Salud Mental 2013;36:159-165
ISSN: 0185-3325
DOI: 10.17711/SM.0185-3325.2013.019

Employability Strategies in Population with Mental Disabilities: A Review

Franco Mascayano Tapia,[1] Walter Lips Castro,[1] José Miguel Moreno Aguilera[1]

Update by topics

SUMMARY

Employability and access to the productive market are considered key elements for the full integration of the patient with a mental disability. The aim of this review was to describe and analyze the scientific literature for the main employability strategies: traditional vocational rehabilitation (sheltered employment and social firms) and supported employment (particularly in the form of individualized supported employment). The results of the review suggest that individualized supported employment is the most effective approach in obtaining employment for people with mental disabilities.

Key words: Mental disability, employability, sheltered employment, social firms, supported employment.

RESUMEN

La inserción laboral y el acceso al mercado productivo son considerados elementos claves para la plena integración del paciente con discapacidad mental. El objetivo de la presente revisión fue describir y analizar la literatura científica correspondiente a las principales estrategias de inserción laboral: rehabilitación vocacional tradicional (empleo protegido y empresas sociales) y empleo con apoyo (particularmente en su modalidad de empleo con apoyo individualizado). Los resultados de la revisión indican que el empleo con apoyo individualizado es el abordaje más efectivo en la obtención de empleo en personas con discapacidad mental.

Palabras clave: Discapacidad mental, inserción laboral, empleo protegido, empresas sociales, empleo con apoyo.

INTRODUCTION

La inserción laboral y el acceso al mercado productivo son Employability and access to the productive market are considered key elements for the full integration of persons with a mental disability.[1] Within the research context of employability effects, it is widely spread the acknowledgement of the employment's positive value as an improvement tool both of the clinical and psychosocial situation of those affected by a disabling mental-health condition. Employment not only improves the users' financial situation but also provides organization of their daily activities, with defined and significant routines. Employed users have a personal sense of well-being, a good level of self-efficacy and social identity.[2] In addition, they have better self-esteem and self-image, a reduction of symptomatology, more social contacts and a better quality of life.[3,4] On the other hand, it has also been demonstrated that stable employment is a great support that involves social inclusion of persons with a mental disability, thus guaranteeing them access and exercise of their citizen rights.[5] Some authors state[6] that an effective social inclusion of a patient with a mental-health condition requires his/her incorporation to the working world, job training and access to the labor market.

Notwithstanding the foregoing, today persons with a mental disability have fewer possibilities to find a job compared to other non-mental disabling conditions. In this regard, the productivity level of such individuals only reaches 29%, a significantly smaller percentage if compared to persons with a physical disability (49%) and to the community as a whole (74%).7 The situation is even worse for people with psychotic disorders, among whom only two out of ten persons find certain form of employment.[7] Some factors explaining this situation come both from individual and sociocultural variables. On the personal scope, many users with a mental disorder have low levels of school education, low productivity, reduced social and working skills, symptoms of learning difficulties both affective and cognitive, adverse side effects of drugs and a scant working experience.[8,9] Furthermore, several environmental variables become important barriers to secure an employment. Among them are described the demanding and changing dynamics of the labor market, the lack of work incentives, the disagreement with the particular job to perform, the

[1] Escuela de Psicología, Facultad de Medicina, Universidad de Valparaíso, Chile.
Correspondence: Franco Mascayano. Escuela de Psicología. Universidad de Valparaíso, Av. Brasil 2140, Valparaíso, Chile. E-mail: franco.mascayano@gmail.com
Received: February 15, 2012. Accepted: August 13, 2012.

public stigmatization related to the resulting discrimination both from employers and general population, and, finally, the lack of clinical and vocational programs supporting employability.[10-12]

As mentioned above, employment plays an important role in the recovery of persons suffering from any disabling mental-health condition.[13,14] Nevertheless, it bears mention that one of the factors that significantly forecasts the success to achieve and maintain a job is work motivation. In this respect, according to the studies of Perkinset et al.[15] and Chuaqui,[16] persons with a mental disability have a high work motivation. Therefore, it is important that any properly organized society consider measures that —on a scientific basis— facilitate and foster employability of persons suffering mental problems with a disability.

