CAN ACT LEAD TO MORE WORK? THE ONTARIO EXPERIENCE

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ABSTRACT

While assertive community treatment (ACT) teams are now an important resource for over 3,300 people living with severe and persistent mental illness in Ontario, ACT teams have had limited success reducing the unemployment rate of consumers. Results from the most recent survey of Ontario ACT teams show the unemployment rate stuck at 77% (Ministry of Health and Long-Term Care, ACT Technical Advisory Panel, 2006). This article reviews the characteristics and service outcomes reported by ACT teams in Ontario and explores the paradox of impressive outcomes of reduced hospitalization and improved housing tenure alongside limited progress on the employment front. It also examines the plans of one organization (Canadian Mental Health Association, Toronto Branch) to improve employment results for consumers of its ACT teams.

Despite an emphasis on vocational expectations within ACT principles (see, for example, Assertive Community Treatment Association, 2001; Phillips et al., 2001), the impact of ACT on vocational outcomes is only beginning to receive focused attention in the research literature. A review article examining ACT and vocational outcomes suggests that ACT models are often associated with vocational outcomes that are superior to usual treatment (Kirsh & Cockburn, 2007). It examined seven randomized controlled trials carried out on ACT, six of which favoured ACT in terms of employment outcomes and one that showed no difference. However, even those studies showing the advantages of ACT over other models raised serious questions about the effectiveness of ACT regarding employment. For example, one study showed significant differences in employment between ACT and the controls, but these differences were evident at 30 months and not at 66 months (Mowbray, Collins, Plum, Masterton, & Mulder, as cited in Kirsh & Cockburn, 2007). Other studies showed low rates of employment despite the differences between groups. For example, a retrospective analysis of data from a multisite, randomized controlled trial by Resnick, Neale, and Rosenheck (as cited in Kirsh & Cockburn, 2007) found that although participants assigned to an ACT-based program were 3 times

more likely to be employed after 1 year than those receiving usual treatment, fewer than 10% of clients met the criteria to be classified as workers at the 12-month point. Similarly, a study by Chandler, Spicer, Wagner, and Hargreaves (as cited in Kirsh & Cockburn, 2007) found that although vocational outcomes favoured ACT over a control group, only 19% of ACT clients worked in the 6 months prior to the interview versus 8% of the comparison group. Furthermore, in addition to the randomized controlled trials, the authors of this review also pointed to a quasi-experimental, comparison study of ACT and day treatment conducted by Nieves (as cited in Kirsh & Cockburn, 2007), which showed no advantage for ACT in the realm of employment. The review indicates that although ACT may show some promise over other models in the area of vocational outcomes, there is reason for concern and attention as to just how effective ACT has been, and can be, in this arena.

One of the challenges facing ACT teams has been maintaining a sustained focus on rehabilitation, particularly employment, in their day-to-day work. Chandler et al. (1999) explained that the outcomes reported in their study (cited above) reflected "a minimum of vocational rehabilitation emphasis by the ACT team during the first year of the program" (p. 333). Indeed, in their study of experiences of ACT service providers, Krupa et al. (2004) found that difficulties were experienced in implementing the rehabilitation and recovery mandate of ACT. While rehabilitation functions were embedded in the work of all staff, the most prominent and time-consuming duties were related to treatment, activities of daily living (particularly housing and finances), and supportive counselling. It may be the case that ACT teams are simply not attending to employment in a substantive way as they deal with the day-to-day pressures of managing a complex caseload of persons with multiple needs.

The review by Kirsh and Cockburn (2007) suggests that a vocational specialist or specialized employment service within the ACT team may be a factor that makes a difference. In the review, six studies clearly specified such services: Of the six, two were randomized controlled trials that clearly favoured ACT in terms of vocational outcomes (Chandler et al., McFarlane et al., as cited in Kirsh & Cockburn, 2007); one was a comparison of ACT with and without vocational specialists that favoured the vocational specialist group (Furlong et al., as cited in Kirsh & Cockburn, 2007); and another reported an employment rate of 84% (Mowbray et al., as cited in Kirsh & Cockburn, 2007), which far exceeds the rates commonly found in the literature. The studies that did not include a vocational specialist were more mixed in their results, with two trials favouring ACT vocational outcomes (Chandler et al., Mowbray et al., as cited in Kirsh & Cockburn, 2007), and two studies—one randomized controlled trial (Fekete et al., as cited in Kirsh & Cockburn, 2007), and one quasi-experimental (Nieves, as cited in Kirsh & Cockburn, 2007)—showing no difference between groups. These results suggest that a vocational specialist on ACT teams may indeed have a positive impact on vocational outcomes.

