A COMMUNITY-BASED VOCATIONAL REHABILITATION PROGRAM

AN EVALUATION OF A COMMUNITY-BASED VOCATIONAL REHABILITATION PROGRAM FOR ADULTS WITH PSYCHIATRIC DISABILITIES

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ABSTRACT

The purpose of this research is to examine the effectiveness of a project aimed at the vocational rehabilitation of individuals suffering from chronic psychiatric disabilities. Gastown Vocational Services (GVS) is a specialized vocational rehabilitation program, under the auspices of Greater Vancouver Mental Health Service Society. The project consisted of three distinct phases and utilized a gradual, step-by-step rehabilitative approach to achieve vocational success. The first phase of the GVS project included comprehensive vocational assessment and work-readiness skill training. Participants in this phase met in small groups for three hours, three times a week for a 12-week period. The second phase involved supported work-experience placements in the community. These placements were two to five months in duration. The final phase included assistance in seeking employment, job re-training, or educational programs. Assessment measures were taken before participants began the program, immediately after the 12-week job preparation program, and at six-month follow-up. Seventy-three individuals participated in the training program over a two-year period. Their progress was compared to 18 individuals comprising a Waiting List Control group. The results showed significant improvement in the Intervention group on measures of assertiveness, work behaviour, depression, income, and employment status. No changes were evident in the Waiting List Control group.

INTRODUCTION

Many and varied employment obstacles face adults with psychiatric disabilities, including the stress of work, fluctuating course of symptomology, lack of interpersonal skills, social stigma, and inflexibility in the work environment. The unemployment rates of individuals with disabilities reflect these obstacles and are well above the national average; they range from 12% to 28%, depending on the severity of the disability, compared to a national rate of 10% (Statistics Canada, 1991). Unemployment rates for individuals with serious mental illness have been

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cited as ranging from 70-90% in studies (Rutman, 1994). After hospital discharge, less than 20-30% work competitively (Anthony, 1994). Unemployment rates are a powerful indicator of the rates of serious mental illness that will need treatment in hospital in those aged under 65 (Kammerling, 1992). As a result, some mental health professionals believe that people with psychiatric disabilities are not capable of employment. One program to prepare clients for work found that over 70% remained unemployed (Estoff, 1981). However, work is gratifying and increases one’s self-esteem and sense of fulfillment. Many individuals with psychiatric disabilities want to be a productive part of society. Also, the costs to society of not helping those with psychiatric disabilities obtain employment is high. For example, 80% of the people in our sample group were receiving financial assistance from the government.

Writers and practitioners agree that this population group tends to be "vocationally immature," with limited life and work experiences. "Their knowledge of themselves, including their skills, interests and work values is minimal; their ability to test the reality of self-knowledge against the demands of the working world is sparse" (Anthony & Blanch, 1987, p. 11).

The view taken by the authors is that many adults with psychiatric difficulties are capable of competitive employment, but have trouble finding and/or maintaining work because of their vocational immaturity and skill deficits. They lack self-awareness and coping skills, such as assertiveness, illness management, communication skills, or self-presentation. Thus, if they can be provided with accurate information regarding their vocational strengths and limitations, taught coping and other necessary skills, and given practical supportive work experiences, competitive employment becomes attainable.

Four significant influences on the development of supported employment for this population include the job-coach model, the clubhouse model and transitional employment, the assertive community treatment model, and the "choose-get-keep" model (Bond et al., 1997). As many of these supported employment approaches were available to clients within the community, GVS practitioners believed that a more comprehensive and graduated approach was needed for some clients in order to address effectively their vocational immaturity and skill deficits. In this regard, the GVS approach was unique and new to the community, and was considered to be consistent with a more "traditional" vocational rehabilitation model. This approach included assessment, work adjustment skill training, and individualized work experience, followed by assistance with job placement. Employers at the clients' work-experience placement determined the individual's "job readiness."

Bond et al.'s examination of the effectiveness of vocational programs offering supported employment for people with severe mental illness showed varied employment success rates depending upon the study. Both non-experimental and experimental studies were described and employment results reported. For the non-experimental studies, despite wide variation in sampling, program models, and measurement strategies, the pre-post studies all suggested increased rates of employment—between 35 and 59% after six months (Bond et al., 1997).