The inclusion strategies that we will describe herein are divided into two large categories: 1. traditional vocational rehabilitation, subdivided into sheltered employment and social firms; 2. supported employment. Within this category, we will analyze in depth the model that now has shown greater efficiency for labor integration: the individual placement and support model.

TRADITIONAL VOCATIONAL REHABILITATION

It consists of programs for reestablishing or developing skills in those persons who suffer a mental disability. Its main objective aims both at the achievement and at the maintenance of a job suited for such users. There are pre-employment-stage assessment procedures, work training activities, employment counseling and job placement assistance. Its main characteristic is the train-place paradigm, that is to say, first the person is prepared for a sheltered or competitive work, through a vocational training, and then the rehabilitated person's job placement is fixed.

1. *Labor Integration through Sheltered Employment*. According to the lawyer Miguel Laloma García, Sheltered Employment "is generated for persons with a disability at common companies that comply with certain characteristics intended for facilitating the incorporation of disabled employees into the labor market".[17] The main objective of this kind of work is the fulfillment of a productive job, participation in market transactions and maintenance of a remuneration.[18] Such jobs have been developed for persons suffering from a serious mental illness, a low social functioning level and who have a lack of sufficient education to take part in standardized labor spaces. Remunerations seldom correlate with the quality of manufactured products or with the achievement of tasks performed and are often low rated.[19]

   Sheltered employment comprise labor encouragement approaches such as clubhouses,[20] diversified job placement programs[21] and other vocational encouragement strategies included in psychiatric rehabilitation programs.[22] The purpose of these strategies is twofold: on the one hand, securing a gainful employment for persons with a disability who, regardless of the cause, are not able to access a standardized employment; and on the other, trying to prepare these persons for a possible access to the ordinary market. In general, the workforce mainly comprises persons with a disability, in order to facilitate personal and social development within an understanding and belonging environment.[23] However, the Sheltered Employment's strategies have shown limitations when complying with the objective put forward above. In this regard, employees often do not perform a productive job, remaining in their work mainly for social reasons rather than productivity reasons. Also, in general the promotion to the standardized employment is not attained from the sheltered condition.[18]

   Regarding the effectiveness analysis of these interventions, surveys have been conducted in some sectors of the U.S. population, showing that employment rates range between 30 and 40% for those persons who have participated in a supported employment program.[24] Macias et al.[25] mention that many clubhouses have an average of 19.6% active members participating in casual employment and 17.5% in independent competitive employments. On the other hand, in a recent study comparing a clubhouse's work with a supported employment intervention called "Assertive Community Treatment (ACT) Program", similar results were obtained as for the amount of weekly work hours and monthly income.[26] Nonetheless, McKay, Johnsen and Stein,[27] made a review reporting that during 1998-2001 approximately 1,702 members from 17 different clubhouses achieved a mainly transitional-type job. Likewise, users earned lower wages than those established by the market.

   In spite of the impact on the employability of sheltered employment does not have solid proof which supports it, such interventions have benefits of a therapeutic nature worth mentioning:[28-31]

   a) Reduction of relapses and hospitalizations;
   b) Less problems with the judicial system;
   c) Increase of autonomy, functionality and self-efficacy;
   d) A greater sensation of well-being that would result in the creation of friendship and support networks.

