Perceptions and Practices of Mental Health Professionals Regarding the Employment of People with Serious Mental Illness

by

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Abstract

The Individual Placement and Support (IPS) model of Supported Employment (SE) is an evidence-based practice that leads to successful employment outcomes for people with serious mental illness. Customized Employment (CE) represents the evolution of supported employment as a strategy to also facilitate employment outcomes for people with the most significant disabilities. Interagency Collaboration is another strategy that facilitates successful employment outcomes for people with the most significant disabilities as demonstrated by research. The literature indicates that supported employment (IPS and CE) services along with interagency collaboration are practices that increase the employment outcomes for individuals with the most significant disabilities. However, the practical application and implementation of these three services/practices is limited in the Southern region of the United States. This study looked at the perceptions held by and practices used by mental health and other rehabilitation professionals regarding the employment of individuals with serious mental illness at two sites in Alabama. Results of this study provide a rich description of the sample as well as the participants' knowledge of IPS. A statistically significant association was identified for acceptance, support and value of an employment specialist among mental health team members, and a statistically significant relationship between responses for perceptions and practices of mental health professionals related to the employment of people with serious mental illness.

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CHAPTER 1. INTRODUCTION

Stigma theory argues that the barriers faced by people with disabilities come from inequalities, negative attitudes, and devalued roles caused from stigmatization rather than the diagnosis (Thomson, 1997). Social Role Valorization theory is a social science concept built on a solid foundation of social science research within the following fields: sociology, psychology, education, pedagogy, and drawing upon role theory and learning theory (Osburn, 2006). Social Role Valorization theory is defined as enabling, enhancing, and/or maintaining valued social roles for people, particularly those at value-risk, by using culturally valued standards (Aubry, Flynn, Virley, & Neri, 2013; Wolfensberger, 2000). Social Role Valorization is considered a high-level and systematic schema (a mental concept used to organize knowledge) addressing the predicament of people who are devalued by major sectors of society, that is, people with the most significant disabilities (Wolfensberger, 2000). Social role theory, as Social Role Valorization conceives it, addresses socially-expected patterns of behaviors, responsibilities, expectations and privileges (Lemay, 1999). If people with disabilities are to be accepted and integrated into society, then rehabilitation professionals must consider actions and strategies that enable all people to have positive and valued roles.

Theoretical Framework of the Study

Social Role Valorization (SRV) theory posits that if people are devalued and cast into a negative social role, they may be denied opportunities, be segregated from ordinary community life, experience imposed poverty, lose relationships, or be at increased risk of abuse or harm

(Wolfensberger, 2011). It is critical to explore the value that society places on those social roles, the impact of devaluating social roles, the importance of social roles for the individual, and the use of strategies to improve the social roles of people with disabilities by increasing the employment options for people with the most significant disabilities. Aligning supported employment services with the principles of SRV theory in order to improve the quality of employment outcomes for people with the most significant disabilities is an important first step.

The purpose of SRV is to develop an action plan that will positively change people's experiences. Wolfensberger's (2011) theory is that well-being depends extensively on the social roles people occupy. If they are in valued roles, they are generally afforded the good things in life, but if they occupy devalued roles, they will typically be treated badly by others. Osburn (2006) references a few major examples of the good things in life, such as being accorded dignity and respect, receiving an education, having a voice about one's life, and finding opportunities to work and be productive. People have multiple social roles; some are valued roles while others are devalued. If someone is in a devalued role she or he is devalued, but if she or he moves into valued roles, she or he moves to valued status; therefore, a person's value in society will depend on how much she or he represents what is valued and the number of attributes she or he possesses that are valued. Structuring environments and other practices to maximize valued perceptions of people, their positive perception of themselves, and their competence in achieving and sustaining socially adaptive behaviors puts this change into action (Wolfensberger, 2011).

Wolfensberger (2011) noted that professionals must work to make changes that will reduce or prevent the stigma of the person devalued and to affect societal perceptions and values

so that a given characteristic or person is no longer seen as devalued. Wolfensberger (2000) outlined several strategies for enhancing roles, such as:

- Expanding the positive roles a person already holds;
- Avoiding entry into (additional) devalued roles;
- Enabling entry into positively valued new roles or the regaining of valued roles previously held;
- Extricating someone from currently held devalued roles, reducing the negativity of a devalued role currently held; and/or
- Exchanging currently held devalued roles for less devalued new ones.

These strategies can be used to facilitate changing roles to ones of higher value in society, thereby improving the quality of life experienced by people with the most significant disabilities.

The Social Role Valorization model articulates assumptions that all people thrive when employed, and supported employment is a service that facilitates people with the most significant disabilities into a valued role (Tyree, Kendrick, & Block, 2011). Based on the Code of Federal Regulations (CFR), supported employment is competitive employment in an integrated setting with ongoing support services for individuals with the most significant disabilities (Federal Register, 2012). It is uniquely designed for people for whom competitive employment has not occurred historically or for whom competitive employment has been interrupted or intermittent as a result of a most significant disability. Because of the nature and severity of some individuals' disabilities, they may need intensive and extended support services to work successfully. The potential for supported employment to be the methodology to move people, once excluded, to the valued role of employee cannot be overstated (Tyree, Kendrick, & Block, 2011).

The Individual Placement and Support (IPS) model of supported employment is recognized as the most comprehensively researched model of supported employment for people with serious mental illness (Bond, 2004; Bond, Drake & Becker, 2008). Yet, the Individual Placement and Support model is not readily available in most states (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Evidence-based practices such as Individual Placement and Support are well established in the literature as having a significant impact on successful employment outcomes for people with serious mental illness (Bond, 2004; Bond, Drake, & Becker, 2008). The research-to-practice gap is one of the most frustrating issues in special education and rehabilitation given the difficulty in translating research to practice (Chan, Rosenthal, & Pruett, 2008; Cook & Odom, 2013).

Rehabilitation and special education have taken a passive approach to promoting implementation of evidence-based practices, using training as the way to spread the word and hoping that change will occur. Neither training nor simply hoping for change provides the systematic and ongoing supports needed to implement system change (Cook & Odom, 2013). Too little attention has been devoted to investigating the implementation of evidenced-based practices. Information related to evidence-based practices is often disseminated in traditional ways, such as journal articles and conferences with other researchers, which have little impact on the practitioner who is expected to implement the practices (Cook & Odom, 2013). Cook and Odom (2013) noted that successful implementation takes long-term, multi-level strategies that include seven core components:

- Staff selection,
- Pre-service and in-service training,
- Ongoing consultation and coaching,

- Staff evaluation,
- Program evaluation,
- Administrative support, and
- Systems interventions.

Statement of the Research Problem

This study concentrated on mental health professionals who are working at two different Alabama mental health facilities that are preparing to implement the Individual Placement and Support (IPS) model of supported employment. The focus of this study was the lack of information about the perceptions and practices of mental health and other rehabilitation professionals related to the employment of individuals with serious mental illness.

Purpose of the Study

The purpose of the study was to investigate the perceptions and practices of mental health and other rehabilitation professionals regarding the employment of people with serious mental illness. The information was gathered using a survey instrument soliciting practitioners' self-report of practices and perceptions associated with the employment of people with serious mental illness. The purpose was further delineated by several research questions.

Research Questions

The following research questions guided the study.

1. What are the demographic characteristics (such as years of service and position title) of the participants in this study?

2. What specific background information do participants who serve people with serious mental illness report? Information such as supervising and mentoring staff, challenges

and successes referring to employment specialists, and practical suggestions from mental health professionals to support their clients with vocational pursuits will be described.

3. To what extent do mental health professionals value competitive integrated employment for people with serious mental illness who are in recovery?

4. To what extent is there an association among mental health team members' acceptance of an employment specialist, support of an employment specialist, and value of an employment specialist?

5. To what extent is there a relationship between perceptions of mental health professionals related to the employment of people with serious mental illness and practices of mental health professionals related to the employment of people with serious mental illness?

6. What challenges exist in implementing the evidence-based practice of Individual Placement and Support?

Statement of Hypotheses

The following null hypotheses were developed for this study:

The first null hypothesis addressed the third research question.

Ho_1: There is no statistically significant difference in the value of competitive integrated employment for people with serious mental illness between mental health professionals who had worked for the median number of years and those who had worked more than the median number of years.

The second null hypothesis addressed the fourth research question.

Ho_2: There is no statistically significant association among the variables of acceptance of an employment specialist, support of an employment specialist, and value of an employment specialist among mental health team members.

The third null hypothesis addressed the fifth research question.

Ho_3: There is no statistically significant relationship between the overall score for perceptions of mental health professionals related to employment of people with serious mental illness and the overall score for practices of mental health professionals related to employment of individuals with serious mental illness.

Definition of Terms

Assertive community treatment (ACT) is an evidence-based practice that uses a team to provide comprehensive and flexible treatment and support to individuals with serious mental illness (NAMI, 2007). ACT delivers intensive services in the community where the individual resides and is available 24 hours a day, seven days a week. Teams include peer support specialists and clinicians with expertise in psychiatry, nursing, social work, substance abuse treatment, and employment, all working together to provide integrated and outreach-oriented services (NAMI, 2007).

Competitive employment is working in jobs found in local communities when potential employees compete with each other to fill any vacancies (Hanley-Maxwell, Maxwell, Fabian & Owens, 2010). The Rehabilitation Services Administration defines competitive employment as work 1) in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and 2) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who do not have a disability (Federal Register, 2012).

Competitive integrated employment has three essential elements: income (earning and benefits) typical of any employee, integrated in a setting typically found in the community

interacting with people without disabilities, and advancement opportunity typical of any employee. Supported employment is competitive integrated employment (WIOA, 2014).

Customized supported employment (CSE) is competitive integrated employment designed to meet both the specific abilities of the person with the most significant disability and the business needs of the employer (WIOA, 2014). CSE is selected for an individualized approach during the job development process, and leads to a negotiated employment outcome with employers such that: (a) the employee has a personalized job description that did not previously exist, and (b) the employer has a qualified worker to perform valued job duties within the workplace (Inge, 2008).

Discovery is based on an individualized determination of the strengths, requirements, and interests of a person and matching those to the needs of an employer based on information gathered from the job seeker and support team used during the customized supported employment process (ODEP, 2003).

Evidence-based practice is a process that starts with knowing what questions to ask, knowing how to find the best practice, and knowing how to critically evaluate the evidence for validity and applicability to the particular situation, with the final step being knowing how to evaluate the effectiveness and improve the process (Pruett, Swett, Chan, Rosenthal, & Lee, 2008; Test & Cease-Cook, 2012).

The **Individual Placement and Support** (IPS) model developed by Becker and Drake is the most conceptualized and is recognized as evidence-based supported employment (Bond, Drake, & Becker, 2008). The core principles of IPS are:

- Focus on competitive employment,
- Eligibility based on consumer choice,

- Rapid job search,
- Building relationships with employers,
- Integration of mental health and employment services,
- Attention to consumer preference in the job search,
- Individualized job supports are time-unlimited, and
- Personalized benefits counseling (Bond, Drake & Becker, 2008).

Supported employment (SE) is an overarching term which includes segregated and non-segregated employment with supports and services designed to assist individuals with a variety of disabilities (Manthey, Rapp, Carlson, Holter, & Davis, 2012).

Delimitations of the Study

The scope of this study was limited to mental health professionals at two mental health sites in Alabama, one site north central and rural, and the other one south and urban. The sample for this study was limited to mental health professionals working with adults who have serious mental illness, and who are employed at two different mental health centers in Alabama.

Limitations of the Study

The findings of this research study were based entirely on mental health professionals who work with adults who have serious mental illness, and who are employed at two different mental health centers in Alabama. Results of this study were limited to the extent that the researcher-designed instrument captured perceptions held and practices used by mental health professionals related to the employment of individuals with serious mental illness. Also, this study was limited to the extent that an independent samples t-test, the Spearman rank-order correlation procedure and the Pearson Product Moment correlation statistical procedure accurately revealed the results.

Assumptions of the Study

The following assumptions applied to this study:

1. Participants responded honestly to the questionnaire.
2. Participants were confident in their ability to perceive the employment potential for the consumers they serve.
3. Participants were confident in their knowledge of practices that assist people with serious mental illness reach their employment potential.
4. Questionnaire items were designed to reflect true perceptions held and daily practices used by mental health professionals.

Need for the Study

Extensive research offers evidence that the provision of supported employment services that adhere to the IPS model leads to positive employment outcomes for people with serious mental illness; however, supported employment services using the IPS model are not consistently available across the country. Understanding the clinical team's perspective on the role of employment in recovery and how they perceive the employment prospects of their current clients are important, as mental health professionals' attitudes toward employment can (a) determine the rate of referrals, and (b) help or hinder the clients' vocational progress (Gladman et al., 2015).

Significance of the Study

Supported employment is a cost-effective service that leads to competitive employment outcomes for people with the most significant disabilities within the current VR system (Cimera, 2010). Despite evidence that supported employment is an effective service for individuals with

serious mental illness pursuing employment, only 1.7 percent of individuals served by mental health agencies receive supported employment services (SAMHSA, 2012).

Work helps people previously excluded from society to have the opportunity for a typical life, and that such a life can be obtained in the context of people being in valued social roles within their communities, such as employee (Lemay, 2006; Tyree, Kendrick, & Block, 2011). Employment gives people a sense of purpose and helps to build self-esteem and self-worth, which research has shown decreases symptoms of an individual's mental illness and reduces the need for other services, such as hospitalization and crisis interventions (Becker, Whitley, Bailey, & Drake, 2007).

The results of the survey may yield information about how practitioners' perceive and practice strategies regarding employment of individuals with serious mental illness. This information could provide insights to the researchers about potential professional development needs and goals, current uses of evidence-based practice (EBP), and knowledge of IPS. Harn, Parisi, and Miller (2013) recommend that when implementing EBP, practitioners should measure fidelity early and often to provide timely and responsive professional development and maximize outcomes. This study may contribute to understandings regarding fidelity to IPS and steps to take to assist mental health and rehabilitation professionals improve quality implementation.

CHAPTER 2. REVIEW OF THE LITERATURE

Introduction

Chapter I provided the background information for this study, statement of the research problem, significance and purpose of the study, research questions, statement of hypotheses, study limitations and assumptions. Chapter II provides a review of literature and research on the definition of supported employment, the theory of social role valorization, rigorous studies of the Individual Placement and Support model of supported employment, descriptive studies regarding customized employment, as well as studies concerning interagency collaboration with an analysis of literature relating to employment opportunities for people with serious mental illness.

Stigma theory proposes that people with disabilities face barriers as a result of social inequalities, negative attitudes, and devalued roles, not because of their diagnoses (Thomson, 1997). If people with disabilities are to be better accepted and integrated into society, then rehabilitation professionals must consider actions and strategies that enable all people to have positive and valued roles. Social Role Valorization (SRV) theory is a social science concept within the fields of sociology, psychology, education, and pedagogy, including role theory and learning theory (Osburn, 2006). SRV theory is defined as establishing, sustaining, and/or defending valued social roles for people, particularly those at value-risk, by using culturally valued means (Aubry, Flynn, Virley, & Neri, 2013; Wolfensberger, 2000).

Social role theory as it is interpreted by SRV looks at socially expected patterns of behaviors, expectations and privileges (Lemay, 1999). SRV theory notes that if people are

devalued and cast into a negative social role, they may be denied opportunities, be segregated from ordinary community life, experience imposed poverty, know loss of relationships, or be at increased risk of abuse or harm (Wolfensberger, 2011). To improve the options for people with the most significant disabilities, it is critical to explore the value of social roles, the impact of devaluation, the importance of social roles, and the implementation of strategies to improve the social roles of people with the most significant disabilities, which includes employee. Aligning supported employment services with the principles of SRV theory in order to improve the quality of employment outcomes for people with the most significant disabilities is a critical first step.

Social Role Valorization

Adding Value to Social Roles

SRV theory was inspired by Bengt Nirje's (1969) seminal discussion of normalization, and based on Wolf Wolfensberger's (1980) principle of normalization. Wolfensberger formulated SRV to clear up the confusion that existed around the concept of normalization. Williams (1999) commented on the evolution of SRV, noting that Nirje was primarily concerned with lifestyle while Wolfensberger was originally concerned with environment (normalization) which evolved into concern for relationships (SRV). The primary goal of normalization was the creation, support, and defense of valued social roles for people who are at risk of social devaluation (Wolfensberger, 2011, reprinted from 1983).

Wolfensberger's (2011) theory is that the well-being of people depends extensively on the social roles they occupy. If they are in valued roles, they are generally afforded the good things in life, but if they occupy devalued roles they will typically be treated badly by others. Osburn (2006) references a few major examples of the good things in life, such as being accorded dignity and respect, acquiring an education, having a voice in one's life, and being

given opportunities to work and be productive. The purpose of clarifying SRV is to develop an action plan that will positively change people's experiences. Using the word 'valorizing' focused the goal to add value since the consequences of being devalued resulted in people being treated badly. Additionally, the treatments and interventions they received were also devalued (Wolfensberger, 2011). How one is treated in life is directly related to how one is perceived in life. Smart (2009) referenced an old joke about a rich person being viewed as eccentric versus the poor person being considered mentally ill – even when their behaviors are the same. SRV is a way to look at social roles and the impact these roles have on the perception of the value of individuals with the most significant disabilities.

Devaluation

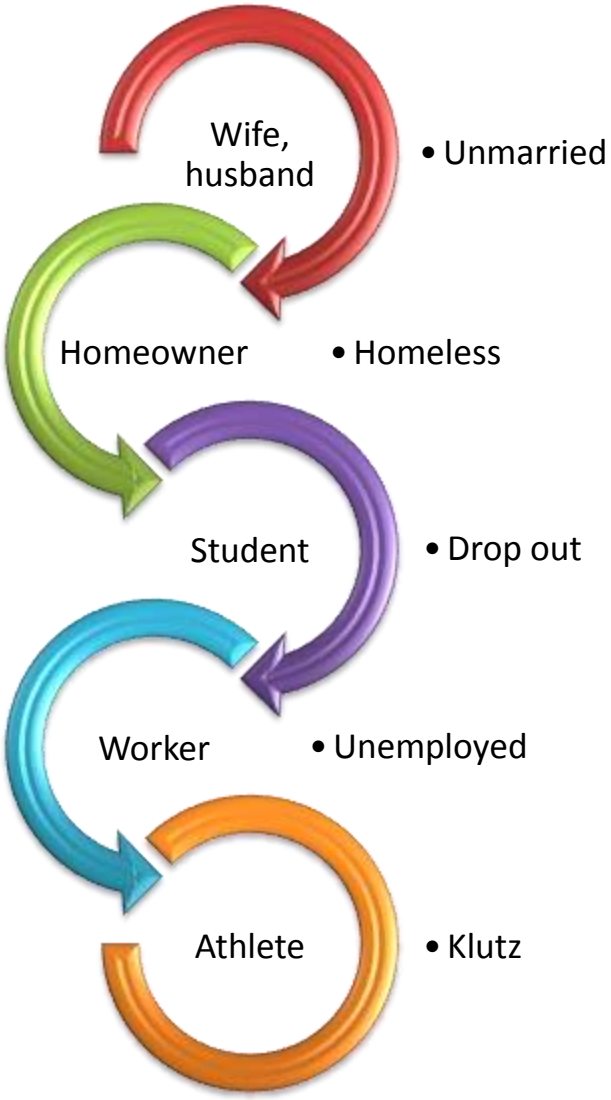
Devaluation is the attribution of low or even no value to one person by another based on some characteristic perceived as negative. Western society today places high value on wealth or material goods, health or beauty of body, youth or newness, competence, independence, intelligence, productivity, achievement, adult individualism, unrestrained choice, pleasure and happiness (Chandler & Lipson, 2013), while devaluing such characteristics as being poor or experiencing poverty, being old or elderly, being incompetent, or wasteful. People with atypical traits, as Smart (2009) noted, or who behave differently are often viewed as being deviant, which is defined by the dominant or defining segment of society. Devaluation occurs when a person becomes perceived or defined as devalued by being different from others in one or more areas that are perceived as significant and negative by the majority in society (Chandler & Lipson, 2013; Wolfensberger, 2000, 2011).

