
Lehman et al. (2002)	PSR	CMHC clients, including those without voc goals	MD	24	02 MD
Mueser et al. (2004)	(1) Brokered SE; (2) PSR	CMHC clients	CT	24	04 CT
Gold et al. (2006)	Sheltered workshop	CMHC clients	SC	24	06 SC
Latimer et al. (2006)	Traditional vocational services	Clients receiving mental health services	Québec Canada	12	06 QUE
Burns et al. (2007)	Traditional vocational services	Clients receiving mental health services	6 European cities	18	07 EUR
Bond et al. (2007)	Diversified placement approach	New admissions to PSR agency	IL	24	07 IL
Wong et al. (2008)	Stepwise conventional vocational services	Outpatients at hospital occupational therapy program	HK	18	08 HK
Twamley et al. (2008)	VR referral	Middle aged and older adult	CA	12	08 CA
Killackey et al. (in press)	Traditional vocational services	Early psychosis program	Melbourne Australia	6	08 AUST

**Acronyms:** SE = supported employment; IPS = Individual Placement and Support; ACT = assertive community treatment; PSR = psychosocial rehabilitation; VR = State-federal vocational rehabilitation system; CMHC = community mental health center; ICCD = International Center for Clubhouse Development

**Note:** Two control groups in the Mueser et al. (2004) study combined into a single control group in the tables and figure to follow.

icant medical conditions that would preclude working or participating in assessment interviews. In many of the IPS studies, participants were required to attend multiple research information meetings in which the project was explained and gave informed consent to participate in the study.

#### Excluded Randomized Controlled Trials

Excluded RCTs fall into 3 categories: RCTs evaluating supported employment prior to the development of the IPS model; recent supported employ-

ment RCTs evaluating a different model than IPS or a program for which fidelity of IPS is uncertain; and RCTs comparing an enhanced form of IPS with IPS without an enhancement.

Five "pre-IPS" RCTs were found. In every case they evaluated a supported employment model falling short on one or several IPS criteria. Four of these (Bond, Dietzen, McGrew, & Miller, 1995; Chandler, Meisel, Hu, McGowen, & Madison, 1997; Gervy & Bedell, 1994; McFarlane et al., 2000) have been re-

viewed in earlier reviews (Bond, 2004; Bond et al., 2001). One comparing the Program of Assertive Community Treatment (PACT) to usual services has never been published (Test, 1992; Test, Allness, & Knoedler, 1995).

The second category consists of 4 recent RCTs that either have evaluated a different model of supported employment (Macias et al., 2006; Rogers, Anthony, Lyass, & Penk, 2006) or an approach in which the fidelity to the IPS model was unknown or uncertain (Shafer, 2005;

Tsang, 2006). The specifics of these 4 studies are as follows:

The Massachusetts EIDP study findings are reported in two papers (Macias et al., 2006; Schonebaum, Boyd, & Dudek, 2006). The former paper uses the standardized definition of competitive employment and limits the analysis to participants enrolling in the study with an avowed interest in working. The latter paper uses the full randomized sample with an expanded definition of competitive employment. The reported experimental differences given in two papers are fairly similar. This study evaluated a new established PACT team in which a supported employment position was created. Although in many respects adhering to IPS principles, the role description for the supported employment position followed the PACT model in which the employment specialist has significant clinical duties, which compromises model effectiveness.

Although the “choose-get-keep” model developed by Anthony and his colleagues (Danley & Anthony, 1987) was originally viewed as a kind of supported employment model, in a recently reported randomized controlled trial of this model (Rogers et al., 2006), the authors label their approach “psychiatric vocational rehabilitation.” The choose-get-keep model differs in important respects from the IPS model, centering on its emphasis on prevocational career planning.

The Shafer EIDP study, which has not been published, compared a supported employment approach to services as usual (Shafer, 2005). The investigators did not specifically monitor their services to achieve high fidelity to IPS. We have been unable to obtain a final report of the study.

The study conducted by Tsang et al. (2006) had two experimental conditions: one was IPS only and the second was IPS plus skills training. These two experi-

mental conditions were compared to a treatment-as-usual control group.

Although the authors state that they implemented IPS with high fidelity, the critical ingredients of the model were not followed. In addition, the findings from this study are not usable in the current review, because their employment outcome measures combined competitive employment and what the report labels “partially competitive employment.”

The third category of excluded studies consists of RCTs comparing IPS to an enhancement of IPS. Two studies from the EIDP (Maine and Texas studies) compared supported employment to an enhanced form of supported employment and would be excluded for this reason (although in neither study did the investigators closely adhere to the IPS model, so they would be excluded for that reason as well). Since the completion of the EIDP, there have been a growing number of studies comparing supported employment to supported employment plus an enhancement. Enhancements have included both skills training (Mueser et al., 2005; Wallace & Tauber, 2004) and cognitive training strategies (Bell, Greig, Zito, & Wexler, 2007; McGurk, Mueser, & Pascaris, 2005). While these studies are answering important questions about supported employment, they lie outside the scope of the current review, which compares supported employment to other vocational approaches.

### Outcome Measures

This review focuses exclusively on competitive employment outcomes, defined as jobs paying at least minimum wage in integrated community settings (i.e., employing nondisabled workers) and are jobs that anyone could hold, not just individuals with disabilities. By this definition, protected jobs, such as transitional employment (Propst, 1992), sheltered employment, and

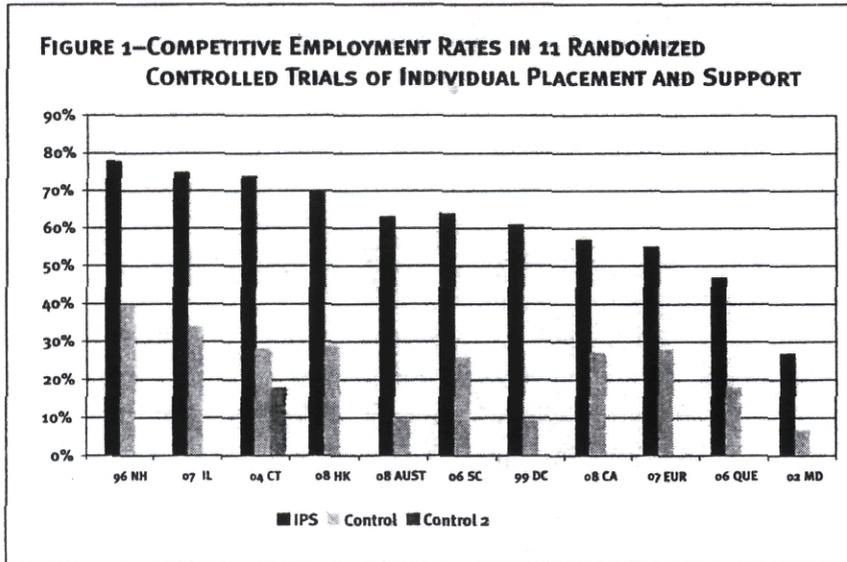
other set-aside jobs (Black, 1988) were excluded.

