

EDITORIAL

Why Can't We Fund Supported Employment?

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Work is one of the most valued social rules in modern society, contributing to a person's sense of economic well-being, self-esteem, personal identity, and social status. Conversely, the inability to work or sustain employment due to a psychiatric condition is the primary factor in determining eligibility for disability benefits, such as Social Security Disability Income or Social Security Supplemental Income. Just as work is valued strongly by society, it is also important to people with serious mental illness. Work is important recovery goal for this group (Iyer, Mangala, Anitha, Thara, & Malla, 2011; Provencher, Gregg, Mead, & Mueser, 2002), and studies consistently report that over 50% of those surveyed are interested in competitive employment (Mueser, Salyers, & Mueser, 2001; Westcott, Waghorn, McLean, Statham, & Mowry, 2015).

Considering the importance of work to society and its members alike, one would expect that any program shown to help people with serious mental illness return to work would be welcomed in the field with open arms and that there would be a rush to make this program available to all who wanted it. Unfortunately, this has not been the case. Although supported employment has proven superior to all other vocational rehabilitation models for people with serious mental illness, it continues to be inaccessible to most people who need it and to lack a reliable funding base. In this editorial, we contemplate why we cannot "do the right thing" and fully fund supported employment for persons with serious mental illness.

Supported Employment

This year marks the 20th anniversary of the publication of the first randomized controlled trial of the individual placement and support (IPS) model of supported employment for people with serious mental illness (Becker & Drake, 2003), which demonstrated superior competitive work outcomes over 18 months compared to a group skills training approach (Drake, McHugo, Becker, Anthony, & Clark, 1996). The importance of this study cannot be

underestimated, as it directly challenged the assumption of all other vocational rehabilitation models of the day: that people with this disability cannot obtain mainstream competitive employment without first completing preparatory skills training or noncompetitive work experiences. Supported employment, as standardized in IPS, takes a different approach by prioritizing rapid job search for competitive work in the community (e.g., within a month of enrollment) and the provision of follow-along supports to facilitate job maintenance or transition to another job. Other distinguishing features of the model include zero exclusion from program enrollment, respect for client preferences about jobs and disclosure of their psychiatric disorder, integration of vocational and mental health services, assistance with job development, and benefits counseling.

Following publication of this landmark study, over 20 randomized controlled trials comparing supported employment to other vocational programs have been published (Marshall et al., 2014; Modini et al., 2016; Mueser, Drake, & Bond, 2016). The overwhelming results of these studies, conducted across multiple countries and treatment settings, have been that supported employment has been found to be more effective in improving competitive work outcomes than any of the alternative vocational models. For example, most of these studies found that 50%–75% of participants in supported employment obtained competitive work over follow-up periods of 18–24 months, compared to under 40% in most of the comparison vocational rehabilitation programs. There is also some evidence that people with serious mental illness who are receiving disability benefits and return to work may reduce their dependence on public disability programs over the long term (Cook, Burke-Miller, & Roessel, 2016).

There are useful resources to facilitate the implementation of the IPS model of supported employment, including a manual (Becker & Drake, 2003), other guides and workbooks (Becker & Bond, 2004; Swanson & Becker, 2011; Swanson, Becker, Drake, & Merrens, 2008; Swanson, Courtney, Meyer, & Reeder, 2014), a growing learning community (Becker, Drake, & Bond, 2014), a validated fidelity scale to evaluate the quality of the program (Bond, Becker, & Drake, 2011), and standard methods for training employment specialists and providing consultation to agencies. The use of these resources has enabled high-quality supported employment programs to be implemented in routine mental health treatment settings (McHugo et al., 2007).