People have multiple social roles. Some may be valued roles while others are devalued; therefore, a person's value in society will depend on how much he or she represents what is

valued and the number of conditions he or she possesses that are valued. The negative consequences of this devaluation embody a cause and effect process. Society devalues certain qualities and conditions; therefore, the person seen as having these qualities becomes devalued and is then rejected, cast into devalued roles, distanced from people with a valued status, symbolically "branded" as devalued and then subjected to all sorts of discrimination, social and physical abuse, and even violence (Chandler & Lipson, 2013; Wolfensberger, 2000). Typically, society and even the field of rehabilitation take a deficit-based versus strength-based approach to look at the goals and roles people pursue, which greatly impact the employment options open to people with the most significant disabilities. Before taking a look at how to change this process, it is important to identify the major role domains available to individuals in society.

Social Roles

Major role domains identified by Wolfensberger in 1983 (2000, 2011) include relationships, residence, occupation, education, leisure/sports, community, civic, religious belief, and culture. Wolfensberger (2000) provided examples of positive and negative roles people have in society; a few are illustrated in Figure 1. Inside each loop is an example of a role valued by society and to the right of the loop is an example of a devalued role. The red loop depicts relationships (wife, husband vs. unmarried); the light green loop captures residence (homeowner vs. homeless); the purple loop portrays education (student vs. drop out); the blue loop represents occupation (worker vs. unemployed); and the orange loop denotes leisure/sports (athlete vs. klutz) (see Figure 1).



Source: Wolfensberger, W. (2000). A brief overview of social role valorization. *Mental Retardation, 38* (2), 105–123.

Figure 1. Examples of People's Roles in Society within Five Domains

If someone is in a devalued role he or she is devalued, but if he or she moves into valued roles he or she moves to valued status. Identifying social roles is important because roles give a person a "place" in society that defines who he or she is in the world. Roles affect almost all aspects of one's life and the more an individual holds "larger than life" roles that are valued, the more others will accept his/her devalued roles (Wolfensberger, 2000). Social roles impact our interactions with others as evidenced by such questions as "What kind of work do you do?" "Who are your parents?" and "Where are you from?" Social roles also define who we have relationships with, who we associate with (are permitted to be with), and where and with whom we live.

There are multiple ways in which value is conveyed. Wolfensberger (2000) suggested these messages are communicated in such ways as physical context and environments (residence), language used with or about people (people-first language), and/or personal appearance (fashion statements). These value-laden messages are expressed when people with the most significant disabilities are "housed" in hospitals and special schools (devalued), but their image/role is enhanced if they live and are schooled with other valued people; that is, their peer group. For people with the most significant disabilities to be valued and integrated into the community, their roles and how they are perceived must change and be moved into valued positions with valued messages.

Action Strategies

Providing support for specific experiences and relationships relevant to the individual is a way to put the change from devalued to valued roles into action. Structuring environments and other practices to maximize valued perceptions of people, their positive perception of themselves and their competence in achieving and sustaining socially-adaptive behaviors also puts this

change into action (Wolfensberger, 2011). Wolfensberger (2011) further noted that professionals must work to make changes that will reduce or prevent the stigma of the person devalued and to effect societal perceptions and values so that a given characteristic or person is no longer seen as devalued.

Wolfensberger (2000) outlined several strategies for enhancing roles such as: a) expanding the positive roles a person already holds, b) avoiding entry into (additional) devalued roles, c) enabling entry into positively valued new roles or the regaining of valued roles previously held, d) extricating someone from currently held devalued roles, e) reducing the negativity of a devalued role currently held, and/or f) exchanging currently held devalued roles for less devalued new ones. These strategies play out in ways such as developing skills to increase someone's value, continuing as a student to avoid the devalued role of being unemployed, pursuing sports, and becoming an employee in an integrated setting. Another stratagem is giving an individual a voice in planning his/her own life, and encouraging him/her to make decisions about the future, employment, residence, and relationships.

Self-Determination

Self-determination is another approach being utilized for those people wanting to improve the value of their social roles (Wehmeyer, 1998; Wright, 1959). The concept of "self-determination" within the context of normalization for people with intellectual disabilities has been examined since 1969 with Nirje's seminal text on the principles of normalization (Wehmeyer, 1998). Some current best practices in the disability field, such as person-centered planning, empowerment, client choice, unpaid personal relationships, circles of support and even the use of people-first language, come from self-determination and SRV principles that are based on empirical research (Caruso & Osburn, 2011; Wehmeyer, 1998; Wright, 1959). These

strategies can be used to facilitate changing social roles to ones of higher value in society, thereby improving the quality of life experienced by people with the most significant disabilities.

For the field of rehabilitation, a key principle is assisting people with the most significant disabilities by taking action to move them into valued roles, such as sending someone to school to develop skills that will enhance existing roles, or pursuing employment at businesses that are valued by the person or family (e.g., Belk's vs. Dollar General), or forfeiting benefits (SSI or SSDI) to avoid the double devalued role of being unemployed and/or receiving benefits. These efforts make it possible for someone to move from unemployed and incompetent to competent and employed, or working at a devalued business to one that is valued, or being viewed as lazy and unmotivated to employee.

Obtaining competitive integrated employment versus attending a day program also impacts the perceived value of the person, in that the day program is less valued than employment. Too often people with the most significant disabilities get stuck at devalued day programs because providers and families choose to keep them in a day treatment program because it is easier, or the provider can earn more money. But this keeps people with the most significant disabilities in devalued roles. Efforts to improve these value-laden messages are critical to change the perceived value of people with the most significant disabilities. People can move in and out of valued roles, and rehabilitation professionals should be advocates for the equitable treatment and community integration of people with the most significant disabilities that will facilitate their movement to positively viewed roles. Once an individual is moved into the valued role of employee, she or he has an image positively valued and she or he is then more likely to be provided with experiences, expectations, and other life opportunities that generally will increase his/her competencies (Wolfensberger, 2011 reprinted from 1983).

Employment as a Valued Social Role

SRV's developmental model articulates assumptions that all people thrive when employed, and supported employment is a service that facilitates people with the most significant disabilities into this valued role of employee (Tyree, Kendrick, & Block, 2011). Based on the Code of Federal Regulations (2012), supported employment is competitive employment in an integrated setting with ongoing support services for individuals with the most significant disabilities. Supported employment is uniquely designed for people for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a serious disability, and for whom, because of the nature and severity of their disabilities, intensive support and extended services are needed in order for them to work successfully.

In addition, formal SRV theory is based on an understanding that all people, and especially people with the most significant disabilities, have vastly more growth potential that can be actualized when an individualized or customized approach is utilized to ensure the talents and strengths of the person are considered. Tyree, Kendrick, and Block (2011) recognized that competency development is natural; personal competency is highly culturally valued; the more competent an individual is the more accepting society will be of any negatively valued differences; and competencies are necessary in order to perform valued roles.

The mission, goal, and purpose of most human service agencies and providers are competency enhancement and skills development. Supporting individuals to build relationships and attain socially valued roles are central to creating truly inclusive communities. The potential for using supported employment to be the methodology to move people, once excluded, to the valued role of employee is significant. Therefore, aligning supported employment with the

principles of Social Role Valorization has the potential to be transformational within the domain of supported employment.

Employee Role through Supported Employment

In the vocational rehabilitation system, supported employment services includes ongoing support services provided for a period not to exceed 18 months, unless under special circumstances a longer period to achieve job stabilization has been jointly agreed to by the individual and the rehabilitation counselor and established in the individualized plan for employment, before an individual with the most significant disabilities makes the transition to extended services. Extended services are the delivery of ongoing support services and other appropriate services, after an individual with the most significant disabilities has made the transition from federal/state vocational rehabilitation agency support/funding. Ongoing support services are those services that are needed to support and maintain an individual with the most significant disabilities in supported employment. Supported employment (SE) has shown promising outcomes since it became available in the early 80s; however, access to SE services remains difficult if not impossible for people with serious mental illness (Becker et al., 2007; Bond, 2004) and for people with the most significant intellectual and developmental disabilities (Citron et al., 2008; Griffin et al., 2008).

Marc Gold challenged the assumption of "unemployability" for people with the most significant disabilities (Tyree, Kendrick, & Block, 2011) and this evolved into the concept of Customized Employment (CE). Customized employment is the advancement of supported employment and is designed to look at the unique strengths and talents of the individual. CE methodologies use a person-centered approach to identify strengths and individual qualities instead of looking to identify all the things the person cannot perform. For too long, the attitude

has been that if a person has a significant disability, work was not an option. This has kept people with the most significant disabilities in devalued roles. Identifying and pursuing services that lead to employment allows people with the most significant disabilities to move to the role of employee — a valued role.

One of the unique aspects of customized employment is the use of a vocational profile that involves reviewing experiences in seven areas: family relationships, community relationships, economic status, key life experiences, consequences of impairment, individual choice, and future aspirations (Williams, 1999). This life history approach allows the job developer to gain an appreciation of the unique experiences of each individual when considering options for employment. The purpose of the profile, also called Discovery, to find out the truth about a person and is based on an empathetic relationship versus a formal quantitative assessment (paper pencil tests) (Williams, 1999). Discovery moves vocational evaluations from a deficit-based approach to a more functional strength-based community assessment approach that increases the chance of identifying the gifts and talents of an individual (Griffin, 2014). Given this new context, supported employment is emerging as an improved human service practice with increased expectations about integrated employment possibilities, thus securing employment so that individuals with the most significant disabilities gain the valued role of employee.

Supported Employment (SE) and Social Role Valorization (SRV)

SRV offers a relevant and compelling lens for examining supported employment (SE) practices and the quality of service delivery. SRV emphasizes that people previously excluded from society could have the opportunity to have all of the advantages of a typical life, and that such a life can be obtained in the context of people being in valued social roles within their

communities, such as employee (Lemay, 2006; Tyree, Kendrick, & Block, 2011). SRV theory emphasizes the provision of supports for people so that they may obtain, grow into, and maintain valued social roles. SRV could also influence many service delivery practices, specifically supported employment. The assertion that people with the most significant disabilities should have access to the same everyday life opportunities and experiences that their fellow citizens enjoy stems from the theory's recognition of the negative effects of social devaluation.

Social roles define people's identities, as people tend to conform to the expectations of others. Therefore, it is important to raise the expectation and consider employment for all and to do so in a way that the person is an integral part of the process. This can be achieved through the application of several strategies: (a) informed choice, which provides accurate and relevant information in ways that are understood so that a real decision can be made; (b) pursuit of a typical and valued life, which is living in and interacting with others in the community; (c) utilization of natural supports in the workplace, which means people with the most significant disabilities are not separated from the workforce; and (d) exploring in depth a company's culture, closely adhering to the existing orientation and following typical on-the-job education (Tyree, Kendrick, & Block, 2011). Clearly, employment is a meaningful part of adult life; therefore, it is important to strengthen the valued roles and avoid the devalued roles (Smart, 2009; Wolfensberger, 2000). Assimilating the company culture and avoiding a "client" approach to bringing someone on board requires vigilance from employment specialists who move a person from the "human service client" role to that of valued employee.

Tyree, Kendrick, and Block (2011) further emphasized the importance of quality services to ensure quality employment outcomes, noting the following strategies: a) devoting time to get to know and understand the job seeker while discerning his/her personal interests and talents

related to employment; b) negotiating a job that capitalizes on these personal interests and talents; and c) ensuring that excellent instruction about job expectations are provided, and that the instruction is delivered to the fullest extent feasible by those within the business who typically provide it. These principles have formed the standard for Customized Employment, a flexible blend of strategies, services, and supports that builds on the SE approach, which promises to offer the rehabilitation field an effective option to increase employment outcomes of job seekers with the most significant disabilities (Griffin, Hammis, Geary, & Sullivan, 2008; Luecking, Cuozzo, Leedy, & Seleznow, 2008).

In 2001, the U.S. Department of Labor coined the term 'Customized Employment' (CE), which represents the evolution of supported employment, such that the job developer starts with the person and engages employers through a negotiation to develop a position based on employer needs and candidate skills (Griffin, Hammis, Geary, & Sullivan, 2008). The principal components of CE include:

1. Discovery to create a vocational profile;
2. Individualized job search planning;
3. Job development and negotiations;
4. Provisions of individualized supports in the workplace; and
5. Ongoing post-employment supports and monitoring to ensure successful employment. (Luecking, Cuozzo, Leedy & Seleznow, 2008)

Finding and retaining a meaningful job is not a simple process. The tasks involved consist of more than job leads, skills training, or job coaching. It is also important to offer benefits counseling, resolve transportation issues, address family matters, determine medication adjustments, tackle social situations at work, and intervene with the employer as needed (Drake,

Becker, Bond, & Mueser, 2003). This complexity requires a team effort to coordinate and provide the array of services needed with the client at the center directing it all. For many years, vocational and clinical services for individuals with serious mental illness (SMI) have been separated (Drake, Becker, Bond, & Mueser, 2003). However, the research of the Individual Placement and Support (IPS) model of SE demonstrated that closer coordination between clinical and vocational service providers leads to better employment outcomes (Drake, Becker, Bond, & Mueser, 2003) as all issues can be timely and effectively addressed by the team.

As defined in the 1973 Rehabilitation Act (as amended), SE features the following: (a) clients work for pay, preferably at the prevailing wage; (b) clients work as regular employees in integrated settings that include employees without disabilities; and (c) clients receive ongoing supports. IPS provides a standardized approach to integrating SE services and mental health services within a mental health program. The IPS model is based on empirically-validated principles of vocational rehabilitation (Drake, Becker, Clark, & Mueser, 1999). Mental Health (MH), Vocational Rehabilitation (VR), Centers for Medicare and Medicaid Services (CMS), and supported employment providers will need to synthesize funding mechanisms in order to support the IPS and CE approaches.

Despite evidence that people rarely move from day programs into the realm of typical employment, the notion that congregated and segregated programs "need" to exist to make one "ready" for typical employment still somehow persists (Tyree, Kendrick, & Block, 2011). Despite research to the contrary, funding continues to support employment service approaches that congregate people with disabilities, such as workstations in industry, mobile work crews, and enclaves as opposed to quality approaches to supported employment. Using the empirical research of SRV theory to demonstrate evidence for change and for adherence to quality

standards of both CE and IPS, SRV principles may facilitate the change that is needed. Efforts are underway to increase the utilization and application of standards for supported employment as a methodology to increase the employment outcomes for people with the most significant disabilities that will increase the potential of moving them into the valued role of employee.

Social Integration Conditions for Effective Employment

Supported Employment sets the framework for successful employment for people with the most significant disabilities, which includes the relevant social integration conditions that must be present for success: (a) personalized supports or adaptations provided for the worker in typical ways; (b) opportunities for interactions with employees without disabilities while involved in the typical work and social functions of the business; (c) the person is clearly in the role of a valued employee, such that the work responsibilities and place of employment is socially valued; and (d) people with the most significant disabilities work in personalized jobs and are not grouped together if more than one person with a disability is employed at the same company (Tyree, Kendrick, & Block, 2011).

Setting these as the standards for providers, delivering training about these principles, and establishing expectations of model coherency are critical to move the SE practice forward. Model coherency sets the expectation that the service is designed and provided to meet the needs of the individual, not the agency providing the service, using the right materials, methods, and language (Lemay, 2006; Wolfensberger, 2000). Typically organizations provide SE as an add-on service by organizations designed to sustain segregated employment, day programs, or residential programs (Tyree, Kendrick, & Block, 2011). The researcher's own experiences found that Medicaid waivers pay providers more to have someone in a day program than to pursue employment and provide the needed supports. This practice creates a huge disincentive. Further

research is needed to develop evidence of practice, followed by using the evidence to convince leadership to implement this service model strategy within the rehabilitation field to facilitate quality employment outcomes that provide people with the most significant disabilities the opportunity to be valued employees.

In addition, formal SRV theory provides cautions about practices often confused with social integration such as: (a) "dumping" a socially devalued person into the community when the person lacks adequate abilities to cope, is without support systems, and/or the community area is already saturated with other services to devalued people; (b) denying people needed special services; and (c) serving a wide variety of devalued people within the same setting (Tyree, Kendrick, & Block, 2011). These practices appear to be typical in the current system, though unintentionally, as the system is set up to reinforce these practices. Efforts to build the infrastructure and effect system change are critical to prevent these practices from continuing.

Interagency collaboration is considered a best practice given the complex needs of individuals with the most significant disabilities. It is not realistic to expect one single system to pay for and effectively provide the array of services needed; however, when agencies collectively work together, these resources can create positive results (Luecking et al., 2008). Agencies working together allow for braiding funding as well as opportunities to share practices that hold providers accountable for quality services. Work provides people — with or without disability — financial security, purpose, economic options, social relationships, the chance to develop skills and competencies, and the opportunity to make a difference (Smart, 2009). This is why it is so important to put SRV into action to increase the employment rate of people with the most significant disabilities.

SRV Principles to Improve Supported Employment

Tyree, Kendrick, and Block (2011) suggested four principles of SRV to move someone to valued social roles through supported employment: (a) providing opportunity for authentic choice, (b) building on the valued social role of employee, (c) recognizing and addressing a person's vulnerability, and (d) pursuing quality employment that meets the unique strengths of the individual. Many SE providers pursue the easy job versus the position the person chooses. Informed choice has been a part of vocational rehabilitation (VR) since at least the early 1990s, but it is not really a part of the developmental disability (DD) or mental/behavioral health (MH or BH) systems.

Transitioning the adult service systems toward pursuing the individual's stated choice would help achieve quality of life plans. If adult service agencies charged with meeting the needs of people with the most significant disabilities (mental health, developmental disabilities, vocational rehabilitation, Medicaid) actively consider value-risk statuses and promote valued statuses, it could lead to more people with the most significant disabilities having valued roles. The rehabilitation professional must also ensure that the job fits the person in all areas in order to structure the workplace for success. Discovery is designed to look at all aspects of the individual to identify personal preferences and positive employment options. An individualized approach to employment results in exclusively designed services, supports, and jobs negotiated to fit the needs of a specific job seeker and employee for both CE and IPS. These strategies also address aspects of other employment approaches, such as supported employment services, supported self-employment services, individualized job development, and/or job carving and restructuring (Griffin, Hammis, Geary, & Sullivan, 2008).

Employment

According to the National Organization on Disability (NOD) 2010 survey, only 21% of all working-age people with disabilities report that they are employed compared to 59% of people without disabilities. This unemployment rate means that people with disabilities are much more likely to be living in poverty (NOD, 2010), and thus, individuals with the most significant disabilities who need supports are often given negative labels and stand at risk of rejection, segregation, isolation and limited opportunities (Citron, Brooks-Lane, Crandell, Brady, Cooper, & Revell, 2008). In order to change this experience, new or improved services identified as evidence based practices in achieving successful employment outcomes for people with the most significant disabilities must be available to the state agencies funded to provide this service, specifically the state/federal vocational rehabilitation program.