All studies reported competitive employment rates, defined as working a competitive job at any time during follow-up. Several other competitive employment outcome measures were also examined. When reported, we compiled the following outcomes: days to first job (i.e., time from study entry to first job start), annualized weeks worked (that is, number of weeks worked per year; dividing total weeks worked by 1.5 for studies with 18-month follow-up and dividing total weeks work by 2.0 for studies with 2-year follow-up), and job tenure (i.e., weeks worked) in longest job held during the follow-up period. (Job tenure is measured from job start date. The end date is determined from either job ending date or end of follow-up, whichever comes first.) As seen below, information was not available on these variables for all 11 IPS studies.

For the two measures of duration of employment—weeks worked per year and job tenure, we calculated the findings for both the full intent-to-treat sample (everyone enrolled in the study) and the worker sample only (those who obtained at least one competitive job during follow-up). We calculated weeks worked in a third way as well: weeks worked after obtaining first competitive job. Each of these methods for estimating duration of employment assesses it in a different way.

### Data Analyses

Data were either recorded directly from published reports or hand calculated from information presented in these reports. As noted above, the Connecticut study was the only study included with two control groups (Mueser et al., 2004). Campbell (2007) examined effect sizes for the differences on 3 competitive employment outcomes between the two control groups in this



study and found the effect sizes for the differences to be small. Based on these findings, we collapsed the outcomes for the two Connecticut control groups into a single control group for all employment outcomes.

Effect size for each study for the difference in employment rate between supported employment and controls was calculated using the arc sine approximation (Lipsey, 1990). An unweighted overall effect size was calculated as the simple mean of the individual effect sizes. For all other outcome measures, means are reported without standard deviations, which are not available from the published studies. Overall means were calculated weighting individual means by sample sizes.

Effect sizes were also estimated for published review articles using arc sine method on overall percentage working. It should be noted that this method of estimation gives slightly different estimates than the unweighted overall effect size method described above.

**Results**

*Competitive employment rates.* In all 11 studies, the competitive employment rate was significantly higher for the IPS condition than for controls, as shown in Figure 1. Averaging the rates across studies, the competitive employment rate was 61% (Median = 64%) for IPS compared to 23% (Median = 27%) for controls. The average difference in percentage employed between supported employment and controls was 38%, ranging from 20% to 55%. The individual study effect sizes ranged from .56 to 1.18. The overall unweighted effect size was .83.

Using a stem-and-leaf diagram (Tukey, 1977), the Maryland IPS sample (Lehman et al., 2002) was a statistical outlier, falling more than the interquartile range (19%) below the lower quartile (55%) in the distribution of competitive employment rates. With this outlier removed, the mean competitive employment rate for IPS was 65%. The next two lowest employment rates were for two non-U.S. studies in Canada (Latimer et al., 2006) and Europe (Burns et al., 2007). However, two other non-U.S. studies were above the median (Killackey et al., in press; Wong, Chiu, Tang, Mak, Liu, & Chiu, 2008).

*Other competitive employment outcomes.* Four IPS studies reported the frequencies of participants who worked 20 hours or more per week, as shown in Table 2. Aggregating across these studies, 134 (43.6%) of 307 IPS participants and 53 (14.2%) of 374 controls held such jobs, yielding an effect size of .67.

Days to first competitive job was reported in 7 IPS studies, as shown in Table 3. Overall, the average time to first competitive job was 50% faster to first competitive job for IPS compared to controls (138 days versus 206 days). Excluding the extreme values (less than 3 months in the Québec (Latimer et al., 2006) and Hong Kong studies (Wong et al., 2008) and over 6 months in the Hartford study (Mueser et al.,

**TABLE 2—PERCENTAGE OF PARTICIPANTS EMPLOYED IN A COMPETITIVE JOB 20 HOURS OR MORE A WEEK IN 4 IPS STUDIES (BASED ON TOTAL SAMPLES)**

Study	IPS	Controls
96 NH	34 (46.6%)	15 (22.4%)
99 DC	34 (45.9%)	4 (5.3%)
07 IL	43 (46.7%)	22 (23.1%)
04 CT	23 (33.8%)	12 (8.8%)
<b>Total</b>	<b>134 (43.6%)</b>	<b>53 (14.2%)</b>

2005), the range was between 4 months and a little over 5 months as the average length of time to first job for IPS participants.

Proportion of time in competitive employment, as measured by annualized weeks worked, is reported for the same 7 IPS studies, as shown in Table 4. The results are reported for both all study participants, including those who never worked, and for the worker sample. The Maryland study (Lehman et al., 2002) reported substantially lower rates of weeks work in the full sample. Excluding the Maryland study, annualized average weeks worked for IPS ranged from 10.0 weeks for the South Carolina study (Gold et al., 2006) to 17.0 weeks for the Québec study (Latimer et al., 2006). Overall, the average weeks worked for IPS was 2.5 greater than for controls. When the samples are limited to participants who obtained competitive employment during follow-up, the weeks worked are virtually the same for IPS and controls.

Duration in longest held competitive job for those who worked at least one such job, is shown in Table 5. The average job

**TABLE 3—MEAN DAYS TO FIRST COMPETITIVE JOB IN 7 IPS STUDIES**

Study	IPS	Control
08 HK	72 (N = 32)	118 (N = 13)
06 Qué	84 (N = 51)	89 (N = 39)
99 DC	126 (N = 45)	293 (N = 7)
06 SC	133 (N = 42)	322 (N = 20)
07 IL	156 (N = 69)	193 (N = 32)
02 MD	164 (N = 47)	287 (N = 12)
04 CT	197 (N = 51)	277 (N = 31)
<b>Total</b>	<b>137.6 (N = 337)</b>	<b>205.9 (N = 154)</b>

tenure for IPS participants in these studies ranged from 37 weeks for the Illinois study (Bond et al., 2007) to 10 weeks in the New Hampshire study (Drake et al., 1996). It should be noted that this measure was influenced by length of follow-up. Except for the Connecticut study (Mueser et al., 2004), which found far greater job tenure for IPS participants, IPS and control samples looked fairly similar on this measure.