2. *Labor Integration in Social Firms*. The European Confederation of Social Firms and Co-operatives (CEFEC) defines a social firm as an ordinary business created for the employment of people with a disability or other disadvantages in the labor market.[32] Social Firms originated in Italy during the 1960's, and since then they

have spread mainly throughout Europe, North America and Asia. These businesses are characterized by a supportive behavior, allowing people with a disability to have an employment. Workforces are made up by 20-50% employees with a disability and remunerations are calculated upon a productivity base rate.7 These institutions strive for integrating the economic and social factors. Such firms assess each individual's limitations and necessities. From these assessments a customized employability program is planned, which goal is the acquisition of sufficient skills that may provide access to the job market. To achieve the latter it has been proved that the most effective strategy is training and learning within a common working environment. On the contrary, it has been demonstrated that having only theoretical training is useless for learning a practical skill, which could produce frustration in the individual.[33]

According to Peter Stadler,[34] a CEFEC member, currently in Germany there are over 600 social firms, each of them with a workforce in which 25-50% of employees have a disability. As for the study of Smit, van Genabeek and Mike Klerkx,[35] which gathered data from five European countries (Germany, Italy, Belgium, United Kingdom and Sweden), it detected that most of the social firms offer market wages and permanent employment for their users. In addition, the majority of these social firms engage employees with some degree of mental disability. According to such authors, joint working activity among persons with and without a mental disability encourages social integration in those who have a disability, thus strengthening their job performance. Similar conclusions have been reached in other researches conducted in European countries like Spain,[36] Finland,[37] Portugal[38] and Ireland.[39] The same has been described in social firms incorporated in the United States, Australia, New Zealand, Japan and Korea.[40] However, since aforementioned studies are neither experimental nor quasi-experimental, their results should be viewed with caution due to the lack of cross-checking with other employability models.

Finally, as with sheltered employment, some authors point out that social firms' involvement generates therapeutic benefits, including less demand of mental health services, reduction of social isolation and increase of both self-confidence and motivation in user.[41,42] The foregoing results in a better quality of life of users. In this regard, a qualitative study conducted by Svanberg, Gumley and Wilson,[43] identified positive experience factors that had a beneficial effect on workers' welfare. Among such factors are: the flexible work structure at social firms, the meaning and diversity of working activities, the sense of integration to a social group and, lastly, the development of leadership.

Supported Employment. It is based on the train-place paradigm, that is to say, competitive job placement of persons with a disability is promptly promoted. Therefore, training and supporting processes are offered to them according to the necessities that may arise during their working activities. The individual placement and support model was created in the United States in the 1990's, thanks to Robert Drake and Deborah Becker,[44,45] originated from the integration and normalization socials concepts. It was designed in order to favor labor integration of persons with a disability who are motivated to work.

According to the American psychologist Gary Bond, based on the Rehabilitation Act Amendments, supported employment is characterized by the following:[46]

- *Presence of the Job Coach Figure*. A professional person who accompanies the person with a disability in the workplace, helping him/her in the job training process. This figure is essential because it provides the support that will facilitate the integration. Also, the job coach should encourage the person to be involved in his/her training, in solving any problem and in achieving that agents (family, friends or others) related to the person also take part in this process.
- *Support in Workplace*. This is a key feature of the model since this will allow the person to access the job and maintain it. There are different support levels that will depend on the person's and the environment's necessities, which will vary depending on timing. Within these types of support are the intermittent, limited, broad and widespread support. It has been observed that the group of people with a chronic mental disorder generally needs a broad and widespread type support.[47]
- *Person-Centered Planning*. The whole support employment process is based on the persons' interests, motivations and skills, hence involving them. Therefore, an individual assessment should be made, mainly focusing on how the person acts in his/her environment rather than on the difficulties this implies.
- *Job Positions in Common Firms on an Equal Footing*. The person must be integrated in job positions in firms that are competitive within the labor market on the same terms as the rest of his/her coworkers.

Regarding ways of supported employment implementation, the most studied and standardized for persons suffering a mental disability is the Individualized Placement and Support (IPS). Main features of IPS are as follows: a) the presence of service provider agencies to attain a competitive employment, b) a fast job search assisting clients to obtain an employment expeditiously, c) an interaction between agency and clients for the location of a job in accordance with the client's preferences, strengths and previous working experience, d) continued support and follow-up by the agency regarding the client's job performance, and, finally, e) a close relation between the agency and the psychiatric treatment of each client. Bond et al.[48] determined that such

Translation of the original version published in spanish in:
Salud Mental 2013, Vol. 36 Issue No. 2

characteristics are positive predictors for employability in persons with mental disability.