Research increasingly describes an expanding array of employment outcomes available to individuals with the most significant disabilities while transitioning into employment, such as customized employment, resource ownership, job carving, microenterprise, and business within a business (Brooke, Revell, & Wehman, 2009). These employment outcomes reflect careful job matches negotiated with businesses in the community. Brooke, Revell, and Wehman (2009) outlined seven core indicators of quality competitive employment services:

1. Benefits planning – the impact of going to work and receiving disability benefits is important to effectively plan for a successful employment outcome prior to accepting an offer of employment;
2. Individualization of job goal – the individual with the disability is empowered to make the decisions regarding the type of position pursued and where the position is secured;

3. Quality of competitive job – is to be determined by the wages and hours of the position such that the person is being paid real wages for real work;
4. Consistency of job status with that of co-workers – parity is present between employees with disabilities and other employees without disabilities;
5. Employment in an integrated job setting – position secured is in a work setting with people with disabilities working with people without disabilities in positions that are not simply set aside for people with disabilities;
6. Quality of job-site supports and fading – long term supports at the worksite are provided for as long as needed with supports decreasing as competencies are increasing; and
7. Presence of ongoing support services for job retention and career development.

Many youth with the most significant disabilities will need supported employment in order to be successful in the workplace. Supported employment by definition requires extended supports. Employment supports through DD services or Medicaid waivers ensure greater access to supported employment. However, if an individual does not receive these supports, the limited resources available may prevent successful employment. VR's time-limited funding responsibility for supported employment points out the need for long-term supported employment funding and service commitment from other state agencies such as state mental health and/or developmental disability (Metzel, Foley, & Butterworth, 2005). However, all adult service agencies have limited resources to meet the ever-growing demand for services by people with the most significant disabilities, particularly if that individual wants to go to work.

The supported employment process assesses a person's ability and interests and then identifies viable work opportunities. Assistive technology may enhance the consumer's abilities

while job-site training reinforces and strengthens these abilities (Inge, Strobel, Wehman, Todd, & Targett, 2000). Together, this package of supports can facilitate employment for people with the most significant disabilities (Inge et al., 2000). Funding for supported employment services remains a serious problem, and the persistent lack of funding for long-term support will severely limit those who can benefit from supported employment (Brooke, Revell, & Wehman, 2009; Inge et al., 2000; Karakus, Frey, Goldman, Field, & Drake, 2011).

Research conducted by Inge, Strobel, Wehman, Todd, and Targett (2000) indicated that successful employment outcomes (including supported employment) can only be achieved when adult employment programs become efficient and effective selling their services to meet employers' priority needs. When employment programs for people with the most significant disabilities approach businesses with the idea of creating jobs, businesses often fear they will increase costs rather than company efficiency. Therefore, the researchers emphasized the need to view the effort from a job restructuring approach — meeting an employer's priority need — rather than the notion of creating jobs for people with the most significant disabilities (Inge et al., 2000).

The report by Karakus, Frey, Goldman, Fields, and Drake (2011) to Health and Human Services on federal financing of supported employment summarized that coordination and collaboration among state agencies, including mental health, vocational rehabilitation, developmental disabilities, and Medicaid, are critical to forming a viable and successful plan for providing and funding customized services that lead to employment for people with the most significant disabilities. The need is even more critical in developing strategies that effectively empower people with the most significant disabilities to become part of the labor force (Inge, 2008).

Definitions

Before examining the effectiveness of supported employment, it is necessary to understand the terminology to avoid confusion over semantics. **Evidence-based practice** (EBP) is a process that starts with knowing what questions to ask, knowing how to find the best practice, and knowing how to critically evaluate the evidence for validity and applicability to the particular situation with the final step being knowing how to evaluation the effectiveness and improve the process (Pruett, Swett, Chan, Rosenthal, & Lee, 2008; Test & Cease-Cook, 2012). The hierarchical levels of evidence include: 1) strong evidence from at least one systematic review of multiple random controlled trials, 2) strong evidence from at least one well designed random controlled trial, 3) evidence from well-designed trials without randomization, 4) evidence from well-designed non-experimental studies from more than one research group, and 5) opinions from well-respected authorities based on clinical evidence or descriptive studies (Pruett, et al., 2008).

Delivering quality employment services to individuals with the most significant disabilities requires a substantial commitment of time, energy, and resources (Kugler & Thomas, 2007); yet too often, services are developed based on either personal experiences or anecdotal evidence. Therefore, it is critical that research be conducted that shows how to implement evidence-based practices that yield improved employment outcomes. Three evidence-based practices will be examined: Customized Employment (CE), Individual Placement and Support (IPS), and Interagency Collaboration.

Hanley-Maxwell, Maxwell, Fabian and Owens (2010) defined **competitive employment** as working in jobs found in local communities when potential employees compete with each other to fill any vacancies. In contrast, customized supported employment's primary focus is on

contribution instead of competition (Phillips, et al., 2008). This differs from what has been described as typical employment practices used by Vocational Rehabilitation (VR) which aim to place job seekers within the context of competitive hiring practices (Szoc & Harvey, 2009). However, the Vocational Rehabilitation Program defines **competitive employment** as work (a) in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and (b) for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled (Federal Register, 2012, 361.5 (11)). There is no actual stipulation by VR that work must be obtained competitively for work to be considered competitive, but rather the focus is on real jobs at real wages as defined above. **Competitive integrated employment** (WIOA, 2014) has three essential elements: income (earning and benefits) typical of any employee, integrated in a setting typically found in the community interacting with people without disabilities, and advancement opportunity typical of any employee. Supported employment is competitive integrated employment.

Supported employment (SE) is an "umbrella term" that includes segregated and non-segregated support and services designed to assist individuals with a variety of the most significant disabilities in obtaining employment (Manthey, Rapp, Carlson, Holter, & Davis, 2012). However, for the purposes of this study, the definition used is from the Rehabilitation Services Administration, which defines supported employment as an integrated competitive job in the community that pays at least minimum wage and is located in a work setting that includes people who do not have a disability. Ongoing supports are provided as long as the individual needs assistance and are intended for people with the most significant disabilities (Federal Register, 2012).

One of the cornerstones of supported employment is the network of supports that are developed to assist the individual as the job is developed, secured, and maintained. Typically the employment specialist who assisted the individual with securing the position will provide training and coaching to help the person to learn the job, but just as often support is provided off the job site with supportive counseling and problem solving (Pratt, Gill, Barrett, & Roberts, 2014). Supports are provided as long as the individual needs the service, but within vocational rehabilitation, supports are provided as long as the person is employed at that specific job (Federal Register, 2012).

Although there are several SE models, the **Individual Placement and Support** (IPS) model developed by Becker and Drake (2003) is the most conceptualized and is recognized as evidence-based supported employment (Bond, Drake, & Becker, 2008). The core principles of IPS are 1) 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, 7) develop relationships with employers to understand their business needs, and 8) personalized benefits counseling (Bond, 2004; Bond, Drake & Becker, 2008).

IPS uses assertive outreach, based on the **assertive community treatment** (ACT) case management model for service, to deliver most services in clients' natural settings in the community rather than treatment facilities (Mueser et al., 2004). ACT is an evidence-based practice that uses a team model to provide comprehensive and flexible treatment and support to individuals with serious mental illness (National Alliance on Mental Illness [NAMI], 2007). ACT delivers intensive services in the community where the individual resides and is available 24 hours a day, seven days a week. Teams include peer support specialists and clinicians with

expertise in psychiatry, nursing, social work, substance abuse treatment, and employment, all working together to provide integrated and outreach-oriented services (NAMI, 2007).

Customized employment is not new, but rather a flexible blend of accepted strategies, services, and supports designed to increase employment options for job seekers with complex needs through voluntary negotiations within the employment relationship (Citron et al., 2008). Citron et al. (2008) noted the following methodologies of customizing a job include, but are not limited to:

- **Job carving** is the act of analyzing work duties performed in a given job and identifying specific tasks that might be assigned to an employee with the most significant disabilities;
- **Job creation** is a way to modify or restructure existing jobs or bring together a combination of job tasks that fulfill unmet job place needs of an employer while capitalizing on the skills and strengths of workers with the most significant disabilities;
- **Resource ownership** is a mutually-beneficial process of acquiring materials, equipment, or skills that, when matched to a job seeker's interests and customer needs, generates profits for the employer and wages for the employee (Griffin et al., 2008);
- **Microenterprise** describes an approach toward helping people develop sustainable jobs through the creation of ultra-small (micro) businesses;
- **Business within a business** is defined as establishing a small business within a larger one that complements the existing larger business;

- **Job negotiations** is defined as working collaboratively with the job seeker and the employer to discuss modification of a job to meet the unique needs of the individual and to satisfy employer needs;
- **Job sharing** is two or more people sharing one job, each performing a different aspect of the job based on the unique skills of each individual;
- **Natural supports** are those provided at the workplace by individuals who naturally exist at the site, such as a co-worker or supervisor (Pratt, et al., 2014); and
- **Self-employment** is working as your own boss, typically with CE it is a small business with supports.

Many of the practices defined above are specifically selected for an individualized approach during the job development process. This leads to a negotiated employment outcome with employers such that: (a) the employee has a personalized job description that did not previously exist, and (b) the employer has a qualified worker to perform valued job duties within the workplace (Inge, 2008).

Rehabilitation professionals are encouraged to work together with their clients to integrate assessments, typically referred to as a vocational profile, into the rehabilitation process; customized employment designates this process as **Discovery** (Phillips et al., 2008). VR traditionally uses quantitative assessments such as a vocational evaluation (using pencil and paper tests) to determine skills and abilities to predict vocational outcomes (Parker, Hansmann & Schaller, 2010). However, for persons with the most significant disabilities, these types of assessments are not typically reliable or valid (Parker, Hansmann & Schaller, 2010). Rather than being based on an evaluation, Discovery is based on an individualized determination of the

strengths, requirements, and interests of a person and matching those to the needs of the employer (ODEP, 2003).

Supported Employment

VR is measured by the "employment outcome of an individual, entering or retaining full-time or, if appropriate, part-time competitive employment, in the integrated labor market, that is consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice" (Federal Register, 2012, 361.5 (16)). Therefore, the rehabilitation counselor needs to use effective practices that will facilitate the successful employment of people with the most significant disabilities. The techniques of IPS and CE build on proven principles, services and strategies, and result in individually designed services, supports, and occupation(s) negotiated to fit the needs of the specific job seeker (Griffin et al., 2008; Luecking et al., 2008). To consider the value of supported employment, one must look at the research to evaluate the potential impact of IPS and CE services and strategies on the employment outcomes for people with the most significant disabilities.

Individual Placement and Support

Individual Placement and Support (IPS) is a well-established evidence-based practice with over 20 years of research that demonstrated a consistent increase in employment outcomes for people with the most significant disabilities, specifically, serious mental illness (Bond, Drake, & Becker, 2008). The IPS model of supported employment is well-defined and is built on a foundation of eight core principles: (1) Consumer choice – individuals who are interested in work are eligible for IPS without exception; (2) Integrated services – vocational and mental health services are part of the same treatment team; (3) Competitive employment in an integrated setting; (4) Place and train – individuals go to work as soon as they feel ready, without extensive

training or career exploration; (5) Personalized supports – after the job is secured, ongoing supports are provided for as long as the individual and employer want/need them; (6) Person-centered services – the client's personal preferences, experiences, strengths, and choice drive the job search, not the employment specialist; (7) Benefits counseling – provided to clients to ensure successful navigation through the system; and (8) Building relationships with employers – employment specialists meet with businesses to identify hiring needs and qualities of a qualified candidate (Bond, 2004; Bond, Drake & Becker, 2008).

Unemployment is common for persons with serious mental illness (SMI) with competitive work rates typically ranging between 10% and 20% (Mueser et al., 2004). "Despite the high rate of unemployment, most clients with serious mental illness want to work" (Mueser et al., 2004, p. 479). In IPS, employment specialists and sometimes the VR counselor serve on the client's treatment team alongside other clinical members, including case managers and psychiatrists. Each employment specialist provides the full range of vocational services, identifying job interests and vocational assessments, job finding and job support.

As previously noted, research demonstrated that synchronization between clinical and vocational service providers leads to better employment outcomes. Drake, Becker, Bond, and Mueser (2003) conducted eight random controlled trials that compared integrated and non-integrated (separated) services. The typical difference in employment rates was three or more times greater with integrated programs (Drake, Becker, Bond & Mueser, 2003). Data analysis suggest that four factors were consistently associated with the integrated service delivery option:

1. Engagement and retention — higher dropout rate with non-integrated programs;
2. Communication — non-integrated programs had higher incidences of miscommunication and difficulties coordinating services. Integrated programs had stronger team communication;
3. Philosophy of mental health treatment — vocational experts joining existing MH treatment teams may change the mindset of clinicians; and
4. Employment plans and clinical understanding — together the vocational process became more clinically informed, and vice versa, building on the strength of each other (Drake, Becker, Bond & Mueser, 2003).

Mueser et al. (2004) conducted a study that compared three models of SE: IPS, psychosocial rehabilitation, and standard services. The target audience was people with serious mental illness (46% African Americans and 30% Latinos) for a total of 204. The participants were randomly assigned to the three models and followed for two years. Those receiving IPS had significantly better work outcomes (74% vs. 18% vs. 28%), with one-way ANOVAs and MANOVAs and chi-square analysis indicating no differences at baseline (Mueser et al., 2004).

Bond et al. (2007) conducted a randomized control study comparing two approaches for individuals with serious mental illness to pursue their vocational goals: IPS and the diversified placement approach (DPA), which emphasizes work readiness and offers a range of vocational options, including agency-run businesses and agency-contracted placements with community employers. The 187 participants were randomly assigned to IPS or DPA. Over two years, IPS had significantly better competitive employment outcomes than DPA but there was no significant difference with paid employment (Bond et al., 2007).

Becker et al. (2007) reviewed six states and the District of Columbia that were implementing the evidence-based IPS model of SE. The researchers used a case study approach and identified five diverse strategies used to implement SE services:

1. Instituting state-level administrative procedures and reconfiguration of local staffing to enhance collaboration between MH and VR;
2. Promoting SE services through media, on-line training, and training by early adopters;
3. Hiring benefits specialists;
4. Teaching outcomes-based supervision; and
5. Building capacity for SE fidelity reviews (Becker et al., 2007, p. 13).

Becker, Lynde, and Swanson (2008) further reviewed key strategies for implementing IPS, specifically the Johnson and Johnson partnership with Dartmouth Community Mental Health Program. The researchers collaborated with nine states and Washington, DC to provide technical assistance and training to develop high fidelity that resulted in good employment outcomes for individuals with serious mental illness. Evidence-based models of SE are by far the most effective way to help people with serious mental illness work in competitive integrated positions (Becker, Lynde, & Swanson, 2008). During the first year, the program delivered informed support for implementing SE, created a state-level steering committee, developed in-state technical assistance capacity, and selected sites for initial implementation (Becker, Lynde, & Swanson, 2008). During the second year, the program implemented SE with high fidelity to the IPS model and developed plans to expand statewide. Ongoing technical assistance and training are required to develop and sustain high fidelity to the model that results in good

outcomes (Becker, Lynde, & Swanson, 2008). The researchers identified ten key dissemination strategies:

1. State level SE champion – leadership skills, advocacy, knowledge about IPS, and ability to interface effectively with MH and VR;
2. Training and technical assistance capacity – one full time SE trainer/consultant to ensure supervisors learn the skills to be able to provide ongoing support for job development and job supports;
3. SE fidelity reviews – local capacity to effectively evaluate SE delivery;
4. Integration between MH and VR – strong leadership at state level;
5. Communication across state SE trainers;
6. Educational and training materials;
7. Involvement of MH and VR directors;
8. Incremental learning – start small and build on what works;
9. Site selection – one of the most important early tasks – selecting the best sites! Careful evaluation is key; and
10. Importance of partnership with a large employer – Johnson & Johnson brings credibility (Becker, Lynde, & Swanson, 2008, pp. 297–298).

Bond, Drake, and Becker (2008) reviewed eleven randomized controlled trials of IPS for individuals with serious mental illness and were able to conclude "that the majority of IPS participants obtained competitive employment, at a rate far higher than clients enrolled in other vocational services" (p. 386).

Campbell, Bond, Gervey, Pascaris, Tice, and Revell (2007) researched utilizing fidelity scales that measure the degree of implementation to ensure SE services are reliably and validly

delivered. The researchers used opportunity sampling to survey SE providers – 33 community mental health centers, 18 psychosocial rehabilitation centers, 31 comprehensive rehabilitation centers, and 24 in other social service agencies – and then completed telephone interviews using the Quality of Supported Employment Implementation Scale (QSEIS) to explain the quality of services (Campbell et al., 2007).

The researchers compared the four types of provider organizations on the QSEIS measures using univariate one-way analysis of variance with Tukey's post-hoc t-tests. The researchers used an explanatory mixed method design by conducting a quantitative survey with follow-up qualitative interviews. The researchers found that the community mental health centers rated significantly higher on fidelity than the other programs (Campbell, et al., 2007). Given the significance of the findings, the researchers noted the following implications: integrating SE services with mental health services is critical, current funding of such services is through separate agencies resulting in fragmentation of services, and when provider organizations emphasize job readiness services the employment outcomes are much lower (Campbell, et al., 2007).

Bond, McHugo, Becker, Rapp, and Whitley (2008) identified four factors that facilitated movement toward fidelity:

1. Discontinuing non-evidence-based vocational services, such that the site is transformed to only offer evidence-based services (to only offer IPS vs. sheltered enclave services);
2. Making rapid structural changes through administrative action, and fidelity review feedback, sites can implement changes quickly through administrative action (adopting caseload sizes limits of 25);

3. Measuring key process indicators to move toward desired changes, track performance in the areas where change is preferred (measuring the number of employer contacts per week to compare with expectations);
4. Gradually improving integration of employment specialists with clinical services, primarily through supervisor leadership is necessary because change is difficult given the history of skepticism, but assigning employment specialists to the team is the first step.

As IPS is disseminated and the movement gathers momentum, providers need guidance about implementing and sustaining high-quality services. Bond, Drake, and Becker (2008) identified two main components for successful implementation:

1. An implementation resource kit which contained such materials as videos illustrating the practice, a practitioner workbook, brochures for different stakeholders, and quality improvement tools; and
2. Consultant/trainer who provided assistance according to a framework developed for the project. The training included a kickoff session to introduce the practice to all stakeholders and skill-based models for practitioners, followed by a needs-based training and ongoing clinical supervision to the program leaders and practitioners. (p. 301)

This literature review examined several empirically-based studies that explored insights into current practices. Twenty years of research and analysis conducted with controlled experiments successfully demonstrated significant evidence of practice within IPS. As a service strategy, IPS indicates that people with significant psychiatric disabilities can secure employment when professionals combine rapid job search and vocational rehabilitation services as part of the

clinical treatment team, and then maintain employment with supports and assistive technology within the workplace (Mueser et al., 2004). A compilation of the studies reviewed is found in Table 1.