For the experimental study, there was a comparison made between the rapid entry into supported employment with a job coach (experimental model) compared
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to the (control) group which offered pre-vocational training before supported employment. Results documented at 12 months indicated that 26% of the experimental group had obtained employment, compared to 17% of the control group (Bond et al., 1997). One specific study, with 86 clients, which examined accelerated entry into supported employment found that, after three years, 59% of the accelerated participants were competitively employed, compared to 6% of the gradual participants (Bond, 1995). Some examples of the types of job placements included: janitorial, factory, retail cashier, food preparation, and secretarial work. The conclusion was that “for this population, early entry into competitive employment, with intensive support, is more effective than approaches incorporating pre-vocational training” (Bond, 1995, p. 1).

The purpose of this manuscript is to document the effectiveness of the GVS community-based vocational program. This three-phase program (described below) offered a gradual, step-by-step vocational rehabilitation approach with assessment, pre-vocational skill training, and work-experience placements to achieve employment success.

Phase I: Skills Training

Clients participated in a 12-week program in small groups of seven to nine individuals. They attended three hours per day, three days per week. Psycho-educational sessions, facilitated by two registered occupational therapists, covered the following topics: Communication, including Conflict Resolution; Self Esteem/ Confidence Building; Stress Management; Assertiveness Training; Interviewing Skills; Résumé Preparation; Work Behaviours; Career/Market Research; Dressing for the Job; Health Promotion/Illness Management; Money Management; Confidence-Building; and, Anger/Frustration Management.

Sessions incorporated a variety of modalities, including didactic teaching, cognitive-behavioural, role-play and videotaping techniques, group interaction, and staff feedback. A very important aspect of the Phase I program was the support and feedback offered by other group members. The primary purpose of Phase I was to develop in clients’ the coping skills necessary to be successful in a work setting. It was also expected that these skills could be applied to “non-work” situations and have a positive impact on overall life satisfaction. The second purpose was to carry out comprehensive vocational/psychological assessments in order to determine appropriate vocational goals for each individual. Establishing the client’s educational and employment potential were key assessment features. A comprehensive psychological evaluation—including cognitive, personality, and diagnostic testing—was performed by a registered psychologist. Aptitude, interest, and work-values testing was conducted by occupational therapists. Clients were provided with a comprehensive report outlining assessment results and recommendations for career/employment options with or without further training or education.

Phase II: Work-Experience Placements

Upon completion of the Phase I program, participants were placed in work settings in their community. Specific individualized placements were determined based on the interests and aptitudes of the client as determined by comprehensive
vocational assessment. The expectations of these work placements were to approximate employment settings as closely as possible. A vocational rehabilitation consultant was employed to perform the following functions during Phase II: finding suitable employers, educating them about psychiatric disabilities, providing “job coaching” (assisting clients to problem-solve job-related issues), and providing a liaison between employer and employee. Employers evaluated the job performance of Phase II participants at the mid and end points of each placement. Placements were typically three-months’ duration. Clients participated in as many placements as necessary until their employer/supervisor deemed them to be competitively employable in that position. This phase also allowed each client an opportunity to explore as many work experiences as desired in order to clearly establish a career direction.

**Phase III: Competitive Employment**

Once clients were deemed competitively employable by their employers, in accordance with the Work Behaviour Scale, they were given assistance to find appropriate employment. A few clients (fewer than 1%) were offered employment in their Work Experience Placement position. On other occasions, they were assisted in job search techniques by the GVS Job Coach/Marketer.

During Phases II and III, clients were provided with ongoing education, encouragement, and support by peers and staff during evening groups held on a weekly or bi-weekly basis. The clients in the study remained in the GVS program for all phases of their vocational rehabilitation. The transition phases (e.g., from skills learning to applying them in a work setting) are when clients typically need considerable support. Further, clients were assisted in their job search by the GVS marketing staff, who had already developed a close relationship with the client. In this way, clients did not lose motivation or momentum by being shuffled to another agency, placed on a waiting list, or faced with the difficulty of having to develop a new relationship with another staff person from another vocational program.

