B.C.'s Mental Health Reform

PSYCHOSOCIAL REHABILITATION AND RECOVERY

BEST PRACTICES
This report is one of seven mental health best practices reports. The reports reflect the efforts of 44 industry representatives who formed the best practices working groups. Following literature reviews and consultation, they documented what they collectively recognized as services and strategies that produce positive health outcomes for individuals.

The Ministry of Health is grateful for the expertise and diligence these mental health consumers, family members and service providers brought to the work.

The reports on Best Practices for B.C.'s Mental Health Reform are:

- Housing
- Assertive Community Treatment
- Crisis Response/Emergency Services
- Inpatient/Outpatient Services
- Consumer Involvement and Initiatives
- Family Support and Involvement
- Psychosocial Rehabilitation and Recovery
# B.C.'s MENTAL HEALTH REFORM
BEST PRACTICES FOR
PSYCHOSOCIAL REHABILITATION AND RECOVERY

## Contents

**BEST PRACTICES WORKING GROUP PSYCHOSOCIAL REHABILITATION AND RECOVERY**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>3</td>
</tr>
<tr>
<td>Process</td>
<td>4</td>
</tr>
<tr>
<td>Findings</td>
<td>4</td>
</tr>
<tr>
<td>Employment</td>
<td>5</td>
</tr>
<tr>
<td>Recommendations</td>
<td>8</td>
</tr>
</tbody>
</table>

1. **INTRODUCTION**

2. **A MODEL FOR EDUCATION AND EMPLOYMENT IN PSYCHOSOCIAL REHABILITATION**

3. **EDUCATION**

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Assessment</td>
<td>11</td>
</tr>
<tr>
<td>3.2 Models of supported education</td>
<td>12</td>
</tr>
<tr>
<td>3.3 Goals of supported education</td>
<td>13</td>
</tr>
<tr>
<td>3.4 Expected outcomes</td>
<td>14</td>
</tr>
<tr>
<td>3.5 Target population(s)</td>
<td>14</td>
</tr>
<tr>
<td>3.6 Barriers and accommodations</td>
<td>14</td>
</tr>
<tr>
<td>3.7 Evaluation</td>
<td>15</td>
</tr>
<tr>
<td>3.8 Feedback from the experts</td>
<td>15</td>
</tr>
<tr>
<td>3.9 Concluding comments</td>
<td>16</td>
</tr>
</tbody>
</table>

4. **EMPLOYMENT**

<table>
<thead>
<tr>
<th>Subsection</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Employment or work for persons with serious and persistent mental illness</td>
<td>17</td>
</tr>
<tr>
<td>4.2 Assessment</td>
<td>18</td>
</tr>
</tbody>
</table>
5. PRE-EMPLOYMENT AND EMPLOYMENT SERVICES
   5.1 Pre-employment services 20
   5.2 Employment 29

6. RECOMMENDATIONS
   6.1 Provincial 35
   6.2 Regional 35

APPENDIX A: PRINCIPLES OF PSYCHOSOCIAL REHABILITATION (PSR) 39

GLOSSARY 43

BIBLIOGRAPHY
   Supported education 51
   Employment 53
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Important note

The principles of psychosocial rehabilitation form the philosophical foundation for all best practices in mental health. These principles emphasize both consumer involvement in developing and realizing personal care and life goals and treatment and supports that help consumers manage their symptoms and build on their strengths.

The principles of psychosocial rehabilitation are included in Appendix A of this report.
EXECUTIVE SUMMARY

The Review of Best Practices in Mental Health Reform has demonstrated that people with serious mental illness have the capacity to work or return to school.

Experts in the field of vocational and educational supports for people with mental illness have recognized a quiet revolution that is changing the way people with serious mental illness are perceived, either by themselves or by others. As more and more people return to school and gain or maintain jobs, previously held stigmas and perceptions are subsiding. People with mental illness want to gain new knowledge and to obtain and maintain meaningful employment that will enhance their quality of life.

This quiet revolution is slow but strong in British Columbia. It began in the 1970s and 80s with a growing dissatisfaction on the part of people with mental illness who were "stuck" in sheltered workshops and wanted a better life. It gained momentum with the consumer empowerment movement in the 1990s. The revolution continues as more research becomes available and as evidence-based practice is implemented in new and reformed vocational and educational support programs. These reformed programs demonstrate positive outcomes such as decreased hospitalizations, increased employment, decreased need for income assistance, greater social interaction, increased self-esteem and an overall improved quality of life.

Returning to school and preparing for or maintaining employment is a process that helps people in their recovery. It promotes the development of self-esteem and a new positive self-image. It counteracts the feelings of worthlessness that many people with serious mental illness have internalized because of the social stigma attached to their disabilities.

The practice of psychosocial rehabilitation, with a focus on early intervention and recovery, is the driving force behind this quiet revolution focusing on wellness, independence, self-determination, hope, personal capacity for growth and development, potential partnerships, seamless services based upon individual needs and ongoing evaluation as part of continuous improvement.

Psychosocial rehabilitation involves four life-related domains:

- personal life—services that help an individual gain or regain practical skills in the areas of personal care, home management, relationships and use of community resources
- leisure
- education
- work.

Psychosocial Rehabilitation and Recovery
Standards referred to in the Adult Mental Health Division’s *Guidelines for Rehabilitation Services* (1996) currently provide direction for services provided in each of the four domains. This report focuses on education and work.

In British Columbia, it is well recognized that people with serious mental illness are significantly underrepresented in the labor force, as well as in education and pre-employment programs. This report intends to provide regional health authorities with best practices information from which to develop a menu of options to support a range of supported education and employment opportunities for these people.

**Process**

The working group was composed of two co-chairs and a liaison with the Ministry of Health. They worked with a researcher from the University of British Columbia, who conducted an extensive literature search based on information from 1993 to 1999, including web-based resources. This report reflects the trends in the literature, as well as feedback from over 40 experts at focus groups and feedback from the November 4 to 5, 1999, consultation forum on best practices in mental health. Because of time constraints, the working group has not yet conducted its planned focus groups with families, consumers and individuals who represent specific age, gender and cultural groups.

**Findings**

Supported education and employment are closely linked. The model below highlights the individual as central to psychosocial rehabilitation services. It identifies assessment and support as critical to all components of the system. The two-way arrows signify movement between and among the components, allowing the individual to access services as and when required.
Supported education

Educational support for people with serious mental illness is relatively new to the field of psychosocial rehabilitation. Assessment is a critical and integral part of supported education. A range of assessment tools were found in the literature to support individuals in establishing their educational goals. The literature, supported by the experts, identified three models through which education is facilitated for people with serious mental illness:

- Self-contained classroom—where all students in a class have psychiatric disabilities and the curriculum is designed for the benefit of this population.
- On site support—where students attend general classes where they receive support from the educational facility.
- Mobile support—similar to the on site support model, where the support is provided by external mental health teams or workers, supporting the student in whichever educational facility they choose.

The literature and focus groups both identified key issues related to supported education:

- Consumer choice and involvement in the process is critical.
- Education of faculty and staff at the educational institutions is essential.
- Integration of the services between the mental health agency and educational institution is essential.
- Support and ongoing communication among those involved must be in place before, during and after supported education services are received.
- Supported education needs to focus on the larger picture of lifelong learning, including employment.

Supported education is an important part of the full range of core services for people with serious mental illness. The literature and experts reported that it is not a difficult or extremely expensive service. For the most part, educational resources are in place. What is missing are the specialized mental health resources required to make supported education work. In many cases, a shift in attitude among educational and mental health workers is required to further develop this key service.

Employment

The literature and experts provided strong evidence that work has many benefits for people with serious mental illness, including improvements in their psychiatric symptoms, improvements in their psychiatric symptoms, reduced hospitalization, greater

Psychosocial Rehabilitation and Recovery
social interaction, decreased levels of anxiety, enhanced self-esteem and self-confidence and overall improvement in their quality of life.

Formal vocational assessments were identified as key components to successful support of individuals as they seek and maintain employment. These assessments include career clarification and identification of strengths, weaknesses and challenges. Experts and the literature recommend a range of assessment tools.

