A Review of 21st Century Research into the Development of Supported Employment (SE) Programs: Major Findings, Debates, and Dilemmas

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Having a job is key to one’s dignity and sense of purpose. Despite the fact that the unemployment rate for individuals with psychiatric “disabilities” is between eighty and ninety per cent¹, this is no less true for people who have been diagnosed as having severe cognitive and physical “developmental disabilities”.² Over the past ten years, the combination of governmental SE coverage modifications (e.g., the removal of eligibility restrictions for Medicaid home Based Waiver), and increased funding for SE has resulted in higher growth rates for SE than for other day services (Becker, et al., 2006). Consequently, there is great interest in the nature and impact of SE as an occupational intervention approach.

What follows, is a review of research (comparative studies and case studies; both longitudinal and cross-sectional) on several of what researchers have identified as the essential dimensions of supported employment programs in the United States. These dimensions will be emphasized in an examination of recent research articles drawn from the universe of pertinent literature. The examined literature pertains to SE for consumers with developmental and/or with psychiatric disabilities. The purpose of this review is to enhance, by synthesizing and summarizing the latest important findings, DBH/MRS insight into the state of SE programs today.

¹ As reported by the National Mental Health Association in its publication - Supported Employment for Persons with Psychiatric Disabilities: A Review of Effective Services. 2001.

² On 1/26/05, at the “Consensus Validation Conference” of the National Council on Disability Social Security Study in Wash., D.C. “Employment Brief #1 reported that, “the most recent data of 2005 show that people with disabilities are only half as likely as those without disabilities to be employed (38% compared to 78%), and there is an especially low employment rate among those who have difficulty with self-care (17%) or difficulty going outside the home alone (17%).
Inclusion Criteria

Criteria for a research article’s inclusion in this review are as follows:

- Academic studies examining SE services for people with a clinical diagnosis of severe mental illness
- Focus on SE programs in the U.S.A. for adults between eighteen and sixty-five years of age.
- Quantitative measurement of indices
- Professional conference research papers
- Federal Government reports
- Reviews organizing significant bodies of pertinent basic research
- Published since the year 2000

The studies discussed in this review used numerous methodological approaches. Different time frames (cross-sectional and longitudinal), sample selection techniques (often random), and various research models (e.g., experimental, or case study) were employed.

A brief history of the development of SE precedes said discussion.
Supported Employment (SE): A Brief History of Its Development

SE began in the mid-1970s. It started out as a phase in the development of vocational rehabilitation services for people with severe disabilities who experience barriers to community integrated employment. Its roots are to be found in the mid 1950s and early 1960s, however.

One must go back to 1955 to find the first Commission on Mental Health. It was created by The Mental Health Study Act of 1955. It was charged with developing recommendations for changes in mental health policy in the United States. That Commission issued a report in 1960 which became the basis of The Community Mental Health Act of 1963, which was signed into law by President Kennedy.

During the early 1960s, dismantling of the U.S. Mental Health Care system occurred. When states started closing hospitals, newly released patients were promised that they would be able to get vital daytime services, such as SE, in community settings. This was mandated in 1963 by the Community Mental Health Centers Act. The point of this legislation was the study of the status of mental health consumers in the United States. Back then, legislators and policy makers were considering a paradigm shift from institutionalization of the mentally ill, to treatment of the mentally ill on a community, outpatient basis. So this legislation was considered “far reaching,” because it called for the complete de-institutionalization of all people with mental illnesses to facilities in the local neighborhoods where they could be near their loved ones and live close to normal lives.

A major flaw of this legislation was the fact that during the period of 1960 through 1963, no planning was done for their discharge. Community outpatient clinics were totally unprepared to handle the new
influx of clients. This resulted in the first instances of homelessness.

Enter Drs. Arnold Marx, Leonard Stein, (MDs), and Mary Ann Test (PhD.), from the research ward of Mendota State Hospital in Madison, WI. In April, 1970, they were charged with developing and evaluating more effective ways of helping the "treatment failures" (persons with chronic schizophrenia) to leave the hospital and remain in the community.