Such an explicit focus on employment is a characteristic of supported employment, an established best practice in community mental health. Bond et al. (2001) describe supported employment as

> programs [that] typically provide individual placements in competitive employment—that is, community jobs paying at least minimum wage that any person can apply for—in accord with client choices and capabilities, without requiring extended prevocational training. . . . They actively facilitate job acquisition, often sending staff to accompany clients on interviews; and they provide ongoing support once the client is employed. (p. 314)

In a Cochrane database review of 18 randomized controlled trials, Crowther, Marshall, Bond, and Huxley (2001) found that supported employment was significantly more effective than prevocational training with regard to the number of people in competitive employment; for example, at 18 months 34% of people in supported employment were employed as compared to 12% in prevocational training. Clients in supported employment also earned more and worked more hours per month than those in prevocational training (Crowther et al., 2001). Bond (2004) also pointed to the effectiveness of supported employment in helping clients to attain competitive employment; his review included four studies of day-treatment conversion to supported employment and nine trials comparing supported employment to traditional vocational approaches. Indeed, the effectiveness of this model has been well established in the literature, and it is being promoted as a best practice in community mental health, as evidenced by a recommendation for a national supported employment initiative in the recent report issued by the Standing Senate Committee on Social Affairs, Science and Technology (2006).

Taken together, the outcome literature on ACT and supported employment suggests that the incorporation of supported employment into ACT teams makes sense and could potentially improve outcomes in a substantial way. This paper describes such efforts in one Toronto mental health agency. It examines the current state of affairs with regard to ACT and employment in Ontario, and discusses an initiative to improve outcomes. It is hoped that this discussion will stimulate further questions and an ongoing research agenda in this domain.

The Ontario Experience

The province of Ontario funded three ACT teams in the late 1980s as demonstration projects. Ten years later, the Ministry of Health and Long-Term Care decided to fund teams across the province to reduce pressure on psychiatric hospital beds. ACT teams were seen as part of the community resource base that would enable people with serious and persistent mental illness to reduce time in hospital and improve their quality of life. By 2006, 71 teams were funded and in place across the province.

For accountability purposes the Ministry supported the development of a simple set of questions, ranging from client demographics and numbers served to impacts of ACT on hospital use, housing, and employment. Submission of aggregate data from the teams provided the government what it needed and did not impose a great burden on the teams, whose prime responsibility was clinical service.

METHOD

The Toolkit for Measuring Psychosocial Rehabilitation Outcomes (referred to as the PSR Toolkit) was used as it collects a core set of data, which can be used to describe and monitor client-level outcomes. The PSR Toolkit was developed by the Research Committee of the International Association of Psychosocial Rehabilitation Services (1998), in collaboration with the Evaluation Centre at the Human Services Research Institute, and the Substance Abuse and Mental Health Services Administration. It contains domains that directly relate to the questions formulated by the Ministry's technical advisory panel. These items were tested in a pilot study and provided teams with brief, face valid

indicators (International Association of Psychosocial Rehabilitation Services, 1998). In addition to the simplicity of the toolkit, using it to collect ACT client information facilitated comparisons with other community mental health programs such as intensive case management.

In 1998 the Ontario Federation of Community Mental Health and Addictions Programs (referred to as "the Federation") received funding from the provincial government to distribute the PSR Toolkit to member agencies in order to provide them with an ability to collect and monitor client demographic and outcome data. The Federation developed an agreement with the International Association of Psychosocial Rehabilitation Services to distribute a Canadianized version of the toolkit in electronic and paper form.

Ontario ACT teams were asked to submit aggregate data beginning in 2002 and to report on client characteristics and outcomes annually based on clients registered with ACT teams at the end of each fiscal year (March 31). Fifty-five ACT teams submitted aggregate data to the Ministry of Health and Long-Term Care using the Common Data Set (CDS), which is based on the toolkit and now mandated by the Ministry. Definitions for hospitalization, housing, and employment outcomes are derived from the CDS manual, which also is based on the domains and definitions in the PSR Toolkit. The domains are intended to be mutually exclusive; for example, clients counted in casual employment would not be counted in supported work.