Two broad service components of employment were identified: pre-employment and employment itself. Within each component, the following service types were identified:

- **Pre-employment services:**
  - pre-vocational assessment
  - work readiness
  - pre-vocational counseling
  - volunteer work
  - transitional employment

- **Employment services:**
  - supported employment
  - consumer-run business
  - home-based business
  - peer support
  - work experience

**Pre-employment services**

The available literature (1993-1999) on pre-employment services is not strong. In fact, the trend in the literature almost discounts pre-employment approaches, suggesting instead the rapid-placement, place-train approaches. Experts unanimously argued that there is a strong need for recognized and funded pre-employment services. It was recognized that not everyone follows the same path in psychosocial rehabilitation and that the progression towards employment is not always direct. Pre-employment services fill a critical gap for those individuals requiring support in building self-esteem, interpersonal skills, work skills and a work history, all of which are integral to successfully obtaining and maintaining employment. However, it was noted that placing many individuals more quickly into actual jobs, and providing flexible levels of support for long periods of time, are promising new developments that need to be tested further in both urban and rural settings.
Key issues relating to pre-employment services were identified:

- Ensure individual access to pre-employment services within three months of referral.
- Recognize different types and levels of assessment, all of which may be the right ones for some people, some of the time.
- Be aware of different learning styles and develop strategies to deal with cognitive needs and anxiety.
- Tie the individual’s strengths and challenges to strategies and the labor market.
- Ensure that coordination exists among mental health providers and between pre-employment and employment services.

Employment services

Supported employment

In supported employment, individuals work (for minimum wages or better) as regular employees in integrated and competitive settings, receiving ongoing, long term and adequate support when required.

Approaches or models that guide the provision of supported employment include:

- Program of Assertive Community Treatment (PACT) or Assertive Community Treatment (ACT)
- Individual Placement and Support (IPS)
- Choose-get-keep (CGK)
- Hybrids

Key issues relating to supported employment services were identified:

- Recognize the importance of:
  - assessment and career counseling and their connection with supported education
  - pre-employment training, such as building self-esteem and life skills training.
- Emphasize supported employment as only one option within the spectrum of employment services. Other “packages” need to be made available with different service options depending upon need.
- Recognize that the place-train model may only work for certain people and certain jobs, usually entry-level jobs.
- Consider paid work in non-integrated settings as an option (e.g., Picasso Café model).
• Be aware of employment barriers such as:
  – financial disincentives (e.g., the Disability Benefits 2 $200 earning exemption limit)
  – fears about losing benefits (e.g., continuation of extended health care benefits)
  – lack of transportation to the work location.

Consumer businesses and services
Consumer involvement in employment has been expanded to include businesses and services that are owned and operated by consumers, including consumer-run businesses, consumer-run services and home-based businesses, whether consumer or staff developed and operated.

The literature and the experts were very supportive of the concept. However, more research and data are required to further advance these models.

Peer support
Peer support was not addressed in the literature review but was later included, based on recommendations from the co-chairs and experts. Peer support can be built into all employment strategies.

Recommendations
This report makes a series of key recommendations based on the literature, feedback from the experts during the focus group sessions and feedback from the audience at the November 4 to 5 consultation forum. These recommendations offer both provincial and regional mental health providers ways to strengthen and reform education and employment services and to strengthen psychosocial rehabilitation services as a whole. Feedback from consumers, families and gender and culturally specific groups still needs to be incorporated. Many barriers need to be examined and addressed if we are to allow consumers to fulfill their dreams and hopes in relation to education and employment.

While we consider this report a starting point in the development and reform of psychosocial rehabilitation services in British Columbia, we hope it provides health authorities with enough basic knowledge to start the process of strengthening the quiet revolution taking place in the regions. We look forward to opportunities to assist the provincial and regional health authorities to advance this work in future reports.

Many thanks to our researcher, Lesley Bainbridge, and to the many people who provided feedback and guidance in the development of this report.
1. INTRODUCTION

The areas of education and employment for persons with serious and persistent mental illness are treated extensively in the literature, although there is currently much more information about employment than about education. For the purposes of this project, the peer-reviewed literature was searched from 1993 to 1999. In addition, we reviewed web-based resources, as well as those developed for specific organizations or programs. This report represents trends in the literature, as well as feedback gathered from the experts in focus groups, as a basis for improving best practices in mental health services in British Columbia.

The report addresses both education and employment for people with serious and persistent mental illness. A framework or model is presented to highlight the interconnectedness among the component parts of education and employment services in mental health and to establish a context for this report and its associated data.

Education for people with serious and persistent mental illness is relatively new to the field of psychosocial rehabilitation. At this point, despite fewer references than in the area of employment, there is strong evidence, from those who have examined the concept and published on the topic, to suggest a promising area of support for consumers of mental health services. The report highlights issues such as assessment, a definition of supported education, models or approaches in this area, goals, target population, eligibility criteria, expected outcomes, feedback from the experts and recommendations.

The next section of the report provides an overview of the literature findings in relation to the value of employment or work for persons with serious and persistent mental illness. The area of assessment is then considered, prior to a discussion of the broad categories of pre-employment and employment and the types of services considered in each. Each type of service is reviewed by a definition, models or approaches in this area, goals, target population, eligibility criteria, expected outcomes and feedback from the experts. Overall recommendations are then presented.
2. A MODEL FOR EDUCATION AND EMPLOYMENT IN PSYCHOSOCIAL REHABILITATION

Education and employment for persons with serious and persistent mental illness are fundamental to the practice of psychosocial rehabilitation. In this context, the overall framework of psychosocial rehabilitation forms the foundation of our discussions. The main principles of psychosocial rehabilitation are related to recovery and early intervention.

Within the psychosocial rehabilitation context, both recovery and early intervention relate to the principles of independence, self-determination, hope, personal capacity for growth and development, potential, partnerships, seamless service based on individual need and ongoing evaluation as part of continuous improvement.

In concert with these principles, the goals of rehabilitation are to maximize individual strengths, re-establish, develop and/or maintain individual skills and abilities and facilitate individual support, resources and community involvement.

In an ideal system, the areas of education and employment are closely linked through seamless movement among various components of the system. The following model highlights the centrality of the individual in establishing best practices in mental health services. It also identifies assessment and support as critical to all components. The two-way arrows signify movement between and among the component parts of the system, allowing the individual to access services as and when required without lengthy waits or inappropriate referrals. The components of personal life and leisure have yet to be examined, but are included in the model as a reminder that they balance the education and employment aspects of individuals' lives. To illustrate the interconnections, we offer the following model:
3. EDUCATION

This section describes supported education, highlighting the importance of assessment, with a definition, goals, models or approaches, target population(s), expected outcomes, feedback from the experts and recommendations. Additional data, available through the Greater Vancouver Mental Health Service Society, will provide useful material for building on this report in areas such as outcome measures and data collection.

While it is evident that supported education is a relatively new approach for people with serious mental illness, there is research to support the viability and desirability of this approach to education in the mental health context. In this promising area for further development, we hope the following information will guide future initiatives as part of best practices in mental health for British Columbia.

3.1 Assessment

Assessment is a critical and integral part of supported education. To assist individuals in establishing educational goals, several areas of assessment must be considered. These include:

- basic skills, such as vocabulary, mathematics skills and reading, as well as social skills
- medications (e.g., actual or potential effect[s] on cognition, medication-related memory problems and/or drowsiness, possible alternatives to current medication for reducing interference by symptoms with ability to engage in educational activities)
- accommodations required to address cognition, learning disabilities, classroom environment or class schedule (e.g., breaks)
- supports and resources required (e.g., financial assistance, help with registration, orientation to campus, opportunities for quiet time and withdrawal, central support people [peer and professional])
- access to transportation.

The literature includes these assessment tools related to supported education:

- Educational Preference Survey
- Career Orientation Placement and Evaluation Survey
- Career Ability Placement Survey
- Career Occupational Preference System
- ASSET Test
• Harrington O'Shea Career Decision Making System
• Wide Range Achievement Test
• Rosenberg Self-Esteem Scale
• Coping Mastery Scale
• Zung Anxiety Test
• Personality Assessment Inventory (includes several scales and inventories administered through interview)

Following assessment, a clear educational plan is developed with the individual, who is then offered appropriate supported education opportunities based on their preferences, needs and abilities.

3.2 Models of supported education

As stated earlier in the report, supported education is a relatively new service in the psychosocial rehabilitation range of services. It is heavily supported by current research and by the experts in the field as providing options for individuals who wish to enter or go back to school in order to upgrade their educational qualifications, to enhance their employment skills, to learn new skills with a view to future employment or lifelong learning for the pleasure and reward of the activity.

The literature and the focus group appear to endorse as most descriptive this definition of supported education:

Supported education provides an effective means of facilitating individuals with psychiatric disabilities to [successfully] access, pursue, [and maintain] educational opportunities [of their choice].