They faced recurring problems. Almost all of the patients who were "successfully" discharged and carefully linked with the existing aftercare services rotated back to the hospital within weeks or months; usually in a psychotic and disheveled state. So they argued that the same on-going support & treatment, i.e., "round-the-clock care," that helped alleviate client symptoms was just as important (if not more so) following discharge.

Marx et al. believed that the hospital’s failure to "train" effectively their patients enough to live in their communities was due to adherence to certain misguided assumptions. Consequently, they came to view the hospital, itself, as the problem. They argued, instead, that some patients were simply too sick to be treated in hospital (Dixon, 2000).

The identification and acceptance of this failure led, in turn, to the development of a number of community-based initiatives. Among these were halfway houses, community psychosocial rehabilitation centers, and semi-sheltered work-living groups; the idea being that the community was where the patient needed help the most.

It followed, that the community should become the 'therapy arena'. It had a number of advantages over the hospital setting in the context of rehabilitation and community life such as the presence of
'healthy role models' in the community, and the expectations of normal behavior in society. Based on these assumptions, Marx et al. moved hospital-ward treatment staff into the community. They demonstrated their argument’s validity. Consequently, a community treatment program – the Assertive Community Treatment\(^3\) (ACT) model was established in 1972.

In the wake of their success, SE – a rehabilitative component of ACT, was broadly defined in the 1973 Rehabilitation Act. Then, during the 1980s, “Supported Employment” emerged as a vocational rehabilitation model in its own right as stipulated in the Rehabilitation Act Amendments of 1986 – when SE was more specifically defined as competitive work in integrated work settings with the provision of follow-along supports for people with the most severe disabilities.

Further advances followed in the 1990s. In 1997, the Balanced Budget Act (P.L.105-33) laid out SE modifications. It removed eligibility restrictions for Medicaid Home Based Waiver funding for SE. This led to higher growth rates for SE than for other day services. Yet, waiver-funded SE accounted for less than 16% of those getting waiver-funded\(^4\) day services, and spending on SE accounted for only 12% of day habilitation funding. At that time, most funding went to day

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\(^3\) This is a team treatment approach. It is designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia. Teams are comprised of professionals with backgrounds in social work, rehabilitation, counseling, nursing and psychiatry. The services provided include case management, initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other services and supports critical to an individual’s ability to live successfully in the community. ACT services are available 24 hours per day, 365 days per year.

\(^4\) The Medicaid Home and Community-Based (HCB) Waiver, for instance, is the primary funding source for long-term care for individuals with developmental disabilities. It finances services for people with developmental physical disabilities so as to allow them to live in the community and remain as independent as possible.
support, pre-voc services, and other segregated options (Becker, et al. (2006).

Again, in 1998 the Rehabilitation Act was amended with Title IV of the Workforce Investment ACT (WIA) of 1998 - Public Law 105-220, 112, Statute 936. This revision included the amendments to the Rehabilitation Act of 1973. It tied the provisions of the Rehabilitation Act more closely to the integrated workforce system as mandated by the WIA; the intended effect being to render more comprehensive and customer-focused the emerging workforce investment system.

By the dawn of the 21st Century, SE had attained “flagship” status. In 2001, SE was endorsed by the National Alliance for the Mentally Ill. In 2003, SE was endorsed by the President’s New Freedom Commission on Mental health. Today, SE is widely seen as the occupational intervention of choice for vocational rehabilitation programs, nationwide.

\[5\] Codified as: Section 504 of the Rehabilitation Act, 29 U.S.C. § 794d ...
Introduction to Supported Employment Research Discussion

Among all of the approaches to vocational rehabilitation, “supported employment” (SE) is the only approach that has “a systematic body of rigorous research showing effectiveness in helping mental health (MH) consumers.” (Bond, et al., 2005:4). Today SE (as opposed to certified Club Houses and vocationally integrated Assertive Community Treatment [ACT], for instance) is the only vocational rehabilitation approach that, on the basis of randomized controlled trials, has been established as an “evidence-based” practice (Machias et al., 2006).