**Excluded Studies**

Although not a focus of the current review, some comments on the excluded studies are warranted. Nine studies were located comparing a non-IPS supported employment program to some other vocational model. Four had significant findings suggesting superior competitive employment findings for supported employment (Bond et al., 1995; Gervy & Bedell, 1994; McFarlane et al., 2000; Test et al., 1995), while two reported significantly better employ-

**TABLE 4—ANNUALIZED WEEKS WORKED IN COMPETITIVE JOBS IN 7 IPS STUDIES**

	All Study Participants		Participants Working a Competitive Job			
			Total Follow-up Period		Time Period from 1st Job Start	
	IPS	Control	IPS	Control	IPS	Control
06 Qué	17.0 (N = 75)	14.1 (N = 74)	25.0 (N = 51)	26.8 (N = 39)	32.5 (N = 51)	35.4 (N = 39)
07 IL	16.2 (N = 92)	8.2 (N = 95)	21.6 (N = 69)	24.3 (N = 32)	25.6 (N = 69)	26.1 (N = 32)
04 CT	14.9 (N = 68)	2.3 (N = 136)	19.8 (N = 51)	9.8 (N = 31)	27.1 (N = 51)	15.8 (N = 31)
08 HK	13.0 (N = 46)	7.0 (N = 46)	8.6 (N = 32)	24.9 (N = 13)	21.4 (N = 32)	31.7 (N = 13)
99 DC	10.1 (N = 74)	0.8 (N = 76)	16.6 (N = 45)	8.7 (N = 7)	21.6 (N = 45)	18.7 (N = 7)
06 SC	10.0 (N = 66)	2.9 (N = 77)	15.8 (N = 42)	11.3 (N = 20)	19.3 (N = 42)	20.2 (N = 20)
02 MD	6.0 (N = 113)	1.6 (N = 106)	14.4 (N = 47)	14.1 (N = 12)	18.6 (N = 47)	23.2 (N = 12)
<b>Total</b>	<b>12.1 (N=534)</b>	<b>4.8 (N=610)</b>	<b>19.2 (N=337)</b>	<b>18.9 (N=154)</b>	<b>24.2 (N=337)</b>	<b>25.5 (N=154)</b>

ment outcomes for their supported employment intervention but did not clearly differentiate between competitive employment and set-aside jobs, so that the interpretation of their results is clouded (Chandler et al., 1997; Tsang, 2006). Two studies found no differences in employment outcomes for supported employment and the comparison group (Rogers et al., 2006; Shafer, 2005). Finally, one study had mixed results, on balance favoring the comparison group over supported employment (Macias et al., 2006). Combining the employment rates for 4 early studies (Bond et al., 1995; Chandler et al., 1997; Gervey & Bedell, 1994; McFarlane et al., 2000), we found that the combined employment rate was 53% for supported employment and 16% for controls, for an effect size of .82.

**Comparison with Other Reviews**

We compared our competitive employment rates with 5 earlier reviews, as shown in Table 6. The aggregated competitive employment rate for supported employment was highest in the current review, while, with the exception of the Cook (2005) review, the mean competitive employment rate for controls was

**TABLE 5—WEEKS WORKED AT LONGEST COMPETITIVE JOB DURING FOLLOW-UP IN 6 IPS STUDIES (WORKER SAMPLE ONLY)**

Study	IPS	Control
07 IL	36.8 (N = 69)	32.7 (N = 32)
04 CT	25.5 (N = 51)	4.4 (N = 31)
02 MD	21.6 (N = 47)	23.1 (N = 12)
06 SC	19.0 (N = 42)	20.0 (N = 20)
06 Qué	14.6 (N = 51)	12.7 (N = 39)
96 NH	10.0 (N = 57)	10.0 (N = 27)
<b>Total</b>	<b>22.0 (N = 317)</b>	<b>16.3 (N = 161)</b>

also higher than the other 4 reviews. All six reviews concluded that the competitive employment rate for supported employment is at least twice that for clients receiving some other form of vocational assistance. Using the arc sine method, the effect sizes for the overall IPS/control difference ranged from .43 to .79 in previous reviews, compared to .79 in the current review.

**Discussion**

This review examined evidence-based supported employment in order to estimate expected outcomes. We conclude that the majority of IPS participants obtain competitive employment, at a far higher rate than clients enrolled in other vocational services. Most IPS clients work part time; about two-thirds of those who obtain competitive employment work 20 hours or more per week. This could be due to preferences, limited stamina, or fear of losing health

**TABLE 6—AGGREGATED COMPETITIVE EMPLOYMENT RATES IN 6 REVIEWS OF SUPPORTED EMPLOYMENT**

Study	Supported Employment	Control	Effect Size Reported by Authors	Effect Size Using Arc Sine	Number of Studies	Number of Studies of High Fidelity IPS
Bond (2004)	56%	19%	0.85	0.79	9	5 (56%)
Burns et al.(2007) <sup>a</sup>	58%	21%		0.78	6	6 (100%)
Cook et al. (2005)	55%	34%		0.43	7	3 (43%)
Crowther et al. (2001)	34%	12%		0.54	5	2 (40%)
Twamley et al. (2003)	51%	18%	0.79	0.72	5 <sup>b</sup>	3 (60%)
<b>Current Review</b>	<b>61%</b>	<b>23%</b>	<b>0.83</b>	<b>0.79</b>	<b>11</b>	<b>11</b>

<sup>a</sup> Findings aggregated by the current authors for this table

<sup>b</sup> Twamley review included 11 RCTs of vocational programs, 5 of which were supported employment studies used in this table.

insurance. Undoubtedly the number of hours worked per week is influenced by the rules governing receipt of disability payments and Medicaid eligibility. Less than 1% of IPS participants left disability rolls during the follow-up period. Consistent with the principle of rapid job search, the time to first competitive job for IPS participants is nearly 10 weeks less than for controls, although the average for IPS of 20 weeks to first job is somewhat of a surprise. Time to first job strongly affects longitudinal competitive employment outcomes; in most studies, the large majority who work at all do so in the first six months. Thus, this might be an area for model improvement, which we speculate might require better job development strategies (Carlson & Rapp, 2007). In addition, the use of the vocational profile to help identify job types and work settings that match the individual's preferences, skills, and experiences is another area that may help improve and speed up the job seeking process and increase job tenure as well (Becker, Drake, Farabaugh, & Bond, 1996).