The experts considered the elements of success and individual choice to be important features of the definition. The concept of maintenance was added through feedback from the 1999 consultation forum.

This definition of supported education is implemented through three main models or approaches, as follows:

The self-contained classroom
In the self-contained classroom, the approach is one of segregation. All students in a class have psychiatric disabilities and the curriculum is designed for the benefit of this population.

Examples of self-contained classrooms include:

- curriculum designed to address study habits, interpersonal skills, computer skills, basic academic upgrading and other general content relevant to the needs of these specific students
- specialized certificate training which leads to competitive employment, such as tourism and administrative office training
- segregated classroom located within an educational institution where students may participate in all the other student activities on campus and may use the resources available to other students or segregated classroom located within a sponsoring agency
- students may receive the support from educational program staff, who themselves receive education on how to provide the support or staff from the sponsoring program may provide the support.

On site support
In the on site support model, classrooms are integrated (i.e., students with psychiatric disabilities are integrated into regular classrooms). On site support for the student is provided by staff at the educational facility. One variation on this model is when the support services or special classes are taught by a mental health service provider with an on site office.

Mobile support
As in the on site support model, classrooms are integrated, but here the mobile support to students is provided by external mental health teams or workers, following the student to whichever education facility they choose to attend.

3.3 Goals of supported education

- to enhance the individual student’s educational/vocational development in an integrated setting by helping to enhance skill sets that empower the student personally and by helping the student make a viable contribution vocationally in an increasingly “knowledge-based” world
- to help the student access a program that meets their needs, with the support they need
- to facilitate a successful/positive experience for the student
- to help students see education as a viable option
- to maintain an educational process throughout the “cycles” of mental illness (e.g., may need time out occasionally, but may wish to re-enter the process after a break; role for assistance from supported education programs/counsellors).
3.4 Expected outcomes

- Career development
- Employment readiness
- Increased self-esteem
- Personal development
- Higher rates of competitive employment
- Decreased number of hospitalizations

3.5 Target population(s)

- School-aged individuals
- Adults and older adults who are interested in educational opportunities as a means to employment or as a goal in itself

3.6 Barriers and accommodations

People with psychiatric disabilities often exhibit cognitive, perceptual, affective and interpersonal deficits intrinsic to or resulting from the mental illness. In addition, there can be feelings of anxiety, hopelessness and guilt combined with perceptual problems, difficulty in processing and/or retaining information, effects of learning disabilities and limited attention span. Individuals with serious mental illnesses cannot predict when they might become ill or how long they might be away from a classroom setting because of relapse. When medications are prescribed, it frequently takes time to determine the dosage that is most effective at allowing full participation in an educational setting.

One of the most complex barriers for persons with mental illness to overcome is the stigma associated with psychiatric illnesses. Symptoms of serious mental illness can begin appearing during the school years. Often an individual’s personal beliefs and readiness to participate in an educational experience become a barrier that requires exploration and strengthening to ensure that they have sufficient self-esteem and confidence to achieve the identified educational goals. Additional barriers that routinely arise are primarily safety and security, stable housing, a dependable level of financial security and available transportation.
Accommodations are often required to ensure satisfactory educational experiences for people with serious mental illness. The types of modifications include:

- educating mental health professionals, educational counsellors and family members to ensure that supportive, encouraging attitudes are present
- educating teachers and instructors within the secondary and post-secondary education systems
- educating physicians about the benefits of education for a career, English as a second language and lifelong learning, so that individuals can request adjustments in medication that allow full participation in classroom learning.

Modifications might need to occur in areas such as workload or scheduling assignments, frequency of breaks or arranging appropriate support services. Within the learning setting, environmental modifications could be required to reduce distractions, noise and/or activities and increase spatial field to provide adequate personal space and room to move around freely. Education and advocacy are needed in the mental health system and among involved social support ministries to ensure that adequate resources are in place to provide secure housing, income support and transportation for individuals before they initiate an educational experience.

3.7 Evaluation

With respect to evaluation, the data in the literature (available from Greater Vancouver Mental Health Service Society) contain material that will be of use in establishing supported education services and programs, as well as evaluating existing ones. The data highlight the importance of supported education. Since it is a relatively new approach for people with severe and persistent mental illness, there is broad scope for research in a variety of areas and for cost-effectiveness studies.

3.8 Feedback from the experts

The comments, opinions and ideas offered by the focus group on supported education were interesting, useful and supportive of the literature. Individual choice and involvement in decision making related to supported education were seen as imperative. In addition, appropriate education of faculty and staff in educational institutions helps to facilitate supported education initiatives. The experts felt it was essential that consumers receive whatever support they need before entering school, during school and in whatever their next step might be (e.g., transition to work).
The primary observation of the group was the need for effective integration of services, both educational and those related to mental health services. Integration here includes good communication among all concerned. Recognizing that education is linked to employment and leisure, depending upon the individual’s goals and needs, the focus group emphasized the need for seamless movement among supported education services and among education, employment and leisure services.

It is important to collect outcome data and evaluation processes and relevant data must be decided on early in the process of establishing supported education services.

3.9 Concluding comments

Supported education services are to a large extent dependent on partnerships. Mental health services, working in concert with colleges, universities, open learning agencies, university-colleges, high schools and any other educational organizations, can open multiple doors for individuals with serious mental illness. Development of these partnerships is critical and, as stated earlier in the report, relies heavily on excellent communication and seamless integration. A shift in attitude is also required among educational and mental health staff to further develop this key service.

For many individuals with serious and persistent mental illness, supported education is opening new horizons previously not entertained. A comprehensive and well-integrated system of supported education services, already underway, must be increasingly developed and supported as part of the overall psychosocial rehabilitation approach.
4. EMPLOYMENT

The literature extensively addresses the concept of work or employment in general for people with serious and persistent mental illness. The value of work-related activity is underscored time and again.

This section of the report highlights the features of work and employment in a generic sense and then discusses assessment and further descriptors of a number of types of pre-employment and employment services.

4.1 Employment or work for persons with serious and persistent mental illness

Throughout the literature, there are references to material generic to work or employment for people with serious and persistent mental illness. Significant parts of the literature deal with specific models or approaches to employment in one of two phases: pre-employment and employment. These areas are addressed separately in this report. But there are issues and findings that influence the overall concept of work for people with persistent and serious mental illness, including strong evidence to show that work has many benefits for all people with serious mental illness. The literature suggests that improvements in symptoms, lower hospitalization rates, greater social interaction, decreased anxiety, enhanced self-esteem and self-confidence and reduced stress are all potential benefits from engagement in a work or employment setting.

Job preferences were found to be generally stable over time and considering individual preference has been shown to increase job satisfaction and tenure. Work history has been shown to be the best predictor of future employment (underscoring the need for pre-employment services such as work experience, work enclaves and transitional employment), while diagnosis and symptom severity are seen to be poor predictors.

Accommodations in the workplace must be considered. These are "changes that are made in a particular workplace environment or in the way things are usually done that make it possible for a person with a disability to do the job" (Greater Vancouver Mental Health Service Society, 1998). There are guidelines, either mandated through legislation or suggested as public policy, that offer assistance in determining individual needs and employer capacity to meet them. The accommodations may mean changes to the work environment or to the work schedule.
Education of employers and co-workers is essential to dispel the many myths surrounding mental health disorders and to encourage inclusivity in the workplace.

Finally, a number of rigorous studies demonstrate that people with serious psychiatric illness have the capacity to work and that employment programs should be encouraged even for the most disabled individuals. Continuous, time-unlimited support and attention to individual preferences appear essential to the success of supported employment approaches.

It is therefore clear in the literature relating to employment and serious mental illness generally, that pre-employment and employment services are imperative. There is no one model for service delivery that meets all needs of all people. For this reason, a number of assessment, pre-employment and employment options must be available to people with serious mental illness. Emerging best practices must be implemented that strive to streamline services, to meet individual needs at the right time and in the right place and to encourage and facilitate seamless access to appropriate services.

4.2 Assessment

For individuals to experience success in pursuing employment goals, it is essential to begin with a comprehensive assessment. Assessment activities are most effective when they occur within the natural (or as close as possible to natural) environment where the employment or work activities will take place. Information that is necessary to ensure successful performance in a specific job should be the focus of the assessment activities.

The model identifies assessment as a key component of employment services in the areas of both pre-employment and employment. In the area of pre-employment it is an integral part of:

- identifying strengths and resources
- identifying challenges
- career clarification, and
- facilitating seamless movement among the various employment components.