Evidence-based (EB) practices are “well defined practices that have demonstrated positive client outcomes based on thorough research studies. Such practices are usually required by Medicaid, state MH authorities, etc. Typical considerations in determining whether a given programmatic practice is EB include: 1) detailed operational definition of the program & validated “fidelity scale” that measures the extent to which said program is implemented as intended, 2) program evaluation by multiple robust research studies with consistent results showing the effectiveness of specific outcomes, 3) studies showing ‘generalizability’ across settings & populations, 4) The body of research must be represented by multiple investigator groups so as to offset ‘allegiance effects’ (Bond et al, 2005).
**Supported Employment, defined**

SE is a comprehensive employment service for people who, because of their disabilities, need ongoing support services in the competitive work force. Staff from public or private, non-profit rehabilitation agencies provide services to both the employer and the employee, including: recruiting, matching an employee to tasks and duties within the company, assisting in training the employee and co-workers/mentors in working most effectively with the employee, and assisting the individual in addressing work-related needs (e.g., transportation, counseling, and living in the community). Typically, supported employees work twenty hours or more per week, at or above minimum wage.

In the universe of vocational rehabilitation services, SE is one of three main types of job service provision. The other two are “Sheltered Employment” and “Supported Education & Training.”

SE is distinguished by two practices. First, SE requires that consumers be rapidly placed (minus extended preparation) in competitive jobs. Second, SE provides on-the-job support from trained employment specialists. Recently, these distinctions have been the focus of considerable research interest.

By the beginning of the 21st Century, a substantial and diversified job placement system, devoted to obtaining employment for consumers with developmental disabilities, had been established.7 Reportedly, there were “about three thousand (3,000) U.S. ‘psychiatric rehabilitation’ providers offering pre-vocational training of some

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7 Such disabilities include cognitive, physical, and sensory types.
sort, and there were more than thirty-six thousand (36,000) people with mental illness in SE schemes⁸” (Crowther, et al., 2001:205).

As a research topic, SE is often studied as a “cause.” That is, it is conceived as an independent social factor impacting upon both the lives of consumers (for instance, quality of life (QOL), expanding social networks, financial independence), and upon society at large such as tax base contribution.

In other cases, SE is examined as an “effect”; as in those cases where it is argued that organized job support for the developmentally diagnosed depends on other social factors like funding levels, staffing; or on the breadth of its initiatives like training, on-the-job support, job creation.

Examples of each of these approaches, as they pertain to the various dimensions noted above, are considered next.

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⁸ While this figure appears to refer to the USA as a whole, the number is suspiciously low; given the reported rise in the number of SE participants over the last decade.
Studies Examining SE impact:

The impact of SE has been considered from several angles. Corrigan (2005) examines the effectiveness of SE vis a vis medical clinical “continuum of care” models. He discusses the body of evidence supporting SE “place-and-train” programs regarding employment services (e.g., IPS\(^9\)). He argues for the greater effectiveness of such programs over “train-and-place” programs. He cites research suggesting that, from the ten per cent baseline commonly found in individuals with psychiatric disabilities who do not receive some kind of SE services, the employment rate “almost tripled for participants in “place-and-train” vocational programs( Ibid:3). He notes that SE owes such superior outcomes to its sensitivity to “the impact of community and societal factors on the disabilities of people with mental illness” (Ibid:2).

In a similar vein, Bond (2004) makes a case buttressing SE. He found that SE programs led to higher rates of competitive employment placements both in case studies of day treatment programs converting to SE, and in randomized control trials comparing SE to a variety of alternative approaches (e.g., sheltered workshops, or psychosocial rehab programs) in states in the following regions of the USA - New England (New Hampshire, Connecticut), Mid-Atlantic (Maryland, Washington, D.C.), Eastern, and Southeastern. It was reported that “Between 40% and 60% of consumers enrolled in SE obtain[ed] competitive employment” (Bond, 2004:345). On the other hand, less that 20% of similar consumers did so when NOT enrolled in SE (Ibid.).

\(^9\) IPS (Individual Placement & Support) is an “employment services” approach. It emphasizes a) rapid job placement in socially integrated work settings, b) subsequent training, and c) on-going support with no time limits (Cook et al., 2005).
In their seminal research report, Cook et al. (2005) assessed the impact of SE by studying over a twenty-four month period employment services for people with severe psychiatric developmental disabilities in eight SE program sites included in the Employment Intervention Demonstration Program\(^{10}\) (EIDP). The Cook research team analyzed three vocational outcomes – 1) obtaining competitive employment, 2) working forty or more hours in a single month, and 3) monthly earnings. They confirmed the superiority of SE when it comes to obtaining jobs for consumers with psychiatric disabilities. By doing so, they extended the scope of their study of “best practices” in vocational rehab to more racially and ethnically diverse populations, at multiple geographic regions, using different SE models.