This review represents an advance over earlier reviews in several respects. First, it has the largest and (for the moment) the most up-to-date collection of pertinent randomized controlled trials. Second, it is one of only two reviews limited to rigorous evaluations of IPS programs. Thus, our review is based on a homogeneous set of studies, giving the clearest picture of the potential for evidence-based supported employment. None of the previous reviews included more than 6 high-fidelity IPS studies. Notably, the Cook et al. (2005) analysis included two studies comparing enhanced supported employment to supported employment only, which confounds the impact of supported employment. We also note that the current is a substantial update of the Cochrane review on vocational rehabilitation (Crowther, Marshall, Bond, & Huxley,

2000; Crowther et al., 2001). We attribute our somewhat stronger results to growing maturation of the field with both higher fidelity supported employment programs and stronger control groups. The differential advantage for evidence-based supported employment remains about the same, but our conclusions are stronger because the comparisons appear to be more rigorous.

Could the current review be subject to the "file drawer" problem – failing to include studies that have not been published (Rosenthal, 1984)? We can give a partial answer to this question: Of four unpublished studies, three are known to have strongly positive results (Nuechterlein et al., 2005; Test et al., 1995; Tsang, 2006), while a fourth study, the Arizona study from the EIDP, had null results (Shafer, 2005). Moreover, of these unpublished studies, only the Nuechterlein et al. study (2005) conforms to the sampling criterion of high-fidelity IPS. We deem it implausible that any unpublished studies could tip the balance of evidence present here.

Some comment is warranted about the inclusion of Maryland study (Lehman et al., 2002) as one of the 11 IPS high-fidelity studies. This study was a statistical outlier. In terms of sample inclusion criteria, it clearly deviated from the other IPS studies in that it was the only study among those reviewed that did not require participants to have a goal of competitive employment. The poorer competitive employment outcomes are consistent with this difference in sample inclusion criteria.

Three widely repeated criticisms of supported employment concern *exclusion of clients who do not have vocational goals*, *high dropout rates* (i.e., the contention that supported employment has a high attrition rate) and *brief job tenure* (supported employment helps clients get jobs but not to keep them, i.e., most supported employ-

ment jobs are short term). The current collection of studies sheds light on these three issues.

*Exclusion of individuals who do not have competitive employment goals.* Some observers have criticized evidence-based supported employment for its lack of outreach to individuals who do not have competitive employment goals (Macias, DeCarlo, Wang, Frey, & Barreira, 2001; Roberts & Pratt, 2007). This criticism violates the ethical principle of informed choice. Of course we agree that all consumers with severe mental illness should be encouraged to pursue work, and case managers and others within the mental health center should create a culture in which work is valued (Gowdy, Carlson, & Rapp, 2004). At the same time, from the shared decision-making perspective (O'Connor et al., 2007), the decision to pursue work should be an active choice based on a clear understanding of what the decision means.

*Early termination rates in IPS studies.* Although only a handful of studies report the findings regarding program retention, the studies that do show a strong advantage for supported employment. Five IPS studies compared rates for dropping out of vocational services. Although the criterion for early termination differed across studies, all 5 studies found substantially greater program retention for IPS. In the NH study, early attrition (dropping out of services within first two months) was higher in the control condition (38%) than in IPS (0%) (Drake et al., 1996). In the DC study, despite the addition of an extra staff person to help link clients with providers in the comparison condition, early attrition (dropping out of services within first two months) was greater in the control condition (16%) than in IPS (5%) (Drake et al., 1999). In the Hartford study, approximately 50% of the participants assigned to both control conditions dropped out

within a few weeks, whereas less than 10% of IPS participants dropped out during this early period (Mueser et al., 2004). In the Québec study, 9% of IPS participants failed to receive at least one service contact during each of the first and second 3-month periods in the study, compared to 70% of those in usual services (Latimer et al., 2006). In the Illinois study, 18% of IPS participants dropped out within 6 months, compared to 35% of controls (Bond et al., 2007).

Thus it is time to suspend the concern that supported employment programs have high dropout rates. This conclusion was warranted in 1997 based on the available data at that time (Bond, Drake et al., 1997), but the research now shows that high-fidelity supported employment programs have minimal attrition.

*Job tenure.* Another widely repeated criticism of supported employment is that it helps people get jobs, but not retain them (Mueser et al., 2005). The current review suggests that the average longest-held job among IPS participants who obtain work is 22 weeks. Two factors affect the interpretation of this finding. First, there is wide variation across studies. Second, the longest-held job is a biased statistic in a short-term study, because it gives no credit for jobs held past the follow-up. Annualized weeks of work is probably a better statistic; on average, IPS participants who obtain at least one competitive job work 19 weeks out of 52, or about 36% of the available time. Moreover, this figure is not adjusted for the initial period of unemployment looking for a job, which averaged 21 weeks for the first job. If we remove the initial job search period and calculate the duration of employment over the period of time after the start of the first job, IPS participants average 24.2 weeks per year, or 47% of the 52-week year.

We found that among those who obtained at least one competitive job, IPS

and control participants did not differ in job tenure and other employment outcomes. This finding sometimes has been misinterpreted to suggest that although IPS helps individuals get a first job sooner, it provides no advantage over usual services in helping them keep the job. However, these subgroups are no longer equivalent (e.g., the IPS subgroup of those with a job includes more than twice the proportion of the enrolled sample as the comparison group). The resulting sampling bias undoubtedly favors the non-IPS comparison program because IPS helps a wider range of participants obtain employment.

To study duration of employment properly, longer-term studies are needed. Two such studies present a clearer picture of the stability of long-term employment than do the studies in the current review. Salyer and colleagues (2004) conducted follow-up interviews 10 years after clients had enrolled in an IPS program, finding that 47% were currently working and 33% had worked at least 5 years during this period. Even more impressive results were obtained by Becker and colleagues (2007) who interviewed clients 8 to 12 years after enrollment in IPS, finding that 71% were currently working and the identical percentage had worked for more than half of the follow-up period.

One contribution of this review is to highlight common outcome measures that every supported employment study should measure and report. Although the field is making good progress in converging on standardized measures, the inability to include all studies in all comparisons is a limitation of this review.

### Study Limitations

One confound in our comparative analysis is the lack of standardization of follow-up period. Follow-up was 6

months in one study, 1 year in 2 studies, 18 months in 4 studies, and 2 years in 4 studies. For the competitive employment rate variable, participants in studies with longer follow-up have more opportunity to obtain work. However, the reality is that the probability of obtaining a first job diminishes over time. As already noted, a second limitation of this set of studies is their relatively short follow-up period, especially for measuring job tenure, as measured by time on longest job held. This is an inadequate indicator of employment outcome in short-term follow-up studies, because the measure does not capture the successful job tenure for a participant who is employed at the end of the follow-up period and continues to work for years thereafter.

### Future Directions

The number, consistency, and effect sizes of studies of evidence-based supported employment establish that it is one of the most robust interventions available for persons with severe mental illness. Recognizing this, researchers have moved ahead to examine a variety of enhancements to amplify outcomes through early interventions, motivational interventions, cognitive interventions, alteration of benefits, and other approaches. We review these efforts at the end of this special section (Drake & Bond, *this issue*).

In the meantime, research should also address the myriad issues related to dissemination of evidence-based practices (Drake & Skinner, *in press*). The Scylla and Charybdis of U.S. mental health services continue to be the failure to provide access to evidence-based health care and excessive spending on ineffective health care (Wang, Demler, & Kessler, 2002).

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## NAMI OHIO CONFERENCE SUPPORTED EMPLOYMENT TRACT EVALUATION

Your Role and/or Profession (please check all that apply):

- Counselor (specify type): \_\_\_\_\_ 
  Social Worker 
  Youth/Young Adult  
 Advocate 
  Family Member 
  Consumer 
  NAMI Member 
  Other (please specify): \_\_\_\_\_

Your Job Title/Function/Role: \_\_\_\_\_

Note: A completed evaluation form is requested of everyone participating to support continued program offerings and services.

Date of Training: Friday, May 14 & Saturday, May 15, 2010

Location of Training: The Renaissance Hotel, Columbus, Ohio

NAMI Ohio Facilitator: Betsy Johnson

<b>FRIDAY, MAY 14</b>				
Supported Employment 101, Betsy Johnson, Facilitator				
*Core Principles of SE, Steve Shober/Nicole Clevenger				
*Consumer/Employer Panel Presentation, Jennifer Guthrie/Kimberly Simmons				
*Medical Perspective, Dr. Marion Sherman				
Effectiveness of Presenters	1	2	3	4
Quality of Presentation	1	2	3	4
Met Your Individual Learning Needs	1	2	3	4
Understanding How Employment Impacts Benefits, Belinda Spinosi, Facilitator				
*Medicaid, SSI, SSDI, Work Incentives, Steve Shober				
*Medicaid Buy-In/Expedited SSI, Rick Tully				
Effectiveness of Presenters	1	2	3	4
Quality of Presentation	1	2	3	4
Met Your Individual Learning Needs	1	2	3	4
<b>SATURDAY, MAY 15</b>				
Role of Family Advocates in Promoting SE, Jane James, Facilitator				
*View SE Video				
*Internal Advocacy: Talking to Families, Craig Gebers				
*External Advocacy: Talking to System Representatives, Steve Shober				
Effectiveness of Presenters	1	2	3	4
Quality of Presentation	1	2	3	4
Met Your Individual Learning Needs	1	2	3	4
Challenges and Solutions, Dr. John Finch, Facilitator				
Table Leads: Doug Bailey, Craig Gebers, Amy Price, Stephen Shober				
Effectiveness of Presenters	1	2	3	4
Quality of Presentation	1	2	3	4
Met Your Individual Learning Needs	1	2	3	4

Level of Impact on Your Ability to Advocate for Supported Employment for Individuals with Mental Illness      1      2      3      4      5

Degree to Which the Overall Training Met Your Expectations      1      2      3      4      5

Level of Impact on Your Role and/or Profession      1      2      3      4      5

Please complete reverse side ►►►

# Empowerment & Advocacy Brief



## Meet the CAP Office Staff

### Amy Price, MSW, LISW-S, Chief, Consumer Advocacy & Protection

I joined the Ohio Department of Mental Health's Program Policy and Development division as the chief of the Office of Consumer Advocacy and Protection in March 2009. Previously, I worked in the community mental health system for 20 years in case management, residential, crisis, AOD (alcohol and other drug), and vocational treatment settings. I have 16 years of direct experience working with people experiencing homelessness through Projects for Assistance in Transition from Homelessness (PATH), criminal justice re-entry projects, Rebuilding Lives, and supportive housing programs. I also have 15 years of non-profit management and leadership experience.



I am a licensed independent supervisory social worker who received my master's degree from the Ohio State University. During 2006-2007, I was a fellow in the Mental Health Executive Leadership Program at the Weatherhead School of Management at Case Western Reserve University. I have additional training in Eye Movement Desensitization and Reprocessing therapy, Dialectical Behavior Therapy, Stages of Change model, Integrated Dual Disorder Treatment, Motivational Interviewing, Supported Employment, Cluster-Based Planning, Trauma-Informed Care and Critical Incident Stress Management. I also had the privilege of participating in the early development of the Wellness, Management and Recovery curriculum.

My values include a commitment to advocacy, diversity, community, cultural competency, client rights, continuous quality improvement, innovation, leadership, team building, ethical decision-making, authenticity, professional/staff development and personal growth. I believe in the importance of hope, resiliency and self-determination along with an individual's abilities to grow, change and recover.

### Kathryn Remer, MS Ed, LSW, Consumer & Advocacy Specialist

As the Consumer Advocacy and Protection specialist for the Ohio Department of Mental Health, I supervise the Toll-Free Bridge Line and provide advocacy services to consumers and their families throughout Ohio. I received my bachelor's degree in Music Therapy from Ohio University and a master's degree in Counseling from the University of Dayton. Prior to coming to ODMH Central Office in 2005, I worked as the client advocate program administrator, a SAMI provider and music therapist for Twin Valley Behavioral Healthcare in Columbus. While at Twin



## Learn About CAP's New Project Areas

### Supported Employment (SE)

SE is an evidence-based practice that helps people with severe and persistent mental illness identify, acquire and maintain competitive employment in their communities. SE is assertive about helping people find the work they want as soon as they express a desire to become employed.

There are seven core principles that make the evidence-based SE model different from other vocational programs:

1. Zero Exclusion Policy
2. Consumer Preferences are Important
3. Rapid Job Search
4. A Competitive Job is the Goal
5. Employment is integrated with Mental Health Services
6. Time-Unlimited Support
7. Personalized Benefits Planning

SE increases employment in competitive jobs, the number of hours worked, and the amount of income earned in competitive jobs for people with mental illnesses.

To learn more about SE or to find an agency near you, contact the Ohio Department of Mental Health or the Ohio Supported Employment Coordinating Center of Excellence (SECCOE) at Case Western Reserve University, [www.ohioeccoe.case.edu](http://www.ohioeccoe.case.edu).

SECCOE Contacts: Director of Implementation Services Patrick Boyle, or Nicole Clevenger, consultant and trainer, (216) 398-3933 or toll-free 1-866-760-3933.