As individuals become ready to consider employment options, employment history, work adjustment and social skills are reviewed. A secure and safe living environment, adequate social supports (in place or available upon request) and skill in identifying personal needs and accessing services must be addressed when someone is being encouraged to establish vocational goals.
As the model indicates, the choices individuals make about education, pre-employment or employment often reflect movement among the various options, rather than progressing along a pre-determined pathway. The assessment process identified in the literature and in practice spans an enormous range that includes elements related to:

- symptom management, e.g., positive, negative and general symptoms
- academic functioning, drawing on previous experiences, reviewing skills (e.g., vocabulary, arithmetic, reasoning)
- cognitive-emotional functioning, especially as it relates to work behaviors (e.g., social skills, work habits, work quality, personal presentation)
- preference (e.g., readiness to begin work, choice of job, determining level of vocational support needed)
- skills, abilities and limitations (e.g., basic vocational skill set, ability to work independently, social skills and physical strength, endurance or dexterity)
- competence in adaptive skills to assist in maintaining personal needs and relationships with others
- social supports, both natural (friends and family), professional and feedback from employers or co-workers
- substance use (past and present).

The experts emphasize that there is no one right tool and that it is important that the people administering the test know how to select the most appropriate test and the techniques that have been used to standardize it. In addition, every tool is somewhat limited to a specific population or situation, so application and interpretation must be done on a case-by-case basis. Also, some individuals may not benefit from a specific instrument, but may benefit from using job shadowing or volunteer opportunities to explore vocational skills and options.

If no pre-employment assessment is completed, transition assistance may be required for career clarification and/or identification of necessary skills and supports. There may also need to be consideration of on-the-job situational analysis to identify ongoing skill development needs. In addition, employer feedback during a work experience placement may provide valuable information to assist the individual.

The next section of the report identifies specific pre-employment and employment services as they are described both in the literature and in the field.
5. PRE-EMPLOYMENT AND EMPLOYMENT SERVICES

In addressing the area of employment for people with serious and persistent mental illness, it became clear that there are two broad components of employment: pre-employment and employment itself.

The pre-employment section includes:
- pre-vocational assessment
- pre-vocational counseling
- work readiness/pre-vocational training
- volunteer work
- transitional employment
- work experience.

The employment section includes:
- supported employment
- consumer-run business
- home-based business
- peer support.

It should be noted that, in searching the literature for information on target populations, eligibility criteria and staff-to-client ratios, we found little conclusive material in many instances. These areas are most commonly addressed in specific studies related to education for people with serious mental illness. The results, therefore, cannot usually be generalized to the broader population, but they can form a base from which to develop benchmarks.

In addition, comments from the focus groups would lead us to believe that all people with serious mental illness who express a desire for employment should have access to pre-employment and/or employment services.

5.1 Pre-employment services

Trends in the literature almost discount pre-employment approaches, suggesting instead that the rapid placement, place-train approaches are the most successful. Yet, the experts would argue that many individuals have a strong need for pre-employment. While individual satisfaction with rapid placement is one measure of success for the place-train approach, there are many other indicators that have not yet been tested. In this best
practices report, therefore, pre-employment is recognized as an integral part of employment for people with serious mental illness, one that requires appropriate recognition and funding.

**Vocational assessment/career counselling**

Vocational assessment and career counselling are services that help the individual identify strengths and challenges, as well as skills. Many individuals have limited or negative work experiences, making the decision to re-enter the workforce risky and often frightening. Because vocational assessment and career counselling must be provided with due consideration of clinical issues, such as the timing, intensity and duration of the illness, the time available for these services may need to be protracted. Also, discussions related to financial risks and benefits are essential parts of the decision-making and planning process.

In vocational assessment, situational assessments in areas such as volunteer work or transitional employment are often the most effective ways of obtaining relevant, timely information about individuals. In addition, the individual’s level of interpersonal and social competency can be assessed in these types of situations.

**Goals**
- to increase/improve self-awareness (of strengths/challenges in employment)
- to develop a plan
- to assist individuals in achieving their goals
- to provide personally relevant information

**Expected outcomes**
- development of self-awareness (about whether work is the right option)
- clarification of individual’s career goals and interests
- a plan for employment.

**Target population**

Vocational assessment and career counselling services are relevant to individuals with mental illness (across the age range) who are defining or re-defining their vocational goals.
Staff-to-client ratio

There is nothing in the literature or from the experts to suggest a benchmark for staff-to-client ratio in this type of service. It is also difficult to recommend such a standard because the type of assessment varies significantly from individual to individual (e.g., assessment as part of a group or assessment on an individual basis). In addition, in order to meet the individual's goals, the intensity of the assessment may vary. All these factors influence staffing needs on a sliding scale, which makes benchmarking extremely difficult and which may explain the paucity of information in this area in the literature.

Feedback from the experts

During focus group discussions related to vocational assessment and career counselling, there were some useful considerations that had not yet been identified in the report. The need for good communication between vocational rehabilitation and mental health organizations was emphasized. In addition, although there are different types and levels of assessment (of which some may be the right ones for some people some of the time), funders must also recognize the financial needs of these services.

Pre-employment training/work readiness

Pre-employment training and work readiness form another set of services in the pre-employment section. They include everything used to determine needs and to assist people in achieving their employment goals.

There are several approaches to pre-employment training and work readiness. These include vocational assessment, career counselling, skills training, work experience and job search services.

Goals

- to prepare people for work in a chosen area by providing choices and facilitating acquisition of the necessary skills and tools
- to address self-awareness (e.g., is work the right option?) through personal journey and insight
- to address self-esteem, interpersonal skills, illness management, stress management and anger management
- to clarify what work means to the individual (concept of work)
- to increase work tolerance
- to develop a work identity (worker roles)
- to increase confidence
• to help individuals “grow into” a job
• to build the individual’s physical and mental condition for work.

**Expected outcomes**
• individual goals are met
• behavioral measure of goal attainment (e.g., individual progressed from being able to work six hours per week to working 15 hours per week)
• quantifiable progress
• successful transition into the next phase, such as educational upgrade or improved employment status

**Eligibility criteria**
• interest
• motivation
• insight
• stability (i.e., housing and mental health supports in place)
• physical capacity
• a desire to work
• can function and manage their substance misuse if it is an issue
• staff-to-client ratio

Although there is little in the literature on which to base staff-to-client ratios for this type of service, experts in the field who are involved in existing programs suggest that 1:15 or 1:20 is a reasonable ratio.

**Feedback from the experts**
In the focus group related to pre-employment training and work readiness, points not yet raised in the report included the need to fund pre-employment programs and to recognize them as integral parts of the psychosocial rehabilitation framework. A continuum of services that include pre-employment training and work readiness provides options for individuals for whom direct employment is not appropriate or desirable. In addition, the experts noted that there needs to be a greater number of options, such as part-time jobs and volunteer work, which have no time limits and for which stipends are received. The fear of losing government benefits needs to be addressed by entering pre-employment programs and significantly increasing public awareness of the importance of work.
Volunteer work
Volunteer work can be defined as any work-related activity performed in an integrated setting by an individual in a volunteer capacity that is related to the individual’s goals and preferences.

It is recognized that volunteer work is not usually related to pay as such, but more often to such compensations as honoraria, verbal and written recognition or a feeling of contribution to society or another’s well-being.

Approaches/models
Little is found in the literature relating to formal approaches or models for volunteer work. However, there are handbooks, manuals, policies and procedures and other guidelines that have been documented and developed for local use in agencies, communities, regions, etc. One such example is found in the Ottawa-Carleton area of Ontario. The Central Volunteer Bureau of Ottawa-Carleton has created a handbook that outlines the steps in a model developed for persons with a psychiatric disability and how this approach can benefit the individuals as well as the community.

The steps modelled by the Ottawa-Carleton bureau include:
- referral
- consultation with referring professional
- client contact
- client interview
- staff assessment
- job search
- client placement
- follow up
- termination
- evaluation.

Full details of each step can be found in the bureau’s handbook. Other approaches to volunteer work that were identified by the experts include:
- mental health partnering with a community volunteer service
- mental health running its own volunteer service with
- volunteer buddies (general public)
- consumer peer support buddies
- staff supporting clients to find and keep volunteer placements.
Goals

- to provide individuals with opportunities to develop skills, gain work experience, increase self-esteem and feel useful though meaningful activity
- to develop a social/peer network in the wider community
- to provide an experience that may feel “safer” than employment if it is in a very supportive environment
- to provide an end goal for some individuals who are satisfied with the volunteer role and do not wish to use it as a step to employment
- to make benefits accessible to the individual

Expected outcomes

- new skills
- personal satisfaction
- future employment

Target population

The target population for volunteer work specifically includes three groups:

- those who want to work as described above
- those who want to volunteer as an end-goal
- those who are worried about losing benefits.