Their major findings confirmed all of their research hypotheses\(^{11}\). So the experimental group (the group receiving SE enhancements) was more likely than the control groups\(^{12}\) to get jobs, work at least forty hours per month, and earn more money. Furthermore, experiment/control group differences increased over time. Finally, despite the effects of participant characteristics such as prior work history, clinical indicators, and demographic factors, the experimental group achieved better outcomes.

\(^{10}\) EIDP is a multi-state collaboration among eight (8) research demonstration sites, a Coordinating Center, and the Center for Mental Health Services/Substance Abuse and Mental health Services Administration (CMHS/SAMHSA), Rockville, MD.

\(^{11}\) The three hypotheses were – (1) experimental group participants receiving an SE intervention would show a greater likelihood than comparison group subjects of achieving competitive employment, 40 or more hours of work per month, and higher monthly earnings; (2) the differences between experimental and control group outcomes would increase over time; (3) the experimental group would achieve superior outcomes despite the effects of participant characteristics including demographic features, clinical indicators, prior work history, co-morbid physical/developmental disabilities, and receipt of disability income support.

\(^{12}\) The experimental group model was tested in AZ. The control group models, and the sites where they were tested are as follows: Clubhouse and Assertive Community Treatment [ACT] (MA), Individual Placement and Support [IPS] (CT & MD), ACT/IPS (SC), Family/ACT & Mental Health Employers Consortium [MEC] (ME), Employment Assistance through Reciprocity in Natural Supports [EARNS] (TX), Long-term Employment Training and Supports [LETS] (PA).
Notably, there have been some efforts to establish among “best practices” other vocational rehabilitation models. For instance, in a randomly controlled trial, Machias, et al. (2006) compared ACT with a certified Clubhouse model\(^\text{13}\) in the delivery of employment services.\(^\text{14}\) They found that, in relation to the clubhouse program, to a statistically significantly extent, the ACT program had better service engagement and retention over a two-year period. Yet, they found no significant difference in employment rates.

On the other hand, compared to ACT, Clubhouse participants worked, on average, for a longer time. They also worked more hours per day, and earned more money. It was concluded that while the ACT program

\(^{13}\) The “Clubhouse Model of Psychosocial Rehabilitation” is a comprehensive and dynamic program of ‘treatment’ for people with severe and persistent mental illness. In contrast to traditional day-treatment models, clubhouse participants are called "members" (as opposed to "patients" or "clients") and treatment focuses on their strengths and abilities, not their illness. The clubhouse is unique in such that it is not a clinical program, meaning there are no therapists or psychiatrists on staff. All clinical aspects of the program have been removed so as to focus on the independence of the individual, rather than their illness. Additionally, all participation in a clubhouse is strictly on a voluntary basis.

\(^{14}\) Clubhouses offer a “tiered” employment program designed to integrate interested members back into meaningful and gainful employment in the community. The first step of the program is Transitional Employment (TE), in which members can work in meaningful part-time jobs outside the clubhouse procured through partnerships with community entities and businesses. The member selected by the clubhouse community for these position(s) are trained by a clubhouse staff and/or member who are in charge of that particular placement. As an incentive to the employer, job attendance and performance are guaranteed, as a staff and/or member will support or even fill-in for the clubhouse member if he or she needs to be absent for any reason. Each member contribution at a Transitional Employment position is designed to be transitional and temporary lasting for six to nine months, as these positions belong to the clubhouse, and are designed in such a way so that ideally all members will have an opportunity to work. Each member of a clubhouse who participates in a Transitional Employment position is guaranteed to earn minimum wage or above. Additionally, all clubhouse TE positions are entry level so that all members have the opportunity to work in all positions. The single most important factor in placing members in TE positions is the individual's desire to work.