Despite the strong evidence documenting the effectiveness of supported employment and resources to guide its implementation, it continues to be inaccessible to the vast majority of persons with

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serious mental illness who could benefit from it (Bruns et al., 2016; Twamley et al., 2013). A variety of challenges have been reported to implementing supported employment programs both within the United States and abroad, such as weak administrative and policy leadership, lack of organizational standards for supported employment, insufficient access to or utilization of relevant expertise, poor coordination among different provider or state/country agencies, and high turnover of vocational staff (Hasson, Andersson, & Bejerholm, 2011; Morris, Waghorn, Robson, Moore, & Edwards, 2014; van Erp et al., 2007; Waghorn, Dias, Gladman, & Harris, 2015; Williams, Lloyd, Waghorn, & Machingura, 2015). However, by far the most frequently cited barrier to increasing access to supported employment is the problem of funding the program (Drake, Bond, Goldman, Hogan, & Karakus, in press; Hogan, Drake, & Goldman, 2014).

Current Options for Funding Supported Employment

Supported employment has been difficult to fund since the first promising studies of the approach. The primary challenge has been the lack of a single, reliable, broadly available stream of funding that can be utilized to provide supported employment services to persons with serious mental illness (Karakus, Frey, Goldman, Fields, & Drake, 2011). This is due in large part to the model's integration of clinical and rehabilitation services that are reimbursed by different funding authorities. The result is that funds must be pooled from myriad sources, including state general revenue, state vocational rehabilitation, Medicaid, federal Mental Health Block Grant, and Social Security Administration work incentive programs. Success in securing funding to implement and sustain supported employment in routine treatment settings has required a high level of leadership and collaboration, cooperation between various state or federal governmental agencies, creativity, and expertise with the complexities of mechanisms for funding treatment and rehabilitation services.

The cost of implementing most evidence-based practices for persons with psychiatric disability (e.g., cognitive-behavioral therapy, illness management and recovery, family psychoeducation, integrated treatment for co-occurring substance use disorders, assertive community treatment) is covered by Medicaid. However, supported employment has not been routinely covered by Medicaid, except for services deemed to be medically necessary for helping an individual obtain and keep competitive work. A variety of options exist within Medicaid that allow states to modify their Medicaid state plan or to obtain Medicaid waivers that would allow the funding of some or all supported employment services, with additional options created through the Affordable Care Act (Mechanic, 2012; Siegwarth & Blyler, 2014). However, these options are complex and have not been widely utilized by states, leading Karakus et al. (2011) to conclude that states are unlikely to change their Medicaid platform solely for the purposes of funding supported employment.

There are many other potential sources of funding for supported employment, but in most cases, no single one can be tapped that will pay for the full range of services incorporated within the supported employment model (Karakus et al., 2011). For example, State Offices of Vocational Rehabilitation sometimes fund the early stages of supported employment for a limited period of time, paying for assessment, job search, and job supports, but typically

do not cover job supports over the longer term. Other funding sources were mentioned earlier.

As a result of the patchwork of funding options for supported employment, successful implementation has relied on braided funding streams from multiple sources (Hogan et al., 2014; Karakus, Frey, Goldman, Fields, & Drake, 2011). The term *blended funding* is used to describe mechanisms that pool dollars from multiple sources and make them in some ways indistinguishable. *Braided funding* utilizes similar mechanisms, but the funding streams remain visible and are used in common to produce greater strength, efficiency, and/or effectiveness (Karakus et al., 2011). Furthermore, significant efforts toward increasing access to supported employment have been supported through grants and private foundation funding, such as the long-standing collaboration between Dartmouth College and the Johnson & Johnson Foundation (Becker et al., 2014; Drake, Becker, Goldman, & Martinez, 2006). However, the high level of motivation, expertise, and collaboration at the state level required to develop a dependable funding stream for supported employment has thwarted uptake of the program, with no favored solution currently in the offing.

What Are the Barriers to a Coordinated Approach to Funding Supported Employment?

From a systemic perspective, the most important barriers are policies of state or federal agencies that provide the bulk of funding for clinical and return-to-work services for people with psychiatric disorders. With respect to state vocational rehabilitation (VR), the primary obstacles are restricted access to VR funding for people with psychiatric disabilities and VR's short-term service delivery mandate that emphasizes case closure soon after employment and is not compatible with the need for ongoing support (Karakus et al., 2011).

We believe that a stronger argument can be made for expanding access to supported employment through Medicaid funding, since Medicaid it is the primary payor for services to people with serious mental illness. Medicaid payments are primarily limited to services deemed "medically necessary" to help individuals work or otherwise improve their functioning. The medical necessity criterion is based on the traditional distinction between treatment and rehabilitation. Treatment is conceptualized as focusing on the specific symptoms or impairments of a condition, whereas rehabilitation focuses on improving functioning in areas such as work or self-care, which are assumed to be the result of the symptoms and impairments that characterize the condition. However, the validity and utility of the distinction between treatment and rehabilitation for persons with serious psychiatric disorders are dubious and problematic, for several reasons.

First, some psychiatric disorders are defined partly in terms of impairments in psychosocial functioning. This is the case for schizophrenia, where the *DSM-5* B criteria require that for a significant portion of the time since the onset of the disturbance, the individual has experienced a reduction in his or her work or school functioning, social relationships, or self-care (American Psychiatric Association, 2013). Impairment and psychosocial functioning has long been considered a hallmark feature of schizophrenia, which is reflected in the *DSM* criteria by inclusion of impaired functioning as a symptom-level requirement for the diagnosis of the disorder. The inclusion of impaired psychosocial

functioning in the diagnostic criteria for schizophrenia is a reflection of the fact that the symptoms and impairments of the disorder appear insufficient in their own right to fully account for the poor functioning commonly observed in persons with the disorder. Thus, from the perspective of how schizophrenia is defined, it does not make sense to distinguish between interventions that seek to improve work functioning and those that focus on the symptoms of the disorder: Both could rightly be considered “treatment” of the disorder.

Second, the dominant model for understanding factors that influence the symptomatic and functional course of serious mental illnesses, the stress vulnerability model, explicates the interactions between psychobiological vulnerability, the environment (e.g., social support, meaningful structure), and personal resources (e.g., coping skills, social skills; Nuechterlein & Dawson, 1984; Zubin & Spring, 1977). This means that changes in the supports available to people that reduce their exposure to stress or facilitate their learning of coping, social, or other skills can have a direct effect on the severity of their symptoms and the likelihood of symptom relapses. For example, engaging a person with psychotic symptoms in some type of structured activity (e.g., work, recreational activity) reduces the severity of those symptoms (Corrigan, Liberman, & Wong, 1993; Rosen, Sussman, Mueser, Lyons, & Davis, 1981; Wong et al., 1987). The dynamic interplay between the environment, the person, and the course of symptoms and relapses raises further questions about the validity of distinguishing between treatment and rehabilitation; symptoms and functioning are intertwined, each affecting the other.

Third, pragmatically speaking, separating treatment from rehabilitation can be problematic in terms of optimizing overall outcomes. For many people with serious mental illness, the primary motivation for them to improve their symptoms and prevent relapses is the possibility that doing so will help them attain personally meaningful goals, such as returning to work, having rewarding relationships, or living independently. The importance of therapeutically engaging people around their goals, and then enhancing skills and motivation for managing their disorders more effectively by exploring how such changes could help them achieve those goals, is widely recognized. This approach is fully integrated into treatment models such as the illness management and recovery program (McGuire et al., 2014) and integrated treatment for co-occurring disorders (Mueser, Noordsy, Drake, & Fox, 2003). Work is one of the most important goals espoused by people with serious mental illness, and the provision of supported employment can serve as a critical impetus for learning how to cope with their disorder more effectively. Supported employment, as defined in the IPS model, involves the integration of vocational and clinical services, preferably at the team level. The inability to fund supported employment integrated with clinical services represents a lost opportunity to engage people in pursuing a highly valued goal and to use that engagement to enhance their illness self-management.

The Benefits of Integrated Vocational and Mental Health Services

Given that effective vocational rehabilitation is treatment and that the treatment-rehabilitation distinction is misleading argues for the importance of interventions that reduce symptoms, prevent

relapse, and improve functioning in areas such as work or school. If the integration of vocational with clinical services is critical, as specified in the IPS model, we would be wise to heed the lessons learned from past, largely unsuccessful attempts to integrate mental health and substance abuse treatments through the collaboration of different organizations or agencies with different missions and past traditions (Ridgely, Goldman, & Willenbring, 1990). Now, the most widely accepted models for integrated treatment of serious psychiatric and substance use disorders disavow collaboration between mental health and substance abuse treatment agencies as a goal and instead focus on the treatment of both disorders at the same time, by the same team of providers, working for the same agency (Fox et al., 2010; Mueser et al., 2003).