Additional members of the target population include:

- individuals who want to work, but have a limited work history or unstable living arrangements
- a possible sub-group: individuals who wish to use volunteer work for educational purposes (e.g., someone may wish to volunteer in a veterinary clinic before deciding to enrol in a veterinary technician course)
- individuals who may not have the time, the ability or the desire to work the length of time required in an employment setting. Volunteer work may provide these people with decreased time commitments and increased flexibility.

Eligibility criteria

There was a feeling among the experts that there should be access to volunteer opportunities for anyone at any time, anywhere with few exceptions (e.g., someone with a criminal record, but even this may be accommodated for).

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Psychosocial Rehabilitation and Recovery
Additional eligibility criteria may include:

- interest
- preference
- desire/motivation
- feedback from the experts.

The experts in the focus group suggested that increased funding for support workers was necessary to facilitate volunteer work. In addition, it was felt that it would be helpful if community volunteer agencies received assistance to develop more comprehensive databases. The experts also suggested that case managers, clinical staff and other rehabilitation practitioners needed to be educated about the value of rehabilitation specific to the role of volunteer work (i.e., that it can accomplish and assess the same things as employment).

**Transitional employment (TE)**

The issue of transitional employment generated much discussion at the focus groups. As an evolution of the clubhouse model, transitional employment programs are operating successfully, offering transitional services to both clubhouse members and non-members. Despite a range of opinions about transitional employment, ranging from transitional employment as the pure clubhouse model to transitional employment as an outdated approach, there seems to be general consensus that it meets the needs of many individuals and that it can be adapted from its original, strict form to allow for flexibility. For example, the time-limit for transitional employment jobs can be extended where necessary.

For the purposes of this report, transitional employment is defined as:

> Employment that involves a time-limited series of placements in community jobs for the purpose of gaining work experience and building self-confidence. Most placements involve on-the-job-training. Employees in TE jobs are paid at the prevailing rate.

**Approaches/models**

There are two basic models in transitional employment: the traditional clubhouse model and the emerging non-clubhouse model. The traditional clubhouse model provides clubhouse members with jobs that are located in the wider community, paid work, part-time jobs, opportunities regardless of success or failure in previous jobs, encouragement to be active within the clubhouse and case management. In addition, individuals who would not seek employment on their own may join a clubhouse because of its inclusive nature and/or because they know someone who belongs and finds the approach useful. Strong supporters of the clubhouse model suggest that it is the very nature of membership in the clubhouse that makes TE so successful.
Two distinctive features of the transitional employment approach are:

- its traditionally time-limited nature, and
- the concept that the TE agency "owns" the jobs and provides coverage when an individual is unable to work (often one job will be filled by three to four individuals)—this feature can be attractive to employers.

In the emerging non-clubhouse model, a seemingly new ability to adjust the time limits makes transitional employment a viable option for specific individuals. These transitional employment agencies also do not require membership in the clubhouse.

In both transitional employment approaches or models, the types of jobs offered are often simple, with very basic demands. In recent years, however, this is changing; TE opportunities are arising in higher paying jobs with increased responsibilities and therefore stronger job references. A broad range of job placements is essential to meet individual needs and abilities.

Goals

- to develop employability skills by providing opportunities to try work and to develop worker identity and a work history, if necessary
- to enhance "agency" (specific term used by experts in the focus groups) and confidence
- to allow members to explore work with various employers and in different jobs, so that when they do look for more permanent work, their decisions can be based on broader experience and more informed choice (Bilby, *The Clubhouse Journal*, August, 1999)
- to allow members to correct vocational difficulties and build on strengths in a real work setting, so that they are in a better position to succeed when they move on to more independent work
- to develop self-assessment of personal strengths and barriers to employment. This could lead to opportunities to develop and learn inter and intra personal skills, as well as coping strategies
- to promote inclusiveness

Expected outcomes

- a work history
- specific skills
- increased confidence and self-respect
- current job references
**Target population**
The target population for transitional employment is often somewhat more explicit than for other forms of pre-employment services. Individuals who have no work history, who have a large gap in their work history or who have held multiple very short-term jobs may be particularly suited to transitional employment. In addition, the TE agencies that are operated with a true clubhouse approach are mandated to work with individuals at all levels of vocational development and interest.

**Eligibility criteria**
- As for other pre-employment and employment services, experts uphold broad eligibility criteria, encompassing any one who expresses an interest in work or a desire for change.

**Staff-to-client ratio**
The recommended staff-to-client ratio is based on “Benchmarks of Clubhouse Excellence: A Guide for Evaluating Clubhouse Organizational Performance” (Macias and Boyd, 1999). This report suggests a benchmark ratio of 1:5.2.

**Feedback from the experts**
Discussion with the experts suggested support for transitional employment and encouragement for it to become more flexible, e.g., allow transitional employment to be modified to supported employment where and when appropriate and eliminate the strict time limit on transitional employment jobs. In addition, the participants felt that transitional employment provides individuals with opportunities to explore self-assessment and opportunities to enhance their vocational plan. For many individuals, not only is TE the most appropriate form of vocational rehabilitation, the concept and practices related to the clubhouse model may enhance their rehabilitation outcomes.

**Closing comments**
Despite the fact that recent literature seems to discount pre-employment options, the experts make it clear that such services are necessary for many individuals. Although the rapid placement approach is the preferred option for many individuals, there are still many others for whom the place-train model is not appropriate. Recognition of pre-employment approaches by funders and practitioners will enhance the continuum of psychosocial rehabilitation services for persons with severe mental illness in the area of employment.
5.2 Employment

The value of employment has been well documented in the literature. In addition, paid employment has been shown to be effective in providing successful employment opportunities for persons with severe mental illness.

We begin the discussion of employment with the area of supported employment. By far the most researched and published type of employment service, supported employment has been available for years; in recent times, specific models for the provision of supported employment have been developed. They are described below.

Supported employment

Supported employment is understood here as employment opportunities in which "...individuals work for pay (minimum wage or better) as regular employees in integrated competitive settings, and receive ongoing, long term, adequate support when required."\(^2\)

The group of experts felt this definition emphasized most clearly the need by individuals with serious mental illness for reasonable pay, for ongoing support and for knowledge of how to access services when they need them.

Approaches/models

There has been extensive research into a variety of models of supported employment. The most common are:

- **Program of Assertive Community Treatment (PACT) or Assertive Community Treatment (ACT):**
  - rapid placement (i.e., early job placement with no pre-vocational training or early entry to the work force with intensive support)
  - team operates with multiskilling as the approach (i.e., everyone does everything, including job search, marketing, placement and support)

- **Individual Placement and Support (IPS):**
  - utilizes employment specialists and job coaches
  - specialized roles on team
  - core principles include:
    - competitive employment as a goal
    - rapid job search
    - continuous and comprehensive assessment

\(^2\) Adapted from the amendments to the Rehabilitation Act.
- integration of rehabilitation and mental health
- time-unlimited support, fading as individual becomes more independent
- attention to consumer preference

- **Choose-Get-Keep (CGK):**
  - **Choose** phase—focus on individual’s choice and goals, followed by the investigation of relevant job options
  - **Get** phase—individual assisted in getting job with preferred employer; addresses employment planning, direct placement and employment support
  - **Keep** phase—assists workers in sustaining employment; includes assessment of skills and necessary supports and planning for ongoing skill development and accommodation, as needed

- **Hybrids:**
  - **ACT-IPS:**
    - self-contained team provides all services
    - rapid placement into individualized community employment
    - home and community are primary settings
    - daily services
    - assertive outreach
    - consumer and social network form clinical focus
  - **Group employment:**
    - work groups or enclaves (a group of individuals) collectively perform a task, job or service (e.g., yard maintenance, house repair, snow shovelling)
    - specifically target work opportunities where a group (often as large as 10 to 12 people) who do not have the confidence to work independently or have been repeatedly unsuccessful in job placements can work at simple tasks, on an abbreviated schedule, with full on site staff support