The second step is Supported Employment, in which the clubhouse community helps an interested member obtain his or her own employment and serves as a resource and support for résumé makeup, interviewing skills, transportation, and employer liaisons.

The third step is Independent Employment, in which the member is meaningfully and gainfully employed without the intervention (but always with the support) of the clubhouse community.
“can insure continuous integration of [SE] with clinical care” (2006:1406), and certified Clubhouses “can effectively provide [SE] along with other rehabilitative services” (ibid.), both program types “can achieve employment outcomes similar to those of exemplary supported employment teams” (ibid.).

The studies discussed above exemplify research aimed at showing how SE changes the job status of consumers. Next, research focusing on factors determining the efficacy of SE will be discussed.
Studies Examining Factors Impacting SE effectiveness

While it appears that most SE studies focus on its impact on consumers’ lives and fortunes, there are many studies that examine elements that influence the success of SE programs.

Chief among factors determining SE efficacy is funding; both absolute and relative. Information regarding the costs of SE programs such as IPS (defined in footnote #9), and their relation to outcomes is, reportedly, “patchy and equivocal” (Schneider, 2003:145). In an assessment of the costs of occupational interventions, Justine Schneider (2003) examined the issue from the individual perspective15, the taxpayer perspective16, and from the perspective of society at large17. She found that “individuals benefit to a greater degree than the state or society, at least in the short term” (2003:154).

More recently, Latimer et al. (2004) used a non-random “convenience” sample of twelve SE programs18 in rural and urban settings in seven states.19 They sought to determine the costs of evidence-based SE programs in real-world settings.

They separated staff and consumer funding expenses. Direct costs per employment specialist ranged from $37,339 in RI, to $49,603 in MA; averaging out to $44,082.

Much more variation was reported regarding consumer costs. Annual direct costs for consumers varied from $860 in NH to $2,723 in OR. Direct costs per “full-year-equivalent” varied from $1,423 in MA, to $6,793 in IN. Latimer et al. argued that differences in cost-per-

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15 Net earnings minus welfare benefits & change in health and well-being (Schneider, 2003:148)
16 Tax revenue plus welfare benefits saved & savings on alternative program inputs (e.g., day care) minus employment support to service users (ibid.).
17 Savings to the state from alternative programs; increased productivity; & changes in health or well-being (ibid.).
18 The twelve programs were assessed as being faithful to the principles of evidence-based SE programs by virtue of having posted high ratings on the so-called “Supported Employment Fidelity Scale.
19 Those seven states were - IN, KS, MA, NH, OR, RI, & VT.
client arose from differences in rules regarding a given program’s caseload composition (2004:403). But, by assuming a typical caseload of eighteen clients, they estimated the costs per “full-year-equivalent” averaged $2,449 per year; ranging from $2,074 to $2,756 (ibid.).

Another major aspect of SE effectiveness is its likelihood of producing positive program outcomes. In a cross-sectional survey of twenty-six mental health agencies which had linked with federal-state vocational rehabilitation, Becker et al. (2006) identified differences both in access to SE services and in competitive employment efficiency (in terms employment rates). They also pointed out predictors of both “access” and “efficiency.”

It was found that “access” to services varied widely from two to one hundred per cent. Access was found to be a function of the percentage of SE specialists per consumer with serious mental illness. The specialist-to-consumer ratio was, in turn a function of funding.

Alternately, job procurement “efficiency” varied from seven to seventy-five per cent. Efficiency was related a) to implementation of the critical components of evidence-based SE, and b) to the local unemployment rate. Becker et al. (2006) concluded that “state systems and local [vocational rehabilitation] programs should address consolidation of SE resources, and the quality of implementation of SE” in order to reach their employment goals (2006:312).
SE Research on Dimensions other than Job Placement

The scope of SE research extends beyond merely its efficacy regarding job placement. SE studies also examine SE’s impact on the personal well-being of SE consumers. Most recently, the focus of recent SE research has been upon social dimensions.

Jahoda et al. (2007), for example, systematically examined case-controlled and longitudinal studies measuring “quality of life,” “autonomy,” and “social life.” They found that, relative to sheltered workshop workers, “people with intellectual disabilities in competitive employment were found to enjoy a higher level of job satisfaction and... higher self esteem.” (2007:10). Yet despite reporting positively regarding well-being and autonomy there was generally, on the part of SE people, “a lack of perceived social acceptance” (2007:1).