ACT teams reported on cohorts of clients based on length of time in the program as of March 31, 2005. Clients who had been in ACT for 14 to 24 months were placed in Cohort 1, while those who had been in ACT for 24 to 35 months were in Cohort 2. Similarly, Cohorts 3 and 4 had been in ACT for 36 to 47 months and 48 to 71 months, respectively. Clients in Cohort 5 had been in the program for 5 years as of March 31, 2005. Teams were asked to report data on housing, hospitalization, income, and employment at baseline (when the client was admitted to the program) and at the end of the reporting period.

Accordingly, the data presented in this paper were collected from March 31, 2002, to March 31, 2005. The employment data were based on data submitted for the fiscal years 2002/03, 2003/04, and 2004/05. Employment data were extracted from the database and analyzed by cohort for 2002/03 and 2004/05. The data from these two periods were used to compare the effects of ACT teams on consumer employment with other outcomes such as hospitalization.

The Canadian Mental Health Association (CMHA) Toronto Branch commissioned an external review of their three ACT teams, which included the administration of the Dartmouth Assertive Community Treatment Scale (DACTS) developed by Teague, Bond, and Drake (1998), to measure program fidelity as well as employment outcomes. As a result of this review, a decision was made to have an employment specialist from CMHA's employment service work with the ACT teams to improve employment outcomes. The rationale and approach are outlined in the Results section.

RESULTS

The reports since 2001/02 show that Ontario ACT teams are serving the designated target group and achieving significant reductions in hospital days for clients (MOHLTC ACT Technical Advisory Panel, 2003, 2004, 2005, 2006). In total, 3,414 clients were registered with ACT teams across the province as of March 31, 2005. Of these clients, 90% have an Axis I psychotic or major mood disorder,

76% have schizophrenia or schizoaffective disorders, 58% are male and 42% are female, 74% are between 25 and 55 years of age, and 18% are between 25 and 34 years of age.

Seventy-six percent (76%) of ACT clients were receiving Ontario Disability Support payments as of March 31, 2005, which suggests that most ACT clients are considered unable to work due to their psychiatric disability. Thirty-nine percent (39%) of ACT clients have less than a high school education, while 29% are reported as having completed high school. Twelve percent (12%) have completed some college and university, and 12% have completed college or university.

Follow-up data as of March 31, 2005, showed clear improvements in hospitalization and housing. While clients used on average 76 hospital days in each of the 2 years prior to admission, after 1 year in ACT average days in hospital decreased to 25 days, and after 4 years hospital stays decreased further to an average of 16 days. After 6 years in the program, the average hospitalization was 7 days. In 2004/05, 69% of ACT clients had no hospitalizations. Similarly, the data showed that clients were able to improve their housing status while receiving ACT services. On admission to the program, 4% of clients were homeless compared to only 1.2% as of March 31, 2005. Sixty-nine percent (69%) of ACT clients were living in regular housing (single accommodation) as of March 31, 2005, compared to 52% on admission to the service.

Employment Outcomes

Data on employment status were reported for 3,370 ACT clients. Employment status improved compared to baseline rates. As of March 31, 2005, 77% of ACT clients were unemployed, but 23% or 788 clients were engaged in some kind of work (including unpaid work) compared to 9.6% (386 clients) who were working on admission. These rates varied by region of the province. Southwestern Ontario had the highest rate of employment (28%) followed by eastern Ontario with 26%. The central-south and central-west regions had employment rates of 25%. Central-east had a rate of 22%, followed by northern Ontario with 21%. Toronto's rate was 17%. Of the clients who were working as of March 31, 2005, 21% were in assisted/supported work settings, 20% were working independently, 4% were in alternative businesses, 24% had casual work, 12% were working in sheltered workshop, and 19% were doing unpaid work (see Table 1). Comparing follow-up rates of employment with those at baseline reveals that independent work increased by 46%, assisted work increased by 257%, and alternative work (consumer survivor initiatives) increased by 89%.