**Goals**
- to help people to get and keep work through integration into the workforce
- to provide time-unlimited support for the individual in the employment position of their choice
- to gain skills through employment
- to minimize the need for social assistance through long-term, sustainable employment
- to assist the individual in achieving their objectives with as much support as needed

**Expected outcomes**
- employment retention
- new skills
- enhanced self-esteem and confidence
- decreased need for social assistance

**Target population**
- seriously mentally ill people who want to work and who have worked before in competitive employment, but have decreased confidence
- those who have a keen interest in working
- young mentally ill people who are diagnosed early, have no work history and are looking forward to a career
- adults with severe and persistent mental illness

**Eligibility criteria**
- the individual who wants to work, regardless of previous work experience
- functionally stable over six months (i.e., housing and finances are stable, has resources in place to support employment search, etc.)
- individuals who are willing and able
- maximum staff-to-client ratio of one staff to 20 clients

**Feedback from the experts**
Feedback from the focus group reiterated the need for excellent communication among all players in the system. More specifically, good communication must occur to ensure that a detailed intervention plan is identified and implemented at the individual level. As for other services, adequate funding levels are imperative. The differing needs of geographically diverse areas will have to be addressed if an effective continuum of services for employment is to be ensured. The experts suggested a “roving team” that would move about the province sharing expertise and experience to enhance the delivery of supported employment options. Paid work in a non-integrated setting is also seen as an option (e.g., Picasso Café model) for supported employment.

**Consumer-related services/programs**
Consumer run businesses and services are not well represented in the literature. Where research exists, they are defined as “a program or service planned, administered, delivered and evaluated by a consumer group based on needs defined by the consumer group.”

They may include consumer-run businesses, consumer-run services and home-based businesses, whether consumer or staff developed and operated.

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Consumer involvement in employment has been expanded to include businesses and services that are owned and operated by consumers. In addition to consumer-run businesses or consumer-run services, home-based businesses form a part of this approach.

For both approaches that are totally consumer driven and those that are supported by staff, it is vitally important to have strong support from stakeholders with business experience in areas such as the preparation of business plans, finding funding, marketing and other sound business fundamentals.

Goals
- to empower consumers to gain paid employment

Expected outcomes
- employment (long-term)
- new skills
- enhanced self-esteem and confidence
- decreased need for income assistance

Target population
- individuals who have significant drive and vision
- individuals who want to work in an environment where there is direct support with individual flexibility

Eligibility criteria
- personal choice

Feedback from the experts
The focus group members felt that more research needs to be completed and data collected in the areas of consumer-run businesses and consumer-run services. While there are some precedents in Ontario, funding for pilot sites and initiatives in British Columbia is needed. The experts also suggested that a registry be set up to administer questionnaires, provide support and raise awareness.

Peer support
Peer support was not addressed in the literature review, but has emerged as an integral component of employment for persons with serious mental illness.
Peer support is a concept that has been around for many years, yet research into peer helping services is still relatively new. Potential benefits of peer support include the creation of permanent jobs (e.g., case management and rehabilitation assistance), individual empowerment, increased self-esteem for individuals who are peer workers and positive changes in the attitudes of mental health professionals toward the abilities of people with severe mental illness.

The underlying philosophy of peer support relates to the creation of an interpersonal context that is respectful, trusting and warm, allowing individuals to find their own answers and empowering them to make changes that will enhance their lives. Roles of peer support workers can relate to helping individuals understand and manage their illness, providing emotional support, helping individuals identify and clarify problems, motivating individuals, helping individuals follow through on goals and action plans, advocating for individuals, helping individuals re-establish social networks, decreasing isolation of individuals and teaching interpersonal skills.

People who are likely to be successful peer support workers are those who have accepted their psychiatric disorder, have a positive attitude toward mental health professionals, have developed effective coping skills and strategies for dealing with stress, like working with people and can accept individual differences and learn from others. They have good interpersonal skills themselves, a personal sense of self-worth and a desire for self-improvement, respect others’ choices, can learn and work in a team setting, have adequate literacy skills and problem solving abilities, are motivated and are generally stable in their personal life.

Peer support can be built into all employment strategies. It adds value to existing employment programs.

Approaches

- Peer mentoring:
  - one-on-one support, where a consumer who has successfully found and kept employment acts as a role model for another consumer
  - peer mentors can assist in developing realistic goals and modeling wellness
- Peer support groups:
  - connections for people sharing common experiences
  - exchanging information and tips
  - realization that individuals are “not alone” in their challenges
  - sharing success stories
  - can be facilitated by staff, but with consumer decisions about agenda, priority issues for discussion and input to meetings
Peer support groups can be used in three ways. They can be a valuable addendum to education and work programs. In addition, they can be used as an alternative approach to education and employment programs. They can also be used generally within the mental health system, not necessarily related to educational or employment contexts.

Peer groups and support may also be used outside psychosocial rehabilitation programs but still within the mental health system in clinical services. And they may be used outside psychosocial rehabilitation as a service independent of the mental health system.

**Concluding comments**
While it is clear that supported employment options are the most widely researched area of practice in the employment continuum for people with severe mental illness, it is important to consider other alternatives that may better meet individual needs. Further research is necessary into consumer-run businesses/services and peer support options, but they are already providing additional choices for consumers.
6. RECOMMENDATIONS

6.1 Provincial

1. Create provincial leadership in the development and reform of psychosocial rehabilitation and recovery services by:
   - conducting a best practices initiative for personal life and leisure areas
   - promoting reform and advocating for evidence-based practice in rehabilitation and recovery services
   - funding best practices demonstration projects to test pre-employment, employment and supported education initiatives in rural and urban settings
   - establishing working partnerships/linkages with related provincial ministries (Ministry of Social Development and Economic Security [MSDES]) and federal ministries (Human Resources Development Canada [HRDC]) that affect individual rehabilitation and recovery
   - incorporating unique rehabilitation and recovery data elements in the newly proposed provincial database being designed by MHECCU (Mental Health Evaluation and Community Consultation Unit)
   - establishing a provincial registry of rehabilitation practitioners
   - encouraging regional learning needs surveys among mental health professionals (rehabilitation and clinical staff) to develop provincial clinical standards, curricula and educational initiatives
   - organizing provincial best practices conference calls with experts in the field of rehabilitation and recovery services to provide health authorities with the latest information, as well as opportunities for answering questions and receiving guidance in the development/reform of these services.

6.2 Regional

2. Identify a designated contact in each health authority for promoting rehabilitation and recovery services to:
   - facilitate development/reform within the region through fair distribution of financial resources, to provide a range of rehabilitation and recovery services
   - establish regional/local rehabilitation advisory committees
   - participate in a provincial networking committee to collaborate on evidence-based resource development, consultation, consensus building, education and dissemination of information
• review existing data and establish benchmarks for staff-to-client ratios in rehabilitation services (e.g., number of rehabilitation specialists in mental health teams/contracted agencies, leisure programs, pre-vocational programs, TEP, supported employment, supported work)
• identify training needs of staff within the region
• participate in annual review of Rehabilitation Services Guidelines manual
• create a website to provide information and resources for mental health staff, consumers and family members in the regions.
• Encourage regional health planners to distribute financial and human resources fairly to a range of rehabilitation and recovery services, to meet the needs of children and youth, adults and seniors, with consideration for gender and culture, by:
  • providing a range of programs/service in all areas of rehabilitation, i.e., personal life, leisure, education and work
  • providing consumer access to all service levels, i.e., basic support, readiness, rehabilitation process and ongoing support.
• Hire at least one rehabilitation specialist in each region. In rural areas, two regions may need to consider establishing a partnership to ensure that rehabilitation services are available within a reasonable distance.
• Incorporate recovery concepts and PSR principles and practices into all mental health services:
  • integrate recovery concepts and PSR principles into clinical treatment
  • consider rehabilitation services as a primary intervention at the onset of illness
  • assess individual readiness to begin rehabilitation
  • hire at least one rehabilitation specialist on all assertive community treatment teams
  • hire a variety of rehabilitation specialists for mental health teams that utilize case management models where the case manager-to-individual ratio is higher than assertive community treatment team ratios.
• Encourage rehabilitation staff to take steps to ensure that language, age and culture will not be a hindrance in receiving needed rehabilitation services. Specifically, rehabilitation services should make appropriate efforts to determine consumer needs and develop pilot projects to address needs, e.g., training in English as a second language, leisure programming and vocational rehabilitation services.
• Sustain the development of supported education within each region, by:
  • ensuring individual access to supported education within three months of referral
  • ensuring that coordination exists among mental health providers
• creating an advisory committee to work in partnership with Vocational Rehabilitation Services, the Ministry of Social Development and Economic Security and Human Resources Development Canada
• providing training and education and working with college/university staff regarding the needs of the mental health population
• reviewing current supported education practice and, where appropriate, developing and piloting adult services and early intervention approaches for children and youth
• encouraging health authorities to develop a range of pre-employment and employment services:

Pre-employment:
- ensure individual access to pre-employment services within three months of referral
- ensure that coordination exists among mental health providers and between pre-employment and employment programs/services
- develop working committees and partnerships with regional offices of provincial (MSDES) and federal ministries (HRDC) responsible for employment services
- form local community advisory groups, which could create linkages and relationships to the business community and relevant non-profit agencies for developing a range of work experiences, work shadows, volunteer options, etc.