Recent research has drawn attention to how SE clients fare over the long haul. In this vein, Becker, et al. (2007) discussed long-term employment trajectories among SE consumers. They presented eight- to twelve- year employment projections among SE clients in a small New England urban mental health center. Responding to qualitative interview questions, the thirty-eight study participants reported numerous employment-related benefits. These included “relationship enhancement” and “illness management”20 (2007:927).

Becker, et al. (2007) also reported that “part-time employment” and “long-term supports” were major facilitators in maintaining the jobs of study participants. The researchers contended that this was because of the decreased demands of part-time jobs, and because participants believed that part-time work allowed them to keep their Social Security and health care entitlements (2007:922). Concluding,

20 This seems especially important since “psychiatric illness” was reported as the biggest barrier to work (2007:926).
they noted that the long-term trajectories of SE program participants “appear to be positive” (2007:928).

In yet another vein, SE researchers analyzed the consumers’ general work-related behaviors relevant to any job setting. McGuire et al. (2007) conducted longitudinal, standardized21 “situational work assessments” in which staff rate the SE consumers on the job. They evaluated the assessments of fifty-four people, recently admitted to a Chicago-based psychiatric rehabilitation center. Those people were enrolled in a “diversified placement approach” vocational program in which the people worked in various work-settings. They were classified according to the highest job attained during the nine-month study period.

The researchers correlated participants’ employment outcomes with their WBI scores. Since only one (1) correlation was significant in the predicted (positive) direction, it was inferred that WBI scores were not associated with employment outcomes in the full sample of participants who were scored. In a sub-sample of participants obtaining paid employment at some time, however, WBI scores were positively associated with employment outcomes. So, in light of outcomes for that participant sub-sample, it was concluded that their findings “partially” supported “the general finding in the literature on the predictive validity of situational work assessment and future employment outcomes” (2007:52).

Finally, researchers examined barriers to SE. Barriers identified found their roots in both employer and worker issues. For instance, in October 2007, the National Council on Disability reported that when employers were asked, in a 2003 Rutgers national survey, about the

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21 The standardization instrument used was the “Work Behavioral Inventory” (WBI) specifically designed for people with severe mental illness.
greatest barrier to people with disabilities finding employment, the most common answers were the following:

Reluctance of employers to hire, or discrimination/prejudice (20%)  
Lack of skills and experience among job seekers (7%)  
Need for special accommodations (7%)  
Lack of information about job opportunities (7%)  

Similarly, Lenguick-Hall, et al., (2008) reported that most employers have stereotypical beliefs (e.g., roles of “eternal childhood,” “failure,” and “subservience,”) not supported by research evidence.

On the other hand, Lemaire and Mallik (2008) reported, on the basis of retrospectively looking at SE barriers for one-hundred-and-twelve adults with mild to moderate developmental diagnoses (a mental retardation [MR] status), that “inattention, interpersonal, and behavior problems were frequent barriers to maintaining employment” (2008:154); and that “poor attendance, inadequate work quality, or interpersonal problems were responsible for 20.8% of involuntary employment terminations” (ibid.).

Earlier, in a 2001 report prepared by the Iowa Consortium for Mental Health, College of Medicine, The University of Iowa, it was stated that barriers exist on several levels including (1) governmental, (2) program administrators and clinicians, and (3) families and clients.

The barriers were laid out as follows:

Governmental: The federal-state vocational rehabilitation system has been the primary funding source for employment services and this

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22 National Council on Disability, Brief #1 - Recruitment and Retention of People with Disabilities Employment, p.73
funding is sufficient to serve only a small portion of those in need of vocational services. Furthermore, available funds are not currently being used to fund supported employment.

Program administrators and clinicians: As noted above, funding for vocational services is limited. In addition to financial factors, leadership for innovations, even when they are evidenced based, is difficult. Administrators may not have access to information on evidence based practices, they may not value or believe that the outcomes are possible in their setting, and there may be no incentive to change their existing services. Administrators and clinicians trained in an earlier era may hold the opinion that work is not a reasonable goal for persons with schizophrenia and that work may, in fact, produce unmanageable levels of stress. Neither of these widely held opinions are borne out with evidence.

Families and clients: Sometimes clients are discouraged from seeking employment by families who are fearful that the stress of employment will outweigh the benefits. Some clients fear automatic loss of eligibility for Social Security and Medicaid benefits with any employment.
Summary

The sample of articles selected from the universe of SE research reflects certain biases. For example, this reviewer examined only those articles that could be obtained at no cost. Furthermore, only articles retrieved from the internet were reviewed. Finally, the body of reviewed articles is focused heavily on SE as it pertains to those diagnosed with MH issues. Thus there may be considerable literature specifically devoted to the SE for consumers diagnosed with mental retardation that were beyond the reach of this review.

After a brief history of the evolution of SE from its ground-breaking inception, to its attainment of “best practices” status, the findings of more than forty sources of scholarly research on SE were discussed in this paper.

The discussion was organized to consider SE research from several dimensions. As an independent variable, SE was found to have a powerful effect on the labor force participation of consumers with developmental disabilities. Indeed, given the debate regarding the relative effectiveness of ACT, Clubhouse, and SE vocational rehabilitation programs, it is clear that SE is preferable, if affordable.

“Affordability” is, in fact, a crucial factor reported in SE research findings from studies casting SE “dependent” variable. For instance, annual direct costs for consumers were over $2,700 per consumer, and over $49,000 for direct cost per employment specialist. These costs may be prohibitive for agencies suffering budget cuts that scaled back many types of public health service.

Discussed, finally, were quality of life issues related to SE. It was reported, for example, that “autonomy,” “job satisfaction,” and “higher self esteem” were consumer benefits gleaned from SE participation. On the other hand, SE consumers must cope with the
stereotypical beliefs of employers and, reportedly, experienced “a lack of perceived social acceptance.”

In any event, the experience of SE consumers “over the long haul” was encouraging; especially if part-time employment, long-term supports are in effect, and if consumers can come to grips with their own barriers to employment such as “inattention” and “poor attendance.”
Conclusion

In reviewing the body of research discussed above several concerns emerged. First, relatively few articles focused on SE for people with mental retardation diagnoses were seen\(^{24}\). Indeed, while there was some discussion of barriers to placing consumers with severe developmental diagnoses, most of the encountered research focused either, generically, on “people with developmental disabilities,” or, exclusively, at SE for consumers with psychiatric disabilities.

This evident MH SE research “bias”, runs counter to the actual SE experience in Philadelphia County. This county’s Community Integrated Employment (CIE) program serves over a thousand MR consumers with developmental diagnoses from mild to severe levels. This reflects far more job-placement servicing than that afforded the county’s MH consumers, though there are “Clubhouse” and “ACT” programs that serve Philadelphia County MH consumers.

The County is in the process of bridging this service gap, however. As Philadelphia’s Department of Behavioral Health (DBH/MRS) is developing its “Day Re-investment Program,” a major SE component is anticipated.

A hallmark of the field of vocational rehabilitation is the amount of rigorous research that has been conducted. A large body of methodologically sound investigations regarding SE exists. These studies feature extensive use of control groups, random samples, and measurement techniques of replicated reliability. This body of work has yielded a substantial pool of validated hypotheses; prominent examples of which have been discussed above. There is so much confidence in SE

\(^{24}\) This was the case even when the preliminary SE literature search was conducted, and had little to do with the accessibility of a particular article.
research findings that, due to its “evidence-based” grounding, SE has attained “best practices” status.

The recognition of SE as an exemplary occupational intervention option is firmly grounded. It is expected that the ranks of SE program participants will grow. Consequently, one can anticipate continued interest in SE’s long-term impact and (given the present era of fiscal crisis), heightened concern in the likelihood of the continuation of the necessary levels state, federal\(^2^5\), and municipal funding.

\(^{25}\) On 2/12/09, Florida’s Ocala Star-Banner reported that, according to Sen. Bill Nelson (D-FL), the U.S. House and Senate compromised on a $789 billion stimulus bill. It includes $500 million (cut 7% from the originally proposed $540 million) for Vocational Rehabilitation State Grants to help persons with disabilities prepare for gainful employment.
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