**Hypotheses of the Investigation**

The specific hypotheses of this investigation are as follows:

1. The vocational training program will result in increased assertiveness and improved work behaviours as rated by employers.

2. Clients who participate in the vocational training program will experience improvements in depression, anxiety, and quality of life.

3. The vocational training program will result in improved levels of employment or education, housing, and income for participants.

4. Participants in the GVS program will demonstrate significantly greater improvement in the above areas compared to individuals in the Waiting List Control group.
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METHOD

Over a two-year period, 97 individuals were referred by either the local community mental health centre or vocational rehabilitation consultants to the Gastown Vocational Services (GVS) program under investigation. These individuals were seen in an orientation session, which included a detailed description of the program. They were then asked to think about whether they wished to participate and to contact the program office manager by telephone within a week to indicate their decision. The purpose of this procedure was to ensure that individuals were motivated and committed to putting their best efforts into the program. Out of the 97 individuals referred to the program, 73 (75%) chose to continue. Thirteen (18%) of these dropped out, typically within the first two weeks. The reasons for discontinuing, as determined by exit interview, included the following: the program was too stressful, physical illness, conflict with authority figures in the program, and stress external to the program. The final number of participants who completed Phase I totalled 60.

Upon entering the program, data were collected according to the recommendations outlined by Anthony, Cohen, and Vitalo (1978). These researchers recommended that a comprehensive rehabilitation evaluation include the following four types of client outcomes: (a) skill gain, (b) improved quality of life, (c) society benefits, and (d) satisfaction with services. Assessment measures (described below) were administered pre-intervention. Clients then participated in the three-month Phase I program. They again completed the assessment measures immediately following the program and at six-month follow-up.

Client Skill Gain

Within the context of the current vocational program, this category of measures referred to the skills taught to clients during Phase I (e.g., assertiveness training, anger management, stress management). Also included in this category were the actual behaviours that clients exhibited on the job. In this investigation, we assessed Client Skill Gain, utilizing the following measures:

Work Behaviour Scale (Griffiths, 1973; Watts, 1978). This 27-item scale, with demonstrated reliability and validity, was completed by employment supervisors when a client was on a work-experience placement or involved in volunteer work. It contained the following five subscales: Confidence (on the job), Social Interaction, Task Competence, Response to Authority, and Motivation. For the purposes of this paper, only the total score was analyzed and discussed.

The Work Behaviour Scale was administered prior to program involvement, only if the client had, in the last two months, been in a volunteer or employment setting. With participants’ permission, their supervisors were contacted and asked to complete the Work Behaviour Questionnaire. These data were collected on 16 participants.

Assertion I and II (Levenson & Gottman, 1978). This was a 35-item self-report measure of assertive behaviour. The participants rated each item on a 1 to 5 point scale, indicating their degree of discomfort in the situation (Assertion I), and the extent to which they would avoid the situation (Assertion II).
Client Quality of Life

This referred broadly to social and psychological adjustment. It included such factors as social network, friends, recreational/leisure activities, anxiety, depression, and self-esteem. The following measures were utilized to assess Quality of Life:

State/Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970). This 40-item questionnaire assessed State and Trait anxiety.

Beck Depression Inventory (Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961). This is a commonly used 21-item self-report measure of depression.

Social Adjustment Scale (Paykel, Weissman, & Prusoff, 1971). A 54-item self-report measure which assessed functioning in the following areas of life: Work, Social and Leisure Activities, Relationships (Extended Family, Marital, Parental, Family Unit), and Economics. Only the total scores are discussed in this investigation.

Benefits to Individual/Society

In this context, “Benefit” refers to some positive change in the client’s living, working, and/or learning environments, attributable to the vocational rehabilitation program. Examples included the traditional outcome criteria of employment and degree of independent living. Education could also be included in this category.

Outcome measures focused on specific levels, avoiding dichotomous categories (e.g., employed/unemployed, attending school/not attending school) (Farkas & Anthony, 1987). Employment, for example, was broken down into various categories such as pre-vocational sheltered workshops, volunteer, part-time, and full-time work.

