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Individual Placement and Support: A Community Mental Health Center Approach to Vocational Rehabilitation

Deborah R. Becker, M.Ed.
Robert E. Drake, M.D., Ph.D.

ABSTRACT: Individual Placement and Support (IPS) is a vocational rehabilitation intervention for people with severe mental disabilities. IPS draws from components and philosophies of several other models. Employment specialists, who are part of the community mental health center team, provide services in the community. IPS emphasizes client preferences, rapid job finding, continuous assessment, competitive employment, integrated work settings, and follow-along supports. Initial research on IPS shows favorable results.

Competitive work is increasingly a goal for persons with severe mental disabilities. Like others in American society, people with psychiatric impairments want to lead normal lives and view work as one of the principal signifiers of normal adult life. In a statewide survey of

From the New Hampshire-Dartmouth Psychiatric Research Center. Deborah Becker is Research Associate, Department of Community and Family Medicine, Dartmouth Medical School. Robert Drake is Professor of Psychiatry.

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Address reprint requests to Ms. Deborah Becker, New Hampshire-Dartmouth Psychiatric Research Center, 105 Pleasant Street, Concord, NH 03301.

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people with severe and persistent mental illness, 71% of those without jobs expressed an interest in paid employment (Rogers, Walsh, Masotta & Danley, 1991). At any one time, however, less than 15% of those with severe psychiatric disabilities are employed (Anthony & Blanch, 1987).

Despite their own interests, people with severe mental disabilities have received little assistance in gaining competitive employment. Only 3% of those in a national survey had been in supported employment programs (Tashjian, Hayward, Stoddard & Kraus, 1989). Moreover, between 1977 and 1984, competitive employment for Vocational Rehabilitation (VR) clients with severe psychiatric disabilities did not improve (Andrews, Barker, Pittman, Mars, Struening & LaRocca, 1992).

Until recently, community mental health centers (CMHCs) did not emphasize vocational services (Black & Kase, 1986), in part because mental health professionals saw their role as protecting clients from stressful situations, including employment. Independent psychosocial rehabilitation programs and nontraditional rehabilitation agencies have historically provided what little vocational services were available (Katz, 1991).

As CMHCs begin to emphasize vocational services, several existing models are being considered. Current vocational approaches include sheltered work, psychosocial rehabilitation (e.g., clubhouses with transitional employment), skills training, assertive community treatment, supported employment, and job clubs (Bond & Boyer, 1988). Instead of transplanting a vocational model exactly as it has been implemented elsewhere, however, several experts recommend adapting a model, or parts of several models, to fit the needs of a particular agency, clientele, and community (Bachrach, 1988; Stein & Test, 1985; Witheridge & Dincin, 1985). New models should be described with unambiguous terms, standard definitions, and clear outcome criteria (Bond and Boyer, 1988; Bond and McDonel, 1991).

The purpose of this report is to describe a vocational rehabilitation model, Individual Placement and Support (IPS), that has recently evolved in several New Hampshire CMHCs. IPS is a team-oriented, CMHC vocational service that assists persons with severe mental disabilities in obtaining and maintaining competitive employment. IPS emphasizes client choice, rapid job finding, competitive jobs, integrated work settings, and follow-along support services. Excluding clients from employment services, extensive initial assessments, and prevocational training are de-emphasized. Two current studies of IPS in New Hampshire are revealing positive vocational outcomes (Drake,

Becker, Biesanz, Torrey, McHugo, & Wyzik, submitted for publication; Drake, Becker, Fox, & Lounsberry, 1992).

PRINCIPLES

IPS was developed by considering the philosophies, values, and critical components of several approaches to vocational rehabilitation in relation to the particular characteristics of the New Hampshire public mental health system. It draws most heavily from the Program of Assertive Community Treatment (PACT) in Madison, Wisconsin (Russert and Frey, 1991; Test, 1992). Other influences include the supported employment movement (Federal Register August 14, 1987; Wehman, 1986), Boston University's Center for Psychiatric Rehabilitation (Anthony, Cohen, & Farkas, 1990), and several thoughtful reviews of the empirical literature by Bond (Bond & Boyer, 1988; Bond & McDonel, 1991). IPS incorporates the following principles.

1. *Rehabilitation is an integral component of mental health treatment.* IPS assumes that nearly all people with severe mental disabilities can engage in some type of work and that work is good treatment. Furthermore, because symptoms and disabilities are intertwined, rehabilitation and other treatments require careful coordination. That is, work and therapy are dynamically interactive; each influences the other. While some vocational models attempt to separate rehabilitation from other treatments, IPS integrates them closely.