(Project Areas continued next page)

## **NAMI Supported Employment Family Advocacy Project**

This collaboration between NAMI Ohio and the Ohio Department of Mental Health engages families in Supported Employment services by educating the families of individuals with mental illness to advocate for, create and expand high-quality Individual Placement and Support (IPS) programs. These programs result in an increased number of consumers in sustained competitive employment. Family involvement can strengthen the partnerships between providers, family members and consumers around Supported Employment Services.

A Supported Employment Family Advocacy Summit is scheduled May 14-15 at the Columbus Renaissance Hotel. Contact Associate Executive Director Betsy Johnson, NAMI Ohio, at (614) 224-2700 voice; (614) 224-1498 TTY; 1-800-686-AMIO toll-free voice or 1-866-924-1478 toll-free TTY; or visit online at [www.namiohio.org](http://www.namiohio.org).

## **Cluster-Based Planning**

Cluster-Based Planning and Outcomes Management (C-POM), developed in Ohio by Synthesis, Inc., has been identified as a mental health best practice by the Ohio Department of Mental Health. C-POM facilitates clinical practice, evaluation, planning, quality improvement and decision-making.

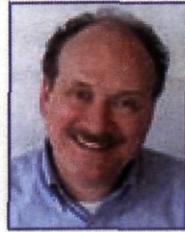
C-POM is based on the understanding that large groups of people (e.g. adults with severe mental disabilities, youth with mental health needs, or adults with substance abuse issues) cannot be treated as if all the individuals were members of a single homogeneous group. Instead, within these populations there are distinct subgroups or "clusters." A cluster is a subgroup of a larger clinical population that shares common strengths, problems, treatment histories, social and environmental contexts, and/or life situations. Cluster-Based Planning identifies these subgroups and describes each in such a way that the information can be used as the basis for treatment

*(Meet the CAP Office staff continued from front page)*

Valley, I also developed a national Music Therapy Internship program. Through this program, I provided training and student supervision as the program's clinical training director.

## **Doug Bailey, MLRHR, CWDP, Employment & Housing Services**

**I** hold a master's degree from the Cleveland State University Graduate School of Business with specializations in human resources and public administration. Currently, I work in Employment and Housing Services, concentrating on Supported Employment projects, Medicaid Buy-In, Community Capital program issues, and several housing-related grant projects. I have worked in disability services for more than 25 years, including nine years with the Ohio Department of Mental Health. During my time at ODMH, I have worked in Employment, served as an area director, spent over a year in Research and Evaluation, and served as the project director for a five-year Social Security Research Grant and for two years leading the Ohio Medicaid Infrastructure



Grant. Before coming to ODMH, I was the director for two community vocational services agencies in northeast Ohio, an assistant area manager with the Ohio Rehabilitation Services Commission/Bureau of Vocational Rehabilitation, and have also been a provider of direct employment and training services for people with disabilities. Prior to my work in disability services, I held positions in human resources with two Fortune 500 companies. I am a member of the National Rehabilitation Association, the National Association of Workforce Development Professionals, and am a Certified Workforce Development Professional.

## **Deborah N. Givens, BA, MHA/Project Lead, Projects for Assistance in Transition from Homelessness (PATH)**

**M**y bachelor's degree in business administration with a concentration in project management is from DeVry University. I am currently earning a Master of Public Administration with a concentration in government administration from Keller Graduate School of Management. I have spent the past 9+ years at the Ohio Department of Mental Health where I serve the public in the capacity of a mental health administrator/project lead. My time is divided between two offices. In the Office of Consumer Advocacy and Protection (CAP) I am the State PATH Contact (SPC) for the Projects for Assistance in Transition from Homelessness (PATH). I'm also the Consumer and Family Partnership Team lead in the Office of Consumer and Recovery Supports where I manage both Block Grant and Transformation State Incentive Grant (TSIG) dollars. Prior to my current position, I was the Housing project manager, working on the Olmstead Initiative, the Capital Application Process, the Housing Assistance Grant Program, Adult Care Facilities and PATH. I have participated on various workgroups such as the Interagency Council on Homelessness and Affordable Housing (subgroups), and the TSIG Content Work Groups and Transformation Work Groups. Prior to joining ODMH, I was employed at the United Methodist Children's Home, the Ohio Department of Rehabilitation and Correction, and Deloitte & Touche, LLP.



or program planning and management.

Clinical experience and continuing research confirm that the members of different clusters typically receive different types and intensities of services, and that the associated costs differ by cluster. Rather than using the same “yardstick” to measure success for each group, treatment goals/outcomes should be geared to each cluster and then individualized for each consumer. Even when individuals in different clusters are pursuing the same long-term recovery goals, their more immediate challenges and paths are likely to be dissimilar.

By clearly describing the clusters, identifying and measuring targeted outcomes for each group, and tracking services and costs by cluster, C-POM assists in answering the question: What works, for whom, and at what cost?

Contact Synthesis, Inc., CEO Bill Rubin at 395 E. Broad St., Suite 100, Columbus, OH 43215; (614) 365-9444 or toll-free 1-800-322-9444; or visit [www.synthesisincobio.com/home.html](http://www.synthesisincobio.com/home.html).

### **Medicaid Buy-In For Workers with Disabilities (MBIWD)**

MBIWD is an Ohio Medicaid program that provides health care coverage to working Ohioans with disabilities. Historically, people with disabilities were often discouraged from working because their earnings made them ineligible for Medicaid coverage. MBIWD was created to enable Ohioans with disabilities to work and still keep their health care coverage. People who enroll in MBIWD no longer have a spend down, and are subject only to a monthly premium payment that, for most, is very low compared to spend down.

To qualify, a person must be:

- 16 to 64 years old;
- disabled per the Social Security Administration, or as determined by Ohio Medicaid, or eligible under the MBIWD medically improved category; and
- employed in paid work (including part- or full-time).

### **Projects for Assistance in Transition from Homelessness**

The Stewart B. McKinney Homeless Assistance Amendments Act of 1990 authorized a federal grant program to address the needs of people who are homeless and have serious mental illnesses. The Projects for Assistance in Transition from Homelessness (PATH) program funds community-based outreach to support services including those related to mental health, substance abuse and case management. Services are provided to people who have not yet been linked with needed mainstream mental health services.

Ohio current has 11 PATH Projects in the following counties: Butler - Transitional Living, Inc.; Cuyahoga - Mental Health Services for Homeless Persons, Inc.; Franklin - Southeast, Inc.; Hamilton - Greater Cincinnati Behavioral Health Services; Lake - Extended Housing; Lorain - Gathering Hope House; Lucas - Neighborhood Properties, Inc.; Mahoning/Trumbull - Help Hotline Crisis Center; Montgomery - Miami Valley Housing Opportunities; Stark - ICAN; and Summit - Community Support Services.

This year, three pilot projects were funded targeting services to veterans: Butler/Hamilton - Transitional Living, Inc., in partnership with Greater Cincinnati Behavioral Health Services; Cuyahoga - Mental Health Services for Homeless Persons, Inc.; and Franklin - Southeast, Inc.

### **ODMH Housing Initiatives**

In January 2010, ODMH Housing Initiatives were reassigned to the CAP Office. Presently, a revitalization of an active partnership between this office and the ODMH Captial Office is taking place. The CAP Office will take the lead on components of the housing projects related directly to Program and Policy Development. This redefined approach will result in a more clearly defined department-wide housing framework and work that is transparent to all parties.

With change comes an opportunity

for growth and continuous quality improvement. Presently, three of the five CAP Office staff members have varying levels of housing experience within the department and/or through previous work in the community.

ODMH also continues to collaborate on a number of statewide housing initiatives, including the Governor's Interagency Council on Homelessness and Affordable Housing and its various subcommittees.

This month, ODMH finalized its Adult Housing Policy for people with severe mental illness. It is on our Web site at: <http://mentalhealth.ohio.gov/partner-resources/policy-memos/index.shtml>.

### **Expedited SSI and Medicaid Demonstration**

*By Rick Tully, ODMH Office of Systems Transformation*

A new tool is available to community mental health provider organizations to expedite access to SSI and Medicaid for adults with severe and persistent mental illness. It represents a win-win scenario by providing access to cash and medical resources for consumers, and expediting Medicaid reimbursement for provider organizations.

ODMH initiated the pilot project in May 2008, as part of its Transformation State Incentive Grant, to address delays experienced by mental health consumers in the processing of SSI and Medicaid applications. ODMH staff worked with the Ohio Rehabilitation Services Commission's Bureau of Disability Determination (BDD), the Social Security Administration, more than 40 community mental health provider organizations, and the Ohio Department of Job and Family Services to develop model procedures for the providers to use in submitting medical evidence to BDD at the time the application is submitted and to use the SSI award to trigger Medicaid eligibility.

These special procedures are only applicable to adults with severe and persistent mental illness. All of

the medical evidence to adjudicate the claim must be submitted with the application to avoid the lengthy process of seeking out medical evidence after the application has been filed. Additionally, special forms have been developed for mental status and activities of daily living that provide an opportunity to present detailed information about the person's behavior and level of functioning.

The results of the demonstration thus far show that when screening criteria are applied properly and procedures are followed, the project successfully achieves the desired 15-20 day processing time at BDD. In most cases, this means an overall processing time from submission of medical evidence to receipt of SSI award notice of a little over one month. These results represent a marked reduction from average caseload statistics.

Three provider organizations have had significant success in

the demonstration: MHS, Inc. and Connections, both in Cleveland, and Eastway in Dayton. Tara Bialek of MHS, Inc., Earnese Hill of Connections and Michael Sanchez of Eastway provided information about their experience for this article. The three provider organizations have submitted and processed 75 applications. All three reported overall average processing time from submission of medical evidence to SSI Award notice of about 30 days, with some cases turning around in less than 10. Allowance rates across the three provider organizations range from 86 to 100 percent.

All three stressed the importance of building relationships with the assigned SSA Field Offices and with the assigned adjudicators at BDD, and working to assure communication flow. The demonstration project has had tremendous support from the SSA Chicago Regional Office, the SSA Area Offices, and

from leadership of BDD. This support and direction from the top reinforces the daily interactions of mental health staff with colleagues at SSA Field Offices and BDD.

The success of the three provider organizations is the result of an investment of effort and commitment. Each organization has re-structured staffing assignments to assure that one person is accountable for the development of the applications. Development time to put the applications together averages about eight hours across the three providers. However, the payoff is in much more rapid access to cash and medical assistance for the organization's clients.

Providers interested in enrolling in the Expedited SSI and Medicaid program may contact Program Administrator Rick Tully, Ohio Department of Mental Health, at [Rick.Tully@mh.ohio.gov](mailto:Rick.Tully@mh.ohio.gov) or (614) 728-9784.

The CAP Office has updated its pages within the ODMH Web site:

<http://mentalhealth.ohio.gov/what-we-do/promote/consumer-advocacy-and-protection/index.shtml>

The June edition of the ODMH Empowerment & Advocacy Brief will spotlight various ODMH Consumer Advocacy Services, including the Consumer and Family Toll-Free Bridge Line. We'll also include articles on Employment, as well as other advocacy programs and services available to consumers and their families.



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### Our Choice: Living in the Community

Conference for Ohioans  
with disabilities, their families  
and advocates

May 26-27, 2010  
Hyatt Regency, Columbus

#### Keynotes

- Steve Gold, attorney and Olmstead advocate, Philadelphia
- Ann O'Hara, director of TAC Housing Group, Boston
- Jim Dickson, VP/Legislative Affairs, AAPD, Washington, DC

#### Presentation of

#### Ohio's draft 2010 Olmstead Plan

- Governor Strickland
- Ohio's Directors of ODODD, ODMH, ODJFS, ODA and RSC

#### Workshops and 20<sup>th</sup> ADA Anniversary Event

FREE Registration to Ohioans with disabilities and family members — includes one night hotel lodging, transportation and other accommodations. Conference registration for everyone else is \$150.

Register by contacting the  
AXIS Center at 614-263-8076 or  
[AXISCenter@aol.com](mailto:AXISCenter@aol.com).

**STATEMENT OF PURPOSE**  
**CEBP – ODMH Peer Employment Partnership**  
July 2010

**Mission:** *The mission of the CEBP–ODMH Peer Employment Partnership is to increase employment for people diagnosed with severe mental illness in Ohio.*

**Vision:** *The CEBP–ODMH Peer Employment Partnership envisions a future where employment is seen as an integral component of wellness and recovery, and people with mental illness are able to obtain and maintain competitive employment of their own choosing. In this vision, peers and peer centers are champions of employment and promote a culture that supports people in developing a working life.*

**Values:** *The values of the Peer Employment Partnership include hope, personal responsibility, self-advocacy, peer support, education, dignity and respect. Employment is valued as a wellness and recovery tool, and employment is a viable option for all people who have been diagnosed with mental illness.*

## **Project Summary**

The Final Report of the President's New Freedom Commission on Mental Health, entitled "Achieving the Promise: Transforming Mental Health Care in America," called for overhauling the nation's public mental health systems. The Commission envisioned a future where wellness and recovery are the expected outcomes of treatment so that people diagnosed with mental illness can live, work, learn and participate fully in their communities.