This group of outcome measures is important with regard to justification for continued funding. To assess Individual/Society Benefits the following scales were utilized:

Employment Status. A nine-point scale which ranged from “0” (no vocational structure) to “8” (full-time competitive employment). The points between included volunteer work, work experience placements, and part-time/full-time work.

Income Status. A seven-point scale from “0” (income assistance for the handicapped) to “6” (earned income).

Housing Status. An eight-point scale from “0” (homeless) to “7” (fully independent living).

Education Status. An eight point scale from “0” (less than grade 12) to “7” (completed university degree).

Client Satisfaction with Services

This category of outcome included the client’s opinion of program efficiency and effectiveness. This information can be used to identify problem areas as viewed from the client’s perspective, and is a good method of keeping tabs on the way in which services are delivered. Client satisfaction typically was assessed by
asking questions related to specific elements of the vocational rehabilitation program. Again, it is important not to rely on simple “yes/no” responses, but rather to determine the degree of satisfaction with various aspects of the rehabilitation program. To assess satisfaction, an eight-item scale was developed which asked for the clients’ opinions regarding how helpful the program was overall, the degree to which they had learned skills that would be useful on the job, the degree to which the program adequately prepared them for a work experience placement, how understandable the content was, and how stressful they found the program. This questionnaire was administered once, immediately upon completion of the Phase I program.

Waiting List Control Group

The vocational program under investigation quickly developed a waiting list due to the lack of similar services available in the community. GVS practitioners took this opportunity to develop a Waiting List Control group for comparison purposes. At three points during the course of this two-year study, clients on the waiting list were contacted and asked if they would be willing to complete the assessment questionnaires previously described. A total of 40 clients were contacted for this purpose; 18 agreed to participate. After three months, the questionnaires were re-administered. For those clients involved in a work setting (N=7), their supervisors were contacted at the beginning and end of the three-month period and asked to complete the Work Behaviour Scale.

It should be emphasized that assignment to the Intervention and Control groups was not random. It is likely that those in the Control group were relatively higher-functioning individuals who felt comfortable coming to an unfamiliar setting to fill out questionnaires.

All clients who were part of the Waiting List Control group were offered admission into the Phase I pre-vocational training program, and thus could not be followed beyond the three-month time period. Those Waiting List clients who chose to participate in the treatment program were excluded from the Intervention group data to keep this sample independent from the Waiting List Control group. This permitted the use of comparison statistics designed for independent samples.

RESULTS

Characteristics of the Sample and Control Group

In the Intervention group (N=60), 50% were female, 75% were single, with an average age of 33 years. Forty-two percent of the sample group had a diagnosis of schizophrenia or schizoaffective disorder (DSM-III R criteria). Other diagnostic categories included 20% bipolar disorder, 12% depression, 11% anxiety disorders. Eighty-five percent had an Axis I diagnosis, 40% of the clients had an Axis II diagnosis, and 25% presented with an Axis III diagnosis. In the Control group (N=18), 77% had an Axis I diagnosis and 50% had an Axis II diagnosis. Overall, there were no significant differences in diagnoses between the Intervention and Control groups.
A description of the population involved in this study is summarized in Table 1. It is evident from this information that this is a chronic population with a limited work history. It is a complex group with multiple problems, in that many had Axis I, II, and III diagnoses. These clearly are not individuals who can spend a few weeks in a job-finding club and obtain employment.