As reviewed above, there are both theoretical and practical reasons for integrating supported employment and clinical services through a single stream of funding. There is also intriguing evidence suggesting that helping people return to work may confer meaningful clinical benefits in addition to the established improvements in quality of life (Charzyńska, Kucharska, & Mortimer, 2015). Longitudinal studies have shown that competitive employment is associated with modest reductions in clinical symptoms and hospitalizations (Luciano, Bond, & Drake, 2014), as well as the utilization of fewer outpatient psychiatric services (Bush, Drake, Xie, McHugo, & Haslett, 2009).

In addition, although most randomized controlled trials of supported employment have not reported differences in rehospitalization rates, two studies have reported such differences. One large ($N = 312$) multisite European study found that people randomized to supported employment were significantly more likely to work over the next 2 years (55% vs. 28%) and less likely to be rehospitalized (13% vs. 45%) than those receiving usual vocational services (Burns et al., 2009). Similarly, in the longest follow-up of a randomized controlled trial of supported employment conducted to date, participants assigned to supported employment were also more likely to obtain competitive work (65% vs. 33%) and were less likely to be hospitalized (21% vs. 47%) than those who received usual vocational services (Hoffmann, Jäckel, Glauser, Mueser, & Kupper, 2014). Although it is unknown at this point whether supported employment produces significant cost offsets by reducing psychiatric service utilization, especially hospitalizations, the general pattern of findings is consistent with the notion that helping people obtain and keep competitive jobs is clinically beneficial.

What Next?

Many years ago, it was erroneously believed that working competitively was too stressful for the vast majority of people with severe mental illness. The anticipated deleterious effects of work never materialized, as supported employment was shown in study after study to improve competitive work outcomes without causing undue stress or precipitating relapses or rehospitalizations. It is now widely accepted that competitive work is not toxic to this group, and there is a gradual growth in the appreciation of the positive effects of employment, ranging from increased economic well-being and self-esteem to community integration and improved clinical stability.

So, if we have made so much progress, why are we still unable to fund supported employment, unlike so many other empirically

supported psychosocial interventions? We conjecture that the primary problem with funding supported employment stems from resistance to the notion that some treatments for serious mental illness are primarily or entirely based on the provision of environmental supports. In the case of supported employment, these supports involve assistance with job development and interviewing (including direct contacts with prospective employers on behalf of the client), on-site or off-site follow-along supports to help the person learn the job or manage other work-related challenges, and being available to the employer to address issues that may arise. Such a notion challenges the belief that people with serious mental illness are fundamentally different from everyone else and that any hope for reintegration into society must start with changing *them*, not their *environment*. If people with serious mental illness can work side-by-side with others who do not have a mental illness, given a little support, then perhaps they are not so different after all.