According to several randomized controlled trials (RCT), the IPS would generate the best results, in respect of employment, for persons with mental disability. As for the implementation cost, it is not only relatively low, but also easily applicable.[49] Drake et al.[50] conducted a study in which the IPS were contrasted with two traditional employability programs. Results showed that the IPS program clients obtained more competitive employments during an 18-month follow-up. In summary, this study concludes that the IPS are a more effective support system than other traditional programs. Another Drake et al. study[51] again show results indicating a higher IPS effectiveness in contrast with the traditional employability programs, regarding both the competitive jobs obtaining and the number of weekly working hours.

Another research conducted by Lehman et al.[52] assessed the effectiveness of the IPS model in connection with regular psychosocial rehabilitation programs for the employability of persons with serious mental illnesses. The individuals in the IPS program showed better employability indicators than the comparison group (42% *vs.* 11%, respectively). Regarding specific data in relation to the obtaining of competitive employment a noticeable difference was observed between the IPS and other programs (27% vs. 7%). On the other hand, the Mueser et al.'s team[53] compared three employability methods on psychiatric population, such as the IPS model. IPS users had a competitive employability (73.9%) higher than users of the other two methods (18.2% and 27.5%). Regarding the remunerations obtained, 73.9% of the IPS program users achieved better salaries than the clients of the other two strategies.

In 2006, Latimer et al.,[54] in a RCT, sought to determine the effectiveness of the IPS model in Canadian population. During the 12-month follow-up, 47% of clients in the IPS group obtained at least a competitive employment compared to 18% of the control group. It is important to point out that the IPS model has been widely spread within the Canadian mental health services.[55,56]

In another RCT, Burns et al.[57] conducted a multi-center study in six European countries (United Kingdom, Germany, Italy, Bulgaria, Switzerland and Holland). Such authors showed the effectiveness of IPS compared to other model services, with regard to the capacity to achieve the employment. A subsequent analysis published by such authors concluded that persons who found employment had a better global functioning, less amount and severity of symptoms and less level of disability.[58] Finally, Bond et al.,[59] also in a RCT, compared the IPS and the Diversified Placement Approach (DPA). It was found that the IPS model is better than the DPA as for the achievement of employability (75% vs. 33%).

In a RCT conducted by Wong et al.,[60] the IPS was applied in users of a Hong Kong hospital. In comparison to participants of regular rehabilitation programs, IPS users had better chances to achieve competitive jobs, higher remunerations, higher number of days worked and a higher capacity to keep their employment. On other hand, Killickey et al.[61] assessed the usefulness of the IPS applied to persons with a first episode of psychosis. It was found that the IPS group obtained better results in the acquisition of employment, in the number of hours worked per week and in the continuance in the employment.

In another RCT, Twamley et al.[62] assessed the employability level in persons of 45 years of age or older, diagnosed with schizophrenia or schizoaffective disorder. The IPS was compared to a regular vocational rehabilitation program. The IPS program caused a positive and meaningful impact in the achievement of a competitive employment, the number of working weeks and the obtaining of better salaries and a better quality of life. A similar study subsequently conducted by the same team observed similar results.[63]

Lastly, in 2010, the Howard et al.,[64] RCT results were published, which compared the IPS model with the traditional vocational services, in London. This study did not have significant differences between compared groups regarding the acquisition of competitive employment. It bears mention that this is the first research that refutes the effectiveness of the IPS model.

DISCUSSION

In the preparation of this paper we have reviewed several strategies for the employability of persons with disabling psychiatric disorders.

In connection with the most traditional approaches of employability, the studies reviewed conclude a moderately positive impact of such interventions, better results in clinical indicators (remission of symptoms, subjective well-being, sense of social belonging, reduction of hospitalizations, etc.), compared to the labor dimensions themselves (competitive employment, market salaries, weekly working hours, etc.).