**TABLE 1**

Characteristics of the Intervention Group and the Control Group

<table>
<thead>
<tr>
<th></th>
<th>Intervention Group (N=60)</th>
<th>Control Group (N=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>33 yrs (8.5)</td>
<td>41 (8.9)</td>
</tr>
<tr>
<td>Gender (m:f)</td>
<td>50:50</td>
<td>61% male</td>
</tr>
<tr>
<td>Illness onset</td>
<td>10.5 yrs (7.9)</td>
<td>16.1 (10.1)</td>
</tr>
<tr>
<td>Recency of hospitalization</td>
<td>3.3 yrs (4.0)</td>
<td>7.1 (8.3)</td>
</tr>
<tr>
<td>Number of hospitalizations</td>
<td>2.6 (2.5)</td>
<td>1.7 (1.8)</td>
</tr>
<tr>
<td>Longest held job</td>
<td>2.0 yrs (1.9)</td>
<td>4.2 (4.1)</td>
</tr>
<tr>
<td>Longest held volunteer job</td>
<td>1.1 yrs (2.0)</td>
<td>1.0 (1.7)</td>
</tr>
<tr>
<td>Recency of employment</td>
<td>3.6 yrs (4.9)</td>
<td>6.9 (7.6)</td>
</tr>
<tr>
<td>Recency of volunteer job</td>
<td>1.0 yrs (2.1)</td>
<td>1.2 (1.9)</td>
</tr>
<tr>
<td>Marital status</td>
<td>75% single</td>
<td>72% single</td>
</tr>
</tbody>
</table>

A statistical comparison of the Intervention group with the Waiting List Control group indicated significant differences. The Control group had the following characteristics: was older (41 years versus 33 years for the Intervention group); had a longer history of psychiatric diagnosis (16.0 years versus 10.5 years in the Intervention group); and, had a more positive work history (held a job for a longer period; 4.2 years versus 2.0 years). Finally, the Intervention group had been hospitalized more recently than the Control group (3.3 years versus 7.1 for the Control group). Overall, these results suggested that the Intervention group was made up of individuals with more severe problems than the Control group. This was likely due to the non-random process of establishing the Control group, as previously mentioned. Other variables to be examined below are consistent with this hypothesis.

**Program Effects**

To test the major hypotheses of this investigation, the 11 dependent measures (Work Behaviour, Assertion I, Assertion II, State Anxiety, Trait Anxiety, Depression, Social Adjustment, Employment Status, Income Status, Housing Status, and Education Status) were entered into a 3 x 2 multivariate analysis of variance (MANOVA). The between-groups factor was Treatment Condition (Intervention vs. Control group) and the within-subject factor was Time (pre/post/six-month follow-up). Alpha level was set at $p < .01$. Significant main effects for Condition and Time were evident, as well as a significant interaction. Univariate analyses of variance were then undertaken for the 11 dependent measures. Tukey tests were utilized for post hoc comparisons.
Skills Acquisition

Examination of the Work Behaviour Questionnaire indicated that, for the Intervention group, there was a significant improvement in work behaviour as rated by supervisors (Graph A). This improvement continued to be significant at six-month follow-up. In the Control group, there was no significant change in work behaviours over a three-month period. It is noted, however, that the Control group was rated as having better work behaviours (compared to the Intervention group) during baseline assessment. At the end of intervention, there was no significant difference between the two groups because of improvements made in the Intervention group. At six-month follow-up, the Intervention group began to surpass the Control group (at three months) although a direct statistical comparison cannot be made.

A similar pattern of findings was evident in self-reported assertiveness (Graph A). In the Intervention group, the level of both avoidance and distress decreased significantly from pre-intervention to post-intervention and follow-up. There was no significant change over time in assertiveness in the Control group. Again, however, baseline measures of avoidance and distress were lower for the Control group than for the Intervention group.

The fact that a very similar pattern of results was evident on two measures—one subjective and the other external ratings—lends validity to the self-report of subjects.
Client Quality of Life

No significant changes in anxiety or social adjustment were evident in either the Intervention or Control group. The two groups did not differ significantly from each other. With regard to depression, a significant decrease was evident in the Intervention group. At baseline, the mean score on the Beck Depression Inventory was 14.5 (mild depression). Immediately post-intervention, the mean score was in the normal range (9.6). This improvement was maintained at six-month follow-up. No significant change in depression was evident in the Control group.

Benefits to Individual/Society

Within the Intervention group, significant improvements in Employment Status and Income Status were evident post-intervention. Both were maintained at follow-up (Graph B). Within the Control group, there was a trend for these measures to drop over time ($p=.07$). No significant changes were noted on measures of Education or Housing status within either group.

At six-month follow-up, 22% of the Intervention group had obtained competitive employment and 56% were on work experience placement.