Employment type varied by region and changed over time. Assisted/supported work ranged from a high of 16% in the central-east region to 3% in northern Ontario in 2003/04. By March 31, 2005, the north had the highest rate of supported work (26%) and central-east's rate had declined to 9%. The rate of independent/competitive employment in 2003/04 ranged from 11% of ACT clients in the central-south region to 0% in Toronto. By March 2005, Toronto was reporting a rate of 14%, and central-west led the province with 39% of clients involved in independent work. In 2003/04, unpaid work or volunteer work varied from 11% in central-south to 3% in the Toronto region. By March 2005, southwestern Ontario had the highest rate of unpaid or volunteer work at 24%, followed by eastern Ontario at 23%. Toronto's rate was 12%. By March 2005, 47% of employed ACT clients were doing casual work in the central-south region, followed by 26% in central-east.

Table 1

Employment Status of Ontario ACT Team Clients, March 31, 2005

Total employed	788 (22%)
Supported work	164 (21%)
Independent competitive employment	159 (20%)
Alternative business	36 (4%)
Casual	187 (24%)
Sheltered workshop	90 (12%)
Unpaid work	152 (19%)

An examination of data from Cohorts 1 to 5 shows that benefits in employment are evident across all work types over time. An analysis of 2002/03 data by cohort shows that unemployment declined to 81% after 1 year in ACT and then declined further to 67% after 4 years. Independent/competitive employment was reported for 6.2% of clients after 1 year in ACT and for 11.5% after 3 years, but the rate decreased to 10.8% after 4 years. Involvement in supported work increased from 6.5% of clients after 1 year to 10.1% after 4 years. Over the same period employment in sheltered workshops increased from 1.9% to 5%, and unpaid work increased from 3.9% to 7.2% (MOHLTC ACT Technical Advisory Panel, 2003).

An analysis of the 2004/05 data shows similar patterns (MOHLTC ACT Technical Advisory Panel, 2006). It is now possible to look at cohort data on entry into ACT (baseline) and compare it with cohort results at the end of the reporting period (March 31, 2005). Cohort 1 (those clients who had been in ACT for 1 year) had an 86% unemployment rate when they entered the program. After 1 year in ACT, the unemployment rate declined to 78%. Clients in Cohort 5, who had been in ACT for 5 years, had an unemployment rate of 92% upon entry. After 5 years in the program, the unemployment rate declined to 71% (see Table 2).

Table 2

Percentage of Ontario ACT Clients Unemployed Over Time (*N* = 3,370)

Cohort	On admission	March 31, 2005
1	86% (*n* = 602)	78% (*n* = 555)
2	87% (*n* = 669)	75% (*n* = 644)
3	89% (*n* = 516)	74% (*n* = 500)
4	90% (*n* = 433)	74% (*n* = 415)
5	92% (*n* = 271)	71% (*n* = 257)

There are some differences in the type of employment settings when Cohort 1 is compared with Cohort 5, as shown in Table 3. Of the Cohort 1 clients who were working, 23% were employed in an independent or competitive setting, compared with 3% for Cohort 5. More clients in Cohort 5 (37%)

were working in supportive employment settings than Cohort 1 (25%). Five percent (5%) of clients in both cohorts were working in consumer-run alternative businesses, and they are included in the supported work totals. However, 13% of Cohort 1 clients were working in sheltered workshops, compared with 8% for Cohort 5. Twenty-one percent (21%) of Cohort 1 clients were doing casual work compared with 25% for Cohort 5.

Table 3
Percentage of Cohort 1 and Cohort 5 Clients Employed by Setting, 2004/05

	Cohort 1 After 1 year (n = 115)	Cohort 5 After 5 years (n = 65)
Employed	20.72%	25.29%
Independent competitive employment	22.60%	3.08%
Supported work	25.22%	36.93%
Sheltered work	13.04%	7.69%
Unpaid work	18.26%	27.69%
Casual	20.87%	24.62%

CMHA–Toronto ACT Client Employment

After reviewing the results of the Ontario ACT teams' client employment data analysis, the CMHA Toronto Branch found the results of their own ACT teams distressingly consistent: competitive employment rates for clients were 7.5% across the three teams. These outcomes were discussed at meetings of the branch's Board of Directors Program Review Committee and with the staff of the individual teams. Comparative data from U.S. sources, the effect of staff vacancies in occupational therapy and vocational specialist positions, and the competing clinical demands of individual client needs were reviewed. None of these issues, however, were seen to justify the poor employment-rate results. One factor identified as a barrier was the "silo effect" of having individual vocational specialists responsible for the vocational needs of ACT clients, while the agency had a full Employment Services team that had relationships with 150 employers in the Toronto area but only minimal engagement with ACT clients.