In the case of sheltered employment, there is no solid proof supporting this type of strategy for employability, much less of competitive type. Likewise, in general acquired jobs are temporary[65] and salaries are often below the average defined by the labor market.[19] According to the sociologist Jorge Chuaqui's approach, we agree that sheltered employment does not respond satisfactorily to the employability problem of persons with mental disability. In this regard, it bears mention that because users perform in an "artificial" environment, they lack of social interaction within a common employment context. In addition to the above, low remunerations and little working goal requirements cause sheltered employment an insufficient intervention for the individual's complete social integration.[16] However, as for the therapeutic benefits which result in a better quality of life, sheltered employment play an essential role.

It is important to emphasize that such strategy should be planned within a limited time and with a specific objective allowing the user to face properly the real conditions of economic survival.

With regard to social firms, positive results have been observed in the obtaining of permanent jobs with market wages and within a working environment allowing a better integration among users and other employees. Experiences reported by different countries through interviews and surveys prove the usefulness of this approach to facilitate employability of persons with a mental disability. Nevertheless, the systematization of labor indicators through experimental studies allowing to compare this approach with other interventions is still an unresolved task.[66] Besides the strictly labor benefits, it is noticeable that social firms foster improvement of a series of clinical-therapeutic aspects of users working at them. Users' greater autonomy, functionality, self-efficacy and empowerment have been detected. Since social firms provide an environment integrated with the community, allowing interaction of users with persons without disabilities, they facilitate the disintegration of prejudices, the reduction of stigmatization and self-stigmatization processes and, therefore, increase the understanding of the mental illness within the community.[67]

Lastly, the results of all the studies reviewed for this paper allow us to conclude that the employability approach that has shown better effectiveness in obtaining a competitive employment for persons with a mental disability is supported employment, specifically the IPS. Compared to other traditional vocational approaches (sheltered employment and social firms) the IPS allows higher job-obtaining rates, better remunerations, more weekly working hours and longer continuance in the obtained employment.[68] Furthermore, evidence shows positive effects that the IPS intervention causes in some clinical indicators such as the level of global social functionality, the occurrence of relapse, the quality of life and self-esteem.[21] Such findings are particularly significant because of two reasons: 1. first-level clinical evidence that supports the effectiveness of the IPS approach and 2. their application within different sociocultural contexts (USA, Europe and China), with similar results.

Despite the evidence reported regarding supported employment, particularly the IPS, we observed that both its implementation and effectiveness research in Latin America is virtually non-existent. This is valid even for countries like Argentina and Brazil, which are formally governed by community psychiatry models.[69] Among the scant published studies, we emphasize one conducted by the Pardo et al.'s Uruguayan team, who implemented a supported employment program in a cooperative. In this case, 57% of users were able to perform —with continuance— the learning and development program.[70] Another study published in a Latin American population is the Hernández et al.'s study,[71] who applied a supported employment in Mexican users. The authors verified that 11 out of 24 participants got a regular job. It is important to mention that both quoted studies are of non-experimental type, thus the results are not of first-level clinical evidence according to the canons of evidence-based medicine.[72] Therefore, we deem important the carrying out of RCTs related to employability programs in persons with a mental disability in Latin America to support the corresponding health management.