**GRAPH B**

**Employment and Income by Group**

Client Satisfaction with Services

Clients rated the GVS program on eight dimensions using a 0 to 100 analogue scale. The average rating was 69.9 ($SD=12.3$). A rating of 50 or higher indicates that clients were at least moderately satisfied with the intervention program.
TABLE 2

<table>
<thead>
<tr>
<th>Intervention Group Employment Status</th>
<th>Pre</th>
<th>Post</th>
<th>Follow-up</th>
</tr>
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<tbody>
<tr>
<td>No vocational structure</td>
<td>55%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Volunteer/sheltered</td>
<td>39%</td>
<td>35%</td>
<td>6%</td>
</tr>
<tr>
<td>Work experience placement</td>
<td>1%</td>
<td>52%</td>
<td>56%</td>
</tr>
<tr>
<td>Competitive employment</td>
<td>5%</td>
<td>8%</td>
<td>22%</td>
</tr>
</tbody>
</table>

DISCUSSION

Results

The results of this experiment confirm the first hypothesis. It was predicted that the vocational training program would lead to increased assertiveness and improved work behaviours. The pattern of findings was similar for both self-report measures of assertiveness and objective employer ratings of work behaviour and performance. Further, these improvements were maintained at six-month follow-up.

The second experimental hypothesis was partially supported. The vocational training program resulted in sustained improvements in depression; however, no significant change in anxiety or quality of life was evident. With regard to anxiety levels, it may be unrealistic to expect these to decrease while an individual is engaged in active vocational rehabilitation. Involvement in work experience placements, ongoing evaluation by supervisors, and looking for and commencing competitive employment are all potentially stressful experiences. Many participants did rate the pre-vocational program as quite stressful. Perhaps the fact that participants' anxiety did not increase during the program attests to improved stress management skills.

The third hypothesis was also partially supported. The vocational training program led to significant improvements in Employment Status and Income Status. Twenty-two percent of the Intervention group was competitively employed at six-month follow-up. Employment was found in computer programming, public relations, advocacy, peer support, auto mechanics, accounting, and self-employment. This is compared to only 5% prior to the program. Over half of the participants had no involvement in vocational activities before the pre-vocational training program. This dropped to six percent at follow-up.

With regard to housing status, it is noted that there was a trend for this to improve (in terms of greater independent living) six months post-intervention. It is likely that there is a lag between increased employment/income and actually changing one's residence. Perhaps if participants were followed for a longer period of time, the trend for increased independent living would reach significance.

Further, the last hypothesis addressed the comparison between the Intervention and Control group. There was no improvement in the Control group on any dependent measure over the three-month assessment period. In fact, there was a
trend for employment and income status to decrease over time. In contrast, the Intervention group demonstrated a variety of sustained improvements already discussed.

Study Limitations

One limitation of the study is the lack of random assignment for the Intervention and Control groups. This resulted in the latter group appearing to be higher functioning, in terms of work history, recency of hospitalization, and in baseline measures of work behaviours and assertiveness. Further, the Control group was not followed beyond the three months. Due to clinical constraints (i.e., the need to provide them with treatment in a timely manner), it could be argued that these clients put little effort into seeking employment because they were waiting to participate in a vocational program. This could account for their lack of progress over the three-month interval.

The lack of longer-term follow-up is also a study limitation. After three months, 56% of the Intervention clients were still on work experience placements. Longer-term follow-up may have resulted in higher rates of employment following completion of work experience placements. In addition, we were not able to determine the number of clients who were able to sustain employment.

CONCLUSION

In summary, the results of this study suggested that many individuals with psychiatric disabilities are capable of achieving vocational success. The GVS program described in this investigation focused on relatively long-term, progressive, step-by-step rehabilitation with skill training, comprehensive assessment, and ongoing support. This may be more expensive in the short-term; however, the authors believe the results for the participants justify the initial cost.