The recognition that people with major psychiatric disorders are capable of competitive work and that the provision of modest supports is the critical ingredient to helping many return to work requires a radical rethinking of how society views mental illness. Resistance to work as a legitimate treatment goal, as well as resistance to the provision of environment supports as a primary treatment strategy, is ingrained in a cultural perspective on mental illness that emphasizes the differences (“us” vs. “them”) rather than the similarities between people. To effectively challenge this perspective and to address the challenges of funding supported employment, it is critical to educate mental health and rehabilitation professionals and the general public about these issues. Even more critical is the importance of advocating for competitive work as a treatment target on par with symptom management and self-care skills. Such advocacy is necessary to highlight the glaring omission of supported employment services from standard Medicaid reimbursement and to establish a steady stream of funding for these services that will enable their integration with more traditional clinical services.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Becker, D. R., & Bond, G. R. (Eds.). (2004). *Supported employment implementation resource kit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Becker, D. R., & Drake, R. E. (2003). *A working life for people with severe mental illness*. New York, NY: Oxford University Press. <http://dx.doi.org/10.1093/acprof:oso/9780195131215.001.0001>
- Becker, D. R., Drake, R. E., & Bond, G. R. (2014). The IPS supported employment learning collaborative. *Psychiatric Rehabilitation Journal*, 37, 79–85. <http://dx.doi.org/10.1037/prj0000044>
- Bond, G. R., Becker, D. R., & Drake, R. E. (2011). Measurement of fidelity of implementation of evidence-based practices: Case example of the IPS Fidelity Scale. *Clinical Psychology: Science and Practice*, 18, 126–141. <http://dx.doi.org/10.1111/j.1468-2850.2011.01244.x>
- Bruns, E. J., Kerns, S. E., Pullmann, M. D., Hensley, S. W., Lutterman, T., & Hoagwood, K. E. (2016). Research, data, and evidence-based treatment use in state behavioral health systems, 2001–2012. *Psychiatric Services*, 67, 496–503. <http://dx.doi.org/10.1176/appi.ps.201500014>
- Burns, T., Catty, J., White, S., Becker, T., Koletsi, M., Fioritti, A., . . . the EQOLISE Group. (2009). The impact of supported employment and working on clinical and social functioning: Results of an international study of individual placement and support. *Schizophrenia Bulletin*, 35, 949–958. <http://dx.doi.org/10.1093/schbul/sbn024>
- Bush, P. W., Drake, R. E., Xie, H., McHugo, G. J., & Haslett, W. R. (2009). The long-term impact of employment on mental health service use and costs for persons with severe mental illness. *Psychiatric Services*, 60, 1024–1031. <http://dx.doi.org/10.1176/ps.2009.60.8.1024>
- Charzyńska, K., Kucharska, K., & Mortimer, A. (2015). Does employment promote the process of recovery from schizophrenia? A review of the existing evidence. *International Journal of Occupational Medicine and Environmental Health*, 28, 407–418. <http://dx.doi.org/10.13075/ijomh.1896.00341>
- Cook, J. A., Burke-Miller, J. K., & Roessel, E. (2016). Long-term effects of evidence-based supported employment on earnings and on SSI and SSDI participation among individuals with psychiatric disabilities. *The American Journal of Psychiatry*. Advance online publication. <http://dx.doi.org/10.1176/appi.ajp.2016.15101359>
- Corrigan, P. W., Liberman, R. P., & Wong, S. E. (1993). Recreational therapy and behavior management on inpatient units. Is recreational therapy therapeutic? *Journal of Nervous and Mental Disease*, 181, 644–646. <http://dx.doi.org/10.1097/00005053-199310000-00012>
- Drake, R. E., Becker, D. R., Goldman, H. H., & Martinez, R. A. (2006). Best practices: The Johnson & Johnson—Dartmouth community mental health program: Disseminating evidence-based practice. *Psychiatric Services*, 57, 302–304. <http://dx.doi.org/10.1176/appi.ps.57.3.302>
- Drake, R. E., Bond, G. R., Goldman, H. H., Hogan, M. F., & Karakus, M. (in press). Individual placement and support services boost employment for people with serious mental illness, but funding is lacking. *Health Affairs*.
- Drake, R. E., McHugo, G. J., Becker, D. R., Anthony, W. A., & Clark, R. E. (1996). The New Hampshire study of supported employment for people with severe mental illness. *Journal of Consulting and Clinical Psychology*, 64, 391–399. <http://dx.doi.org/10.1037/0022-006X.64.2.391>
- Fox, M. B., Drake, R. E., Mueser, K. T., Brunette, M. F., Becker, D. R., McGovern, M. P., & Acquilano, S. C. (2010). *Integrated dual disorders treatment manual: Best practices, skills, and resources for successful client care*. Center City, MN: Hazelden.
- Hasson, H., Andersson, M., & Bejerholm, U. (2011). Barriers in implementation of evidence-based practice: Supported employment in Swedish context. *Journal of Health Organization and Management*, 25, 332–345. <http://dx.doi.org/10.1108/14777261111143563>
- Hoffmann, H., Jäckel, D., Glauser, S., Mueser, K. T., & Kupper, Z. (2014). Long-term effectiveness of supported employment: 5-year follow-up of a randomized controlled trial. *The American Journal of Psychiatry*, 171, 1183–1190. <http://dx.doi.org/10.1176/appi.ajp.2014.13070857>
- Hogan, M. F., Drake, R. E., & Goldman, H. H. (2014). A national campaign to finance supported employment. *Psychiatric Rehabilitation Journal*, 37, 73–75. <http://dx.doi.org/10.1037/prj0000042>
- Iyer, S. N., Mangala, R., Anitha, J., Thara, R., & Malla, A. K. (2011). An examination of patient-identified goals for treatment in a first-episode programme in Chennai, India. *Early Intervention in Psychiatry*, 5, 360–365. <http://dx.doi.org/10.1111/j.1751-7893.2011.00289.x>
- Karakus, M., Frey, W., Goldman, H. H., Fields, S., & Drake, R. E. (2011). *Federal financing of supported employment and customized employment for people with mental illness: Final report*. Retrieved from <http://aspe.hhs.gov/daltcp/reports/2011/supempFR.pdf>
- Luciano, A., Bond, G. R., & Drake, R. E. (2014). Does employment alter the course and outcome of schizophrenia and other severe mental illnesses? A systematic review of longitudinal research. *Schizophrenia Research*, 159, 312–321. <http://dx.doi.org/10.1016/j.schres.2014.09.010>
- Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., . . . Delphin-Rittmon, M. E. (2014). Supported employment: Assessing the evidence. *Psychiatric Services*, 65, 16–23. <http://dx.doi.org/10.1176/appi.ps.201300262>

- McGuire, A. B., Kukla, M., Green, A., Gilbride, D., Mueser, K. T., & Salyers, M. P. (2014). Illness management and recovery: A review of the literature. *Psychiatric Services, 65*, 171–179. <http://dx.doi.org/10.1176/appi.ps.201200274>
- McHugo, G. J., Drake, R. E., Whitley, R., Bond, G. R., Campbell, K., Rapp, C. A., . . . Finnerty, M. T. (2007). Fidelity outcomes in the National Implementing Evidence-Based Practices Project. *Psychiatric Services, 58*, 1279–1284. <http://dx.doi.org/10.1176/ps.2007.58.10.1279>
- Mechanic, D. (2012). Analysis & commentary: Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. *Health Affairs, 31*, 2376–2382. <http://dx.doi.org/10.1377/hlthaff.2011.0623>
- Modini, M., Tan, L., Brinchmann, B., Wang, M.-J., Killackey, E., Glozier, N., . . . Harvey, S. B. (2016). Supported employment for people with severe mental illness: Systematic review and meta-analysis of the international evidence. *The British Journal of Psychiatry*. Advance online publication. <http://dx.doi.org/10.1192/bjp.bp.115.165092>
- Morris, A., Waghorn, G., Robson, E., Moore, L., & Edwards, E. (2014). Implementation of evidence-based supported employment in regional Australia. *Psychiatric Rehabilitation Journal, 37*, 144–147. <http://dx.doi.org/10.1037/prj0000051>
- Mueser, K. T., Drake, R. E., & Bond, G. R. (2016). Recent advances in supported employment for people with serious mental illness. *Current Opinion in Psychiatry, 29*, 196–201. <http://dx.doi.org/10.1097/YCO.0000000000000247>
- Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, M. L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York, NY: Guilford.
- Mueser, K. T., Salyers, M. P., & Mueser, P. R. (2001). A prospective analysis of work in schizophrenia. *Schizophrenia Bulletin, 27*, 281–296. <http://dx.doi.org/10.1093/oxfordjournals.schbul.a006874>
- Nuechterlein, K. H., & Dawson, M. E. (1984). A heuristic vulnerability/stress model of schizophrenic episodes. *Schizophrenia Bulletin, 10*, 300–312. <http://dx.doi.org/10.1093/schbul/10.2.300>
- Provencher, H. L., Gregg, R., Mead, S., & Mueser, K. T. (2002). The role of work in the recovery of persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26*, 132–144. <http://dx.doi.org/10.2975/26.2002.132.144>
- Ridgely, M. S., Goldman, H. H., & Willenbring, M. (1990). Barriers to the care of persons with dual diagnoses: Organizational and financing issues. *Schizophrenia Bulletin, 16*, 123–132. <http://dx.doi.org/10.1093/schbul/16.1.123>
- Rosen, A. J., Sussman, S., Mueser, K. T., Lyons, J. S., & Davis, J. M. (1981). Behavioral assessment of psychiatric inpatients and normal controls across different environmental contexts. *Journal of Behavioral Assessment, 3*, 25–36. <http://dx.doi.org/10.1007/BF01321349>
- Siegwarth, A. W., & Blyler, C. (2014). *How the Affordable Care Act can support employment for people with mental illness*. Washington, DC: U.S. Department of Health and Human Services.
- Karakus, M., Frey, W., Goldman, H., Fields, S., & Drake, R. (2011). Federal financing of supported employment and customized employment for people with mental illnesses: Final report. Retrieved from <http://www.dol.gov/odep/pdf/FFSECEPML.pdf>
- Swanson, S. J., & Becker, D. R. (2011). *Supported employment: Applying the individual placement and support (IPS) model to help clients compete in the workforce* (Updated and expanded ed.). Center City, MN: Hazelden.
- Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). *Supported employment: A practical guide for practitioners and supervisors*. Kearny, NE: Morris Publishing.
- Swanson, S. J., Courtney, C. T., Meyer, R. H., & Reeder, S. A. (2014). Strategies for integrated employment and mental health services. *Psychiatric Rehabilitation Journal, 37*, 86–89. <http://dx.doi.org/10.1037/prj0000049>
- Twamley, E. W., Baker, D. G., Norman, S. B., Pittman, J. O., Lohr, J. B., & Resnick, S. G. (2013). Veterans Health Administration vocational services for Operation Iraqi Freedom/Operation Enduring Freedom Veterans with mental health conditions. *Journal of Rehabilitation Research and Development, 50*, 663–670. <http://dx.doi.org/10.1682/JRRD.2012.08.0137>
- van Erp, N. H., Giesen, F. B., van Weeghel, J., Kroon, H., Michon, H. W., Becker, D., . . . Drake, R. E. (2007). A multisite study of implementing supported employment in the Netherlands. *Psychiatric Services, 58*, 1421–1426. <http://dx.doi.org/10.1176/ps.2007.58.11.1421>
- Waghorn, G. R., Dias, S., Gladman, B., & Harris, M. (2015). Measuring what matters: Effectiveness of implementing evidence-based supported employment for adults with severe mental illness. *International Journal of Therapy and Rehabilitation, 22*, 411–420. <http://dx.doi.org/10.12968/ijtr.2015.22.9.411>
- Westcott, C., Waghorn, G., McLean, D., Statham, D., & Mowry, B. (2015). Interest in employment among people with schizophrenia. *American Journal of Psychiatric Rehabilitation, 18*, 187–207. <http://dx.doi.org/10.1080/15487768.2014.954162>
- Williams, P. L., Lloyd, C., Waghorn, G., & Machingura, T. (2015). Implementing evidence-based practices in supported employment on the Gold Coast for people with severe mental illness. *Australian Occupational Therapy Journal, 62*, 316–325. <http://dx.doi.org/10.1111/1440-1630.12202>
- Wong, S. E., Terranova, M. D., Bowen, L., Zarate, R., Massel, H. K., & Liberman, R. P. (1987). Providing independent recreational activities to reduce stereotypic vocalizations in chronic schizophrenics. *Journal of Applied Behavior Analysis, 20*, 77–81. <http://dx.doi.org/10.1901/jaba.1987.20-77>
- Zubin, J., & Spring, B. (1977). Vulnerability—A new view of schizophrenia. *Journal of Abnormal Psychology, 86*, 103–126. <http://dx.doi.org/10.1037/0021-843X.86.2.103>