REFERENCES

1. Verdugo MA, De Urríes FB. Hacia la integración plena mediante el empleo. Actas del VI Simposio Internacional de Empleo con Apoyo. Salamanca: Instituto Universitario de Integración en la Comunidad; 2002.
2. Tsang HW, Fong MW, Fung MT, Corrigan PW. Reducing employers' stigma by supported employment. En: Lloyd C (ed.). Vocational rehabilitation and mental health. Oxford: John Wiley & Sons; 2010.
3. Ackerman GW, McReynolds CJ. Strategies to promote successful employment of people with psychiatric disabilities. J Appl Rehabil Couns 2005;36:35–40.
4. Becker DR, Drake RE, Naughton WJ. Supported employment for people with co-occurring disorders. Psychiatr Rehabil J 2005;28:332–338.
5. López M, Laviana M, Álvarez F, González S et al. Actividad productiva y empleo de personas con trastorno mental severo. Algunas propuestas de actuación basadas en la información disponible. Rev Asoc Esp Neuropsiq 2004;89:31-65.
6. Boardman J, Grove B, Perkins R, Shepherd G. Work and employment for people with psychiatric disabilities. Br J Psychiatry 2003;182:467-468.
7. Mental Health Council of Australia. Let's get to work. A national mental health employment strategy for Australia. Melbourne: 2007.
8. Cook JA. Employment barriers for persons with psychiatric disabilities: update of a report for the president's commission. Psychiatr Serv 2006;57:1391–1405.
9. Ferdinandi A, Yootanasumpun V, Pollack S, Bermanzohn P. Rehab rounds: predicting rehabilitation outcome among patients with schizophrenia. Psychiatr Serv 1998;49:907–909.
10. Henry AD, Lucca AM. Facilitators and barriers to employment: the perspectives of people with psychiatric disabilities and employment service providers. Work 2004;22:169–182.
11. Marwaha S, Johnson S. Schizophrenia and employment. Soc Psychiatry Psychiatr Epidemio 2004;39:337–349.
12. Tsang HW, Tam P, Chan F, Cheung WM. Stigmatizing attitudes towards individuals with mental illness in Hong Kong: implications to their recovery. J Community Psychol 2003;31:383–396.
13. Borg M, Kristiansen K. Working on the edge: the meaning of work for people recovering from severe mental distress in Norway. Disabil Soc 2008;23(5):511-523.
14. Shepherd G, Boardman J, Slade M. Making recovery a reality. Londres: Sainsbury Centre for Mental Health; 2008.
15. Perkins R, Farmer P, Litchfield P. Realizing ambitions: better employment support for people with a mental health condition. Londres: Department for Work and Pensions; 2009.
16. Chuaqui J. Reintegración laboral de personas con esquizofrenia: tarea incumplida. Revista de ciencias sociales 2008;53:249-264.
17. Laloma M. Empleo protegido en España. Análisis de la normativa legal y logros alcanzados. Madrid: Cinca; 2007.
18. Rodríguez F, García MC, Rodríguez MN. La integración laboral de las personas con trastorno mental grave. Una cuestión pendiente. Psiquis 2004;25(6):26-43.

Translation of the original version published in spanish in: Salud Mental 2013, Vol. 36 Issue No. 2