Employment:
- ensure individual access to pre-employment services within three months of referral
- ensure that coordination exists among mental health providers and between employment and pre-employment programs/services
- develop working committees and partnerships with regional offices of provincial (SDES) and federal ministries (HRDC) responsible for employment services
- form local community advisory groups which could create linkages and relationships to the business community to provide access to employment options
- ensure that financial and human supports are available to assist the development and evaluation of consumer-run businesses/services.

• Establish accountability within each region, by:
• adhering to guidelines established in Rehabilitation Services Manual
• adopting recognized standards for practice and seek accreditation through organizations such as CARF or other recognized accreditation agencies
• implementing standardized data collection utilizing outcome measures
• implementing consumer satisfaction surveys.

Psychosocial Rehabilitation and Recovery
• Each region allocate adequate financial and human resources to develop a range of consumer recovery services that will help consumers participate more fully in the mental health delivery system.
APPENDIX A:
PRINCIPLES OF PSYCHOSOCIAL REHABILITATION (PSR)

These principles are taken from the IAPSRS Ontario Chapter position paper on psychosocial rehabilitation and the psychosocial rehabilitation literature (Cnaan, Blankeitz, Messinger and Gardner, 1988).

Client involvement
Involvement of the person with a psychiatric disability in every aspect of the rehabilitation process is critical to a positive rehabilitation outcome. Services should be based on the needs of the person.

Client involvement in the shaping and evaluation of mental health services should also be facilitated.

Self-determination
Persons with psychiatric disabilities benefit from having control over decisions that affect their lives. They have the right and the ability to make personal decisions.

Differential needs
Persons with psychiatric disabilities have needs that are ongoing, unique and multi-dimensional.

Utilization of full human capacity
Persons with psychiatric disabilities have the potential for growth. They have strengths and assets that can be developed to help them maintain a sense of identity, dignity, self-esteem and competence.

Personal choice
Persons with psychiatric disabilities have the ability to make choices regarding living, learning, working and social environments.

Natural supports
Involvement with the natural support network is critical to a positive rehabilitation outcome.

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Psychosocial Rehabilitation and Recovery 39
**Peer supports**
Persons with psychiatric disabilities and their families can gain support and a sense of belonging and being connected through involvement with their respective peer groups.

**Hope**
Hope is an essential ingredient of PSR. Skills and supports can be developed to enable the individual to develop the confidence to take the lead in their rehabilitation.

**Functioning**
Persons with psychiatric disabilities have the capacity to improve their level of functioning.

**Belonging**
Belonging is an essential ingredient in a psychiatrically disabled person's growth and development.

**Outcome measurement**
It is important to measure the outcome of PSR.

**Commitment of staff**
Genuine concern with the well-being of clients and the belief that they are capable of progress must be of paramount importance to staff.

**Client/practitioner relationship**
The relationship between practitioner and client is a partnership within which a client-centered approach is developed.

**Early intervention**
Prompt crisis intervention is essential in preserving most acquired skills and community ties.

**Environmental approach**
Each individual has the right to live and function in the setting that is least restrictive and that approximates as closely as possible a regular community setting.
Changing the environment
PSR advocates normalization, as well as restructuring and re-educating the environment, to facilitate the integration of people with emotional disabilities.

No limits on participation
The PSR approach maintains no limits on the length of participation and imposes few selection criteria. Once a person has accessed a PSR program, they may be considered part of it for as long as desired.

Work-centered process
Work, especially the opportunity to aspire to and achieve gainful employment, is a deeply generative and re-integrative force and must be a central theme in any rehabilitation process.

Focus on functioning and fulfillment of social roles
Rather than focusing on treatment and the client’s impairment, PSR focuses on utilizing the person’s strengths and abilities for overall better independent functioning and fulfillment of social roles.
GLOSSARY

accountability. The management team is responsible for defining expected outcomes and performance measures, a plan for monitoring service delivery and activity reporting structure. The Ministry of Health is responsible for the expenditure of public funds.

accreditation. External, formal review of an agency’s performance and adherence to standards of delivering care services. Certification by a national organization whose business is the evaluation of compliance by service organizations (such as hospitals) with pre-set standards of care and/or service.

acute care (also referred to as secondary level care). Diagnostic and therapeutic health care (in medical disciplines, including psychiatry) provided by health care professionals, usually in a hospital setting and for a short duration.

acute psychiatry (inpatient). Assessment, diagnosis, treatment, stabilization and short-term rehabilitation of people with serious mental illnesses admitted voluntarily or involuntarily to a hospital psychiatric unit, which often entails emergency psychiatric care.

adult. Person 19 years of age or older.

advocacy. The act of informing and supporting people so they can make the best decisions possible for themselves or an act on behalf of others when they are unable to act on their own.

ALOS. Average length of stay.

Assertive Community Treatment (ACT). An alternative to other forms of community care which, because of its comparative expense, should be targeted to the most appropriate clients (i.e., frequent users of the system, including inpatient care and forensic services). The 1998 mental health plan addresses the two per cent of the population with serious and persistent mental illness, with accompanying functional disabilities. The plan supports intensive or assertive community treatment for only a portion of the most seriously mentally ill, up to 8,200 clients.

best practices in mental health. Descriptions of what can be done to facilitate change for the better in mental health policies, practices and initiatives. Factors that facilitate change include clearly articulated conceptual bases, wide stakeholder involvement, political vision and will, infrastructure supports, the reallocation of funds and personnel from institutions to community, partnerships beyond health, reduction in stigma, enthusiastic leaders, skilled staff and the Canadian Mental Health Association National Framework for Support.
biopsychosocial approach/model. Services that take into account the biological, psychological and social needs of an individual. Involves multidisciplinary care teams, including physicians, nurses, pharmacists, social workers, occupational therapists, dietitians and psychologists.

case management. The coordination of a consumer’s health care, housing, employment, training and/or rehabilitation services, usually by one person (the case manager) operating in a team environment who liaises with all others providing services to the consumer. Case management provides active outreach, coordination of personalized care plans and monitoring of mental health status.

clinical practices guidelines. Systematically developed statements to assist practitioners in decisions about appropriate health care for clients in specific clinical circumstances.

community resource base concept. This concept “assumes the perspective of the person in the centre: the consumer who is actually living and coping with a mental health problem. The majority of consumers now live most of their lives in the community and are influenced by a wide range of factors. These factors include housing, education, work, income, mental health services, consumer groups and organizations, family and friends and generic community services and groups.

consumers. People who use mental health services.

crisis stabilization program. Provides community-based, short-term treatment and stabilization services for individuals in psycho social and psychiatric crises as an alternative to hospitalization. During the client’s stay, a thorough assessment is completed, intensive brief crisis intervention services are provided and an immediate action plan for community re-integration is implemented.

decompensate. The psychotic symptoms return or the person’s ability to function is disrupted.

designated facility. A hospital or provincial mental health facility that may admit involuntary patients under the Mental Health Act.

determinants of health. Factors that influence and determine health status. These include social, economic and physical environments, health services, biological influences and health behaviors and skills.

DSM-IV. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. The American Psychiatric Association’s classification tool to assist care practitioners in classifying mental disorders based on symptoms.

dual diagnoses. Commonly used to describe the condition of people who have a mental illness and either a mental handicap or substance misuse issues.
ECT. Electroconvulsive therapy.

emergency accommodation. Facilities that offer short-term emergency accommodation in a supportive environment for people with marked behavioral and social problems associated with mental illness who have no other immediate housing options available to them, but who do not require care in a hospital or intensively staffed facility.

empowerment. The capacity of choice. Includes the ability to define, analyze and act on problems one experiences in relation to others and in one’s environmental living conditions. As a process, describes the means through which internal feelings of powerlessness are transformed and group actions initiated to change the conditions that create or reinforce inequalities in power.

epidemiology. Prevalence of a disease in a particular community at a particular time.

etiology. Pertaining to the science of the causes of disease.

evidence-based decision making. A process that takes facts, data and evidence into account. It is an essential part of effective and accountable planning, action and evaluation.

family care home. Care provided in approved homes to one or two adults with a serious and persistent mental illness who are unable to live independently. This category of care is not subject to licensing under the provincial Community Care Facilities Act.

forensic. Forensic Psychiatric Services provides assessment, diagnosis, treatment, detention and supervision of people with mental illness who are involved with the criminal justice system.