Table 1

Research of Individual Placement and Support

Author	Conditions	Population	Site	Statistics	Outcomes
Becker, et al., (2007)	Review of seven sites implementing IPS	Case study approach for each site	MD, SC, DC, OR, VT, KS, CT	NA	Johnson and Johnson supported application of SE. Strengthened partnership VR and MH and identified strategies for implementation
Becker, et al., (2008)	Review key strategies for implementing IPS	10 sites implementing IPS		NA	Dissemination strategies developed, improved employment outcomes for 4,787 people receiving IPS services with 49% securing competitive work
Bond (2004)	Reviewed evidence of SE effectiveness, and IPS to alternative approaches	4 studies investigating employment vs. day treatment and 9 trials for IPS	NH, NY, CT, DC, SC, IN, NY, CA, MD	Experimental design, random control trials, pre-post comparisons with percentages	Improved employment outcomes with IPS when followed with fidelity
Bond, et al., (2007)	Compared two approaches: IPS and diversified placement approach (DPA)	Clients (187) with SMI were randomly assigned	IL	Interviewed every three months over 2 years follow up Chi Square & Cohen's d	Competitive employment rates were higher for IPS with 75% IPS and 33% for DPA, but wages did not differ.
Bond, Drake, & Becker, (2008)	Comprehensive Literature review of randomized controlled trials of IPS	11 studies located and reviewed	NH, DC, MD, CT, SC, HK, CA, IL, CAN, AU, EU	Random control trials. Longitudinal review. Meta-Analysis	Employment outcomes 61% for IPS and 23% for control group. Effect size calculated approximation ranged from .56 – 1.23

(table continues)

Table 1 (continued)

Author	Conditions	Population	Site	Statistics	Outcomes
Bond, et al., (2008)	Looked at fidelity of IPS over time (2 years)	9 sites from 3 states		NA	Examined fidelity every 9 months. Identified factors that facilitate fidelity and to implement successfully Qualitative – inter-views, and quantitative – fidelity reviews
Campbell, et al., (2007)	Compared provider type to fidelity of IPS implementation	106 SE programs	Multiple States	Factor Analysis, one-way ANOVA with Post-hoc; Cohen's d	Type of provider is an important factor for fidelity
Drake, et al., (2003)	Looked at impact of MH and VR services integrated with SE services – integrating clinical with vocational services	3 independent studies of SE – comparing outcomes for those receiving integrated services and those not integrated	NH, DC, CT	Quantitative process data, ethnographic findings, and qualitative interview data	Integrated programs were more successful than non-integrated programs. Data coded for analysis
Mueser, et al., (2004)	Compared three approaches: IPS, psychosocial rehabilitation, and standard MH services	Clients (200) with SMI were randomly assigned	CT	ANOVA, MANOVA, and chi square	IPS had significantly better employment outcome. Employment data collected for 2 years with interviews at baseline and every 6 months for 2 years. 74% vs 18% vs 28% respectively. IPS statistically significant outcome based on pairwise comparison

Customized Employment (CE)

Research shows supported employment is a cost-effective service that leads to positive competitive employment outcomes for people with the most significant disabilities within the current VR system (Cimera, 2010). Customized supported employment, conceived as a way for one-stop systems to welcome and serve individuals with the most significant disabilities, centers

on the use of upfront fact-finding as essential to uncover the unique needs, abilities and interests of the job seeker (Inge, 2008). This information is then used in employer negotiations to develop a position and determine job duties (Elinson, Frey, Li, Palan, & Horne, 2008). The mutual benefit that results when job seekers with disabilities are matched to employers' needs has the potential to increase the employment of people with the most significant disabilities (Griffin, Hammis, Geary, & Sullivan, 2008).

Inge, Strobel, Wehman, Todd, and Targett (2000) described how workplace supports were developed and implemented for a group of individuals with the most significant disabilities. Twenty-one individuals secured competitive employment after the project used person-centered career plans, supported employment, and on-the-job assistive technology and training. The study was conducted at a major university research center; the team worked with local rehabilitation counselors and social workers at a nursing home to select participants, whose demographics included: 43% with a diagnosis of cerebral palsy, 38% with spinal cord injuries, 14% with traumatic brain injuries, and 5% with other developmental disabilities (Inge, et al., 2000). Criteria for acceptance into the project were that the individual must have a significant disability and be chronically unemployed; however, there was no statement of how participants were chosen for the study. Inge et al. (2000) stated preliminary findings indicated people with the most significant disabilities could secure employment by combining individualized assessments and job development, and then maintain employment with supports and assistive technology within the workplace. The diverse employment positions had an average wage of at or above minimum wage at that time ($5.87 per hour), with jobs maintained for an average of 15½ months (Inge et al., 2000). The methodology provided the necessary promotion, involvement and long-

term support needed to secure positive employment outcomes for both the individuals and their employers (Inge et al., 2000).

After 2001, "customized employment" was in the vernacular and the *Journal of Vocational Rehabilitation* produced a special edition in 2008 that focused on customized employment. Rogers, Lavin, Tran, Gantenbein, and Sharpe (2008) examined whether adopting customized employment could positively affect the number of young adults with the most significant disabilities in their selection of career choices. A coalition of public and private service provides in Minnesota Anoka County – the workforce center, local school districts, social services, parent advocacy group, and a supported employment provider – was formed to explore new opportunities to improve local school-to-career outcomes. The study described the delivery of transition and customized employment services to 475 young adults with the most significant disabilities over five years. Participants were unemployed, between the ages of 18–24, and had a significant disability, including developmental and intellectual disabilities, serious mental illnesses and behavioral health challenges, traumatic brain injuries, sensory disabilities, and complex health and physical challenges (Rogers et al., 2008).

This interagency partnership focused on the strengths of the individuals and the default option for all participants was employment, regardless of the severity of his/her diagnosed disability (Rogers et al., 2008). The partners in the study established interagency agreements to articulate each agency's role, determined sharing of funds and resources, blended technical staff expertise, and worked collectively toward a common mission (Rogers et al., 2008). The University of Minnesota Institute on Community Integration completed the data collection and analysis. Sixty-two percent of the participants secured integrated and competitive jobs, positions negotiated to reflect their unique talents and skills and paid at or above minimum wage. Of

these, 81% maintained continuous employment for at least three months (Rogers et al., 2008). The study successfully demonstrated that customized employment services and strategies with interagency collaboration expand work opportunities for youth with the most significant disabilities (Rogers et al., 2008).

The Office of Disability Employment Policy (ODEP), U.S. Department of Labor, contracted with Westat, a private research company, to conduct an independent evaluation of 31 ODEP funded demonstration projects across the United States. The primary objective of these projects was to improve employment opportunities for people with the most significant disabilities by enhancing the availability and provision of customized employment services through the one-stop career center delivery system (Elinson, Frey, Li, Palan, & Horne, 2008). Elinson et al. (2008) studied these projects, which tested the feasibility and effectiveness of customized employment approaches in the one-stop career center environment to provide people with disabilities access to services and assistance to obtain and retain employment. The study considered qualitative information obtained through site visits as well as quantitative data with the use of a one-group pretest-posttest design in which pre-implementation data (baseline) was compared to post-implementation data (at follow up) (Elinson et al., 2008). The qualitative data systematically examined these system change indicators: capacity building, coordination, customization of employment and other services, and sustainability, in terms of looking at the outcomes prior to the demonstration project and during subsequent follow-up visits, while the quantitative analysis of the outcomes conducted over several years used random sampling of program participants (Elinson et al., 2008).

Between 2001 and 2006, these ODEP-funded projects served 6,555 customers, with 45% obtaining competitive employment earning an average hourly wage of $8.80, with an average of

75% maintaining the position longer than six months (Elinson et al., 2008). The participants' average age was 36 and the top three represented disabilities included psychiatric diagnosis at 41%, cognitive impairments at 20%, and mobility impairments at 14%, with others (e.g., learning disabilities, hard-of-hearing, communication disorders, vision loss, and other health impaired) at less than 10% (Elinson et al., 2008). While the project afforded short-term system change in the partner agencies, i.e., the use of customized employment, these changes did not continue when the projects ended. The researchers speculated that this could be attributed to the one-stop centers' performance measure of quick jobs for many people as disincentives to serve people with the most significant disabilities and their complex needs (Elinson et al., 2008). Overall, the project was successful in securing customized employment for the participants as well as illuminating several lessons for future efforts, including the aspect of collaboration among agencies, service providers, and the business community to develop and maintain employment for people with the most significant disabilities (Elinson et al., 2008).

Another project funded by ODEP was led by a one-stop career center and included the primary partners of a non-profit employment provider, community rehabilitation providers, the local work incentive planning and assistance provider, as well as Maryland's VR, DD, and education agencies. Luecking, Cuozzo, Leedy, and Seleznow (2008) described this partnership among multiple agencies, reported on employment outcomes achieved through the partnership, and reviewed implications of the outcomes for future partnerships and employment service delivery for individuals with the most significant disabilities. The project's purpose was to help individuals with the most significant disabilities achieve individualized integrated employment using customized employment strategies and braided resources (Luecking et al., 2008).

The 62 participants were drawn from the following categories: individuals on waiting lists for employment support services, transition-age youth about to be on the waiting lists, and individuals being served in segregated settings who desired integrated employment (Luecking et al., 2008). The subjects had reported primary disabilities of intellectual (27%) or psychiatric disabilities (18%), with other diagnosis of mobility disability (15%), ASD (6%), multiple disabilities (6%) and other (LD/TBI/OHI) at 27% (Luecking et al., 2008). The intervention for this study to effect participant employment was customized employment services and strategies, such as: (a) vocational profile, (b) individualized job search plan, (c) negotiation with prospective employers to create an opportunity unique to the individual's skills and abilities, (d) identification and implementation of individualized post-placement supports, and (e) provision of reasonable accommodation (Luecking et al., 2008). The intervention resulted in 55 (89%) of the participants achieving employment; of these, 80% remained employed for at least 90 days, earned an average of $9.31/hour, and worked an average of 22 hours per week (Luecking et al., 2008). The findings appear to uphold the value of customized employment, as the employment outcomes achieved are noticeably better than previously reported for this population (Luecking et al., 2008).

Another use of customized employment strategies and services was developed and addressed by Phillips et al. (2009) when they created a customized transition model to demonstrate students moving successfully from school to work. The model began with a Discovery process that then guided customized work experiences during school and customized employment services (Phillips et al., 2009). The fundamental principles of CE are that the job seeker (a) is the primary source of information, (b) decides the employment direction, and (c) controls the planning process (Phillips et al., 2009). This is a ten-year follow-up project that

looked at effective practices during transition from school to work focusing on self-determination through client involvement, client-centered exploration of strengths and interests for discovery of unique talents, family involvement for transition planning, and interagency collaboration (Phillips et al., 2009). Special education teachers, rehabilitation counselors, and occupational therapists worked with six students and provided customized employment strategies and services, such as job development, work experiences, and placement after graduation (Phillips et al., 2009). The researchers did not provide information about how students were selected to participate, but reported that the students had multiple disabilities and ranged in age from 15–20 years (Phillips et al., 2009). The researchers noted that they believe that if work experiences, job development, and adult services are customized to the individual's needs, and are in place prior to graduation, transition will be more successful for youth with the most significant disabilities (Phillips et al., 2009).

Increasing the employment rate and quality of jobs pursued by people with the most significant disabilities is addressed by ensuring they receive quality supports, job development assistance, and customized options for employment (Butterworth, Migliore, Nord, & Gelb, 2012). In order for employment consultants and job developers to implement effective practices, they must have the skills and knowledge to provide these quality services. Butterworth et al. (2012) addressed this in their study to validate a training curriculum for employment consultants who assist people with the most significant disabilities in securing employment. The researchers hypothesized that those who did receive the training would secure more jobs for their clients at better pay with more work hours (Butterworth et al., 2012). The researchers used an experimental design and solicited subjects from 25 supported employment providers in two states. The sample size was 33 eligible participants, who were randomly assigned, with 19 in the

intervention group and 14 in the control group. The researchers outlined the core components of the training, which included a two-day seminar, fieldwork experience, and mentoring. The employment outcomes reported by the job developers who attended the training were greater than the outcomes reported by the control group by 3.4 placements with higher earnings (12% increase in hourly wages) and work hours (45% increase in weekly hours). The results of a one-tailed t-test were significantly different, with $t(31) = 2.0$, $p = .03$ and the effect size r of the difference reported at .33, a medium effect (Butterworth et al., 2012). The findings indicated that training professionals about a customized approach to job development and provision of job supports has a positive impact on the number and quality of employment outcomes for people with the most significant disabilities (Butterworth et al., 2012). The promising practices identified include strategies to identify job seeker's skills, abilities, interests, and support needs, and strategies to implement individualized career planning, as well as building relationships with employers to facilitate job negotiation and development (Butterworth et al., 2012).

Griffin, Hammis, Geary, and Sullivan (2008) provided a descriptive qualitative review of CE in the field of rehabilitation, which led to the recommendation for change in traditional vocational rehabilitation services. The promise of the CE approach is that stereotypical jobs are reduced and employment better matches the individual's skills and the employer's needs (Griffin et al., 2008). The outcome of this study indicated that the mutually beneficial result of matching the job seeker with disabilities to employer's needs (customizing) has the potential to increase the employment rate of people with the most significant disabilities (Griffin et al., 2008).

Citron et al., (2008) described and analyzed a seven-year system change project designed to develop and deliver customized employment services to people with significant disabilities. The researchers critiqued current practices in the field of rehabilitation, including all the adult

service agencies. Several case studies and qualitative data were used to show the path to organizational improvement using customized employment services through collaboration and braided funding. A causal-comparative design used to analyze 198 participants, with 73 securing customized employment and 59 securing customized self-employment opportunities, identified six organizational change factors:

1. Staff development – Identifying cost effective training options to deliver standardized instruction for consistent application;
2. Community partnerships and multiple funding – Forming relationships with businesses and securing diverse funding options and braiding those funds to meet the needs of the clients;
3. Sustainability – Keeping service delivery and supports in place for the long term;
4. Shift in supervision – Changing roles, looking at staff talents and how to best utilize the skills sets of the personnel to meet the changing needs of the clients;
5. Changes in human resource processes – Changing how business is operated to change culture and outcomes; and
6. Expanding customized employment services. (Citron et al., 2008)

Wehman et al. (2012) examined the effects of supported employment services in securing and maintaining competitive employment for people with autism spectrum disorder (ASD). A prospective study followed and collected data on 33 people as they progressed through SE services, with 29 of the 33 individuals securing employment through the use of CE services that included high levels of social supports and compensatory training strategies for skills acquisition (Wehman et al., 2012). The goal for the researchers was to expand and improve the employment

rate and career advancement of individuals with ASD through customized supported employment services (Wehman et al., 2012).

Research in supported employment (SE) spans more than 20 years, but research in CE is still in its infancy; therefore, practitioners of CE often turn to the research of IPS for evidence of practice. This literature review examined several descriptive studies. While the results of the studies are not empirically rigorous, they do provide relevant insights into current practices. Further research and analysis with controlled experiments are needed to successfully demonstrate evidence of practice. CE as a service strategy indicates that people with the most significant disabilities can secure employment by combining individualized assessments and job development, and then maintain employment with supports and assistive technology within the workplace (Elinson et al., 2008; Inge et al., 2000; Luecking et al., 2008; Phillips et al., 2009; Rogers et al., 2008). Table 2 provides a summary of the studies reviewed.

Table 2

Literature Review of Customized Employment

Author	Conditions	Population	State	Statistics	Outcomes
Butterworth et al., (2012)	Trained job developers to secure customized positions for individuals with the most significant disabilities	Employment consultants/job developers who work at supported employment programs	CT and MN	Experimental design, random-control trials; frequency, percent; descriptive	Improved employment outcomes after training
Citron et al., (2008)	Shifted from traditional segregated service system to one that pursued customized employment services	Consumers (141) at Community Service Board	GA	NA	Described and analyzed 7-year system change effort. Identified service strategies, Individual Case studies shared

Author	Conditions	Population	State	Statistics	Outcomes
Elinson et al., (2008)	Evaluation of ODEP funded demonstration projects	31 demonstration sites	Throughout the United States	One group pretest and post-test design. Comparing baseline to post employment data. Qualitative data	Improved employment outcomes, systems change indicators
Griffin et al., (2008)	Description of customized employment	Set the foundation of CE	Throughout the United States	NA	Definitions of CE shared
Inge et al., (2000)	One model project using person centered planning, SE, AT, and training at worksite	Individuals (21) with significant physical disabilities	VA	Demographic number and percent	Improved employment outcomes with supports (SE and AT)
Luecking et al., (2008)	ODEP funded project, one-stop career center using customized employment with people with the most significant disabilities	Clients (61) of VR, MD Customized employment partnership, and DD agency	MD	Demographic number and percent	Improved employment outcomes, but not sustained implementation at career center
Phillips et al., (2009)	Longitudinal study for impact of customized employment	Transition students (6) with cognitive disability	KY	NA	10-year study investigated impact of customized employment
Rogers et al., (2008)	Interagency partner-ship to look at impact of customized employment and employment first approach over 5 years	Transition aged students and young adults with disabilities	MN	Descriptive	Improved employment outcomes with 62% securing integrated competitive jobs
Wehman et al., (2012)	Looked at CE for individuals with ASD	VR clients with ASD	VA	Descriptive	Exploratory study; collected data on 33 people with ASD receiving SE services. Improved employment outcomes with 82% securing competitive jobs with wages ranging from 7.25 – 10.50 per hour

Interagency Collaboration

Given the complex needs of individuals with the most significant disabilities, it is unrealistic to expect one single system to pay for and effectively provide the array of services needed; however, when agencies collectively work together, these resources can create positive results (Luecking et al., 2008). The literature on best practices consistently emphasizes the importance of collaboration among education agencies, adult service agencies, service providers, individuals with disabilities, families, community organizations, and employers to eliminate services gaps, avoid service duplication, and increase efficient use of limited resources (Hart et al., 2001; Kohler & Field, 2003; Test, 2000; Test, Fowler, White, Richter, & Walker, 2009).

The Vocational Rehabilitation, Education, Mental Health, and Developmental Disabilities adult service agencies must improve interagency collaboration in order to improve their abilities to meet the needs of individuals with the most significant disabilities, particularly individuals with cognitive and psychiatric disabilities. The adult service system for people with disabilities is disconnected, and does not provide the necessary case management services for persons with the most significant disabilities (GAO, 2012; Karakus et al., 2001). All social service systems must understand one another, learn how and when to access services from each other, and consider ways to expand resources through improved coordination (Oertle & Trach 2007). Such interagency collaboration will allow people with the most significant disabilities access to services and the ability to leverage limited available resources to improve employment outcomes with the needed supports for success. The literature on promising practices emphasizes the need for collaboration among agencies (Oertle & Trach 2007).

The adult service systems noted above need to increase staff awareness about the options available for individuals with the most significant cognitive and psychiatric disabilities. The

agencies must also embrace best practices in assessment, person-centered planning, and pursuing individualized employment opportunities in order to move people with the most significant disabilities into the primary labor market (Martin, 2001). The adult systems must become more knowledgeable about each other, and better informed regarding how and when to connect with DD/MH adult services and/or VR services, what resources and supports those agencies can bring to the table, and how individuals qualify for those services.

For VR and people with the most significant disabilities, the biggest impact of legislation was that people with the most significant disabilities were to be considered employable (1992 Reauthorization and the 1997 regulations), which resulted in the expectation of community employment as a viable option to achieve employment (Skiba, 2001). Federal regulations involving services for people with the most significant disabilities have included language that promotes interagency cooperation, including IDEA, the Rehabilitation Act of 1973 (as amended), particularly the 1992 Rehabilitation Amendments (Metzel, Foley, & Butterworth, 2005; Noonan, 2004). However, none of the laws provided additional funding to enable agencies to actually promote such cooperation. Years of experience have shown that no single agency can effectively meet the needs of all individuals with the most significant disabilities. Therefore, the various agencies must work together to combine resources and services.

Effective planning for a successful employment outcome for people with the most significant disabilities must include a review of the critical issues surrounding receiving disability benefits. The possible loss of these benefits is often a great disincentive toward employment for people who depend on SSDI, SSI and Medicare/Medicaid funding for health benefits (Inge et al., 2000). The lack of access to existing funding streams and the absence of

adequate resources to create and sustain needed supports remain a major disincentive for the inclusion of people with the most significant disabilities in the workplace (Skiba, 2001).

An individualized job goal flows directly from using a person-centered process to help people with the most significant disabilities explore career interests (Brooke, Revell, & Wehman, 2009). Workplace supports are often necessary for successfully employing people with the most significant disability. Therefore, (a) detailed job analysis, (b) identification and use of community and workplace supports, (c) systematic instruction, (d) compensatory strategies, (e) orientation training, and (f) workplace accommodations are very important (Brooke, Revell, & Wehman, 2009). Providing such supports for as long as necessary is the core characteristic of supported employment and long-term successful employment. The challenge for all parties involved is securing the funding needed to sustain the support. VR provides time-limited financial support so it is crucial to secure alternative financial resources; several researchers (Brooke, Revell, & Wehman, 2000; West, Kregel, Hernandez & Hock, 1997) suggest the use of natural supports to fill in the funding gap.

The continued lack of adequate funding and resources to provide needed ongoing supports is not the only barrier. Another hurdle to be addressed is that the adult services systems do not necessarily use the same language and often have conflicting performance indicators. Consistency is vital to be able to effectively access multiple service systems; however, most people with the most significant disabilities encounter differences among agencies. Therefore, it is critical for agencies to collaborate. Each state agency has service dollars and employment goals for the people they serve; however, the agencies historically have not treated employment goals the same. VR recognizes a broad range of viable full-time, part-time, supported employment and self-employment options (Skiba, 2001), but other agencies, families and people

with the most significant disabilities often consider non-competitive employment as an option, and that conflicts with VR's measure of successful employment.

These different definitions, funding options, and management of goals can be very confusing, particularly when individuals must access identical community service providers with different performance expectations depending on the funding stream. Opening channels of communication among agencies may lead to the recognition of duplication of services, difference in definitions of employment services, expected outcomes, and varying payment rates used by various agencies for identical services provided by community rehabilitation providers (CRP) (Hart, Zimbricha, & Ghilonib, 2001). The need for collaboration includes education about partner agencies. Common terminology, communication strategies, and accessibility are major elements that contribute to systems consistency, which is essential in providing services for people with the most significant disabilities (Metzel, Foley, & Butterworth, 2005).

Both interagency agreements and collaborations enhance systems change because they concentrate resources, such as funding, personnel, and intent (Metzel et al., 2005). Metzel et al. (2005) also reported that for interagency agreements to be effective, they must identify the specific population to be served, the resources to be committed, the assignment of roles and responsibilities, and reporting requirements. Effective interagency collaboration is often based on trust, and shared knowledge of each agency's roles and responsibilities (Danek, Seay, & Collier, 1989; Halpern, Benz, & Lindstrom, 1992; Szymanski, Hanley-Maxwell, & Asselin, 1990 as cited in Test, 2000).

One way to effectively provide quality services to people with the most significant disabilities is for adult service agencies to work together, combine resources, and braid funding. Sanon (2007) noted several natural areas for interagency collaboration, including assessment,

transition planning, assistive technology, career development preparation for community living, and transportation. Although federal regulations and statutory language required a seamless and coordinated process, the mandates are not funded; therefore, it is not always possible to meet demands with limited resources. Service gaps and other service problems, such as duplication of services, cost effectiveness, and inaccessibility of services, can be resolved with coordination among human service agencies (Metzel, Foley, & Butterworth, 2005).

An understanding of each agency's culture must be developed to promote mutual respect, and reduce "turf" issues (Oertle & Trach, 2007). The lack of progress toward a more collaborative approach may be a result of discrepancies between what is publicly espoused by the organization and the "real" unofficial policy that is opposed to collaboration, such as restrictive funding, lack of administrative support, and lack of incentives to support collaboration across systems (Harley, Donnell, & Rainey, 2003). While VR is expected to take the lead role with service provision and job search activities for individuals with the most significant disabilities, there are insufficient resources to meet the need for long-term support without collaboration. Because of the nature and severity of some individuals' disabilities, they often need intensive and extended support services to work successfully; this takes funding from multiple sources, such as VR, MH, DD, and Medicaid. The potential of supported employment to be the methodology to move people, once excluded, to the valued role of employee is significant (Tyree, Kendrick, & Block, 2011); it also takes the collaboration of multiple agencies and the braiding of multiple funding sources to be successful.

Summary

To increase the positive employment outcomes for individuals with the most significant disabilities, further research must document how evidence-based practices address agency and provider roles and responsibilities that increase the implementation of quality supported and individualized employment services and strategies, subsequently leading to successful employment outcomes for individuals with the most significant disabilities. The results of the research on CE and IPS services and strategies reflect that they positively impact the employment outcomes for people with the most significant disabilities. Evidence-based models of SE are by far the most effective way to help people with serious mental illness work in competitive integrated positions (Becker, Lynde, & Swanson, 2008). Work gives people a sense of purpose and research has shown it also builds self-esteem and self-worth, decreasing symptoms of mental illness and reducing the need for additional interventions (Becker, Whitley, Bailey, & Drake, 2007). This study may yield information about how practitioners perceive and practice strategies regarding employment of individuals with serious mental illness when preparing to implement the evidence based practice of IPS.

CHAPTER 3. METHOD OF STUDY AND INSTRUMENTATION

Introduction

Chapter I provided an introduction and theoretical framework for this study, statement of the research problem, purpose of the study, research questions, hypotheses, definition of terms, significance, limitations, and assumptions of the study. The purpose of this study was to investigate the perceptions held and practices used by mental health and other rehabilitation professionals regarding the employment of people with serious mental illness. For this study, mental health professionals working with adults with a mental health diagnosis at two mental health centers within Alabama were selected. These professionals are currently employed in positions such as case manager, employment specialist, therapist/ counselor and nurse. Chapter II presented a review of literature relevant to supported employment and interagency collaboration, as well as the value of social roles. Chapter III discusses the design of the study, sources of data, profiles of the two sites used in this study, data collection procedures, privacy and confidentiality of data collected, instrumentation, data collection procedures, and method of procedure.

Design of the Study

This survey research study was used to investigate current perceptions held and practices used by mental health professionals regarding the employment of individuals with serious mental illness. The two sites selected to complete the survey are beginning to implement the service called Individual Placement and Support (IPS), which is an evidence-based practice for people

with serious mental illness. The **dependent variables** for this study were the value of competitive integrated employment for individuals with serious mental illness; the acceptance, support and value of employment specialists; the perceptions held by mental health professionals regarding the employment of people with serious mental illness, and the practices used by mental health professionals regarding the employment of people with serious mental illness. The **independent variable** was the number of years mental health professionals worked in the field.

Sources of Data

Population. There are thirty mental health centers in the state of Alabama (ADMH, 2013). Some of these centers offer eligible adults with serious mental illness the following services:

- Adult case management,
- Adult crisis stabilization,
- Adult in-home interventions,
- Adult intensive day treatment,
- Adult outpatient,
- Assertive community treatment, and
- Services for children and adolescents.

Some centers may also offer the following:

- Consultation and education,
- Emergency services,
- Forensic case management,
- Geriatric care,
- Partial hospitalization,

- Indigent drug program,
- Rehabilitative day program, and
- Residential services (ADMH, 2013).

Sample/Participants. The sample for this study was drawn from two of the thirty mental health centers in Alabama. The two sites were selected since both are current pilot sites for implementing IPS in Alabama; one is in the north central part of the state and rural (Site A), and the second is in the southern part of the state and urban (Site B). A nonprobability cluster sampling technique was used to select the convenience sample. Personnel at the two sites who work with adults who have a mental health diagnosis were given an opportunity to respond to the questionnaire. The approximate number of personnel who were given an opportunity to respond to the questionnaire from Site A was 40; the approximate number from Site B was 60. Participants at each of the sites were either clinicians or case managers.

Profiles of the two mental health centers.

Site A is a public, nonprofit corporation governed by a 10 member board appointed by County Commissions under the authority of Alabama Act 310. The center provides an array of services for individuals dealing with mental illness, intellectual disability, and/or substance use disorders. In the substance abuse programs, priority admission is given to pregnant women, women with dependent children and individuals with IV substance use disorders. Services to individuals with intellectual disabilities, other than case management, are based upon available waiver services as approved by the Alabama Department of Mental Health. Services are scheduled based on individual needs. The staff set goals with individuals for the services. Achieving goals may involve talking with the individual and/or with family members.

The center has a total of 196 clinical and non-clinical employees. The medical staff members in that total include one full-time and one part-time psychiatrist, one certified nurse practitioner, two registered nurses, and four full-time LPNs and one part-time LPN. Clinical staff members include all Master's level licensed clinicians, 12 are full-time and four are part-time, and 14 Master's-level clinicians who meet the qualifications with DMH and Medicaid and 19 full-time case managers, BA level and certified. The center is a member of the Alabama Council for Community Mental Health Boards and is certified by the Alabama Department of Mental Health. There are multiple offices located in Clanton, Pelham, and Calera, as well as several group homes located in Calera and Clanton.

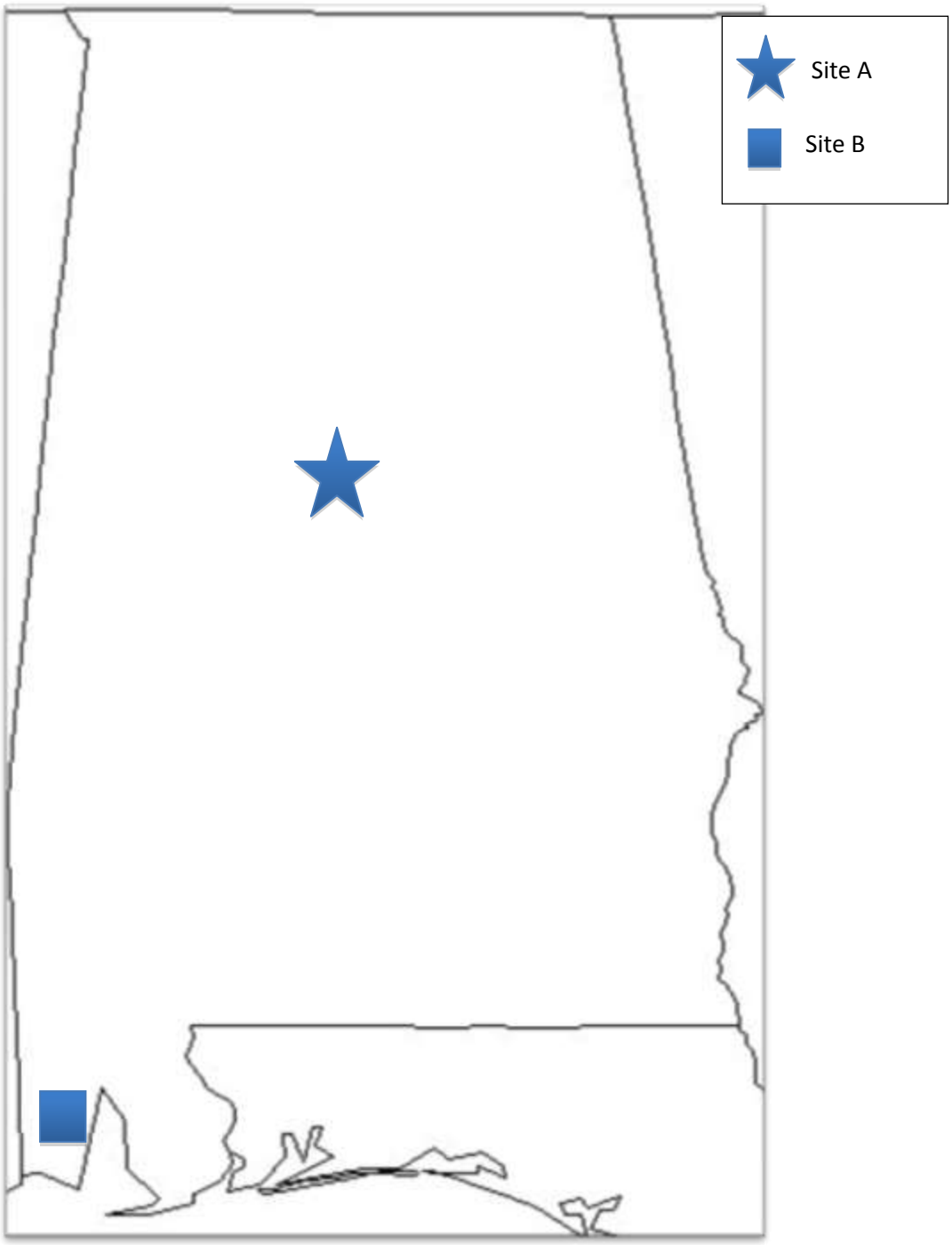
Site B is a comprehensive behavioral healthcare and psychiatric hospital system. The center collaborates with educational, law enforcement and other healthcare and community-based mental health partners to create services available and accessible to those who need them the most. The Joint Commission accredits the center and outpatient services, and the Alabama Department of Mental Health certifies residential services, and the two psychiatric hospitals are licensed by the Alabama Department of Public Health. Most of the services are targeted to residents of Mobile, Baldwin and Washington counties.

The center employs a total of 1,300 clinical and non-clinical staff. The center's medical staff members include 23 full-time psychiatrists and 15 full-time certified registered nurse practitioners (CRNP), as well as 314 licensed and certified behavioral and clinical healthcare professionals.

The center has four main divisions of service that include inpatient, outpatient, residential, and specialized services. Through this continuum of care, children, adolescents and adults receive psychiatric services, behavioral and emotional counseling services, residential

services, substance abuse treatment, developmental disability case management and supportive housing and employment services. Children's outpatient services are offered in seven locations, with case managers and therapists working with patients and their families in their homes, schools and throughout the community. Adult outpatient services are offered in eight locations, with special teams reaching out to patients in the court system, their homes, on the streets or anywhere they may need assistance. Residential services include 2 adolescent transitional age group homes, 25 scattered-site adult group homes, 2 adult intermediate care facilities, and 12 adult foster homes. The continuum also includes two freestanding psychiatric hospitals – one hospital serves adults 19 and older in a modern, high-tech facility located in Daphne; the second is a psychiatric inpatient facility for children in the Gulf Coast region located in Mobile. Specialized clinical services include psychiatric consultation and care provided by psychiatrists to acute hospital patients in Mobile as well as to residents of numerous nursing home and assisted living facilities.

As a public not-for-profit entity, the center oversees a community-based system of mental health, substance abuse and developmental disability services. The Alabama State Legislature established the organization's board of directors under Alabama Act 310 to implement and provide services in 1957. The center is a place where individuals affected by mental illness, substance abuse, and developmental disability can receive individualized treatment. Figure 2 depicts the location of the two sites used for this study.



Note: Map retrieved from http://geography.about.com/library/blank/blxusal.htm. The researcher developed points and legends.

Figure 2. Map showing geographical locations of the two sites used in this study.

Instrumentation. The researcher adapted the Health Professionals Perceptions of Employment Survey (HPPE, Version 2) instrument developed by Gladman, Waghorn, Wishar, and Dias (2015) for this study. Gladman et al. (2015) evaluated the HPPE for face validity to ensure that language used in each question/item had meaning for health professionals and test-retest reliability for internal consistency and to ensure agreement over multiple administrations. Gladman et al. (2015) used a panel of experts comprised of six respondents to review the instrument to establish face, content, and construct validity. The researchers concluded that the "HPPE is an acceptable, reliable, and promising tool for monitoring the integration of mental health services with an evidence-based supported employment program" (Gladman et al., 2015, p. 7). The final version of the HPPE (Version 2) included nineteen items.

Each item on the HPPE (Version 2) is scored differently. For example, three items are open-ended questions (items #1, 7, and 9); three items asked participants to estimate percentages (items #3, 4, and 6); and one item called for a yes/no response (item #2); while another provided three options from which to choose one response (item #5). One item on the HPPE asks participants to use a rating scale for their response (item #8), and one item (#10) used a 5-point Likert-type scale ranging from 5 (often/very important) to 1 (practically never/not important). Six items relate to perceptions held by health professionals, such as the percentage of their active caseload capable of working, consumer access to and benefit of an employment specialist, and importance of employment in recovery. Two items relate to practices used by health professionals. Specifically, items 4 and 5 address percentage of caseload discussing employment and access to an employment specialist respectively. A cover page for the HPPE includes information related to demographic characteristics including years of service in mental health.

The researcher-developed instrument adapted from the HPPE (Version 2) is titled "Health Professionals Perceptions of Employment – Revised" (HPPE-REV.). Gladman granted permission for the researcher to modify the original instrument (a copy of the email granting permission is included in Appendix A). The HPPE-REV includes 15 items from the Gladman instrument (ten of the fifteen items from the HPPE (Version-2) were modified). The HPPE-REV has six-newly developed items that were assessed for internal consistency using Cronbach's Alpha after the survey was administered. Several items were reworded in such a way that meaningful responses could be collected on a five-point Likert-type scale. For example, an item on the HPPE (Version 2) was worded as follows: "If you have access to a co-located employment specialist, how confident are you that the person currently doing that job can succeed in helping all referred clients to gain and maintain competitive employment [Express confidence as a percentage 0–100]." This was reformatted so that respondents could choose from options ranging from very confident to not at all confident.

The researcher reversed the scoring scales for items number 8 and 10 so that the most positive response was represented by a 5 on a five-point scale, whereas on the HPPE (Version 2) scale, a score of five represented the least desirable response. Item 10 (HPPE – Version 2) is: "In your view, how important is competitive employment in clients' recovery plans?" Item 8 (HPPE – Version 2) is: "If you have access to a co-located employment specialist, how well is that person currently accepted, supported, and valued by other members of the mental health team?"

In addition, the researcher added the following items:

- "Are you familiar with the supported employment model of Individual Placement and Support (IPS)? Yes/No.

- "If yes, please provide your ideas in a brief definition:"
- "If yes, how did you learn about IPS?"
- "Of the clients on your caseload that you have discussed vocational goals, how frequently do you discuss their individual vocational goals?"
- "Please give examples of successes that you have experienced when you have referred clients to the employment specialist."
- "Please list and describe strategies you currently use to integrate employment into your existing program."
- "Please describe how you determine whether someone is ready to be referred to supported employment services."

A final item included in the HPPE-REV was one that was omitted from the HPPE (Version 2): "In your team meetings with other mental health professionals, how often are clients' employment issues discussed?"

All the modifications and additions made on the HPPE-REV were the result of input from a panel of experts, which included three mental health and/or rehabilitation professionals and a researcher. The panel of experts served to validate the face, content, and construct validity of the HPPE-REV. A copy of the HPPE-REV is included in Appendix B.

Privacy and Confidentiality of Data Collected

Proper steps were taken to ensure the privacy and confidentiality of the data collected. The researcher obtained permission from the Institutional Review Board (IRB) at Auburn University to conduct the study. A copy of the IRB approved Information Letter is included in Appendix C. Data were recorded on an electronic database via SPSS. Only the researcher had

access to the data, as the database is username and password protected. Data obtained in connection with this study were reported in the aggregate and remained anonymous.

Data Collection Procedures

Information was collected using a questionnaire to examine how mental health and other rehabilitation professionals perceive and practice strategies regarding the employment of people with serious mental illness. The results from the survey could provide the implementation team with insights in planning and delivering effective and efficient IPS services to individuals with serious mental illness who want to go to work.

The HPPE-REV survey instrument was distributed by the researcher at the two mental health centers prior to a scheduled monthly meeting at each site. Mental health professionals completed the survey instrument in approximately 20 minutes. They returned the forms anonymously via a box that was placed in the back of the room. The researcher went to the two sites to distribute the survey instrument to increase the likelihood of obtaining a high response rate, which provided greater confidence in the generalizability of the results (Patten, 2014).

Method of Procedure

Descriptive data such as percentages and frequencies were calculated for the demographic section of the instrument as well as for closed-response questions with opened-response items analyzed for common themes. An independent samples t-test was performed to examine the first null hypothesis, which addressed the third research question, to determine if there was a difference in value of competitive integrated employment between participants who had worked for the median number of years and those who had worked more than the median number of years. The second null hypothesis addressed the fourth research question, and was tested using the Pearson Product Moment correlation procedure to ascertain association among

the variables. The Spearman rank-order correlation procedure was calculated to test the third null hypothesis, which addressed the fifth research question, to ascertain a relationship between the overall score for perceptions of mental health professionals related to employment of people with serious mental illness and the overall score for practices of mental health professionals related to employment of individuals with serious mental illness.

The researcher distributed the questionnaire in one day at each site. Staff members that were not able to attend the survey day were given the opportunity to complete the questionnaire and mail it to the researcher (one was submitted). The data collected were entered into a spreadsheet for statistical analysis in Statistical Package for the Social Sciences (SPSS). The comments and open-ended questions were recorded in a table in a Word document organized by question and participant. The original data from the questionnaire was maintained throughout the study and secured in a locked file cabinet in the researcher's office. This information could not be traced to any of the participants.

Summary

This chapter discussed the methodology used in this study. The sources of data, profiles of the sites, privacy and confidentiality of data collected, instrumentation, data collection procedures, and method of procedure used in this study were presented. The data analysis and results of the study are presented in Chapter IV.

CHAPTER 4. DATA ANALYSIS AND RESULTS

Chapter I provided an introduction and theoretical framework for this study, statement of the research problem, purpose of the study, research questions, hypotheses, definition of terms, significance, limitations and assumptions of the study. The purpose of this study was to investigate the perceptions held and practices used by mental health and other rehabilitation professionals regarding the employment of people with serious mental illness. For this study, mental health professionals working with adults with a mental health diagnosis at two mental health centers within Alabama were selected. These professionals are currently employed in positions such as case manager, nurse, employment specialist, and therapist/counselor. Chapter II presented a review of literature relevant to supported employment and interagency collaboration, as well as the value of social roles. Chapter III discussed the design of the study, sources of data, profiles of sites used in this study, data collection procedures, privacy and confidentiality of data collected, instrumentation, and method of procedure. Chapter IV focuses on the results of the data analysis.

Data Analysis

Descriptive data such as frequencies and percentages were summarized for position title, number of participants, caseload size, and years of service in mental health. This information was used to answer research question one. Research question two was addressed by examining responses regarding mentoring and supervisory duties, percentage of caseload capable of working part-time or full-time, percentage of caseload in which employment is discussed, and

summarizing themes from open responses regarding challenges and successes experienced when referring to the employment specialist, and suggestions to support clients in their vocational pursuits. Research question three was examined by testing the null hypothesis using an independent samples t-test to determine the extent to which mental health professionals value competitive integrated employment for people with serious mental illness. Research question four was investigated by testing the null hypothesis using the Pearson Product Moment correlation procedure to ascertain association among the variables of acceptance, support, and value of the employment specialist for the mental health treatment team. Research question five was explored by testing the null hypothesis using the Spearman rank-order correlation procedure to determine if there was a relationship between perceptions held and practices used by mental health professionals. Research question six was addressed with an analysis of common themes found in responses related to knowledge of IPS, determination of job readiness, availability of employment specialist, and strategies used to integrate employment into current treatment. Six research questions and three null hypotheses were formulated for this study. Results of the analyses are organized by research question and corresponding hypothesis.

Cronbach's alpha was conducted to estimate internal consistency of the HPPE-REV, which looked at the consistency among the items within a test at a single point in time. Cronbach's alpha for the 55 responses to eight scaled items was 0.65, which is a low measure of internal consistency. This result is not unexpected as the items were measuring practices and perceptions. Cronbach's alpha for 63 responses to the five scaled perception items was 0.77, which is above the acceptable value of 0.70 to indicate internal consistency (reliability) among the items.

Results of Research Question One

The first research question was: What are the demographic characteristics of the participants in this study? Participants identified demographic characteristics, which are highlighted in Table 3 and summarized in terms of years of service, caseload size, number of participants, and position title. The total number of participants was 79 with 29 (36.7%) participants from Site A, and 50 (63.3%) from Site B. Participants reported a mean number of years of service in mental health as 9.61 with a standard deviation of 8.32. The median number of years working in the mental health profession was 8. The minimum number of years of service was less than one and the maximum number of years was 35. The positions of the participants included 26 case managers, 4 employment specialists, 18 counselors/therapists, 12 nurses (LPN, RN), 8 coordinators, and 10 administrative positions (program director, assistant directors, project managers, and outreach liaison). Seven participants reported that they had no active clients on their current caseloads, and one participant reported 400 active clients on the current caseload, which was the maximum number of active clients reported for one caseload. The average number of active clients was 56, with a standard deviation of 68. The median number of active clients on a caseload was 31, indicating that approximately 50 percent of the participants reported a caseload of 31 active clients or fewer and 50 percent reported a caseload of more than 31 active clients. Demographic information reported by participants is highlighted in Table 3.

Table 3

Summary of Findings for Research Question One

Years of Service in Mental Health (N = 78)	
Mean	9.61
Standard Deviation	8.32
Median	8.00
Max	35
Min	<1

Participants' Positions (N = 79)		
Position	Number of People	Percent of Total
Case manager	26	33%
Counselor/therapist	18	23%
Nurse	12	15%
Administrator	10	13%
Coordinator	8	10%
Employment Specialist	4	5%

Number of Active Clients per Participant (N = 77)	
	Number of Clients per participant
Mean	56
Standard Deviation	68
Median	31
Max	400
Min	0

Results of Research Question Two

The second research question was: What specific background information do participants who serve people with serious mental illness report? Participants were asked to identify background information; choices included supervising/mentoring role, percentage of caseload capable of working part-time or full-time, percentage of caseload in which employment was discussed, challenges and successes of referring clients to employment specialists, and strategies for supporting clients with vocational pursuits are described in Table 4. Twenty-seven of the 79 participants reported that they had responsibilities for supervising or mentoring other staff members; 52 did not have those responsibilities. Participants were asked to consider their current active caseload (people they have communicated with in the past six weeks) and estimate the proportion that is capable of working. The mean score (N = 70) for the percentage perceived as capable of working full-time was 23% (standard deviation of 23) and the percentage perceived as capable of working part-time was 45% (standard deviation of 32). Participants with caseloads were asked to indicate the percent of their active cases with whom they have discussed vocational goals; 54% of the participants (N= 38) indicated they discussed vocational goals (including education, training, or employment goals) with 50% or less of their caseload, and 46% of the participants (N = 32) indicated they discussed vocational goals (including education, training, or employment goals) with 75%–100% of their caseload. The respondents were asked to share challenges and successes when referring people to employment specialists. Thirty-eight of the 79 participants responded that the client was a factor when considering employment given fears of losing disability benefits, uncertainty about work, not being able to follow the treatment plan, and not following up with the employment specialist after being referred. Seventeen of the 79 participants noted that the employment specialist and/or vocational rehabilitation were a

challenge given difficulties in referring, delay in receiving services, communication difficulties, and the lack of availability of the specialist or the VR counselor.

Table 4

Summary of Findings for Research Question Two

Supervising/mentoring role

34% of participants (N=79) report supervisory or mentoring responsibilities

Percentage of caseload capable of working part-time or full-time

Mental health professionals (N=70) reported that (mean score) 45% of their caseload is capable of part-time work and (mean score) 23% is capable of full-time work.

Percentage of caseload employment is discussed

38 participants reported that they discuss employment with 50% or less of their caseload
32 participants reported that they discuss employment with 75-100% of their caseload

Challenges and successes of referring clients to employment specialists

Challenges

48% reported the client
22% reported the employment specialist
11% reported lack of transportation
10% reported lack of available jobs

Successes

41% reported when refer to the employment specialists people go to work

Strategies for supporting clients with vocational pursuits

1. Work with client to address anticipated barriers
2. Get to know client to identify skills, abilities, interests, motivation, capabilities, goals, and options
3. Refer to benefits counselor
4. Develop relationships with businesses to get to know labor market
5. Communication between mental health practitioners, employment specialists, vocational counselors, consumer, and employer
6. Client compliance with treatment plan

7. Know resources: education and training opportunities available
8. Follow up
9. Setting goals around work
10. Integrate employment team and mental health treatment team
11. Share job leads
12. Job seeking skills – resume development, interview skills, application, and managing symptoms
13. Manage job development efforts to decrease multiple contacts to one business by multiple job developers
14. Refer to VR and employment specialists
15. Promote system management
16. Address transportation needs

Other barriers mentioned included lack of transportation and available jobs. Seven people stated that they had not referred anyone for employment while a different seven people stated that they had not experienced any problems. As shown in Table 4, 32 responses indicated successes when consumers were referred to the employment specialist; people successfully secured employment and received services to improve their employability. Six responses noted that when people went to work they were able to maintain stability, increase self-esteem and confidence, achieved personal independence, and increase friendships. Several responses indicated that there was no referral made or that the work secured was not competitive. Respondents provided strategies (practical ways) of supporting clients with their vocational goals or suggestions to support the employment specialists to help clients achieve their vocational goals. Common themes are summarized from participant responses and are featured in Table 4:

1. Work with client to address anticipated barriers
2. Get to know client to identify skills, abilities, interests, motivation, capabilities, goals, and options
3. Refer to benefits counselor
4. Develop relationships with businesses to get to know labor market

5. Communication among mental health practitioners, employment specialists, vocational counselors, consumer, and employer
6. Client compliance with treatment plan
7. Know resources: education and training opportunities available
8. Follow up
9. Setting goals around work
10. Integrate employment team and mental health treatment team
11. Share job leads
12. Job seeking skills – resume development, interview skills, application, and managing symptoms
13. Manage job development efforts to decrease multiple contacts to one business by multiple job developers
14. Refer to VR and employment specialists
15. Promote system management
16. Address transportation needs

Results of Research Question Three

The third research question was: To what extent do mental health professionals value competitive integrated employment for people with serious mental illness who are in recovery? The following null hypothesis was formulated to answer the third research question:

Ho_1: There is no statistically significant difference in the value of competitive integrated employment for people with serious mental illness between mental health professionals who had worked the median number of years and those who had worked more than the median number of years.

All of the 79 participants responded to this survey item. Thirty-eight of the participants strongly valued competitive integrated employment for people with serious mental illness who are in recovery; 21 strongly valued competitive integrated employment and 17 very strongly valued competitive integrated employment for people with serious mental illness who are in recovery.

An independent samples t-test was performed to test the first null hypothesis for difference in value of competitive integrated employment between participants who had worked the median number of years (eight) and those who had worked more than the median number of years. Results of the test, $t_{(77)} = .605$, $p = .547$, with the 95% confidence interval of the difference (-.141) ranging from -.604 to .322 indicating a very narrow array of scores. Therefore, the null hypothesis was retained. The mean score for participants with eight or fewer years of service (N = 43) was 3.58, with a standard deviation of 1.05 and the mean score for participants with more than eight years of service (N = 36) was 3.72, with a standard deviation of 1.00.

Results of Research Question Four

The fourth research question was: To what extent is there an association among mental health team members' acceptance of an employment specialist, support of an employment specialist, and value of an employment specialist? The following null hypothesis was formulated to answer the fourth research question:

Ho_2: There is no statistically significant association among the variables of acceptance of an employment specialist, support of an employment specialist, and value of an employment specialist among mental health team members.

The second null hypothesis was tested using the Pearson Product Moment correlation procedure to ascertain associations among the variables. Pearson correlation coefficients were statistically significant at the .01 alpha level for all pairs of correlations, with the strongest correlation (.769) between acceptance of an employment specialist and value of an employment specialist. The correlations between the remaining pairs were also very strong: acceptance of an employment specialist and support of an employment specialist (.674), and support of an employment specialist and value of an employment specialist (.673). Therefore, the null hypothesis for associations of acceptance of an employment specialist, support of an employment specialist, and value of an employment specialist among mental health team members was rejected.

Results of Research Question Five

The fifth research question was: To what extent is there a relationship between perceptions of mental health professionals related to the employment of people with serious mental illness and practices of mental health professionals related to the employment of people with serious mental illness? The following null hypothesis was formulated to answer the fifth research question**:**

Ho_3: There is no statistically significant relationship between the overall score for perceptions of mental health professionals related to employment of people with serious mental illness and the overall score for practices of mental health professionals related to employment of individuals with serious mental illness.

The third null hypothesis was tested using the Spearman rank-order correlation [Spearman rho (ρ)] procedure to ascertain a relationship between perceptions and practices of mental health professionals related to the employment of people with serious mental illness.

Results of the analysis show a moderate correlation and a statistically significant relationship ($\rho = .292$, $p = .031$) between responses for perceptions ($N = 55$) and practices ($N = 69$) of mental health professionals related to the employment of people with serious mental illness. Therefore, the null hypothesis for no relationship between perceptions and practices was rejected.

Results of Research Question Six

The sixth research question was: What challenges exist in implementing the evidence-based practice of Individual Placement and Support (IPS)? Common themes are summarized from participant responses regarding knowledge of IPS and where it was learned, determining job readiness, availability of an employment specialist, and strategies used to integrate employment into current treatment. As highlighted in Table 5, sixty (60) of the 79 participants responded that they did not know the Individual Placement and Support model of supported employment. Of the clinicians and case managers who responded that they did know IPS, their responses ranged from a program that assists people with serious mental illness to find and keep a job to a document used to develop an individual plan of care. The 18 respondents who said they knew IPS stated that they learned from co-workers, a Dartmouth College presentation, or from the SAMHSA grant recently awarded to ADMH to implement IPS.

Table 5

Summary of Findings for Research Question Six

Knowledge of Individual Placement and Support (IPS)

76% of the participants responded that they did not know the IPS model of supported employment.

The 24% that indicated they did know about IPS, indicated that it was:

- Program that assists people with serious mental illness to find and keep a job
- Helps individuals with serious mental illness with supports for success, funding, and sustain work
- Team approach with wrap around services
- Evidence-based practice that believe all individual with serious mental illness can work and working will decrease relapse and increase quality of life
- Document used to develop an individual plan of care or to assess needs and set goals

The 18 respondents that said they knew IPS, stated that they learned from:

- Co-workers
- Dartmouth
- SAMHSA grant recently awarded to ADMH to implement IPS

Criterion to determine a client is ready for work

- Compliance with treatment and medication
- Stated desire to work
- Medical stability
- Treatment team agrees with work as a goal

Availability of employment specialist

53% of the mental health professionals reported that an employment specialist was available and had the needed skills to assist consumers with employment goals

Strategies mental health professional reported to integrate employment into treatment

- Ask the client if he or she wants to work
- Avoid the topic of work
- Talk about work as often as possible
- Refer the person to vocational rehabilitation

The participants were asked to indicate the availability of an employment specialist, someone available to assist people with serious mental illness with their employment goals. As shown in Table 5, forty-two (42) of the 79 participants (greater than 50%) reported that they had access to an employment specialist who was linked to their mental health team and was capable of assisting their clients with work goals. Eleven participants indicated that an employment specialist was available, but not able to deliver suitable employment services. Thirteen respondents stated that the employment specialist was not located within the center but was available in the community. Seven participants felt the provider arranged to assist clients with their vocational goals was not able to meet the needs of the clients, with three respondents indicating there was no one available to assist their clients with work goals. Three people chose not to respond to this question.

The participants were asked to describe how they determine if someone is ready to be referred to supported employment services; as shown in Table 5, the responses fell into four vital areas: 1) compliance with treatment and/or medication, 2) stated desire to work, 3) medical stability, and 4) treatment team agrees work is viable. The participants were also asked to describe current strategies used to integrate employment into the existing program; as indicated in Table 5, the responses formed four overarching themes: 1) Ask the client if he or she wants to work, encourage the client to consider work, or discuss work with the client; 2) Avoid the topic of employment as most people with SMI cannot work; 3) Talk about work as often as possible and brainstorm possibilities; and 4) Refer to VR if work is mentioned.

Summary

This chapter discussed the results of the data analysis. Descriptive data presented in this chapter summarized the demographic characteristics (see Table 3) and background information (see Table 4) of the mental health professionals used in this study. The chapter provided the results of the independent samples t-test for difference in value of competitive integrated employment between participants who had worked for the median number of years (eight) and those who had worked more than the median number of years. Results of the t-test were $t_{(77)} = .605$, $p = .547$; the results were not statistically significant.

The chapter also described the outcome of the Pearson Product Moment correlation procedure to ascertain associations among the variables. The null hypothesis for association of acceptance, support, and value of an employment specialist among mental health team members was rejected. The chapter also stated the results of the Spearman rank-order correlation procedure to ascertain a relationship between perceptions and practices of mental health professionals related to the employment of people with serious mental illness. Results of the analysis show a statistically significant relationship ($\rho = .292$, $p = .031$) between responses for perceptions and practices of mental health professionals related to the employment of people with serious mental illness. Therefore, the null hypothesis for no relationship between perceptions and practices was rejected.

The majority of respondents indicated they did not know the IPS model (see Table 4). The participants were asked to describe how they determine if someone is ready to refer to supported employment services (see Table 5) and if they had access to a qualified employment specialist (see Table 5). The participants were also asked to describe current strategies used to integrate employment into the existing program (see Table 5). An overview of this study,

summary of results, limitations, implications, conclusion, recommendations for practical applications, and summary are presented in Chapter V.

CHAPTER 5. SUMMARY AND CONCLUSIONS

Chapter I provided an introduction and theoretical framework for this study, statement of the research problem, purpose of the study, research questions, hypotheses, definition of terms, significance, limitations and assumptions of the study. The purpose of this study was to investigate the perceptions held and practices used by mental health and other rehabilitation professionals regarding the employment of people with serious mental illness. For this study, mental health professionals who work with adults with serious mental illness receiving services at two mental health centers in Alabama were selected. These professionals are currently employed in positions such as case manager, nurse, coordinator, and therapist/ counselor. Chapter II presented a review of literature relevant to supported employment and interagency collaboration, as well as the value of social roles. Chapter III discussed the design of the study, sources of data, profiles of sites, data collection procedures, privacy and confidentiality of data collected, instrumentation, and method of procedure. Chapter IV focused on the results of the data analysis. This chapter will present an overview of the study, summary of results, limitations, implications, conclusion, recommendations, and summary.

Overview of the Study

Social Role Valorization (SRV) is inconsequential if one is in a valued role, but SRV is significant for those in non-valued roles. People who are already in a valued role may not be aware of the importance of valued roles, as they have never felt devalued. But for many who exist in primarily devalued roles, this concept is important. It will be very critical for the

rehabilitation counselor, who has many valued roles, to be aware of the importance of developing and pursuing valued roles for the rehabilitation client, particularly for those persons with the most significant disabilities. SRV explicitly addresses and proposes positive strategies that can be enlisted to help affected people acquire valued social roles, thereby offsetting to a considerable degree, the tendencies toward social devaluation (Tyree, Kendrick & Block, 2011). Using personal outcome measures to ensure that employment plans are individualized and focus on the priorities of the individual is critical. These outcome measures include such priorities as friends, social relationships, and community participation (Curran, 2008). The stigma of disability may not be eliminated, but using social relationships to establish value in society brings about quality of life for many individuals (Curran, 2008; Novak, Rogan & Mank, 2011). SRV, a broad intervention, has dimensions of social justice and can be utilized to challenge a society that discriminates on the basis of ability and social positions (Lemay, 1999).

Recent legal precedents, such as the Olmstead Decision (1999), give people with the most significant disabilities the opportunity to establish themselves in a community that enables people to live in integrated neighborhoods and to be valued members of the community (Minton, Fullerton, Murray, & Dodder, 2002). Kelsey and Smart (2012) noted that social justice is the fundamental valuing of fairness and equity of resources, rights, and treatment. Pursuing social justice, community inclusion, universal access, and full participation in the community allows all people, particularly those with the most significant disabilities, to secure valued social roles. SRV promotes activities for people with the most significant disabilities to mirror those within the general society that includes socially valued roles (Minton, Fullerton, Murray, & Dodder, 2002). If the rehabilitation field (including the adult service agencies of vocational rehabilitation, developmental disability, and mental health) aligns supported employment

services with the principles of Social Role Valorization and advocates for such change, the opportunity for individuals with the most significant disabilities to obtain valued social roles, particularly the role of employee is increased.

Both the IPS and CE models seek to help individuals with the most significant disabilities find jobs that meet their unique needs, interests, and skills, and to support them in ways that enable them to succeed in the workplace (Karakus et al., 2011). A review of the empirical random-controlled trials of IPS programs concluded that vocational outcomes are consistently significantly higher than alternative control programs (Karakus et al., 2011). Given the descriptive nature of the CE studies, there is a need for further research and analysis with controlled experiments to demonstrate successfully evidence of practice around customized employment. Most of the CE studies focused on changing a system (career centers) that is not funded or measured by the employment outcomes of people with the most significant disabilities. Although the studies are not always empirically rigorous, they do suggest several important strategies relevant to current practices. Customized employment services and strategies offer the potential to build on supported employment services and strategies to provide the rehabilitation field increasingly effective approaches to help people with significant intellectual disabilities and/or developmental disabilities achieve better employment outcomes, both in terms of the nature of the positions and earning potential (Luecking et al., 2008).

The use of strategies and services that facilitate obtaining integrated, non-stereotypical, individualized, and paid employment for people with the most significant disabilities is critical for the success of vocational rehabilitation and the individuals it serves (Federal Register, 2012). However, no single system can pay for and provide the array of services needed to meet effectively the often-complex needs of individuals with the most significant disabilities

(Luecking et al., 2008). When agencies work together, their combined resources can create positive results. Service gaps, duplication of services, cost ineffectiveness, and inaccessibility of services can be resolved through coordination between human service agencies and funders (Metzel, Foley, & Butterworth, 2005). Collaborative efforts that pull together a multitude of resources, funding, and expertise contribute to successful employment outcomes for individuals with the most significant disabilities (Fesko, Varney, Dibiase, & Hippenstiel, 2007). Such partnerships have emerged when they have utilized Customized Employment and committed to use Individual Placement and Support models of supported employment.

It is confounding that despite the evidence that supported employment is effective in assisting people with serious mental illness to seek, secure, and sustain employment, SE continues to be unavailable for most people (SAMHSA, 2012). Work gives people a sense of purpose and research has shown it also builds self-esteem and self-worth that decreases symptoms of mental illness and reduces the need for additional interventions (Becker, Whitley, Bailey, & Drake, 2007). The focus of this study was to obtain information about the perceptions held and practices used by mental health and other rehabilitation professionals related to the employment of individuals with serious mental illness. In this study, the researcher investigated how mental health professionals perceive and practice strategies regarding the employment of people with serious mental illness. The information was gathered using a survey instrument soliciting practitioners' self-report of current practices and perceptions associated with the employment of people with serious mental illness.

The researcher used a convenience sample for this study by selecting the two pilot sites that are implementing the IPS model of supported employment. The researcher is the evaluator on the implementation team to bring IPS to Alabama. The two sites were contacted to request

that clinicians and case managers at the sites complete the survey. Each site was contacted through electronic mail and sent a letter requesting their participation, information about the study and how to participate. In fall 2015, responses were received from 79 case managers and clinicians employed in mental health professional positions.

The significance of the study has practical applications. Understanding how practitioners perceive and practice strategies regarding employment of individuals with serious mental illness, could lead to improving implementation and availability of IPS. In addition this information could provide insights to researchers about potential professional development needs and goals, current uses of EBP, and knowledge of IPS. This study may contribute to understandings regarding fidelity to IPS and steps to take to assist mental health and rehabilitation professionals improve quality implementation, thereby increasing access to the service and improving employment options for people with serious mental illness.

Summary of Results

This study revealed the answers to the following research questions:

1. What are the demographic characteristics (such as years of service and position title) of the participants in this study?

2. What specific background information do participants who serve people with serious mental illness report? Information such as supervising and mentoring staff, challenges and successes referring to employment specialists, and practical suggestions from mental health professionals to support their clients with vocational pursuits are described.

3. To what extent do mental health professionals value competitive integrated employment for people with serious mental illness who are in recovery?

4. To what extent is there an association among mental health team members' acceptance of an employment specialist, support of an employment specialist, and value of an employment specialist?

5. To what extent is there a relationship between perceptions of mental health professionals related to the employment of people with serious mental illness and practices of mental health professionals related to the employment of people with serious mental illness?

6. What challenges exist in implementing the evidence-based practice of Individual Placement and Support?

The results for all six questions are summarized in detail in Chapter 4. The responses indicated a low level of support toward consumers seeking employment. Practitioners stated that the client was typically the foremost difficulty, and shared the challenges experienced pursuing employment with consumers, including fear of losing disability benefits, uncertainty about work, not being able to follow the treatment plan, and not following up with the employment specialist after being referred. In contrast, clinicians and case managers reported that when consumers were referred to the employment specialist, they successfully secured employment and received services to improve their employability. It is important to note that many of the perceived challenges could be resolved when programs implement IPS. However, seventy-six percent of the participants responded that they had no knowledge of the Individual Placement and Support (IPS) model of supported employment. This study provides information that may be useful with SE implementation research to enhance program planning and improvement, and to increase availability of IPS services, which research indicates improves the employment outcomes for individuals with serious mental illness.

Conclusions

To the extent that the data collected in this study were valid and reliable and the assumptions of the study were appropriate and correct, the researcher made the following conclusions based on the results of this study:

1. There is no difference in length of service in determining if mental health professionals value competitive integrated employment, with over 48% of the participants strongly valuing or very strongly valuing competitive integrated employment.

These findings concur with the literature (Becker, Whitley, Bailey, & Drake, 2007; Lemay, 2006; Tyree, Kendrick, & Block, 2011) that work helps people have the potential for a more typical life, gives people a sense of purpose, and facilitates building self-esteem and self-worth.

2. The mental health professionals who completed the survey are not confident in the employment potential of the consumers they counsel.

The mental health professionals who completed the survey believe their clients capable of working only part-time (45%) and full-time (23%), which means some are considered incapable of working. Congruently, the results indicated that 54% of the participants with caseloads discuss vocational goals with 50% or fewer of their clients, while 46% of the participants discuss vocational goals with 75% to 100% of their clients.

3. There is an association among the variables of acceptance, support, and value of an employment specialist among mental health team members.

The association among acceptance, value, and support of the employment specialist is statistically significant with greater than 50% of the participants reporting access to a qualified employment specialist. However, there is a concern that clinicians and case managers may not

refer to the employment specialists since they expected their clients to be compliant with treatment and/or medication and to be medically stable before considering someone for employment.

4. There is a relationship between perceptions and practices of mental health professionals related to the employment of people with serious mental illness.

The relationship between perceptions and practices of mental health professionals related to the employment of people with serious mental illness is statistically significant. Previous research by Gladman et al., (2015) also reported that understanding the clinical team's perspective about the role of employment in recovery and how team members perceive the employment prospects of their current clients are important, since mental health professionals' attitudes toward client employment can determine such practice as their rate of referrals, which could help or hinder the clients' vocational progress. Current practices and perceptions reported by mental health professionals are not supportive of employment for consumers with SMI. It is hoped that with over 75% of the participants unfamiliar with IPS, a better understanding of its principles will change the expectations of employment for individuals with serious mental illness.

Implications

The results of this study further suggest several implications:

1. While mental health professionals value competitive integrated employment in the recovery of their clients, they do not believe their clients are ready to go to work.

Changing this perception through education about and implementation of the Individual Placement and Support model of supported employment could change current practices so that more clients are referred to the employment specialist, thereby increasing the number of people with SMI who go to work. The IPS evidence-based model of SE is by far the most effective way

to help people with serious mental illness work in competitive integrated positions (Becker, Lynde, & Swanson, 2008). The mental health and the vocational rehabilitation agencies should have someone available who is competent to provide training regarding the principles of IPS and to offer technical assistance during the implementation of IPS that will facilitate the understanding and application of those principles by mental health and rehabilitation professionals.

2. Overall, mental health professionals recommended a few strategies for success with employment that are in alignment with IPS strategies and principles.

While the participants indicated competitive integrated employment (a principle of IPS) was part of the recovery process, they also shared numerous concerns about clients being able to pursue vocational goals. One of the principles of IPS is that all individuals who state they want to work are given an immediate opportunity to seek employment; however, several participants reported that they would not refer until they felt the consumer was ready.

It is pertinent to note that the principles of IPS could address most of the concerns raised. As shown in Table 6, strategies reported by the mental health professionals are often analogous to IPS principles. Participants reported that clients were hesitant to seek employment for a variety of reasons: the uncertainty of getting a job, anxiety about the workplace, concerns over juggling medication while at work, and the fear of losing benefits. Yet a principle of IPS is the delivery of benefits counseling so the consumer can explore the impact of going to work while receiving disability benefits. This process allows the individual to develop a viable work plan while making informed choices, and thereby reducing fears. While participants shared concerns about clients' successes, an IPS principle addresses the integration of vocational services with mental health treatment, which increases the availability of needed supports to go to work.

Numerous participants also recommended the need for increased communication and collaboration among the counselor, the employment specialist, and the vocational rehabilitation counselor to improve employment outcomes. In addition, practitioners reported that the client should be consulted throughout the process; the IPS corollary also requires that the client's preferences be honored.

Table 6

Comparison of IPS Principles and Comparable Strategies Proposed

IPS Principles	**Comparable Strategies Proposed**
Zero Exclusion	No comparable response
Competitive jobs	Competitive work is part of recovery
Vocational Services are integrated with Mental Health Treatment	Communication among counselor, VR, consumer, employment specialist and employer is important
Benefits Counseling	Refer to benefits counselor
Rapid Job Search	Refer to VR and/or employment specialist when client states they want to go to work
Employment Specialist builds relationship with employers	Develop relationships with businesses
Individual job supports are time-unlimited	No comparable response
Individual preferences are honored	Ask the client what they want to do for work

Current practices noted by the participants are to refer clients to VR or the employment specialist when work is mentioned. IPS principles expand the role of the mental health professionals to ensure job search is initiated quickly, to make certain the employment specialist

builds relationships with the business community, and to confirm workplace supports are arranged and delivered as long as the individual needs such supports. Given the numerous areas of overlap and the possibility that IPS can address the concerns raised, one could anticipate a positive response toward change and implementation of the IPS model, which also builds on existing successes to increase utilization of the employment specialists and the employment of people with serious mental illness.

Recommendations

The research for this study concentrated on mental health professionals who work at two different Alabama mental health facilities that are preparing to implement the Individual Placement and Support (IPS) model of supported employment. The focus of this study was to obtain information about the perceptions held and practices used by mental health professionals related to the employment of individuals with serious mental illness. The study was designed so it could be replicated at other mental health centers or other agencies considering implementation of IPS.

It might be useful to repeat the survey after the sites receive training regarding IPS and begin to implement an employment focused program. The study indicates that extensive training and ongoing technical assistance is needed for implementation to be successful. In addition, future research could expand the scope to include all mental health centers in Alabama. This could help determine who has an employment focus, the level of professional development needed, and readiness for system change. The survey responses could provide information regarding mental health and other rehabilitation professionals' perceptions about IPS and practices that could lead to fine-tuning implementation.

Summary

"It no longer makes sense for researchers to gather with one another to identify what they think is important, write a research proposal, obtain funding to support their research, find partners to identify participants for their study, and conduct their research without substantial collaboration" (Klingner, Boardman, & McMaster, 2013, p. 195).

This study examined the current perceptions and practices of mental health professionals related to the employment of individuals with serious mental illness. Mental health professionals at two mental health centers located in Alabama were selected to participate in this study. The participants, 53 clinicians and 26 case managers, reported a median number of eight years of service in the mental health profession. Sixty (60) of the 79 participants responded that they did not know the IPS model. The results of the study indicated that there is an association among the variables of acceptance, support, and value of an employment specialist by mental health team members. Thirty-two respondents indicated that when they referred consumers to the employment specialist, individuals successfully secured employment and received services to improve their employability. Forty-two of the 79 participants (greater than 50%) reported that they had access to an employment specialist who was linked to their mental health team and who was capable of assisting their clients with work goals.

Another finding was that there is a relationship between perceptions and practices of mental health professionals related to the employment of people with serious mental illness. Current perceptions indicated that only 68% of participants believe clients were capable of working (full- or part-time) and a majority indicated they discussed vocational goals with slightly over 50% of their clients. Current practices indicated that the majority of participants

expected their clients to be compliant with treatment plans prior to being considered for employment.

The results of the research on IPS clearly indicate that this model positively impacts the employment outcomes of people with serious mental illness. Therefore, to increase positive employment outcomes for individuals with serious mental illness, the perceptions and practices of mental health and other rehabilitation professionals must align with the principles of IPS.

REFERENCES

Alabama Department of Mental Health. (2013). *Mental illness provider directory*. Montgomery, AL.

Aubry, T., Flynn, R. J., Virley, B., & Neri, J. (2013). Social role valorization in community mental health housing: Does it contribute to the community integration and life satisfaction of people with psychiatric disabilities? *Journal of Community Psychology, 41*(2), 218–235.

Becker, D. R., Baker, S. R., Carlson, L., Flint, L., Howell, R., Lindsay, S., Moore, M., Reeder, S., & Drake, R. E. (2007). Critical strategies for implementing supported employment. *Journal of Vocational Rehabilitation, 27*(1), 13–20.

Becker, D. R., Lynde, D., & Swanson, S. J. (2008). Strategies for state-wide implementation of supported employment: The Johnson & Johnson–Dartmouth Community Mental Health Program. *Psychiatric Rehabilitation Journal, 31*(4), 296–299. doi:10.2975/31.4.2008.296.299

Becker, D., Whitley, R., Bailey, E., & Drake, R., (2007). Long-term employment trajectories among participants with severe mental illness in supported employment. *Psychiatric Services, 58*(7), 922–927.

Bond, G. (2004). Supported employment: Evidence for an evidence-based practice. *Psychiatric Rehabilitation Services*, 58, 922–928.

Bond, G. R., Dincin, J., Fraser, V. V., Salyers, M. P., Drake, R. E., Becker, D. R., & Haines, M. (2007). A randomized controlled trail comparing two vocational models for persons with severe mental illness. *Journal of Consulting and Clinical Psychology*, 75(6), 968-982. doi: 10.1037/0022-006X.75.6.968.

Bond, G., Drake, R., & Becker, D. (2008). An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal,* 31, 280–290.

Bond, G. R., McHugo, G. J., Becker, D. R., Rapp, C. A., & Whitley, R. (2008). Fidelity of supported employment: Lessons learned from the national evidence-based practice project. *Psychiatric Rehabilitation Journal*, *31*(4), 300–305. doi: 10.2975/31.4.2008.300.305.

Brooke, V., Revell, G., & Wehman, P. (2009). Quality indicators for competitive employment outcomes: What special education teachers need to know in transitioning planning. *Teaching Exceptional Children, 41*(4), 58–66.

Butterworth, J., Migliore, A., Nord, D., & Gelb, A. (2012). Improving the employment outcomes of job seekers with intellectual and developmental disabilities: A training and mentoring intervention for employment consultants. *Journal of Rehabilitation*, *78*(2), 20–29.

Campbell, K., Bond, G., Gervey, R., Pascaris, A., Tice, S., & Revell, G. (2007). Does type of provider organization affect fidelity to evidence-based supported employment? *Journal of Vocational Rehabilitation*, *27,* 3–11.

Caruso, G. A., & Osburn, J. A. (2011). The origins of "best practices" in the principle of normalization and social role valorization. *Journal of Policy and Practice in Intellectual Disabilities,* 8(3), 191–196.

Chandler, K., & Lipson, L. (2013, June 7). The power of roles. Georgia Advocacy Office.

Cimera, R.E. (2010). The national cost-efficiency of supported employees with intellectual disabilities: The worker's perspective. *Journal of Vocational Rehabilitation*, *33*, 123–131.

Citron, T., Brooks-Lane, N., Crandall, D., Brady, K., Cooper, M., & Revell, G. (2008). A revolution in employment process of individuals with disabilities: Customized employment as the catalyst for system change. *Journal of Vocational Rehabilitation*, *28*, 169–179.

Chan, F., Rosenthal, D., & Pruett, S. (2008). Evidence-based practice in the provision of rehabilitation services. *Journal of Rehabilitation, 74*(2), 3–5.

Condon, E., & Callahan, M., (2008). Individualized career planning for students with significant support needs utilizing the Discovery and Vocational Profile process, cross-agency collaborative funding and Social Security Work Incentives. *Vocational Rehabilitation, 28*, 85–96.

Cook, B. G., Cook, L., & Landrum, T. J. (2013). Moving research into practice: Can we make dissemination stick? *Exceptional Children, 79*(2), 163–180.

Cook, B. G., & Odom, S. L. (2013). Evidence-based practices and implementation science in special education. *Exceptional Children, 79*(2), 135–144.

Curran, J. (2008). Social capital: Working towards a community that is open to all. *Journal of Vocational Rehabilitation, 29*, 179–183.

Drake, R. E., Becker, D. R., Bond, G. R., & Mueser, K. T. (2003). A process analysis of integrated and non-integrated approaches to supported employment. *Journal of Vocational Rehabilitation, 18*(1), 51–58.

Drake, R. E., Becker, D. R., Clark, R. E., & Mueser, K. T. (1999). Research on the Individual placement and support model of supported employment. *Psychiatric Quarterly, 70*(4), 289–301.

Dreher, K., Bond, G., & Becker, D. (2010). Creation of a measure to assess knowledge of the individual placement and support model. *Psychiatric Rehabilitation Journal, 33*, 181–189.

Elinson, L., Frey, W. D., Li, T., Palan, M., & Horne, R. (2008). Evaluation of customized employment in building the capacity of the workforce development system. *Journal of Vocational Rehabilitation, 28*, 141–158.

Federal Register. (November 1, 2012). 7(11) and 12(C) of the Act; 29 U.S.C. 705(11), 706(18), 711(c), and 795(j) and 709(C)). 34 CFR 361. Washington, DC: Author. Available at http://cfr.regstoday.com/34cfr363.aspx

Fesko, S., Varney, E., Dibiase, C., & Hippenstiel, M., (2008). Effective partnerships: Collaborative efforts that support customized employment. *Vocational Rehabilitation, 28*, 159–168.

Fixsen, D., Blase, K., Metz, A., & Van Dyke, M. (2013). Statewide implementation of evidence-based programs. *Exceptional Children, 79*(2), 213–230.

Gladman, B., Waghorn, G., Wishart, L., & Dias, S. (2015). Reliability of health professionals' perceptions of employment for people with severe mental illness. *Journal of Rehabilitation, 81*(1), 3–8.

Government Accountability Office. (2012). Report to Congressional Committees: Employment for People with Disabilities, Little is known about the effectiveness of fragmented and overlapping programs. Washington, DC: Author. Available at www.gao.gov

Griffin, C. (2014). Bringing fidelity to customized employment processes. Unpublished Job Training and Placement Report.

Griffin, C., Hammis, D., Geary, T., & Sullivan, M. (2008). Customized employment: Where we are, where we're headed. *Journal of Vocational Rehabilitation*, 28, 135–139.

Hanley-Maxwell, C., Maxwell, K., Fabian, E., & Owens, L. (2010). Supported employment. In E. M. Szymanski & R. M. Parker (Eds.), *Work and disability* (3rd ed.; pp. 415–449). Austin TX: ProEd.

Harley, D., Donnell, C., & Rainey, J. (2003). Interagency collaboration: Reinforcing professional bridges to serve aging populations with multiple service needs. *Journal of Rehabilitation*, *69*(2), 32–37.

Harn, B., Parisi, D., & Stoolmiller, M. (2013). Balancing fidelity with flexibility and fit: What do we really know about fidelity of implementation in schools? *Exceptional Children*, *79*(2), 181–193.