A decision was made to increase the capacity of the CMHA–Toronto ACT teams to utilize "best practice" principles and methods to assist clients in achieving their employment goals. The first step was to engage the help of outside expertise in assessing the fidelity of the three teams to empirically defined ACT standards. Two fidelity assessment consultants from the ACT Centre of Indiana, at the University of Indiana, were retained in the spring of 2005. The assessment included a week-long site visit to the CMHA–Toronto teams.

The purpose was to obtain evidence, utilizing the Dartmouth Assertive Community Treatment Scale (DACTS), to determine if the poor employment outcomes were the result of lack of adherence to ACT standards (Teague, Bond, & Drake, 1998). A second fidelity measure, the Supported Employment

Fidelity Scale (U.S. Substance Abuse and Mental Health Services Administration [SAMHSA], 2003), was used to determine the extent to which best practices for client employment intervention had been adopted by the teams, specifically those of the supported employment model (Deluca, Bond, & Moser, 2000). The Supported Employment Fidelity Scale is divided into three sections—staffing, organization, and services—and comes with an Implementation Resource Kit that outlines the methodology to be used:

> The rater obtains objective information from a variety of sources, including agency records, employment specialists, other practitioners and supervisors, program managers and consumers. Individual meetings are recommended. The rater tries to obtain accurate information and not to lead respondents to the desired answers that may not reflect the actual practice at the site. The format for interviewing is conversational and the questions listed here are not meant to be used as a structured interview. (SAMHSA, 2003, p. 1)

Each of the 15 items comprising the subscales is rated on a 5-point response format, ranging from 1 = *no implementation* to 5 = *full implementation*, with intermediate numbers representing progressively greater degrees of implementation. Agencies in the United States that fully implement supported employment according to the scale criteria have been shown to have higher competitive employment rates than those that do not (Corbiere, Bond, Goldner, & Ptasinski, 2005).

The results showed that, across the three DACTS subscales (human resources, organizational boundaries, nature of services) the three teams scored above "moderate fidelity" to the ACT model. The same was not true for the supported employment fidelity. In their report in February 2005 to CMHA–Toronto, the consultants summarized: "The total score on the Supported Employment Fidelity Scale is 39, consistent with the fact that the supported employment model is not currently being implemented at this time." On the Supported Employment Fidelity Scale, a minimum score of 56 suggests fair supported employment implementation, and a score of 66–75 represents good supported employment fidelity. For the CMHA–Toronto ACT teams, any observed fidelity to the supported employment model was on the basis of individual adoption of best practice initiatives for employment intervention by team members, rather than team-based adherence to a particular model.

These results came as no surprise. The CMHA–Toronto teams had worked to meet provincial standards for ACT fidelity since their inception in 1999. However, those standards did not prescribe any vocational/employment intervention model beyond the expectation that a vocational specialist would be a consistent feature of each team. Until now, vocational specialists on the teams have been responsible for individualized vocational assessments, vocational planning/goal setting, resumé writing, interview preparation/evaluation, and job coaching. While these vocational components were applied, they were not utilized to maximum effectiveness.

The consultants made several recommendations for transitioning toward the supported employment model, which the CMHA–Toronto ACT teams decided to implement. An employment services group has been formed consisting of the team leaders, occupational therapists, and vocational specialists. Their work has been supplemented by the hiring in February 2006 of a full-time employment specialist to provide direct employment opportunities for ACT clients and to "champion" supported employment initiatives on the teams, within CMHA, and in the community. The employment specialist is assigned half-time to each of the two CMHA–Toronto ACT teams that service the eastern suburb of

Scarborough. The employment specialist's work differs from that of other team members in that it focuses purely on client employment issues, with no non-employment or case management duties (e.g., the specialist is not the primary contact person for any client). Duties include developing and maintaining a "job bank" of employment opportunities by networking with local employers. The employment specialist is supervised by the Employment Services supervisor rather than ACT team leaders, thereby reducing the "silo" effect.

The focus on employment outcomes since the review and the addition of an employment specialist is contributing to a more employment-oriented mindset among team members. The CMHA–Toronto employment services group set 30% as the "benchmark" goal for competitively employed ACT clients in the fiscal year ending in March 2007.