Rehabilitation is therapeutic in several ways. Work can lead to changes in motivation, self-confidence, structured activities, and relationships. In addition, work often impacts directly on the client's psychiatric disorder. Though work can increase stress and the need for medications, it often motivates clients to manage their own symptoms and may reduce the need for medications. In a reciprocal fashion, other treatments influence rehabilitation. For example, addressing medication noncompliance and interpersonal difficulties, which are often impediments to long-term employment, can improve the effectiveness of rehabilitation.

2. *The goal of IPS is competitive employment in integrated work settings.* Clients in a statewide survey (Rogers et al., 1991) and in our focus groups in New Hampshire indicated a preference for competitive jobs in integrated work settings (i.e., settings that contain non-disabled workers) rather than sheltered or volunteer work. Although research has not shown that integrated work settings are always more beneficial

than sheltered settings, integrated settings are more normalizing and more likely to involve clients in community life. Clients report that they feel stigmatized in enclaves of other disabled workers. IPS follows a place-train strategy (Wehman, 1986) in which clients enter competitive jobs and receive needed training and support on the job. Some clients will inevitably need to transition through volunteer jobs or other prevocational activities. Nevertheless, since expectations tend to provide a self-fulfilling prophecy, and low expectations (e.g., sheltered employment) may result in clients failing to fulfill their wishes and potentials, IPS focuses consistently on competitive work as the ultimate goal.

3. *People with severe mental disabilities can obtain jobs rapidly.* IPS emphasizes entering work as soon as possible rather than preparing for work. Newman (1970) described several advantages of rapidly obtaining employment in terms of assessing employability, reinforcing capabilities, and experiencing the worker role. Bond and Dincin (1986) found that clients were more likely to engage in competitive employment if they participated in an accelerated placement program rather than a prevocational program. Their clients expressed dissatisfaction with prevocational assessments and training, and preferred rapid placements in real jobs in the community. Focus groups in several New Hampshire CMHCs confirmed that clients prefer to seek jobs without lengthy prevocational training and assessment.

4. *Vocational assessment is continuous.* IPS incorporates assessment as an ongoing process that continues after acquiring a job (Wehman, 1986). Each work experience provides more data about the client as a worker and helps in planning for the next job. Job endings are, therefore, always framed in positive terms. This approach contrasts with traditional programs in which clients' vocational abilities are assessed through extensive tests and evaluations conducted prior to acquiring employment.

5. *Follow-along supports are often necessary to sustain employment.* Job retention is more difficult than job finding for many people with severe mental disabilities. Follow-along support includes any services that assist clients in keeping their jobs—e.g., transportation, advocacy and education with the employer, and counseling about work relationships. The levels and sources of support vary depending on the individuals' needs.

6. *Services are based on clients' preferences and choices.* Services are client-centered in both planning and delivery. IPS encourages clients to select competitive employment as a goal and to participate fully in the process. The New Hampshire mental health system has been based on a collaborative philosophy for many years. Treatment planning occurs in regular client-centered conferences. This philosophy has been applied to vocational rehabilitation at the Boston University's Center for Psy-

chiatric Rehabilitation by conceptualizing the process from the client's perspective—i.e., choosing, getting, and keeping a job (Anthony, Howell & Danley, 1984). Those clients who are unable to express their views, make choices, and initiate activities independently can also fit easily into IPS because it is implemented in a highly individualized manner. Depending on levels of disability and verbal, cognitive, and interpersonal skills, clients need varying degrees of staff guidance and support in finding, acquiring, and maintaining a job.

7. *Services are usually provided in the community.* Client contact and training is *in vivo,* in the client's natural environment. This approach has several advantages: Since skills learned in the CMHC do not generalize easily to other settings, clients learn skills in the community settings where they will be used. Clients feel empowered when meeting CMHC staff in a setting more neutral than the clinic, which may be perceived as stigmatizing. By observing people in their natural environment, the employment specialist can assess clients' needs, behaviors, and support networks more directly. Assertive outreach in the community is often essential. Clients sometimes disengage when they are fearful, discouraged, or pressured by network members not to work. Employment specialists can reach out at these critical times to provide necessary support and encouragement.

8. *A team approach promotes integrated services.* A team approach with regular communication between the employment specialist and other treatment team members permits the careful integration of mental health and rehabilitative services. Symptoms, illness management, interpersonal behaviors, and activities and relationships on the job are interrelated. The employment specialist, for example, conveys pertinent job-related information such as job starts, terminations, and work problems. The employment specialist may also identify symptoms that occur at work. The case manager, the nurse, and the psychiatrist in turn inform the employment specialist of changes in the client's medicines, living arrangements, and important relationships. They describe both chronic interpersonal difficulties that are likely to arise on the job and prodromal symptoms. The team collaborates with the client as these interactions inevitably shift with changes in vocational status.

PROGRAM DESCRIPTION

A staff of employment specialists, integrated with the CMHC treatment teams, implement the IPS program and provide liaison with other agencies. The program will be described in several phases including

referral, engagement, assessment, acquiring employment, and job support.

Organization

A vocational coordinator and two or more employment specialists comprise the IPS staff who work closely with one or more treatment teams within the CMHC. The coordinator supervises the employment specialists, manages referrals, and acts as administrative liaison to other departments and programs. Employment specialists carry caseloads of 20–25 clients, varying with the level of client needs, and usually work in pairs to provide coverage and support for each other.

The coordinator typically has a master's degree in rehabilitation, while employment specialists come from a variety of backgrounds. The most successful employment specialists are assertive, high-energy, task-oriented, and optimistic. They firmly believe that most people can work if the right situation is found. They also believe in doing the job outside of the clinic, in the community. Other qualifications include: knowledge of severe mental illness, including diagnoses, medication management, and treatment; knowledge of a broad range of occupations and jobs; ability to interact with employers; assessment and counseling skills; and ability to work as a team member with staff from other disciplines.

While the core of IPS is integrating vocational services with other CMHC services, employment specialists also link clients with outside agencies, such as private vendors, the Department of Employment Security, and the Division of Vocational Rehabilitation (VR), as needed. For example, VR can provide additional assessments, training, job-related equipment and supplies, placement, and support. VR may also purchase IPS services. CMHC and VR offices typically develop official agreements, but the personal relationship between VR counselor and IPS employment specialist is critical.

Referral

Clients can be self-referred or referred by family or CMHC staff. Those who are 18 years and older and have a major mental illness that qualifies them for services in the CMHC's community support program are eligible. The only additional requirement is expressing interest in competitive employment. IPS assumes that clients can make appropriate choices about their own rehabilitation program. After attending an

educational group, clients make an informed choice about whether to participate (Drake, Becker & Anthony, submitted for publication). Consistent with our philosophy of attending to clients' preferences, clients are rarely screened out by staff. Our research indicates that a high proportion of those who select IPS are able to obtain competitive jobs.

Engagement

Upon starting the IPS program, clients are linked with an employment specialist with whom they meet individually. Establishing a trusting, working relationship with the client is the *sine qua non* of vocational rehabilitation. Some clients prefer not to meet at the CMHC because of the stigma about mental illness. Getting to know clients in the community, in their world, allows the employment specialist to observe relationships, daily routine, home environment, interests, and habits—all of which are useful for job exploration and assessment.

Readiness for work of course varies. Some clients want to go to work quickly; others express an initial desire to find a job, but then back off from any activities related to a job search. The employment specialist meets regularly with clients, even if they do not always talk specifically about work. If a client drops out at any point, the employment specialist reaches out in an assertive manner to attempt to renew the process.

Vocational Assessment

The initial vocational assessment includes the client, the CMHC staff, the case record, family members, and previous employers. Key data include work background (education and work history), current adjustment (physical health, endurance, grooming, interpersonal skills, medication management, symptomatology), work skills (job-seeking skills, job skills, aptitude, interests, motivation, work habits relating to attendance, dependability, stress tolerance), and other work-related factors (transportation, family support, substance use, expectations regarding personal, financial and social benefits of working). The goal is to specify a first job. Afterward, assessment occurs continuously as the client and employment specialist learn what kinds of jobs and supports are likely to be successful and satisfying.

Job choices should be congruent with the client's abilities, preferences, and style. The IPS employment specialist tries to help the client find a job that is tailored to his or her needs rather than to change the client to fit a specific job. For example, if a client has a long history of

poor hygiene and grooming, they find a job that accommodates this appearance. The nature of the psychiatric disorder often determines the optimal type of job, the work environment, and needed job supports. The client who has paranoid, referential thoughts around other people will probably feel more comfortable preparing food alone in the kitchen rather than serving in a fast-food restaurant. Someone who continually feels restless will probably prefer a delivery position rather than a desk job. A client who shouts at hallucinatory experiences will probably do better in a noisy outdoor work setting than in a quiet office.

The goal of IPS is competitive employment in integrated settings with follow-along supports, yet some clients feel so overwhelmed that they will only consider volunteer or sheltered jobs as a first step. Clients can gain confidence and good work habits through volunteer or sheltered jobs (e.g., workshop jobs or CMHC-based sheltered jobs), but these settings can also reinforce dependency. IPS therefore emphasizes competitive work, even if only for a few hours per week with supports, to gain experience.

Each IPS client has an employment plan that includes vocational goals, timelines for achieving the goals, supports needed for obtaining the goals, and people responsible for implementation. The vocational plan, modified as needed by new information, is incorporated into the client's individual CMHC treatment plan.

Obtaining Employment

When job preferences have been identified, the employment specialist and client work together to find a job in the community. In the job-seeking process, the client takes the lead as much as possible. When clients do not want the employer to know about their mental illness or their involvement with the CMHC, the employment specialist assists indirectly in the job search, for example, by coaching the client for job interviews. If psychiatric symptoms interfere with developing the skills to negotiate a job with an employer, the employment specialist often helps to secure the job. Even when a client obtains work independently, the employment specialist, with permission, often contacts the employer in order to anticipate potential problems. The employment specialist provides education, guidance, and support to the employer as needed.

Employment specialists help with the job search in varying ways. Their approaches are creative, flexible, and imaginative. They may review newspaper want ads, but nontraditional approaches seem to be

more successful. Some go unannounced to a business to learn about its operation, needs, current job openings, and possibilities for future opportunities. They also find openings in new businesses that are hiring personnel, in businesses that are expanding, and from employers at the Chamber of Commerce. A major source of leads is through personal contacts. Employment specialists talk to as many people as possible—e.g., their own family and friends, other staff, and family members of clients—about the types of jobs they are seeking. Members of the Alliance for the Mentally Ill are often helpful. Through all employer contacts, employment specialists build a network of employers to whom they can refer clients as job candidates.

Sometimes a job must be created. For example, an employment specialist whose client enjoyed landscaping noticed the unattractive grounds around a local business and asked to speak to the manager. She told him about her client and arranged a trial work period. The client was hired on a time-limited basis, and soon afterward the job became a permanent part-time position.

When negotiating a job, the employment specialist provides the employer with several benefits, including knowledge of the client, ongoing supports, crisis intervention, and information about employment practices, such as the Americans with Disabilities Act and the Targeted Jobs Tax Credit. Our experience indicates that employers are interested in all of these.

Job Support

When the client is working, the employment specialist provides follow-along support to the client and the employer. They discuss problems as they occur. The client may need frequent contacts initially, even daily meetings to go over what happened at the job. Although on-site job coaching is available, most people with severe mental illness need minimal assistance in this area. They benefit instead from off-site guidance and support to address difficulties such as interpersonal problems.

The employment specialist tries to intervene before a problem appears. For example, with the help of his employment specialist, a client acquired a job at a gas station working 20 hours per week. After two weeks, the manager offered to increase his weekly work hours to 40. The client expressed interest in working full-time, but the employment specialist knew that in previous jobs the client had become overwhelmed and had lost jobs when he increased his work hours. The employment specialist discussed with the client the previous work

pattern and suggested that it might be best to continue with part-time employment and slowly increase to full-time work. The client asked the employment specialist to talk with the employer about the work hours, and the employer subsequently adjusted the work hours to a part-time schedule that proved to be manageable for the client.

After a client has been working, the need for the employment specialist's involvement often decreases and becomes sporadic. Clients typically do well but have periods of difficulty as symptoms of the illness or interpersonal problems arise. At these points, the employment specialist may help the client to negotiate a reduction in work hours or a leave of absence, or just increase supports. With appropriate supports, work can be a stabilizing factor during difficult times.

Along with the employment specialist, other treatment team members provide services that help the client to maintain employment. The psychiatrist adjusts medication as needed. The case manager provides support to the client on a variety of issues that may affect work performance. One client, for example, struggled with expressing sexual urges inappropriately at work. The client met with his case manager to discuss how to prevent this problem from interfering on the job.

DISCUSSION

One distinctive feature of the New Hampshire mental health system is its emphasis on mental health services research. The New Hampshire-Dartmouth Psychiatric Research Center is an integral part of the Division of Mental Health (DMH) and participates in planning, implementing, and evaluating many programs (Drake & Teague, 1990). Research data are used continuously in the process of modifying programs and shifting resources from ineffective programs to those that achieve better outcomes (Drake, Becker, & Bartels, in press). As the IPS model began to emerge in New Hampshire, DMH sponsored conferences and meetings to clarify the model and moved rapidly to evaluate the model.

Because IPS is part of a research program, a detailed treatment manual (Becker & Drake, 1993; available from the authors) has been developed, clinicians have received specific training and supervision in the model, and services and outcomes are tracked carefully. Two research projects on IPS are currently underway in New Hampshire. In the first, which is sponsored entirely by DMH, one CMHC agreed to close its partial hospitalization program and to convert the staff posi-

tions to IPS employment specialists. Clients in this program were followed longitudinally and compared with those in a similar partial hospitalization program that did not close. One-year outcomes showed that competitive jobs increased significantly (to 39%) in the IPS program and remained the same (12%) in the comparison partial hospitalization program (Drake et al., submitted b).

The second project, which is funded by the Substance Abuse and Mental Health Services Administration, compares IPS with vocational services provided by a private vendor outside of the CMHCs. Clients who are randomly assigned to IPS or to the private vendor model are followed carefully for 18 months. The project includes an ethnographic component to elucidate key process issues and a cost-effectiveness component to clarify the economic aspects of providing vocational services in the two models. This experiment is in progress, but one-year results favor IPS and show a greater than 60% rate of competitive employment (Drake et al., 1992). Thus, a strong empirical base for IPS is rapidly emerging.

Persons with severe mental disabilities, like the rest of us, are undoubtedly acculturated into their roles and self-images as workers or non-workers. Rehabilitation specialists have sometimes argued that mental health settings are stigmatizing and socialize clients into dependence and disability (Anthony et al., 1990). The IPS model explicitly directs employment specialists and clients to focus on competitive jobs in integrated work settings in the community, but places the vocational staff within teams in the CMHC to facilitate clear communication and coordination. Our research indicates that this arrangement influences how case managers and other staff regard vocational goals. Many of the same clinicians who were previously indifferent or even skeptical toward vocational rehabilitation have been positively affected by IPS and, despite their initial resistance, have become advocates for vocational services. Their conversions appear to have influenced the cultures of the mental health centers. On the other hand, we have found that interorganizational communication difficulties and conflicts often arise when vocational services are provided by an outside vendor.

Since IPS was developed specifically for New Hampshire's mental health system, its success may be related to the context. New Hampshire's ten CMHCs are relatively well-supported small programs that emphasize comprehensive services for people with severe mental disabilities. All services are provided or coordinated by case management teams that range from intensive Continuous Treatment Teams to less intensive teams of clinical case managers. IPS staff can easily attend

team meetings and relate to one or more of these teams within a center. The CMHCs are located in small cities or towns with relatively culturally homogeneous populations of between 60,000 and 150,000 people. In other settings, with larger or more culturally diverse populations, less coherent mental health centers, or systems with a different orientation, the IPS model may be more difficult to implement. IPS should be studied in several other settings.

Also of interest are the differences between IPS and PACT: (a) IPS staff join more than one case management team rather than becoming completely integrated with just one team; (b) unlike PACT, IPS employment specialists focus on vocational services and do not share roles with case managers; and (c) IPS offers services to clients who express interest in working rather than to all clients. These differences represent empirical questions that may be worthy of further research.

In a similar vein, current findings regarding IPS address short-term rather than long-term effects. Clients' vocational adjustments over a number of years should be studied in detail to understand their evolution and the factors that determine longitudinal success and its relationship to quality of life, symptoms, community tenure, and other important outcomes. Moreover, long-term vocational adjustment should be considered in terms of career development, not just job acquisition or maintenance.

SUMMARY AND CONCLUSIONS

IPS offers supported employment as an integrated component of the CMHC treatment program. The treatment team collaborates in supporting clients in their vocational pursuits. Clients rapidly obtain competitive jobs that are congruent with their personal preferences and their clinical and rehabilitative needs. Vocational assessment is an ongoing process that incorporates information from each additional job experience. Ongoing supports are arranged to enable the client to keep the job, but job endings are viewed as opportunities for learning rather than as failures. The short-term success of IPS, in terms of obtaining jobs and modifying the culture of CMHCs, appears to be excellent. Because IPS is being developed in association with a mental health services research center, its outcomes and cost-effectiveness, including long-term impact, are being studied carefully.

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