Hart, D., Zimbricha, K., & Ghilonib, C. (2001). Interagency partnerships and funding: Individual supports for youth with significant disabilities as they move into postsecondary education and employment options. Institute for Community Inclusion at the University of Massachusetts, Children's Hospital, Boston, MA, and Massachusetts Rehabilitation Commission, Boston, MA, USA. *Journal of Vocational Rehabilitation*, *16*, 145–154.

Hartman, H. (2009). Step by step: Creating a community-based transition program for students with intellectual disabilities. *TEACHING Exceptional Children, 41*(6), 6–11.

Henn, M., & Henn J. (2007). Editorial: Facilitating integrated employment outcomes for individuals with significant disabilities: Parents' perspective. *Journal of Vocational Rehabilitation*, 26, 1–31.

Hollingsworth, D. K., Johnson, W. C., & Cook, S. W. (1989). Life lines, Beatrice Wright: Broad lens, sharp focus. *Journal of Counseling and Development, 67*, 220–229.

Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. section 1400 et seq. (2004). (P.L. 108-446).

Inge, K. (2008). Customized employment. *Journal of Vocational Rehabilitation*, *28*, 133–134.

Inge, K., Strobel, W., Wehman, P., Todd, J., & Targett, P. (2000). Vocational outcomes for persons with severe physical disabilities: Design and implementation of workplace supports. *NeroRehabilitation*, 15, 175–187.

Karakus, M., Frey, W., Goldman, H., Fields, S., & Drake, R. (2011). US Department of Health and Human Services, Federal financing of supported employment and customized employment for people with mental illnesses: Final Report. Washington, DC: Westat, Inc. Available at http://aspe.hhs.gov/daltcp/Reports/2011/supempfr.htm

Kelsey, D., & Smart, J. F. (2012). Social Justice, disability, and rehabilitation education. *Rehabilitation Education*, *26*(2&3), 229–240.

Klingner, J. K., Boardman, A. G., & McMaster, K. L. (2013). What does it take to scale up and sustain evidence-based practices? *Exceptional Children, 79*(2), 195–211.

Kohler, P. (1993). Best practices in transition: Substantiated or implied? *Career Development of the Exceptional Individual*, 16(2), 107–121.

Kohler, P. (1998). Implementing a transition perspective on education: A comprehensive approach to planning and delivering secondary education and transition services. In F. R. Rusch & J. G. Chadsey (Eds.), *Beyond high school: Transition from school to work* (pp. 179–203). Belmont, CA: Wadsworth Publishing.

Kohler, P., & Field, S. (2003). Transition-focused education: Foundation for the future. *Journal of Special Education, 37*(3), 147–183.

Kugler, R., & Thomas, C. (2007). Quality employment services: Where research and practice meet. MassWorks. Serviced for Education and Employment Technical Assistance Project. Institute for Community Inclusion, University of Massachusetts, Boston.

Lemay, R. (1999). Roles, identities, and expectations: Positive contributions of role theory to normalization and social role valorization. In R. J. Flynn & R. A Lemay (Eds.), *A quarter-century of normalization and social role valorization: Evolution and impact.* Ottawa, ON: University of Ottawa Press.

Luecking, R. G., Cuozzo, L., Leedy, M. J., & Seleznow, E. (2008). Universal one-stop access: Pipedream or possibility? *Journal of Vocational Rehabilitation*, *28*, 181–189.

Malloy, J., Cheney, D., & Cormier, G. (1998). Interagency collaboration and the transition to adulthood for students with emotional or behavioral disabilities. *Education & Treatment of Children*, 21(3), 303.

Manthey, T., Rapp, C., Carlson, L., Holter, M., & Davis, J. (2012). The perceived importance of integrated supported education and employment services. *Journal of Rehabilitation*, *78*(1), 16–24.

Martin, E. D. (2001). *Significant disability: Issues affecting people with significant disabilities from a historical, policy, leadership, and systems perspective*. Springfield, IL: Charles C. Thomas Publishers, LTD.

Mazzotti, V., Rowe, D., Kelley, K., Test, D., Fowler, C., Kohler, P., & Kortering, L. (2009). Linking transition assessment and postsecondary goals. *TEACHING Exceptional Children, 42*(2), 44–51.

Metzel, D. S., Foley, S. M., & Butterworth, J. (2005). State-level interagency agreements for supported employment of people with disabilities. *Journal of Disability Policy Studies,* 16(2), 102–114.

Minton, C., Fullerton, A., Murray, B., & Dodder, R. A. (2002). The wishes of people with developmental disabilities by residential placement and age: A panel study. *Journal of Disability Policy Studies,* 13(2), 163–170.

Mueser, K. T., Clark, R. E., Haines, M., Drake, R. E., McHugo, G. J., Essock, S. M., Bond, G. R., Becker, D. R., Wolfe, R., & Swain, K. (2004). The Hartford study of supported employment for persons with severe mental illness. *Journal of Consulting and Clinical Psychology, 72*(3). 479–490. doi: 10.1037/0022-006X.72.3.479.

National Alliance on Mental Illness (NAMI). (2007). Fact sheet on assertive community treatment: Investment yields outcomes. Arlington, VA.

National Organization on Disability. 2010 Survey of Americans with Disabilities. Washington, DC: Author.

Noonan, P. (2004). *Developing interventions to improve interagency collaboration in providing transition services for youths with disabilities*. Unpublished dissertation, University of Kansas.

Novak, J. A., Rogan, P. M., & Mank, D. M. (2011). Supported employment and social relationships in the workplace. *Journal of Vocational Rehabilitation*, 35, 193–195.

Oertle, K., & Trach, J. (2007). Interagency collaboration: The importance of rehabilitation professionals' involvement in transition. *Journal of Rehabilitation, 73*(3), 36–44.

Office of Disability Employment Policy. (2003). Fact sheet on customized employment. Washington, DC: U.S. Department of Labor.

Osburn, J. (2006). An overview of social role valorization theory. *The SRV Journal*, 1(1), 4–13.

Patten, M. L. (2014). *Understanding research methods* (9th ed.). Glendale, CA: Pyrczak Publishing.

Parker, R. M., Hansmann, S., & Schaller, J. L. (2010). Vocational assessment and disability. In E. M. Szymanski & R. M. Parker (Eds.), *Work and disability* (3rd ed.; pp. 203–244). Austin TX: ProEd.

Phillips, W., Callahan, M., Shumpert, N., Puckett, K., Petrey, R., Summers, K., & Phillips, L. (2009). Customized transitions: Discovering the best in us. *Journal of Vocational Rehabilitation, 30*, 49–55. doi: 10.3233/JVR-2009-0452.

Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (2014). *Psychiatric rehabilitation* (3rd ed.). Boston, MA: Academic Press.

Pruett, S., Swett, E., Chan, F., Rosenthal, D., & Lee, G. (2008). Empirical evidence supporting the effectiveness of vocational rehabilitation. *Journal of Rehabilitation*, 74(2), 56–63.

Rogers, C., Lavin, D., Tran, T., Gantenbein, T., & Sharpe, M. (2008). Customized employment: Changing what it means to be qualified in the workforce for transition-aged youth and young adults. *Journal of Vocational Rehabilitation*, *28*, 191–207.

Sanon, K. (2007). Understanding and accessing transition to employment and adult services. *EP Magazine*, 30–32.

Skiba, J. A. (2001). Reaching the door to employment: Is it really open? *Journal of Vocational Rehabilitation*, 16, 39–46.

Smart, J. F. (2009). *Disability, society, and the individual* (2nd ed.). Austin, TX: Pro Ed.

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2012). 2012 CMHS Uniform Reporting System Output Tables 1. U.S. Department of Health and Human Services.

Szoc, R., Harvey, J. (2009). Identifying knowledge, skills, abilities, and other characteristics: Final Task Report (Contract No.GS-10F-0042M). Church, VA: EconSys and ICF International Falls.

Test, D. W. (2000). Implementing the transition mandate: The relationship between programs, personnel and services. *Special Services in the Schools,* 16(1/2), 23–34.

Test, D., & Cease-Cook, J. (2012). Evidence-based secondary transition practices for rehabilitation counselors. *Journal of Rehabilitation, 78*(2), 30–38.

Test, D., Fowler, C., White, J., Richter, S., & Walker, A. (2009). Evidence-based secondary transition practices for enhancing school completion. *Exceptionality*, *17*, 16–29. doi: 10.1080/09362830802590144.

Thomson, R. G. (1997). *Extraordinary bodies: Figuring physical disability in American culture and literature.* New York, NY: Columbia University Press.

Tyree, M., Kendrick, M. J., & Block, S. (2011). Strengthening the role of the employee: An analysis of supported employment using social role valorization theory. *Journal of Vocational Rehabilitation, 35*, 197–209.

Wehman, P., Lau, S., Molinelli, A., Brooke, V., Thompson, K., Moore, C., & West, M. (2012). Supported employment for young adults with autism spectrum disorder: Preliminary data. *Research & Practice for Persons with Severe Disabilities*, 37(3), 160–169.

Wehmeyer, M. L. (1998). Self-determination and individuals with significant disabilities: Examining meanings and misinterpretations. *Research and Practice for Persons with Severe Disabilities,* 23(1), 5–16.

West, M. D., Kregel, J., Hernandez, A., & Hock, T. (1997). Everybody's doing it: A natural study of the use of natural supports in supported employment. *Focus on Autism & Other Developmental Disabilities*, 12(3), 175–181, 192.

Williams, P. (1999). An exploration of the application of social role valorization in special hospitals. Journal of Psychiatric and Mental Health Nursing, 6, 225–232.

Wolfensberger, W. (2000). A brief overview of social role valorization. *Mental Retardation, 38*(2), 105–123.

Wolfensberger, W. (2011). An "If this, then that" formulation of decisions related to social role valorization as a better way of interpreting it to people. *Intellectual and Developmental Disabilities,* 49(6), 456–462.

Wolfensberger, W. (2011). Social role valorization and, or versus, "empowerment*". Intellectual and Developmental Disabilities,* 49(6), 469–476.

Wolfensberger, W. (2011). Social role valorization: A proposed new term for the principle of normalization. *Intellectual and Developmental Disabilities*, 49(6), 435–440.

Wright, B. A. (1959). A new look at overprotection and dependency. *Exceptional Children*, 115–122.

APPENDIX A

Email Granting Permission to Use HPPE

From: Beverley Gladman <beverley_gladman@qcmhr.uq.edu.au>

Subject: RE: HPPE

Date: May 12, 2015 at 5:23:51 PM CDT

To: Christine Fleming <clf0006@auburn.edu>

Hello Christine,

Thank you for your email regarding your use of the Health Professionals Perceptions of Employment (HPPE) survey instrument.

I am content for you to use and/or modify the original HPPE for your dissertation research.

Please find attached requested copy of the revised Health Professionals Perceptions of Employment (HPPE) survey instrument as used in article "Reliability of Health Professionals' Perceptions of Employment for People with Severe Mental Illness" *Journal of Rehabilitation.*

I wish you well with your study,

Kind regards,

Beverley Gladman BPsychSc; MSuicidology (Hons)

Ph.D. Candidate

FACMBS/Medicine - PAH Honorary Fellow

Senior Research Scientist

Social Inclusion and Recovery Research

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This communication is confidential and may be legally privileged. If you have received it by mistake you must not use, disclose, copy or retain it. Please immediately notify us by return e-mail and then delete the e-mail you received in error.

From: Christine Fleming [mailto:clf0006@auburn.edu]

Sent: Wednesday, 13 May 2015 12:42 AM

To: Beverley Gladman

Subject: HPPE

Hello Dr. Gladman,

I am working with the mental health and vocational rehabilitation agencies to bring IPS to Alabama. I am also a doctoral student.

I recently read your article "Reliability of Health Professionals' Perceptions of Employment for People with Severe Mental Illness" in the *Journal of Rehabilitation* and was interested in your survey of health professionals.

I am currently working on my proposal for my dissertation and think your survey instrument could be used to assess the perceptions and practices of the mental health and other rehabilitation professionals at the two pilot sites. I am requesting a copy of the revised HPPE and seeking permission to potentially use it or modify if for my dissertation research.

I look forward to hearing from you. Thanks, Christine

Christine Fleming, MS, CRC

Executive Director & Assistant Clinical Professor
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APPENDIX B

Health Professionals Perceptions of Employment–Revised (HPPE-REV) Survey

1. **Date completed: _____**

2. **Mental Health Center: _____**

3. **Position Title: _____**

4. **Health Discipline: ____**

5. **Number of Years of Service in Mental Health: ____**

Introduction to the study: Please answer all questions. Your identity will be protected through secure storage of these documents and through reporting only aggregated results of this survey. This information is being collected as part of my doctoral research requirements.

Any queries about this survey may be addressed to Christine Fleming, MS, CRC, Auburn University, Department of Special Education, Rehabilitation, and Counseling, Auburn, AL 36849, at ChristineFleming@auburn.edu, or 334.844.2077, or Professor E. Davis Martin, PhD, at (334) 844-7685, or martiev@auburn.edu.

Thank you for completing this survey. Your information is very important and will help to manage and develop an IPS program at your site.

6. In the space below, write the approximate number of active clients you have on your current caseload. *Note: Active clients are those with whom you have been in touch during the past six weeks.*_____

7. Do you have responsibilities for supervising or mentoring other staff? Please circle:

Yes or No

8. Please consider your current active caseload. Of the active clients, what proportion do you consider is: *[Please express as a percent so that both figures add to 100%]*

a) Capable of full-time work? _____

b) Capable of part-time work? _____

Directions: The following six questions ask you to circle a response that reflects your answer based on five options:

9. Of the active clients on your caseload who are not currently working, what is the closest percent with whom you have discussed their individual vocational goals? *[Vocational includes education, training or employment goals]*

Skip to Question 12 if you don't have a caseload.

5. 100%

4. 75%

3. 50%

2. 25%

1. 0%

10. Of the clients on your caseload that you have discussed vocational goals, how frequently do you discuss their individual vocational goals? *[Vocational includes education, training or employment goals]*

5. Very Often (weekly)

4. Often (once or twice a month)

3. Occasionally (once every three months)

2. Rarely (once every six months)

1. Practically Never (once every 12 months or less)

11. In your team meetings with other mental health professionals, how often are clients' employment issues discussed?

5. Very Often (weekly)

4. Often (once or twice a month)

3. Occasionally (once every three months)

2. Rarely (once every six months)

1. Practically Never (once every 12 months or less)

12. In your view, how important is competitive employment in clients recovery plans?

5. Very important, not to be overlooked

4. Important enough to need discussing with all clients

3. Sometimes important

2. Rarely important, but only if the client requests vocational assistance

1. Not at all important or not usually relevant to clinical recovery

13. Is there an employment specialist who can assist clients directly with their employment (a position in the community interacting with people who have disabilities and people who do not have disabilities, earning at least minimum wage, full-time or part-time) goals?

5. Yes, there is a co-located employment specialist linked to this mental health team who is capable of assisting clients with work goals.

4. Yes, there is a co-located employment specialist linked to this mental health team, but securing a position in the community interacting with people who have disabilities and people who do not have disabilities, earning at least minimum wage, full-time or part-time is inconsistent.

3. Yes, although not co-located within our mental health center, an employment specialist is available in the local area.

2. Although access to an employment specialist has been arranged, the provider is not able to deliver suitable disability employment services in the local area.

1. No, there is no co-located employment specialist, nor is there an employment specialist available who is capable of assisting clients with work goals.

14. If you have an employment specialist available, how confident are you that the current job development process can succeed in helping all referred clients to gain and maintain competitive employment. *[If N/A go to Q20]*

5. Very confident (100%)

4. Confident (75 - 99%)

3. Neutral (50 – 74%)

2. Little confidence (25 – 49%)

1. Not confident at all (0)

15. Please give examples of challenges that you have experienced when you have referred clients to the employment specialist.

_____

_____

_____

16. Please give examples of successes that you have experienced when you have referred clients to the employment specialist.

_____

_____

_____

17. If there is an employment specialist available, to what degree do other members of the mental health team currently accept that person/position? Please circle a number for your response.

5 4 3 2 1

_____

(Very much accepted) (Not at all accepted)

18. If there is an employment specialist available, to what degree do other members of the mental health team currently support that person/position? Please circle a number for your response.

5 4 3 2 1

(Very much supported) (Not at all supported)

19. If there is an employment specialist available, to what degree do other members of the mental health team currently value that person/position? Please circle a number for your response.

5 4 3 2 1

(Very much valued) (Not at all valued)

20. Please suggest any practical ways that you can support clients with their vocational goals, or support the employment specialist to help clients achieve their vocational goals?

a)_____

b) _____

c) _____

21. Are you familiar with the supported employment model of Individual Placement and Support (IPS)? Please circle: Yes or No.

If yes, please provide your ideas about IPS in a brief definition:

_____

_____

_____

_____

22. If you answered yes to item #21, how did you learn about IPS?

_____

_____

_____

23. Please describe how you determine whether someone is ready to be referred to supported employment services.

_____

_____

_____

24. Please list and describe strategies you currently use to integrate employment into your existing program.

_____

_____

_____

APPENDIX C

Institutional Review Board (IRB) Approved Stamped Information Letter

Auburn University Institutional Review Board has approved this document for use from
7/6/15 to 7/5/16
Protocol # 15-280 EP 1507

AUBURN
UNIVERSITY
DEPARTMENT OF
SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT.)

INFORMATION LETTER
for a Research Study entitled
"Perceptions and Practices of Mental Health Professionals Regarding Employment of People with Severe Mental Illness"

You are invited to participate in a research study looking at the perceptions and practices of mental health and other rehabilitation professionals related to employment. The study is being conducted by Christine Fleming, from Auburn University Center for Disability Research and Service. You were selected as a possible participant because you work with individuals' diagnosed with severe mental illness and are age 19 or older.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete a survey regarding your perceptions and practices regarding people with severe mental illness obtaining and maintaining employment and to sign this consent form. If you decide to complete the survey, the instrument will be distributed and you will be asked to complete it and then drop it off in a drop box. Your total time commitment to complete the survey will be approximately 20 minutes.

Are there any risks or discomforts? The risks associated with participating in this study include possibly experiencing some discomfort sharing your perceptions and practices regarding your caseload, employment, and IPS. To protect your identity, the researchers will not collect any personal identifying information and data analysis will be conducted anonymously.

Are there any benefits to yourself or others? There are no anticipated direct benefits to participating in the focus groups.

Will you receive compensation for participating? No.

Are there any costs? If you decide to participate, you will not incur any monetary costs.

2084 Haley Center, Auburn, AL 36849-5222, Telephone: 334-844-7676, Fax: 334-844-7677
www.auburn.edu/cdrs

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, please stop completing the survey and remove yourself from the session. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Center for Disability Research and Service, The Department of Special Education, Rehabilitation, and Counseling, Alabama Department of Mental Health, AltaPointe Health Systems, or Chilton-Shelby Mental Health Center.

Your privacy will be protected. Any information/data obtained in connection with this study will remain anonymous. We will protect your privacy and keep confidential the data obtained. Data collected will be kept in the locked office of the primary researcher. Results of this study will be used to complete dissertation and may be published in a professional journal and/or presented at a professional conference.

If you have questions about this study, please ask them now or contact Christine Fleming at 334.844.2077, cll0006@auburn.edu or my major professor, E.Davis Martin, PhD, at martiev@auburn.edu or 33484.7676. A copy of this document will be given to you to keep.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334)-844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

Investigator's signature Date 7/31/15

Christine Fleming
Print Name

Co-Investigator Date

Printed Name

The Auburn University Institutional Review Board has approved this document for use from 7/6/15 to 7/5/16
Protocol # 15-280 EP 1507