19. Chuaqui J. El estigma de la esquizofrenia. Ciencias Sociales 2005;2(1):45–66.
20. Dincin J. Psychiatric rehabilitation. Schizophrenia Bull 1975;1:131-147.
21. Bond GR, Drake RE, Becker DR, Mueser KT. Effectiveness of psychiatric rehabilitation approaches for employment of people with severe mental illness. J Disabil Policy Stud 1999;10:18-52.
22. Waghorn G, Lloyd C. The employment of people with mental illness. AeJAMH 2005;4:1–43.
23. Díaz D, Chacón S. Proceso de inserción laboral de personas con esquizofrenia. Análisis desde una institución de apoyo. Revista Psicología 2006;1:27-55.
24. Rutman ID, Armstrong K. A comprehensive, national evaluation of transitional employment programs for the psychiatrically disabled. Philadelphia: Matrix Research Institute; 1985.
25. Macias C, Jackson R, Schroeder C, Wang Q. What is a clubhouse? Report on the ICCD 1996 survey of USA clubhouses. Community Ment Health J 1999;35:181-190.
26. Schonebaum AD, Boyd JK, Dudek KJ. A comparison of competitive employment outcomes for the clubhouse and PACT models. Psychiatr Serv 2006;57(10):1416–1420.
27. McKay CE, Johnsen M, Banks S, Stein R. Employment transitions for clubhouse members. Work 2006;26:67–74.
28. Di Masso J, Avi-Itzhak T, Obler DR. The Clubhouse model: An outcome study on attendance, work attainment and status, and hospitalization recidivism. Work 2001;17:23-30.
29. Johnson J, Hickey S. Arrests and incarcerations after psychosocial program involvement: Clubhouse vs. Jailhouse. Psychiatr Rehabil J 1999;23:66-70.
30. Warner R, Huxley P, Berg T. An evaluation of the impact of Clubhouse membership on quality of life and treatment utilization. Int J Soc Psychiatry 1999;45(4):310-320.
31. Leff HS, Wise M. Measuring service system implementation in a public mental health system through provider descriptions of employment service need and use. Psychosoc Rehabil J 1995;18(4):51-64.
32. Spear R. National profiles of work integration social enterprises: United Kingdom. Working papers series. Liège: EMES European Research Network; 2002.
33. Aiken M. What is the role of social enterprise in finding, creating and maintaining employment for disadvantaged groups? Londres: Office of the Third Sector; 2007.
34. Stadler P. Successful structures to develop social firms in Germany –What can we learn for a development on the European level? Praga: CEFEC Conference; 2010.
35. Smit A, van Genabeek J, Klerkx M. Work integration social enterprises. European experiences with social economy. TNO: Hoofddorp; 2008.
36. Vidal I, Claver N. Work Integration social enterprises in Spain. EMES working papers series. Liège: EMES European Research Network; 2004.
37. Pättiniemi P. Work integration social enterprises in Finland. Working papers series. Liège: EMES European Research Network; 2004.
38. Perista H, Nogueira S. Work integration social enterprises in Portugal. Working papers series. Liège: EMES European Research Network; 2004.
39. O'Hara P, O'Shaughnessy M. Work integration social enterprises in Ireland. Working papers series. Liège: EMES European Research Network; 2004.
40. Warner R, Mandiberg J. An update on affirmative businesses or social firms for people with mental illness. Psychiatr Serv 2006;57(10):1488-1492.
41. McKeown K, O'Brien T, Fitzgerald G. Vocational rehabilitation and mental health: the European project on mental health in Ireland 1989-1991: Azimuth: Evaluation Report Summary 1; 1992.
42. Lanctôt N, Durand MJ, Corbière M. The quality of work life of people with severe mental disorders working in social enterprises: a qualitative study. Qual Life Res (en prensa).
43. Svanberg J, Gumley A, Wilson A. How do social firms contribute to recovery from mental illness? A qualitative study. Clin Psychol Psychot 2010;17(6):482–496.
44. Drake RE, Becker DR, Anthony WA. A research induction group for clients entering a mental health center research project. Hosp Community Psych 1994;45:487-489.
45. Drake RE, Becker DR, Biesanz JC, Torrey WC et al. Rehabilitative day treatment vs. supported employment: I. vocational outcomes. Community Ment Hlt J 1994;30:519-532.
46. Bond GR. Supported employment: evidence for an evidence-based practice. Psychiatr Rehabil J 2004;27:345-359.
47. Lloyd C. Evidence-based supported employment. En: Lloyd C (ed.). Vocational rehabilitation and mental health. Oxford: Wiley Blackwell; 2010.