As part of transforming the mental health system, the Ohio Department of Mental Health (ODMH) funded the Peer Employment Partnership to facilitate people's recovery through employment. To that end, the CEBP will collaborate with peer centers/consumer operated services (COS) to support people who are thinking about or are working toward employment goals.

## **Project Rationale**

For too long, employment has been seen as a priority "after stabilization" rather than as part of the recovery process. For a variety of reasons, providers and family members have discouraged employment for many people diagnosed with mental illness. For instance, many feared that the stress of working would cause a relapse of symptoms. Unfortunately, many people diagnosed with mental illness absorb this often-repeated message, and lose confidence in their ability to engage in a job search, find employment or remain employed. This lack of hope contributes greatly to the high unemployment rate for people with mental illness.

The high unemployment rate has forced many people to become dependent on public assistance, which has caused many people to live in extreme poverty. Living in poverty creates its own stressors, and contributes to a high co-morbidity rate and significant decrease in life expectancy for people with mental illness.

The Peer Employment Partnership will help people's wellness and recovery by providing them with the opportunity to reintegrate into their communities by working. Employment will help

people become more financially independent, increase people's self-esteem and allow them to see themselves in other roles, such as employees or coworkers, instead of just "consumers."

## **Project Goals**

The following are the goals of the project:

**Goal 1: Provide people diagnosed with mental illness the opportunity to learn about employment in peer-to-peer settings.**

In order to achieve the first goal, the peer center/COS will use multiple strategies to educate people about employment and available employment services and supports. This includes the use of posters and distribution of other educational materials related to employment in groups and individual interactions with members. The CEBP will assist peer centers/COS in developing a culture of work within the organization. Some of the topics that will be addressed are disclosure, how to help people develop work goals that are based upon their values and preferences for employment, and current research findings on the impact of employment on mental illness. (Research shows that employment can facilitate recovery rather than hinder it as is feared by many well-intentioned family members and providers.)

The measurable outcomes are the number of people who participated in employment support groups and number of people who participated in individual discussions about work.

**Goal 2: Provide people with mental illness with information about how their benefits would be impacted if they returned to work.**

In order to achieve the second goal, the peer centers/COS will answer basic questions about benefits concerns and work incentives, as well as help people access more in-depth professional benefits consultations when desired. The CEBP will provide peer centers/COS with a toolkit that contains facts, worksheets, and other resources to help staff address questions about how various benefits would be impacted by earned income from a job. In addition, the CEBP will provide training and ongoing technical assistance to the peer centers/COS to build skills necessary to serve this function.

The measurable outcomes are number of people who received assistance with benefits questions, and number of people who received information about professional benefits consultations.

**Goal 3: Help people with mental illness to resolve ambivalence about the decision to start or return to work.**

In order to achieve the third goal, the peer centers/COS will help people weigh the pros and cons of returning to work and provide information to help people make informed decisions about employment. Staff will demonstrate an ability to tolerate different levels of readiness/willingness to change and assist individuals in realizing hope for a working life. The CEBP will provide expert training in motivational interviewing techniques and stage appropriate interventions. Ongoing technical assistance and support will be provided in this area.

The measurable outcomes are: number of people who completed the payoff matrix for employment.

**Goal 4: Help people with mental illness to learn about and access community resources and employment services when desired.**

In order to achieve the fourth goal, the peer centers/COS will become knowledgeable about Supported Employment or traditional employment services (if evidence-based Supported Employment is unavailable in the community), including those provided through the local offices of the Bureau of Vocational Rehabilitation (BVR). Peer centers/COS will attempt to develop relationships with staff at these offices in order to help people get questions answered and to facilitate a self-referral for employment services. The CEBP will assist peer centers/COS in conceptualizing, developing, and implementing a method of linking people with services.

The measurable outcomes are number of people who received information about employment services and how to make a self-referral and number of people currently participating in employment services outside of the peer center/ COS.

**Goal 5: Provide peer support to people with mental illness during all phases of the employment process.**

As a means of achieving the fifth goal, peer centers/COS will assist people in the decision-making phase, while on waiting lists for employment services, during independent job search (without formal employment services from an agency outside of the peer center/COS), while participating in employment services provided by an agency other than the peer center/COS, and as a continuous support to people who are employed. Peer support can be offered in a group setting or during individual interactions with members.

The measurable outcomes are the number of people who received peer support while on a waiting list for employment services, number of people who obtained jobs independently (without employment services), number of people who are currently employed that received peer support.

**Overarching Goals of the Peer Employment Partnership:**

Although not explicitly stated, there are several overarching goals of the Peer Employment Partnership: (1) to create environments where employment is not only encouraged, but seen as an integral component of recovery (2) to incorporate peer support into the delivery of employment services, and (3) to advocate for evidence-based Supported Employment services in an increasing number of communities where these services do not currently exist. Though implicit, these goals may be the most important.

Many people with mental illness may have stopped thinking of themselves as workers long ago. This may be the case for a variety of reasons, such as being in settings where employment was discouraged or where there was an assumption that people with mental illness could not work. Because of these types of environments, many people labeled with mental illness feel that they are "too sick" to work and believe they would fail at a job. Others may not work because they fear losing benefits.

A peer employment program helps transform the mental health system. If peer centers/COS can help people return to work in addition to the local clinical agencies that are also providing employment services, people can choose the type of services they receive as well as choosing where they receive them.

Peer centers/COS can also support the efforts of people receiving employment services in a powerful and important way.

Peers can act as vocal advocates for state-of-the-art employment services to become available in more communities. The peer employment program can support the belief that all people with mental illness deserve access to services that are based on research and that have been proven to yield superior outcomes to traditional employment service models.

In summary, perhaps the most important overarching goal of the Peer Employment Partnership is for peer centers to become champions of employment. By achieving the goals listed above, the CEBP and ODMH believe that if:

- (1) Peer centers developed an atmosphere where people were encouraged to work;
- (2) Peer Employment Specialists explained how employment helps in their recovery;
- (3) Peer Employment Specialists helped people access employment services and other community resources when they choose to do so;
- (4) Peer Employment specialists became role models themselves in providing peer support to people during the employment process;

Then, more people diagnosed with mental illness would begin to work and use employment as a way to reintegrate into their communities, increase financial position, and improve self-esteem and quality of life.

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