In addition to setting the ACT teams' organizational goals, the employment services group has also enlisted the Employment Services staff of the agency to review the individual goals set by clients for recovery and employment. The employment specialist leads the team in assessing and planning the team's role in attaining these goals. These individualized client employment goals are developed as part of the multifaceted service planning process for each ACT team client. Early indications are that the number of ACT clients working or pursuing employment goals is increasing. Prior to the start of the ACT supported employment initiative in February 2006, the two teams had 21 clients (out of 160) competitively employed. After only a few months of implementation, 7 more have become employed. As a result, the CMHA–Toronto teams achieved a 17.5% competitive employment rate at 6 months. Although encouraging, it still places CMHA below the 30% target rate for 1 year. CMHA will need to find employment for 15 additional clients by March 31, 2007, to achieve the target rate. This is over twice the current rate, assuming no job losses.

DISCUSSION

The Ontario ACT employment rate is as good as or better than outcomes in multisite randomized controlled trials (Resnick, Neale, & Rosenheck, 2003; Chandler et al., 1999) cited in the literature. While these data suggest that although employment outcomes improve over time, ACT teams in Ontario are currently not able to deliver the types of vocational outcomes that reduce unemployment rates significantly. There may be a number of reasons for this, including the fact that most ACT teams in Ontario are less than 5 years old. It also appears that ACT teams have not placed a high enough priority on hiring employment specialists. Less than half (49%) of ACT teams had full-time employment specialists as of March 31, 2004, and 15% had part-time specialists. Greater than one third (36%) had no employment specialists (MOHLTC ACT Technical Advisory Panel, 2005).

As can be seen from the data, there are regional variations in employment settings and employment status. Southwestern and eastern Ontario have had experience with ACT teams and clients over a longer period of time. This may explain why their employment rates are higher. These issues, as well as key success factors leading to improved vocational outcomes, require attention by ACT teams across the province.

The high unemployment rate among ACT clients is no surprise, given that estimates of unemployment among people with serious mental illness can be as high as 90% (President's New Freedom Commission, 2002). As the Ontario ACT data show, a significant portion of clients are between the

ages of 18 and 35. Although the Ontario and the CMHA–Toronto data show increased employment over time in ACT, many of these clients have not been able to complete schooling and pursue careers due to the complexities of their illness. The low rates of high school completion and post-secondary education among ACT clients create real challenges in terms of helping clients access jobs in a knowledge-based economy. These challenges require the development of more supported education programs in the province.

CONCLUSIONS

The data showing that ACT employment outcomes do improve over time, but not dramatically, are consistent with the research evidence from the Community Mental Health Evaluation Initiative. This initiative demonstrated that employment outcomes do improve modestly over time, and that having employment specialists makes a difference (Goering et al., 2003; Kirsh & Cockburn, 2007).

The CMHA–Toronto experience shows that having employment specialists on ACT teams may lead to significant employment outcomes when the whole team develops a mindset that sees employment as possible and desirable, and sets employment as a clinical outcome. The variation in employment settings merits further study, as does the relationship among employment specialists, occupational therapists, and other team members.

The data reported by ACT teams has limitations in that it is aggregate data. While the reporting of data by cohorts allows for client comparisons over time, it does not allow for cross-tabulations of diagnosis, age, gender, or other variables in relation to employment outcomes. However, the fact that there is some data available, as well as literature on the subject, suggests that ACT teams and other service providers do have tools available to them if they wish to improve employment outcomes.

RÉSUMÉ

Bien que les équipes communautaires de traitement intensif (ECTI) soient une source d'aide importante pour plus de 3 300 individus vivant avec un trouble de santé mentale sévère et persistant en Ontario, il demeure que les ECTI ont fait peu de progrès au niveau du taux d'emploi de leur clientèle. Les résultats du récent sondage auprès des ECTI de l'Ontario démontrent que le taux de chômage reste à 77% (Ministry of Health and Long-Term Care, ACT Technical Advisory Panel, 2006). Le présent article décrit les caractéristiques et les objectifs des services offerts par les ECTI de l'Ontario. De plus, l'article expose le paradoxe entre, d'une part, l'impressionnante diminution des hospitalisations et l'amélioration du taux d'occupation du logement et, d'autre part, le peu d'avancement au niveau de l'emploi chez la clientèle. Par ailleurs, l'article examine le plan établi par un organisme (Association canadienne pour la santé mentale à Toronto) pour améliorer les résultats au niveau le l'emploi chez la clientèle de ses ECTI.

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