Bond et al.’s (1997) results indicated that a rapid place-train model was more effective than a gradual approach offering assessment and pre-vocational skill training (Bond et al., 1997). “Direct approaches to finding and attaining employment, that is, place-train models, increase rates of competitive employment more than do gradual stepwise approaches” (Bond et al., 1997, p. 342). Unfortunately, the current investigation is limited in that a direct comparison of these two approaches was not made. It does, however, support the principle that clients need direct assistance in finding and keeping jobs. GVS practitioners found that clients required the assistance of job coaches to directly market them to potential employers. This was considered vital to achieving results, even with individuals who presented themselves positively in interview situations. “Self-directed strategies, such as the job club, that require clients to assume most of the responsibility for searching for jobs and for making contacts with employers, do not appear to be satisfactory for the large majority of persons with severe mental illness” (Bond, 1997, p. 343).

The “consumer empowerment movement has focused attention on the aspects of employment that are esteem enhancing, dignifying and rewarding, as well as financially remunerative” (Cook, 1994, p. 4; Fisher, 1994; Harp, 1994). Having a range of different programs with a variety of approaches may, in fact, be more
reflective of clients' needs, thereby offering choice, which is an important consideration in job satisfaction.

Future research needs to examine the differential effectiveness of vocational training programs—in other words, to determine which clients tend to do well in this gradual, step-by-step approach and which would be better served in a supported employment model featuring rapid training and direct job placement.

Clearly, both types of program models or supported employment approaches have demonstrated success. It is likely that individuals who have career and/or educational aspirations, and who desire employment opportunities that are more challenging in nature, may need to develop greater and more effective coping strategies to be successful, and thus may benefit from this type of pre-vocational skill training program. Clients who desire a career may benefit from the opportunity to try the position and/or the work environment. Further, clients who have been out of the work force for a longer period of time, or who have little or no employment history, may also benefit from the pre-vocational component and graduated pace. The place-train approach may be more effective for individuals desiring entry-level positions.

Longer-term follow-up is also necessary. Many individuals with psychiatric disabilities can obtain jobs; a major challenge for them is to sustain employment. It is acknowledged, however, that follow-up research is difficult due to problems maintaining contact with participants. This is particularly true of the psychiatric population as they tend to be quite transient and/or disengage from rehabilitation services even when there have been “aggressive attempts by vocational specialists to keep in touch with them” (Okpaku & Anderson, 1997, p. 40). Nevertheless, vocational rehabilitation with this client group remains a worthwhile pursuit.

RÉSUMÉ

Cette recherche a été effectuée dans le but d’étudier l’efficacité d’un projet visant à la réadaptation professionnelle de personnes qui souffrent d’incapacité mentale chronique. Gastown Vocational Services est un programme spécialisé de réadaptation professionnelle, sous les auspices de la Greater Vancouver Mental Health Service Society. Composé de 3 phases distinctes, le projet abordait le problème de la réadaptation de façon graduelle (pas à pas) dans le but d’assurer la réussite professionnelle des participants. La première phase comprenait une évaluation professionnelle détaillée suivie d’une période de formation pour leur apprendre à faire face aux problèmes susceptibles de survenir sur les lieux du travail. Lors de cette phase, les participants se sont rencontrés en petits groupes pendant 3 heures, 3 fois par semaine au cours de 12 semaines. La deuxième phase comprenait le placement des individus dans la communauté afin de leur permettre d’obtenir une expérience de travail tout en étant encadrés. Ces placements étaient d’une durée de 2 à 5 mois. La phase finale incluait l’aide dans la recherche d’un emploi, le recyclage ou des programmes instructifs. Une estimation du profil des participants a été enregistrée avant qu’ils ont commencé le programme, immédiatement après les 12 semaines du programme de préparation au travail et après une période de 6 mois avais écoulée. Soixante-treize personnes ont participé au programme de formation au cours d’une période de 2 ans. Leurs progrès ont été comparés à ceux de 18 personnes du liste d’attente qui ont formé un groupw témoin.
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(«Waiting List Control group»). Les résultats ont démontré une amélioration significative en ce qui concerne le groupe expériment («Intervention group») au niveau de l'assurance, du comportement sur les lieux du travail, de la dépression, du revenu et de l'emploi. Aucun changement n'est apparu évident en ce qui concerne le groupe témoin.

REFERENCES