48. Bond GR, Resnick SG, Drake RE, Xie H et al. Does competitive employment improve nonvocational outcomes for people with severe mental illness? J Consult Clin Psychol 2001;69:489–501.
49. Bond GR, Drake RE, Becker DR. An update on randomized controlled trials of evidence-based supported employment. Psychiatr Rehabil J 2008;31:280-290.
50. Drake RE, McHugo GJ, Anthony WA, Clark RE. The New Hampshire study of supported employment for people with severe mental illness. J Consult Clin Psychol 1996;64:391–399.
51. Drake RE, McHugo GJ, Bebout RR, Becker DR et al. A randomised clinical trial of supported employment for inner-city patients with severe mental disorders. Arch Gen Psychiat 1999;56:627–633.
52. Lehman AF, Goldberg R, Dixon LB, McNary S et al. Improving employment outcomes for persons with severe mental illnesses. Arch Gen Psychiat 2002;59:165–172.
53. Mueser KT, Clark RE, Haines M, Drake RE et al. The Hartford study of supported employment for persons with severe mental illness. J Consult Clin Psychol 2004;72:479–490.
54. Latimer E, Lecomte T, Becker D, Drake RE. Generalisablity of the individual placement and support model of supported employment: Results of a Canadian randomised controlled trial. Brit J Psychiat 2006;189:65-73.
55. Corbiere M, Lancto t N, Lecomte T, Latimer E. A pan-Canadian evaluation of supported employment programs dedicated to people with severe mental disorders. Community Ment Health J 2009;46:1-12.
56. Menear M, Reinharz D, Corbière M, Houle N et al. Organizational analysis of Canadian supported employment programs for people with psychiatric disabilities. Soc Sci Med 2011;72(7):1028-1035.
57. Burns T, Catty J, Becker T, Drake RE et al. The effectiveness of supported employment for people with severe mental illness: a randomized controlled trial. Lancet 2007;370:1146–1152.
58. Burns T, Catty J, White S, Becker T et al. The impact of supported employment and working on clinical and social functioning: Results of an international Study of individual placement and support. Schizophr Bull 2009;35(5):949–958.
59. Bond GR, Salyers MP, Dincin J, Drake RE et al. A randomized controlled trial comparing two vocational models for persons with severe mental illness. J Consult Clin Psychol 2007;75:968–982.
60. Wong KK, Chiu R, Tang B, Mak D et al. A randomized controlled trial of a supported employment program for persons with long-term mental illness in Hong Kong. Psychiatr Serv 2008;59:84–90.
61. Killickey E, Jackson HJ, McGorry PD. Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual. Br J Psychiatry 2008;193:114–120.
62. Twamley EW, Narvaez JM, Becker DR, Bartels SJ et al. Supported employment for middle-aged and older people with schizophrenia. Am J Psychiatr Rehabil 2008;11:76–89.
63. Twamley EW, Vella L, Burton CZ, Becker DR et al. The efficacy of supported employment for middle-aged and older peoplewith schizophrenia. Schizophr Res (en prensa).
64. Howard LM, Heslin M, Leese M, McCrone P et al. Supported employment: randomised controlled trial. Br J Psychiatry;196:404-411.
65. Macias C, Kinney R, Rodica C. Transitional employment: An evaluative description of Fountain House practice. J Vocat Rehabil 1995;5:151-158.
66. López M. El empleo y la recuperación de personas con trastornos mentales graves. La experiencia de Andalucía. Norte Salud Mental 2010;36(8):11-23.
67. Secker J, Dass S, Grove B. Developing social firms in the UK: a contribution to identifying good practice. Disabil Soc 2003;18(5):659-674.
68. Campbell K, Bond GR, Drake RE. Who benefits from supported em-

Translation of the original version published in spanish in: Salud Mental 2013, Vol. 36 Issue No. 2

ployment: a meta-analytic study. Schizophr Bull 2011;37(2):370–380.
69. Caldas de Almeida J, Cohen A (eds.). Innovative mental health programs in Latin America and the Caribbean. Washington DC: PAHO; 2008.
70. Pardo V, Del Castillo R, Blanco M, Etchart M. Descripción y evaluación de un programa de rehabilitación laboral para trastornos mentales. Rev Psiquiatr Urug 2005;69(2):111- 126.
71. Hernández J, Peralta J, Ruiz M, Angulo L et al. Rehabilitación laboral de las personas con esquizofrenia. Rev Mex Med Fis Rehab 2010;22(4):108-112.
72. Brownson RC, Gurney JG, Land GH. Evidence-based decision making in public health. J Public Health Manag Pract 1999;5:86–97.

Declaration of conflict interest: None

Translation of the original version published in spanish in:
Salud Mental 2013, Vol. 36 Issue No. 2