FTE (full-time equivalent). FTE is the unit used to describe a full-time position. For example, two half-time positions equal one FTE.

functional impairment. An individual’s reduced ability to perform usual daily activities. A number of measurements exist to gauge a person’s level of functioning (and level of functional impairment). The global assessment of functioning (an aspect of assessment that is part of the ASP DSM-IV) is one such tool.

governance. The authority to operate a health care program. Governing bodies, such as boards of directors or trustees, generally define the vision, mission and values of an organization and set goals, objectives and priorities for its operation.

guidelines. A suggestion or set of suggestions that guides or directs action. The purpose of a guideline is to provide additional information that assists service providers to comply with policy. Guidelines may be suggestions on how to carry out or implement policy. Whereas health authorities and services providers must comply with Ministry policy, they do not have to comply with guidelines.
health authorities. Public bodies mandated under the Health Authorities Act to govern, manage and deliver health services in a defined geographic area. Refers to either Regional Health Boards (RHBs) or Community Health Councils (CHCs). Community Health Service Societies (CHSSs) are included here, although they do not have status under the act and derive their authority from their constitution and bylaws, established pursuant to the Society Act.

RHBs govern the delivery of all health services within a designated region.

CHCs govern the delivery of acute and continuing care-based services, such as hospitals and intermediate-care facilities, in areas of the province where there are no RHBs.

CHSSs govern the delivery of services that are broadly regional in nature—public health, community health care nursing, community rehabilitation, case management, health services for community living and adult mental health services—in areas of the province where there are no RHBs. Collectively, the CHSSs and the CHCs within a region govern the delivery of all health services in the region.

health status. A group or community’s status of health, evaluated by means of universal epidemiological indicators, such as the rates of illness and death, life expectancy and potential years of life lost, and compared with other populations.

integration. Organization of service entities along a continuum, ranging from cooperation between agencies to full amalgamation of governance, management and service delivery structures, in order to ensure that the client’s needs are met in a coherent, unified, holistic and efficient manner.

mandate. The scope of an organization’s responsibility.

Mental Health Act. British Columbia’s Mental Health Act was proclaimed in 1964. Its purpose is to ensure “…the treatment of the mentally disordered who need protection and care…” The main focus of the Mental Health Act is to provide authority, criteria and procedures for involuntary admission and treatment. The act also provides protection to ensure that these provisions are applied in an appropriate and lawful manner.

mental health crisis. An acute disturbance of thinking, mood, behavior or social relationship that requires an immediate intervention; which involves an element of unpredictability that is usually accompanied by a lack of response to social controls and may be defined as such by the client, the family or other members of the community, including family physicians or police.
multiaxial assessment. An assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict the outcome. There are five axes included in DSM-IV:

Axis I  Clinical Disorders
Axis II  Personality Disorders
Axis III  General Medical Conditions
Axis IV  Psychosocial and Environmental Problems
Axis V  Global Assessment of Functioning

operating budget. The amount of funding necessary to pay for the cost of running an organization.

organic brain syndrome. A psychological or behavioral abnormality associated with a temporary or permanent dysfunction of the brain caused by disease processes, strokes or accidents.

outreach. Services are taken to the consumer (e.g., at home, at work, in a facility) rather than requiring the consumer to attend a clinic or hospital.

partnership model in mental health. Services provided through individual care planning carried out in a partnership among the Ministry of Health, service providers, local governments, family members, other unpaid caregivers and consumers to meet the needs of consumers, in the context of all the roles and functions of all parts of the mental health system.

psychosocial rehabilitation. Psychiatric rehabilitation services designed to assist a person with a serious mental illness in effectively managing the illness and compensating for the functional deficits associated with the illness. People who receive psychosocial rehabilitation services are significantly more likely to be able to return to work or school or to resume a participating role in the community. The range of psychosocial services may include rehabilitation, case management, residential treatment and support, crisis services, social services, housing, vocational rehabilitation, substance abuse treatment, peer support and family support.

psychotropic drug. Any medication that has a primary effect on the central nervous system with the intention of improving moods or thinking. The term "typical" psychotropic drug refers to relatively old products. The term "atypical" refers to psychotropic drugs that are relatively new and designed to treat a wider range of symptoms with fewer side effects.
**primary care.** Preventive, diagnostic and therapeutic health care provided by general practitioners and other health care professionals. The first level of care normally accessed by clients and patients. Primary care may include referral to more specialized levels of care, e.g., secondary (hospital or specialist care). Family doctors are often referred to as “primary care physicians.”

**quality assurance (QA).** An ongoing program to ensure that standards of service delivery are being met.

**residential care.** Provided in community-based, licensed facilities that are staffed to provide full-time care, supervision and psychosocial rehabilitation for people whose social and/or mental functioning prevents them from living more independently. These facilities average 13 residents and are regulated by the Community Care Facility Act and the Adult Care Regulations. The facilities are subject to program standards, guidelines, policies and procedures.

**residential care for specialized needs.** Augmented resources provided to community care settings, to respond to the complex care needs of people with severe neuro-psychiatric disorders and very challenging behaviors.

**residential program/services.** An organized program enabling clients to have the best possible quality of life, while remaining or becoming integrated into the community. Residential services may be provided in rural or urban areas, in houses, apartments, townhouses or other culturally appropriate settings.

**respite.** Temporary, short-term care, designed to give relief or support to a family caregiver who has responsibility for the ongoing care and supervision of a family member with a serious mental illness. Respite can be provided inside or outside the home.

**secondary level care.** (See acute care)

**serious mental illness.** Generally, illnesses such as schizophrenia, manic depression and bipolar disorder represent the most serious mental illness. It is acknowledged, however, that there are others for whom medical risk and level of impairment, regardless of diagnosis, defines their mental illness as “serious.”

**stakeholders.** Representatives of the British Columbia mental health care community of interest (e.g., consumers, families, professionals, unions, health authorities).

**standard.** An established, measurable, achievable and understandable statement that describes a desired level of performance against which actual performance can be compared. Used by service providers to attain and maintain quality of care or service delivery, they state what consumers and the public can expect from a service. While a policy tells service providers what to do, a standard is a tool that allows a service provider to measure, monitor and compare actual performance against a benchmark.
**supported education.** An effective means of helping individuals with psychiatric disabilities to achieve success in accessing and pursing educational opportunities of their choice.

**supported housing.** A variety of living arrangements (usually self-contained living units) for people with a serious and persistent mental illness who are able to live independently with the assistance of a range of support services and the provision of a housing subsidy.

**tertiary care.** The care of people with serious, complex and/or rare mental disorders who, by reason of severe psychotic behavior or the need for specialized staff or facilities, cannot be managed by the resources available at the primary and secondary levels of care in the province. It also includes specialized services such as child and adolescent, psychogeriatric, alcohol/substance abuse and forensic mental health services.

Tertiary mental health care includes specialized intensive acute care assessment and short-term treatment programs and both short-term (episodic) and long-term institutional care for severe chronic cases. It excludes long-term care that does not require daily access to the special clinical resources that are available only within the tertiary care programs.

**utilization data.** The information required to compare observed use of resources with recognized standards for use.

**utilization management.** Process by which agencies decide on the efficient use of care resources, comparing the observed use of resources with recognized standards of appropriate, timely and cost-effective utilization. The objective is to ensure that the right services are provided to the intended consumers, when they most need them, at the lowest cost consistent with high quality care.

**values.** The beliefs of an organization that underlie its principles and actions, and form the basis for planning and operating services.
BIBLIOGRAPHY

Supported education


Michigan Supported Education Program. (1998) www.ssw.umich.edu/msep/supported.html


**Note:**
Example of self-contained classroom:
- Student Success College Prep Program: Douglas College, New Westminster Campus (fall term) and David Lam Campus, Coquitlam (spring term).

**Employment**


**Note:**
Examples of international transitional employment programs can be found in: