
**Adapting the Individual Placement and Support Employment Program for Vancouver's
Homeless Population**

Christina Panagio, MACD candidate

School of Public Administration

University of Victoria

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- Client:** Michael Anhorn, Executive Director,
Canadian Mental Health Association Vancouver-Fraser Branch (CMHA)
- Supervisor:** Dr. Kimberly Speers, Assistant Teaching Professor
School of Public Administration, University of Victoria
- Second Reader:** Dr. Thea Vakil, Associate Professor and Associate Director
School of Public Administration, University of Victoria
- Chair:** Dr. Lynne Siemens, Associate Professor
School of Public Administration, University of Victoria

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Executive Summary

Introduction

A recovery goal for as many as 70% of people who experience homelessness is to find competitive employment (Drake, Bond & Becker, 2012, p. 3). Yet this goal is not easy to accomplish. Not surprisingly, given the challenges of finding and maintaining employment while homeless, the rate of unemployment among homeless people in Canada is estimated to exceed 80% (Poremski, Distasio, Hwang & Latimer, 2015, p. 380). Finding a place to live and a job is even more challenging for those who experience mental health challenges and numerous services have been developed to assist this population to help them reach their goals.

The Individual Placement and Support (IPS) program has been coined the “gold standard” for vocational interventions with mental health clients, and has consistently shown dramatic increases in employment for people who have serious issues with mental health in 19 randomized controlled trials (Bond, 2013, p. 2). The IPS programs have been developed and implemented internationally, and have been heavily researched to determine the costs and benefits of this type of program compared to other vocational services (Knapp et al., 2013, p. 60; Bond, Drake, & Becker, 2008, p. 280).

The Canadian Mental Health Association – Vancouver Fraser Branch (CMHA) delivers an IPS program for its clients who have serious mental health concerns such as bipolar disorder and schizophrenia across Vancouver and Burnaby. The program has a 51% success rate at helping its clients find and retain employment over a two-year period.

While successful employment results have been achieved for people in the IPS program who have been in contact with mental health services at the CMHA and elsewhere (Bond, 2013, p.5), the CMHA is now seeking promising practices for adapting the program to benefit people who have experienced homelessness. The IPS Dartmouth Supported Employment Centre provides the fidelity scale that the CMHA uses to measure its program’s efficacy. The fidelity to the model has been correlated to the success of IPS programs (Becker, Smith, Tanzman, Drake, & Tremblay, 2001, p. 834; Becker, Xie, McHugo, Halliday & Martinez, 2006, p. 304; Gowdy, Carlson & Rapp, 2004, p. 152; McGrew & Griss, 2005, p. 304), and the CMHA has been able to maintain a high fidelity program based on the Dartmouth criteria. One of the CMHA’s concerns is therefore to reach and maintain the high fidelity of its IPS model while reviewing the possible ways in which an IPS program could utilize and augment mental health teams that already exist for people who have experienced homelessness within many of the supportive housing developments and within the community. These mental health teams include, but may not be limited to, Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams.

The CMHA also has a number of other concerns and questions that it would like to address before it develops its IPS program for people who have experienced homelessness. The research questions for this report were developed so that the CMHA could acquire practical

information from IPS specialists and researchers who have worked closely with people who have experienced homelessness. The primary research question that was explored was:

What are the most effective ways to adapt the CMHA's current IPS program for people who have experienced homelessness?

The secondary and supplementary questions that supported the primary question were:

1. Who are the stakeholders who would be important to contact regarding program enhancement, program adaptation, funding opportunities, communication, and project involvement?
2. What are the benefits and promising practices of an IPS program that is geared towards people who have been homeless?
3. What is the existing literature on IPS programs that have been adapted for this population?
4. How can the CMHA sustain the fidelity of the IPS while adapting the program for this population?
5. Is IPS cost effective in comparison to other vocational programs that address the needs of people who have experienced homelessness?

Methodology and Methods

This project is designed as a gap analysis to investigate some of the ways the CMHA could adapt or use their IPS program for people who have experienced homelessness. The research uses a qualitative methodology with a focus on grounded theory methods, and includes a cost-benefit review and stakeholder analysis to support the findings and recommendations.

Methods include a literature review, a focus group discussion with seven participants who work in the mental health, employment or housing fields, and 12 semi-structured interviews with key informants including IPS researchers and IPS specialists, to obtain their perspectives and recommendations for developing an IPS program for people who have experienced homelessness, and also for adapting the program.

Findings and Analysis

There is significant demand for employment services amongst people who have experienced homelessness or who are homeless, and it is generally accepted that employment provides psychosocial benefits to people who have serious mental health concerns (Poremski, Whitley & Latimer, 2015, p. 1; Schnur, Warland, Young & Zralek, 2013, p. 2-4; Marrone, 2015, p. 16), and yet there are a number of challenges to obtaining employment for people who have experienced homelessness. In addition, while it is also generally agreed in the literature that supported employment (SE) is the most effective approach for securing employment for people who have severe mental illness (Bond, Drake & Becker, 2008; Marshall, Rapp, Becker & Bond, 2008), SE programs are sparsely implemented (Latimer, Bush, Becker, Drake & Bond, 2004, p. 402).

There are also a number of barriers that people who have been homeless generally have to address in order to obtain and retain competitive employment (Poremski, Whitley & Latimer, 2014, p. 181; Poremski, Woodhall-Melnik, Lemieux & Stergiopoulos, 2015, p. 14). Considering these barriers to employment, the IPS model of supported employment is considered to have the best outcomes for people who have serious mental health issues and for people who have experienced chronic homelessness.

The literature review includes five examples of research projects that looked at IPS programs for people who have experienced homelessness. All of these research studies illustrated the need for high fidelity in order to see promising outcomes.

The cost-benefit literature review and analysis mainly looked at the cost of the available programs and the benefit of potentially lower hospital use for people who have mental health concerns. While most U.S. studies showed that the offsets for hospital use are about equal to costs for IPS, some studies did show a reduction in the use of hospital care for people who were employed. The CMHA would benefit from a full cost-benefit analysis of IPS in Canada because it is difficult to generalize the results using the U.S. studies, considering that Canada has a different health care system.

In addition, the review found that the costs associated with finding employment through IPS are only slightly higher to WorkBC on a per client basis for Tier 3 clients, and about half the amount that it costs for WorkBC to assist a person in their Tier 4 classification. At the same time, IPS has a better track record of finding employment for its clients. WorkBC has a 34% success rate for its Tier 3 classification of clients, and a 17% success rate for its Tier 4 classification of clients. The CMHA has a 51% success rate at helping people find employment within the first year.

Corresponding with the literature, the interviewees agreed that maintaining a high fidelity would ensure greater success in measurement outcomes for an IPS program. They also noted some of the restrictions that the barriers of homelessness might generate, and also some of the problems that IPS specialists face in maintaining their autonomy while working in a team that is based on case management, such as an Assertive Community Treatment (ACT) or Intensive Case Management (ICM) team. At the same time, they also provided suggestions for mitigating these issues. The main suggestions included developing a strong culture of IPS within the mental health team, and communicating the program's strengths and efficacy consistently to the clinicians while employing their own 'hardiness'.

Options to Consider and Recommendations

Four options are provided to the CMHA for consideration as the organization continues to develop its employment programming for people who have experienced homelessness. The criteria for developing these options included finding programmatic adjustments or adaptations based on their usefulness to the health authorities and people who have experienced homelessness and who wish to find employment.

Although many of the interviewees of the project worked with ACT or ICM teams, the options below propose approaching and working with alternative mental health teams and employment centres. One reason for this is that many ACT teams in the Vancouver area already have a vocational counsellor as part of their team, and so for now it would benefit clients more if the CMHA found other opportunities to implement IPS. The CMHA, however, could eventually approach the health authorities about working on ICM teams in addition to the options listed below.

One alternative is Vancouver Coastal Health Authority's upcoming system for delivering low-barrier primary care services for people who have issues with mental health and substance use (Ministry of Health, 2012, p. 11). CMHA's IPS specialists have been consulted in the preliminary phases in the program's development, which is set to begin in late 2016, in regards to the types of employment services that would benefit ICT clients. At the moment, VCH is planning to place 2 or 3 Integrated Care Teams in Vancouver's Downtown Eastside.

Option 1: Partner with Vancouver Coastal Health's Integrated Care Teams (ICT)

Many people who have experienced homelessness and who have issues with mental health are not eligible, or may not be able to access, the intensive case management and mental health support of an ACT or ICM team. Therefore, it would benefit clients of Vancouver Coastal Health's new Integrated Care Teams to be able to access an IPS program. Concerns around meeting fidelity and ensuring that the integrated health team connect the client with IPS support would be mitigated by:

- Incorporating a research component to the program
- Providing training to the Integrated Care Team staff
- Consistently communicating outcomes and client stories with the Integrated Care Team staff
- Arranging informational sessions each week so that potential clients who are interested in employment can learn about IPS.
- Maintaining the independence of the IPS specialist to do what is detailed in his or her job description
- Ensuring adequate supervision and support of the IPS staff.

Whether the CMHA joins an ACT, ICM or ICT team, it would also benefit the CMHA to develop staff training specific to working with people who have experienced homelessness based on the recommendations from the interviewees and the literature review findings of the project.

Option 2: Partner with one-stop employment centres to provide complementary services for Tier 3 and Tier 4 clients

This option recommends that the CMHA develop a program to provide community support workers to provide advocacy and support to people who live in supportive housing by taking them to WorkBC offices and helping them through motivational counselling. The community

workers may have 50 or 60 clients, and their goal would be to increase the WorkBC outcomes for clients who have been homeless and who experience mental health issues. This would not be considered an IPS program.

Option 3: Adopt and maintain stakeholder analysis and communications plan

This report has provided the CMHA with a stakeholder analysis in the form of a Stakeholder Influence Chart (see Appendix B) that it can adopt and maintain to help implement a communications plan to engage stakeholders in the development, implementation, and measurement of new CMHA program(s). This will help the program acquire the support and funding it requires to be viable, as well as the interest it needs from prospective clients.

Option 4: Develop a Program Evaluation Framework

To assess the progress of their new or adapted program(s), the CMHA can build an evaluation framework into their programs, which will state that the organization will conduct an evaluation at least every three years. Regular and ongoing monitoring will take place to feed into the evaluation and key performance indicators will be developed at the outset of the initiative to monitor progress.

Recommendations

The CMHA's current IPS programming and resources would allow it to adapt their existing program to implement Option 1, Option 3 and Option 4 right away. They could, as detailed in the findings of this report, review the additional barriers of working with people who have been homeless and adjust their hiring practices to include additional employment specialists who have experience in working with people who have experienced homelessness and who are hardy and resourceful. Option 1 also proposes that the CMHA develops training for IPS specialists that will prepare them for working with clients who have complex needs, such as issues with addictions and homelessness.

While the CMHA is considered a specialist in IPS for people who have serious mental health concerns, it has not necessarily been considered a specialist in working with people who have been homeless. In order to obtain the funding and support they require to be able to implement the programs, they will need to build new relationships with individuals and programs within the health authorities and elsewhere that manage health issues related to homelessness, including mental health teams such as ACT, ICM and ICTs in Vancouver and across the Lower Mainland.

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1.0 Introduction

To improve employment prospects for people with serious mental health concerns such as schizophrenia and bi-polar disorder, the Canadian Mental Health Association – Vancouver Fraser branch (CMHA) established its Individualized Placement and Support Program (IPS) in 2000. The IPS program is the most rigorously researched supported employment program (Drake & Bond, 2011, p. 162), coined as the “gold standard” for vocational interventions with mental health clients has consistently shown dramatic increases in employment in 19 randomized controlled trials (Bond, 2013, p. 2).

The CMHA is now seeking to understand whether the program could be adapted to benefit people who have experienced homelessness or who are at risk of homelessness. A benefit of IPS for this population is that the program has a zero exclusion policy, and therefore all individuals who are part of a mental health team that includes an IPS employment specialist would be able to access the program, as long as they are interested in working and wish to work closely with a supported employment counsellor over two years. This means that supported employment services would be available to them, “...regardless of job readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation (Dartmouth IPS Supported Employment Center, 2008, p. 6).”

This project seeks to answer these questions by reviewing academic and professional literature on IPS and homelessness and related themes, and by conducting one-on-one interviews with IPS specialists and researchers. It will combine the learning from these methods in order to develop recommendations that can be used by the CMHA to either develop new programming, or augment its existing programming.

The CMHA is now looking at this problem because a recovery goal for as many as 70% of people who experience homelessness is to find competitive employment (Drake, Bond & Becker, 2012, p. 3), and yet the rate of unemployment among homeless people is estimated to exceed 80% (Poremski, Distasio, Hwang & Latimer, 2015, p. 380). Competitive employment, as it pertains to vocational rehabilitation, can be defined as, “...work performed by a person with a disability in an integrated setting at minimum wage or higher and at a rate comparable to non-disabled workers performing the same tasks (Logsdon, 2011).”

1.1 Background

According to the Psychosocial Rehabilitation (PSR) Service Framework, previous approaches emphasized prevocational training to prepare individuals for employment when they were ready, whereas supported employment programs first place clients into jobs and training regardless of symptoms or other limitations, and coach them through their experiences. There is strong evidence to show that this “place and train” approach is much more effective in terms of outcomes (PSR Provincial Advisory Committee, 2014, p. 33).

The IPS program has undergone a great deal of empirical scrutiny, and supported employment is considered an evidence-based practice. Findings from a meta-analysis that reviewed 4 randomized controlled trials of IPS showed that IPS outperformed the control group, who participated in other vocational programs, in acquisition, duration, hours worked per week, and total hours and wages (Bond, Campbell & Drake, 2012, 755). Another meta-analysis that reviewed 19 randomized controlled trials of IPS showed that overall, 58% of IPS participants compared to 24% of the control group were able to find competitive employment (Bond, 2013, p.5). The CMHA's Executive Director also reported that the CMHA's current IPS program has shown a 51% success rate for its IPS participants who have issues with severe mental illness to obtain competitive employment. Studies have shown that IPS programs that maintain a high program fidelity to the original model have better outcomes (Bond, 2013, p. 10; Knapp et al., 2013, p. 60).

Individual Placement and Support programs have been developed internationally, and have been heavily researched to determine the costs and benefits of this program compared to other vocational services (Knapp et al., 2013, p. 60; Bond, Drake, & Becker, 2008, 280). For example, a number of studies showed that IPS participants were much more likely to work in competitive settings and worked more hours than individuals receiving comparison services (Knapp et al., 2013, p. 60).

While successful employment results have been achieved for people in the IPS program who have been in contact with mental health services at the CMHA and elsewhere (Bond, 2013, p.5), the CMHA is now seeking to understand whether the program could be adapted to benefit people who have experienced homelessness or who are at risk of homelessness. Most of these people will either be part of a mental health team, such as an Assertive Community Treatment (ACT) or Intensive Case Management (ICM) team, and/or living in supportive housing in Vancouver. Many of these people will be accessing services in Vancouver's Downtown Eastside where, amongst its 17,000 residents (City of Vancouver, 2012), there is a high level of intravenous drug use and a large population with mental health concerns (Linden, Mar, Werker, Jang, & Krausz, 2012, p. 563).

One of the CMHA's concerns is to reach and maintain high fidelity of the IPS model as much as possible, while reviewing the possible ways in which an IPS program can utilize and augment Assertive Community Treatment (ACT), Intensive Case Management (ICM), and other mental health teams that already exist within many of the supportive housing models. A fidelity scale measures the level that an evidence-based practice is implemented (Becker, Swanson, Bond & Merrens, 2011, p. 1). A program that meets high fidelity will therefore follow the standards of the program closely. The IPS Supported Employment Fidelity Scale provides the standards of IPS in order to distinguish between programs that have been fully implemented and those that have not. It is important to note that the fidelity to the model has been correlated to the success of IPS programs (Becker, Smith, Tanzman, Drake, & Tremblay, 2001, 834; Becker, Xie, McHugo, Halliday & Martinez, 2006, p. 304; Gowdy, Carlson & Rapp, 2004, p. 152; McGrew & Griss, 2005, p. 304). Please see the fidelity scale in Appendix A (Dartmouth IPS Supported Employment Center, 2008).

1.2 Project Research Questions

The following report seeks to answer the following research questions:

Primary research question: What are the most effective ways to adapt the CMHA's current IPS program for people who have experienced homelessness?

Secondary and supplementary questions to support the primary question are:

- Who are the stakeholders who would be important to contact regarding program enhancement, program adaptation, funding opportunities, communication, and project involvement?
- What are the benefits and promising practices of an IPS program that are geared towards people who have been homeless?
- What is the existing literature on IPS programs that have been adapted for this population?
- How can the CMHA sustain the fidelity of the IPS while adapting the program for this population?
- Is IPS cost-effective in comparison to other vocational programs that address the needs of people who have experienced homelessness?

1.3 Project Client

The Canadian Mental Health Association Vancouver-Fraser branch (CMHA) brings together community-based experience and expertise on providing community supports for the mental well-being of all Canadians. Its mission is to facilitate access to the resources people require to maintain and improve mental health and community integration, build resilience, and support recovery from mental illness. The CMHA provides employment opportunities through its social enterprises and Individual Placement and Support program (CMHA, n.d.).

The CMHA currently has an IPS program that employs 13 IPS specialists. Four IPS specialists are funded by Fraser Health Authority, seven specialists are funded by Vancouver Coastal Health Authority, and two are funded by a National Supported Employment Project funded by Service Canada's Opportunities Fund. Each CMHA IPS specialist is part of a multidisciplinary mental health team that includes a psychiatrist, a social worker, an occupational therapist, and other professional staff, and any client receiving mental health services from the mental health teams can access the program. The CMHA regularly reviews its program to meet and maintain fidelity measures, and the IPS program scores a very high grade on the Dartmouth Fidelity score (Please see Appendix A for the Fidelity Model).

In addition, the CMHA IPS team already has relevant experience working with people who have experienced homelessness. Over the last three years, it has had an IPS specialist situated on the Strathcona Mental Health team, which provides mental health support to clients with complex needs, including issues with addictions and homelessness.

1.4 Organization of Report

This report is divided into nine sections. It will start by providing the reader with further background information on IPS and the benefits of employment for people who have experienced homelessness, and then describe the methodology used in this study. It will then provide findings from the literature review, a cost-benefit review, and the results from the interviews. The findings from these methods will inform the four options for the CMHA to consider moving forward. A stakeholder analysis was developed to help the CMHA implement the option(s) they choose to implement.

2.0 Literature Review

This section of the report explores existing knowledge of the reasons that work is a priority for people who have been homeless or who have concurrent disorders, and also the benefits and efficacy that the Individual Placement and Support (IPS) model of supported employment has been shown to have in North America and Europe. It will also explore examples of IPS programs that were developed for people who have experienced homelessness and provide the successes and challenges of those programs if the information was available. The literature review also includes a section that outlines the barriers to employment for people who are homeless or who are formerly homeless. Finally, it will consolidate this learning to inform a conceptual framework and the primary data collection of this report.

This paper reviews both academic and professional sources. There is a great deal of research relevant to IPS and employment for people who have experienced homelessness. In order to help write this section of the report, the search terms included, 'IPS and homelessness', 'barriers to employment for people who are homeless', 'IPS and fidelity', and the 'benefits of employment for people who are homeless'. The databases most used included Google Scholar, PsycINFO, and ERIC (Ebscohost).

2.1 Recognizing work as a benefit and priority for the homeless population

2.1.1 Employment Can Be Part Of Recovery For Mental Health And Addictions

Many studies reported that employment can provide benefit to the overall recovery process among people who have mental health and addictions issues (Strickler, Whitley, Becker, & Drake, 2009, p. 262; Dunn, Wewlorski, & Rogers, 2008; Serge, Kraus, & Eberle, 2006, p. 18).

A New Hampshire study found that employment provided study participants who were consistent workers and who had dual diagnosis (mental health issues and addictions issues) with financial, social, structural, moral and personal benefits to people (Strickler, Whitley, Becker, & Drake, 2009, p. 266). The study examined first person accounts of work activity from people with dual diagnosis over a 16-year period. Many of these people did not wish to work at the onset, and yet the study showed that a substantial proportion of the study's participants became consistent workers over time. The people in the study were not receiving vocational services, and yet the study found that 29% became very consistent workers (Strickler, Whitley, Becker, & Drake, 2009, p. 266). The study found that effective management of illnesses was integral to becoming a consistent worker. Finding an optimal job match was also important, which is an integral part of evidence-based supported employment such as the IPS model. Finally, the research found that people were conditioned to their daily pattern – whether they were working or not working. *Created a new identity in other words.*

In a study that analyzed semi-structured interviews with 23 participants who had serious mental health issues, Dunn, Wewlorski and Rogers found that work played a central role in people's lives and had significant effects on their recovery (Dunn, Wewlorski & Rogers, 2008). Richardson, Wood and Kerr highlighted that a strong case can be made to address the barriers

to employment for intravenous drug users, because employment has shown to have a stabilising effect on these people's lives (Richardson, Wood, Li, & Kerr, 2010, p. 293). The study found that employment can reduce injection drug use, encourage long-term heroin abstinence, prevent substance use relapse, promote enrolment into treatment, and reduce involvement in crime.

A concern that is frequently expressed is that working might worsen the mental health of people with severe mental illness (SMI), but Burns et al. reported that instead, there are benefits to the clinical and social functioning such as a slight decrease to depression and better global functioning, fewer symptoms, and less social disability at final follow-up (Burns et al., 2009, p. 949). Burns et al. also reported that there is no evidence of increased hospitalization and no substantial symptom change over time for people with SMI who participated in Individual Placement and Support programs in 6 European countries. In fact, one research study they reviewed showed fewer hospitalizations and emergency service visits than matched controls, although only for clients that reached out to more mental health services (Burns et al., 2009, p. 949).

2.1.2 What employment means for people who have experienced homelessness

In addition to recognizing the psychosocial benefits to employment, researchers are finding that there is a demand for employment services amongst people who have experienced homelessness or who are homeless (Poremski, D., Whitley, R. & Latimer, E., 2015, p. 1; Schnur, Warland, Young and Zralek 2013, p. 2-4; Marrone, 2015, p. 16). Schnur, Warland, Young and Zralek focus on the psychosocial benefits of employment, and state that, "[i]ndividuals experiencing homelessness consistently rank paid employment alongside health care and housing as a primary need, and numerous studies find that increased income is a strong predictor of a person exiting homelessness and maintaining housing (2013, p. 2-4)." Joe Marrone reported that help finding a job was the most cited need for getting out of homelessness by clients who took part in a study of homelessness services (Marrone, 2015, p. 16).

Considering the needs of homeless men in securing safe and stable housing, trauma experts Mimi Kim and Julian Ford state that, "[s]upported housing and employment interventions that combine safe, affordable, and livable housing with a safety net of social and therapeutic activities and services provide a promising approach to the provision of this kind of fully integrated recovery services for homeless men (Kim & Ford, 2008, p. 16)."

2.2 The Individual Placement and Support supported employment model – benefits and efficacy

It is generally agreed that supported employment [SE] is the most effective approach for securing employment for people who have severe mental illness (Bond, Drake and Becker, 2008; Marshall, Rapp, Becker, & Bond, 2008). According to Drake, McHugo, Becker, Anthony

and Clark, “[o]f the approaches to vocational rehabilitation currently available to people with [severe mental disorders], SE has the strongest empirical support (1996, p. 392).”

Amongst the SE programs available, the Individual Placement and Support (IPS) program is the most widely researched and explained model (Campbell, Bond, & Drake, 2011, p. 370).

A study that used a meta-analysis to pool samples from four randomized controlled trials that compared IPS to other well-regarded vocational approaches showed that IPS “...produces better competitive employment outcomes for persons with SMI [severe mental illness] than alternative vocational programs regardless of background demographic, clinical, and employment characteristics (Campbell, Bond, & Drake, 2011, p. 370).” In another study that used a combined data set from four randomized controlled trials of Individual Placement and Support Bond, Campbell and Drake showed that IPS improves job acquisition, job duration, hours worked per week, and total hours and wages (Bond, Campbell & Drake, 2012, p. 751).

Supported employment programs such as IPS have not been used as widely for the homeless population, and more specifically for people who have issues with drug use (Harrison, Young, Flink & Ochshorn, 2008, 239; Poremski, Whitley & Latimer, 2014, 181). This is partly because typical treatment for co-occurring disorders for the last decade addressed psychiatric and substance use issues separately (Harrison, Young, Flink & Ochshorn, 2008, p. 239). Harrison, Young, Flink & Ochshorn claim, however, that the combination of mental illness and substance use issues places individuals at higher risk for unemployment, housing instability, and homelessness, and that programs that address concurrent disorders can be effective (Harrison, Young, Flink & Ochshorn, 2008, 239). Poremski, Whitley and Latimer state that additional research is required to explore how employment interventions can be specifically tailored for people who have issues with homelessness (Poremski, Whitley & Latimer, 2014, 181).

2.3 Barriers to employment for people who have experienced homelessness

Poremski, Whitley and Latimer report that some of the barriers to employment are the same for people who are currently homeless as they are for people who are housed but who have mental illness (Poremski, Whitley & Latimer, 2014, p. 181). Their research also showed that some people in the At Home Chez Soi study, which interviewed 27 people who were recently housed, reported that staying in a shelter made finding employment difficult because of the strict regulations and closing times. Participants in the study also reported the fear of losing their beds if they arrived late, and needing to store their personal belongings if they went to interviews.

In addition, the behaviours and survival mechanisms that someone may have adopted while homeless, such as quitting a job as a problem-solving tool, or the belief that panhandling can make you more money than competitive employment, are also restrictions (Poremski, 2014; Rio, Ware, Tucker & Martinez, 2008, p. 52). For people with mental health concerns, medications can cause side effects that make working difficult. The fear of losing disability benefits and the financial restrictions around work and benefits were also considered to be

barriers (Poremski, Whitley & Latimer, 2014, p. 181), but Poremski reports that this fear was actually noted by less than 1% of participants in the At Home Chez Soi study (Poremski, 2014).

Poremski, Whitley and Latimer reported that having a criminal record was thought to make you unemployable amongst people in their study (2014, p. 183). One participant with depression said that it caused him or her to not apply for jobs, in anticipation of rejection. The length of time it can take for people to obtain the psychiatric care they need could also be considered a barrier to employment, as can physical illness, and poor employment histories.

Johannesen, McGrew, Griss and Born reported that supported employment clients also mention barriers related to their mental illness, such as fear of failure or lack of concentration, and barriers related to the job search and working, such as the difficulty finding a job and keeping a job (Bond, 2007, p. 2). Rio, Ware, Tucker and Martinez also suggest that limited education and literacy, learning disabilities, and struggles with self-confidence and drive may all contribute to these barriers (Rio, Ware, Tucker & Martinez, 2008, p. 52).

Poremski, Woodhall-Melnik, Lemieux and Stergiopoulos researched the barriers that persisted once the participants of the At Home Chez Soi project were stably housed (2015). These included:

- 1) a hesitation to reveal sensitive information around their personal lives, such as mental illness or experiences with homelessness, and explaining absence from work (p. 9).
- 2) fluctuating motivation, which affected about half of the participants. The participants that felt their motivation change needed more time to adjust to living in supportive housing (p. 10).
- 3) continued substance use, or the fear of relapse. The authors report that participants' substance use diminished once participants of the At Home Chez Soi were housed, and some people were no longer taking substances (p. 12).
- 4) fears and anxiety around re-experiencing the trauma related to when participants had been homeless, and being on high alert of possible harms (Poremski, Woodhall-Melnik, Lemieux & Stergiopoulos, 2015, p. 14).

2.4 Fidelity Matters in IPS

There was agreement in the IPS literature that the main priority in developing an IPS program is to sustain the fidelity of the program as best as possible. According to Bond, Drake and Becker (2012, p. 32), and Jansen (Presentation, February 12, 2015), the program is most effective when delivered as it was designed and researched. Please see the fidelity scale in Appendix 1.

In the cases that programs do not reach fidelity there have been issues with outcomes. For example, one group of researchers found that supported employment showed no advantage over traditional vocational rehabilitation services in helping workers *retain* their jobs but then reported that the accuracy with which the services were implemented *varied greatly*, and the outcomes of the programs reflected these inaccuracies (Wallace, Tauber & Wilde, 1999, p. 1147).

2.5 Use of the IPS model for people who have experienced homelessness

A number of organizations have utilized IPS for people who have experienced homelessness. Below are five examples of organizations and the details, challenges, and outcomes of setting up an IPS program specifically for the population.

Los Angeles Gay and Lesbian Center's Jeff Griffith Youth Center. This study adapted the IPS program for homeless young adults with mental illness used a sample of 20 homeless young adults (ages 18–24) with mental illness from the host agency with a comparison sample of 16 homeless young adults with mental illness who received standard agency services. It was conducted at the Los Angeles Gay and Lesbian Center's Jeff Griffith Youth Center, and showed that the IPS group was significantly more likely to have worked at some point over 10 months and IPS participants also worked a greater number of months overall (Ferguson, Xie & Glynn, 2011, 277).

The IPS program improved outcomes of homeless youth with mental illness by modifying the support teams to include the youths' natural support systems, such as street families, street peers, and youth-identified supportive staff, instead of only including immediate family members (Ferguson, 2013, p. 488; K. Ferguson, Personal Communication, April 4, 2015).

Homeless Opportunity Providing Employment. Another Los Angeles study called the Homeless Opportunity Providing Employment examined the impact of housing and employment program for adults who had been homeless for a long time. It compared 56 demonstration clients who received housing and special employment supports with a comparison group of 415 clients enrolled in other programs for 13-month duration. The study showed that this client group could achieve improved work outcomes if the programs provided adequate support and appropriate resources (Burt, 2012, 209; 215).

The At Home/Chez Soi Project. Within the sources regarding adaptations to the IPS model, the literature found a research study on only one Canadian example, the Mental Health Commission's At Home Chez Soi project. The At Home Chez Soi project placed an IPS program within their mental health team that worked with their clients who were housed through their Housing First program.

The Mental Health Commission's At Home/Chez Soi program provided Assertive Community Treatment (ACT) or Intensive Case Management (ICM) within the Housing First model to people who were homeless in Vancouver, Winnipeg, Toronto, Montréal, and Moncton (Mental Health Commission of Canada, 2014b, p. 6). In Montréal, the project provided an experimental sub-study among moderate need participants to test the IPS model (Mental Health Commission, 2014a, p. 6). This randomized control study provided IPS to people with moderate needs who were recently housed in Housing First and who were clients of an ICM mental health team. Of the people that expressed interest in employment, 45 were randomly assigned to take part in IPS and another 45 people were assigned to a comparison group (Mental Health Commission, 2014a, p. 29). Thirty-four percent of the participants who received the IPS intervention obtained competitive employment compared to 22 per cent of the comparison group who

received the other vocational services (Mental Health Commission, 2014a, p. 7). The authors note that the difference was not large enough to be statistically significant (and therefore may have been due to chance). The issues included finding, training, and keeping suitable employment specialists. The two-year program was operated at a good level of fidelity with a full staff for only nine months of the program. The staff and clients found that continued substance use and criminal records also posed significant obstacles to finding work.

The study also investigated the ways in which service users who live in Housing First experience supported employment services and how these differ from those receiving usual vocational services. It showed that trust is important to employment outcomes. Most people in the study said that it took time to build this trust (Poremski, Whitley, & Latimer, 2015, p. 3), but once trust was established a working alliance was able to form. Employment specialists were then able to motivate their clients and change negative beliefs (Poremski, Whitley, & Latimer, 2015, p. 4). The study found that most people who received usual services (the control group) did not meet with their employment specialist consistently, and therefore did not have the same motivation to continue to search for work. The study recommends that employment programs be designed 1) to be sensitive to the experiences of people who have been homeless that make establishing trust difficult, and 2) so that clients see the same employment specialist at each visit in order to build a working alliance (Poremski, Whitley, & Latimer, 2015, p. 1).

Finally, the qualitative results suggest that the results would have been more favourable to IPS if the program were permanent rather than short-term, and that the Montreal study showed relatively high employment rates compared to other participants across the country and that the study may have motivated the ICM case managers to be more active in helping participants find work because IPS was available (Mental Health Commission, 2014a, p. 29).

Hope, Vocation, Progress Project (Clearview Employment Services Model). A report about the Clearview Employment Services Model at the Columbia River Mental Health Services (CRMHS) organization in Vancouver, Washington, USA provides mental health, substance use treatment, housing, and employment services for people with significant mental health issues. The purpose of the Clearview project is to provide employment for people who have SMI or co-occurring disorders and who are in need of housing. Clearview uses IPS supported employment for people with psychiatric concerns.

The organization operates a 26-bed rehabilitation transitional housing program for people with disabilities of mental illness, and staff work with residents to find permanent employment and housing. At the time the report was written, the results of the employment project compared somewhat less favourably to the employment outcomes reported in the evidence-based practice IPS literature (Marrone, 2005, p. 29).

The author of the report, Joe Marrone, states that the program has shown impressive results in terms of attracting an extremely transient and difficult to engage group of people and a very high 90-day job retention rate, and that they were able to do this without any 'readiness' screening, but what the Clearview project does not rate highly on is the ratio of employment staff to clientele. While the ideal ratio according to the fidelity scale is 1 FTE employment staff

to 18–22 clients, the entire staffing of the Clearview project is only 4 FTEs (including employment specialists, a job developer, and a peer supporter) who had engaged over 500 clients in employment planning at the time of the report. This is due to a conscious decision by the program managers to not limit the number of people served in order to maintain fidelity. Marrone states that there needs to be a proper balance between quality and quantity in terms of resources (Marrone, 2005, p. 31), and that striking that balance whereby an organization pays attention to quality of life issues while still affecting a significant number of people is the most beneficial (Marrone, 2005, p. 31-32).

Department of Veterans Affairs (VA) in the U.S.A. A controlled study that looked at the implementation of IPS for homeless veterans in the U.S.A. with substance use issues, many of whom had psychiatric issues, found that in order to implement IPS in health care systems with limited previous experience (such as the nine Veterans Affairs programs that they chose for this study), ongoing and personalized training programs for staff may be needed to ensure better outcomes. Not only does it take time to build the expertise within the organization, but it also yields better results over time (Rosenheck & Mares, 2007, p. 325). Previous to implementing IPS, the VA had set up transitional work placements either on VA grounds or in partner organizations but these jobs were in social enterprises run by the program, and not competitive (Rosenheck & Mares, 2007, p. 326). Employment specialists were funded and trained by teleconference to work in each of the nine locations. Two cohorts of 30 veterans who expressed interest to work were targeted at each site. One cohort received IPS and the other received the VA's traditional employment programming.

The IPS group used a shortened version of the fidelity scale, and also rated items on a 3-point scale rather than a 5-point scale used in the Dartmouth Fidelity scale (for the Dartmouth standard, please see the Fidelity Scale in Appendix 1). The greatest benefit to the involvement in the IPS cohort was the continued engagement that the veterans had with their IPS worker. At the two-year mark, 49% of the veterans who were part of the IPS study were seeing their supported employment worker, while only 28% of the cohort who participated in the traditional employment program were involved in their program (Rosenheck & Mares, 2007, p. 327-328). The IPS group also exceeded the number of days worked by 14% compared to the control group. The study also found that in sites that did not achieve a high standard of fidelity (about 20% of the sites), the difference between IPS and the control group was not as significant. Finally, the study found that using teleconferencing to train the IPS supported employment workers was effective.

2.6 Conceptual Framework

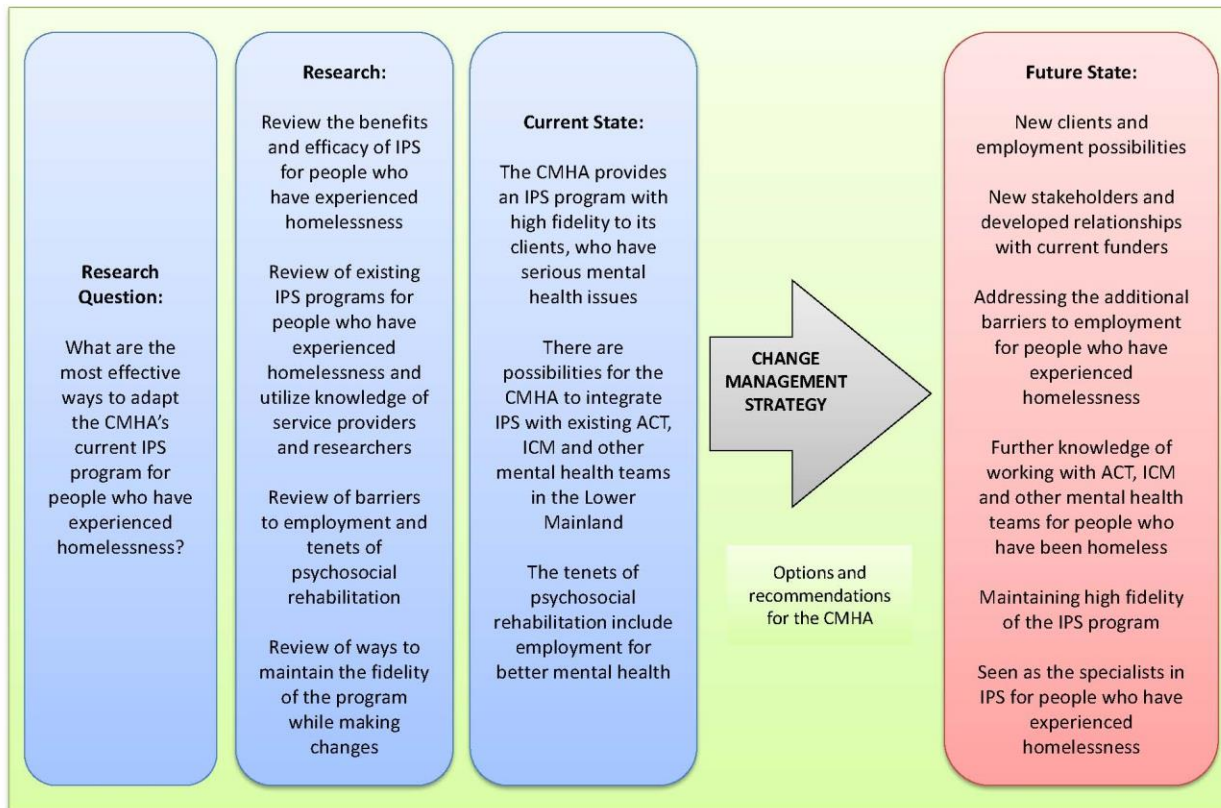
As outlined in the literature, the main motivation for developing a new program is that people who experience homelessness would benefit from employment and also want to work. The main driver for implementing IPS is that it is considered the best program for people who have serious mental health concerns.

Table 1: Motivation, Drivers and Additional skills/knowledge/resources required to develop IPS program for people who have experienced homelessness

<p>Motivation</p>	<p>Psychosocial benefits of employment for people who have experienced homelessness</p> <p>People who have experienced homelessness have a desire to work</p> <p>Generally agreed that supported employment [SE] is the most effective approach for securing employment for people who have severe mental illness</p>
<p>Drivers for utilizing IPS (CMHA)</p>	<p>CMHA is already a specialist in IPS</p> <p>CMHA has been able to achieve high fidelity in its IPS program</p>
<p>Skills/Knowledge/Resources for the CMHA</p>	<p>Maintain fidelity</p> <p>Understanding additional barriers to employment of people who have experienced homelessness</p> <p>Develop program based on needs of clients</p>

The conceptual framework on the next page draws the themes from the literature review together and projects the change from the CMHA’s current state, in which it provides a highly effective IPS program for people who have serious mental health concerns to its desired state, in which it has developed an IPS program for people who have experienced homelessness – the goal of this report.

Figure 1: Conceptual Framework



2.7 Summary

The literature review restates the need for supported employment programs for people who have issues with homelessness. Considering the barriers to employment, and for a number of reasons revealed in the literature, the IPS model of supported employment is considered to have the best outcomes for people who have serious mental health issues and for people who have experienced chronic homelessness.

While there are many barriers to employment that persist after people have been stably housed, the IPS specialist needs to be aware of what they are in order to be sensitive to them and to begin addressing them.

The study also reviewed five research studies of IPS programs. The Los Angeles Gay and Lesbian Center's Jeff Griffith Youth Center study showed that the IPS group was significantly more likely to have worked at some point over 10 months and IPS participants also worked a greater number of months overall. The Homeless Opportunity Providing Employment study showed that, with increased support and resources, their adult client group could achieve improved work outcomes. While the At Home/Chez Soi project's IPS group did not show a statistically

significant difference in work outcomes compared to the control group, the project was having issues with finding, training, and keeping suitable employment specialists for their program which meant that they were not able to attain a high fidelity score. The Hope, Vocation, Progress Project showed a very high 90-day job retention rate, but reported that the project purposely did not maintain fidelity because it had a high client-to-IPS specialist ratio. Finally, the Veterans Affairs IPS project showed a very high retention rate, because 49% of the veterans who were part of the IPS study continued to see their supported employment worker at the two year mark, while only 28% of the cohort who participated in the traditional employment program continued to be involved in their program.

Overall the literature showed that IPS is a promising practice for people who are or who have been homeless, particularly when organizations can achieve a high fidelity score. Additional research studies of IPS programs that work with people who have experienced homelessness would be beneficial.

3.0 Methodology and Methods

This project is designed as a gap analysis to investigate some of the ways the CMHA can adapt or use their IPS program for people who have experienced homelessness. A gap analysis compares an organization's current situation with the future state that the organization wants to achieve, and helps identify what the organization needs to do to bridge the gap to making a project a success (Mikoluk, 2013). The three steps of a gap analysis include identifying the project's or organization's future state, analyzing its current situation, and identifying how it will bridge the gap to make it a success (Mindtools, n.d.).

The research uses a qualitative methodology with a focus on grounded theory methods. Social constructivism served as the underlying theoretical framework. Hence, the researcher recognizes that the subjective meanings behind the participants' discussions and answers, as well as how her own background, shapes her interpretation of the data (Creswell, 1998, p. 8). The methodology will also include a stakeholder analysis as part of the implementation section of the report.

Methods include a literature review, a focus group discussion with seven participants who work in the mental health, employment or housing sectors, and 10 semi-structured interviews with key informants including IPS researchers and IPS specialists, to obtain their perspectives and recommendations for developing an IPS program for people who have experienced homelessness, and also for adapting the program.

3.1 Methodology

The project is designed as a gap analysis and seeks ways in which the CMHA can move from a current state to ways in which it can develop a new program or expand its existing programming (Mikoluk, 2013). The participation of multiple stakeholders, as well as their concerns and interests, was considered important in developing or augmenting a new program for the CMHA. A stakeholder analysis is therefore included in the Implementation section of this report. It provides a detailed matrix that shows each individual's or group's interest in the adaptation of the program, where interests converge, the level of influence, and who will have a voice in the new developments (Bowen, 2011, paragraph 2). The stakeholder analysis was included to assist the CMHA in garnering support, finding allies, developing partnerships, and raising funds for its current or adapted IPS program.

The methodology also includes a cost-benefit literature review and analysis. This analysis looks at both the cost benefits of employment for people who have been homeless, and the cost benefits specifically for an IPS program developed for people who have experienced homelessness.

3.2 Methods

3.2.1 Secondary Data Collection: Literature Searches

The goal of the literature review is to develop a broad understanding of the research questions and inform the framework for developing an IPS program for people who have experienced homelessness. It complements the primary data collection by providing the statistics and background information for the theories that have emerged. In some cases, it helped the researcher frame the questions used in the primary data collection.

Key search items included variations on the terms: Individual Placement and Support, supported employment, barriers to employment for people who experience homelessness, IPS and homelessness, and IPS and fidelity.

3.2.2 Primary Data Collection: Interviews

The goal of the primary data collection was to determine the promising practices for developing a program specifically geared for people who have experienced homelessness and determine the ways in which this program could maintain fidelity.

The study incorporates different perspectives as themes and patterns emerge from the data (Creswell, 1998, p. 15; Patton, 2004, p. 1) by focusing on grounded theory as the main method used in this research project. Primary data was collected through 12 semi-structured interviews and one focus group.

Grounded theory was established to connect developing theories with data collection and analysis processes (Robert Wood Johnson Foundation, n.d.) through an inductive process of looking at the data (Borgatti, n.d.). It involves a constant comparative analysis of the data and the quality of the theory is determined by the way in which the theory is developed.

The interviews and focus group were semi-structured to provide some consistency between interviews and address key themes (see Appendices D and E). After the initial theoretical sampling, additional interviews were conducted to uncover specific theories and practical suggestions for the research study. To ensure anonymity, participants were not identified in this report. This is in accordance with the project's Ethics Review, which was approved on 20-Jul-15 and assigned Protocol Number 15-171.

The list of interviewees was developed in consultation with the client. The inclusion criteria required participants to be professionals working within an IPS program or in a university. The process of selection was based on the objectives for this project.

Interviewees can be categorized into three groups:

Group one: Current employees and consultants of the CMHA Vancouver-Fraser branch (n=3). This group was included because they have an understanding of how the CMHA works and could provide insights into the process and outcomes of the existing and any possible future IPS program. Having worked in IPS programs at the CMHA, they also understand the ways to maintain fidelity, as this was one of the criteria for reviewing the possibilities of developing new programming.

Group two: Individual researchers who specialize in the IPS model and who have researched IPS programs that have been conducted with people who have experienced homelessness (n=3). This group was included because they can provide an overview – both negative and positive – of developing a program specific to this population.

Group three: Representatives of IPS programs in Canada (IPS employment specialists), trainers of IPS or funders of IPS (n=6). This group was included because they are considered specialists in providing employment services to people who have experienced homelessness.

Twelve interviews took place. Ten occurred over the phone and 2 were face-to-face. All of the participants of the focus group came in person to the CMHA offices.

For the stakeholder analysis, a committee of internal stakeholders from the CMHA, including board members and members of the leadership team, were brought together to brainstorm who the key stakeholders were (Bryson, 2011, p.24). Together the participants developed a list of stakeholders in order to identify the positions of each in a Stakeholder Influence Chart. A Stakeholder Influence Chart was compiled to help the CMHA understand the interests of its stakeholders (Bryson, 2011, p. 416), and establish what part each individual or organizational stakeholder would play in a potential project, what type of communication is required, as well as the frequency of communication.

3.3 Data Analysis

The analysis of the data was performed according to the methods as described by grounded theory researcher Steve Borgatti. A key feature of this method is to read and re-read a textual database and to uncover and label variables and their interrelationships (Borgatti, n.d.). As data was collected, it was coded to establish the main concerns and theories. Further sampling was directed by the developing theory, and interviews were conducted until the code categories had been saturated (Grounded Theory Online, n.d.).

Data from the literature was analyzed before the interviews were conducted and the interview questions were formed based on this analysis. While there were some connections between the two lines of evidence, the literature review was only intended to inform the interviews so that a theoretical discussion and unique themes could emerge from the new data.

3.4 Strengths, Limitations and Risks

The knowledge obtained by the interviewees in regards to working within an ACT or ICM team, or adapting and developing their IPS programs for people who have experienced homelessness, was by far the greatest strength of this project. The literature review findings were also a great strength that will hopefully provide the CMHA with the information it requires to fulfill its goals.

This project is limited in its scope, however, in that it only goes as far as providing the CMHA with recommendations for developing a framework for implementation. Should the CMHA wish

to pursue these recommendations, it will have to conduct further research through the program development process.

In addition, in order to ensure that it would be conducted in the time frame available, this project only focused on the development of the IPS program from the perspective of specialists and researcher and it was unable to incorporate the insights and recommendations of current or potential IPS clients who have themselves experienced homelessness and who have searched for and/or found employment. Instead, the researcher has tried to utilize secondary research that was conducted in IPS settings, both in North America and in Europe, to inform the research study on the benefits of IPS for people who have experienced homelessness, the additional barriers for this population, and the challenges of existing programs that have specialized in providing IPS employment services to this clientele.

The project may have also been affected by the researcher's role as a board member of the CMHA Vancouver-Fraser branch. To help mitigate this limitation, the interviewees were informed that their responses were confidential and would not be shared with anyone including the CMHA except in the aggregate form of the report.

The subject of potential harm has been reviewed by University of Victoria's Human Research Ethics Board, which established that the project posed minimal risk to its participants.

4.0 Findings: Current State Analysis

Employment is important for the psychosocial rehabilitation of people who have experienced homelessness and who have mental health and addictions issues. This section will provide an overview of the benefits of employment in general, and also a short description of the Individual Placement and Support program. It also provides the details of a new integrated mental health program that will be made available in Vancouver in late 2016.

4.1 Employment for people who have experienced homelessness

According to Poremski, Whitley and Latimer, the unemployment rate for people who are homeless in Canada is estimated to be between 80-90%, and this can be attributed to the complex relationship between mental illness, employment and housing (2014, p. 181). While these authors believe there may be multiple barriers to finding or returning to work (Poremski, Whitley & Latimer, 2014, p. 181), Bond, Salyers, Rollins, Rapp and Zipple claim that a recovery goal for many people with these issues is to find competitive employment that is congruent with personal preferences and is personally satisfying (2004, p. 571). In addition, Crain et al. claim that, when engaged in paid and competitive employment, these people have better health outcomes, social skills and self-value (2009, p. 459). The Centre for Mental Health also reported that the benefits of work to mental and physical health and the harmful effects of unemployment are also now both widely recognized (2014, p. 1).

According to DeBeck et al., research regarding income-generating activities of people who have substance use issues demonstrated that many individuals would give up high-risk, illegal income generation if they didn't need money for drugs (2011, p. 376). In a similar example, the development of a viable, alternative income source for sex workers who also used illicit drugs was shown to lower high-risk behaviour, including decreases in the median number of sex partners per month and daily drug use (DeBeck et al, 2011, p. 376). A study led by Isaac D. Montoya, clinical professor at the UH College of Pharmacy at the U.S. National Institutes of Health (NIH), found that employment reduces the chronic drug use of female welfare recipients, and they reported that their research yielded such significant results that the findings can be extrapolated to additional populations (University of Houston, 2004, p. 1). Over one year of their study, the employment rate amongst this group rose from 5% to 39% due to outreach and training of the 534 participants. In the study's second year, the researchers looked at the effect of employment on drug usage, finding that drug use fell 79% during this second year among users who remained employed. Hence, drug use frequency decreased as employment hours increased.

Shaheen and Rio argue that facilitating employment is an important practice for preventing and ending homelessness (2007, p. 341), and the development of additional employment opportunities can be considered to be part of a comprehensive plan to solve homelessness (Streetohome Foundation, 2011). Research from Streetohome Foundation shows that a number of the supportive housing providers and non-profit organizations in Vancouver already offer vocational counseling or employment programs through social enterprises, and job

creation and sustainability are common strategies espoused within the non-profit culture (Streetohome, 2011). Figure 1 shows the four-legged stool that Streetohome Foundation refers to in explaining the need for employment, in addition to health care, education and housing, to ensure social integration of all citizens.

Figure 2: Thriving Citizens (Streetohome Foundation, N.D., p. 1)



Although there are some programs that include IPS specialists, it has not been made widely available to people who experience homelessness in Vancouver. Yet, according to Drake, McHugo, Becker, Anthony and Clark, “[o]f the approaches to vocational rehabilitation currently available to people with [severe mental disorders], SE has the strongest empirical support (1996, p. 392).”

By the end of 2014, 1,238 individuals who were homeless or at risk of homelessness in Vancouver moved into buildings that are managed by non-profits that support the Housing First Model. Another 414 more apartments are under construction (Streetohome Foundation, 2015). This was due to an agreement that took place between the City of Vancouver, BC Housing, and Streetohome Foundation that led to the allocation of public and private funds to build these supportive housing units. They also fund the building managers and service providers that provide the healthy meals, life skills training, and health support (Streetohome, 2011). Research shows that people living in this type of housing, which may be supported with a mental health team such as an Intensive Case Management (ICM) team or Assertive Community Treatment (ACT) team, spend on average 73% of their time in stable housing compared to low-income individuals who are at risk of homelessness, who spent only 30% of their time in stable housing

(Mental Health Commission, 2012). This stability provides the residents space to open their lives to new possibilities, including employment (Mental Health Commission, 2012).

4.2 Employment as a Principle of Psychosocial Rehabilitation

Vancouver Coastal Health Authority and Fraser Health Authority both incorporate the tenets of psychosocial rehabilitation (PSR) into their mental health and addictions work. One of the evidence-based practices of PSR is to assist people with mental health and addictions concerns to obtain and maintain employment. This would possibly create more funding opportunities for additional employment placement programs such as IPS.

According to the Psychosocial Rehabilitation (PSR) Service Framework written by B.C.'s PSR Provincial Advisory Committee, employment is very important in the recovery of persons living with serious mental illness and substance use problems, and employment is often cited as the most important need (2014, p. 33). In addition, one of the report's key findings states that, "Supported Employment programs, particularly with the Individual Placement and Support (IPS) model, are by far the most effective in terms of successful employment outcomes and recovery. Accordingly, they should be available to all persons living with serious mental illness and substance use problems." According to the document, previous approaches emphasized prevocational training to prepare individuals for employment when they were ready, whereas supported employment programs first place clients into jobs and training and coach them through their experiences. There is strong evidence to show that this "place and train" approach is much more effective in terms of outcomes (PSR Provincial Advisory Committee, 2014, p. 33).

4.2 The Benefits of IPS

Research shows that, compared to other employment programs, clients in the IPS program are more likely to be competitively employed over an 18-month follow up term (Drake, McHugo, Becker, Anthony & Clark, 1996, p. 391). Unlike many other vocational counselling programs that try to prepare people for finding and retaining work before they start pursuing employment, this program helps people to first find work, and then to find solutions to each of his or her challenges with the support of a counsellor.

It has been evident through the CMHA's IPS program and other IPS programs worldwide that many people who experience homelessness would like to increase their opportunities, albeit on their own terms. According to Poremski, Whitley and Latimer, "[p]eople who are homeless would rather work than rely on welfare and their preference for part-time or full-time employment exceeds 87% (2014, p. 181)."

The IPS program can also help provide a supportive framework for community integration for its participants. The IPS program helps people who have problematic substance use issues, for example, to move away from roles where they require continual support in treatment centres or in supportive housing, towards independence in community settings (Bond, Salyers, Rollins, Rapp & Zipple, 2004, p. 570).

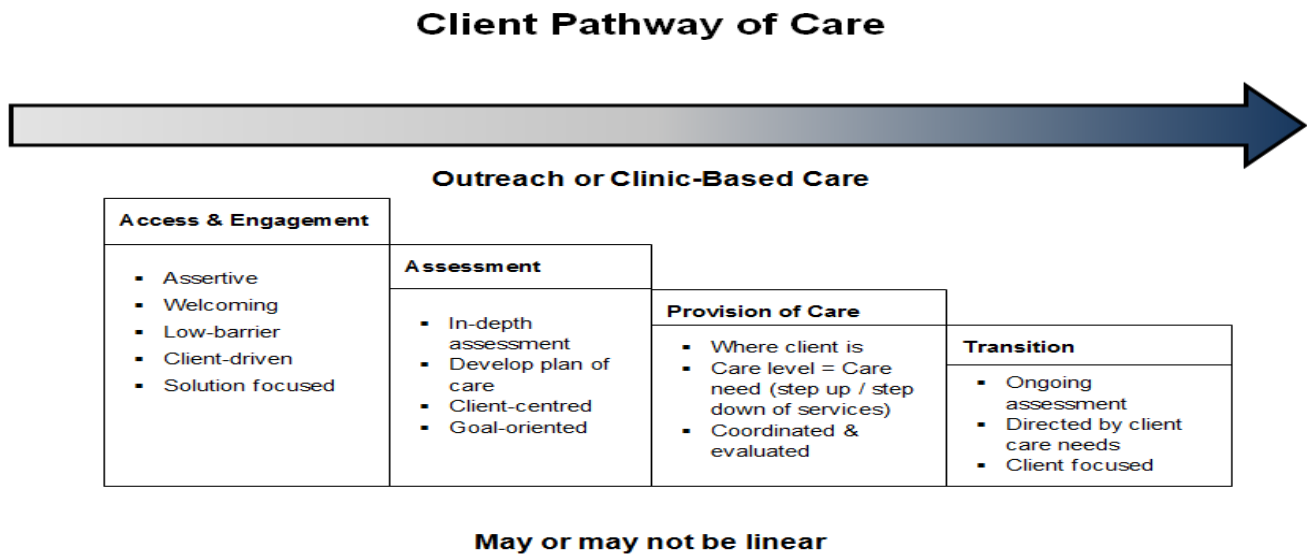
4.4 New possibilities – Vancouver’s Integrated Care Teams

Vancouver Coastal Health Authority (VCH) is developing a new system for delivering low-barrier primary care services for people who have issues with mental health and substance use (Ministry of Health, 2012, p. 11). Each client will have an integrated team working with him or her. The team will include medical professionals, mental health professionals, and substance use health care providers (Vancouver Coastal Health, 2015, p. 2). The Integrated Care Team (ICT) professionals work together and communicate directly about their clients to ensure seamless health care (Ministry of Health, 2012, p. 2), with the goal to streamline services and stop any duplication that may be occurring.

CMHA’s IPS specialists have been consulted in the preliminary phases in the program’s development, which is set to begin in late 2016, in regards to the types of employment services that would benefit ICT clients. At the moment, VCH is planning to place 2 or 3 Integrated Care Teams in Vancouver’s Downtown Eastside.

There will be various access points for potential clients to reach and use the ICT services. They may self-refer to one of the services provided, such as In-Site or a drop-in centre, community partners may refer them, or they may drop-in at an Integrated Care team (ICT) or Community Care team (CCT) (Vancouver Coastal Health, n.d., p. 1). There will also be many opportunities for the Integrated Care Team professionals to address wellness domains such as employment. Below is the proposed service delivery model for the Integrated Care Teams.

Figure 3: Client Pathway of Care (Ministry of Health, N.D., p. 1)



5.0 Findings: Cost-Benefit Literature Review and Comparison with WorkBC

Supported employment for people with severe mental illness is an evidence-based practice, based on similar findings from a number of controlled trials and quasi-experimental studies (Bond, G.R., Becker, Drake, Rapp, Meisler, Lehman, Bell, & Blyler, 2001, p. 313). IPS is more effective than other vocational programs in improving competitive work possibilities over 1-2 years for people who have severe mental illness (Hoffmann, Jäckel, Glauser, Mueser & Kupper, 2014, p. 1183). The evidence also shows that people with dual diagnosis can be successfully employed in competitive jobs and that this kind of employment beholds many benefits to the overall recovery process for people with dual diagnosis (Strickler, Whitley, Becker & Drake, 2009, p. 261-262.).

Despite reporting the desire to work and an increase in personal well-being and self-efficacy benefits associated with being employed, however, people who have serious mental health concerns still experience high unemployment rates (Larson et al., 2007, p. 71). Also, the traditional one-stop employment centres such as WorkBC in Vancouver are not designed for people with serious mental health concerns and are unable to increase employment for this particular group (Project Focus Group, September 24, 2015).

This section will review the costs and benefits of the IPS model of supported employment found in the literature and also compare the costs and effectiveness of IPS to traditional employment services such as WorkBC, which are B.C.'s one-stop employment centres, to assist the Canadian Mental Health Association – Vancouver Fraser branch in reviewing whether the pursuance of an expansion of the program to include people who have experienced homelessness would be beneficial and cost effective for the people of the Province of British Columbia.

5.1 The financial costs and benefits of an IPS program

As with all mental health services, cost considerations are a core issue for government. A number of studies review the cost of providing IPS to people who have serious mental health concerns.

According to David Salkever, Eric Latimer reported annual per-client cost for IPS in the \$3,500-\$5,000 range (in 2005 dollars), and noted that the amount would be lower if the programs reviewed reached the fidelity goal of having one IPS specialist to 20 clients (the programs reviewed did not necessarily reach this number of clients). There may also have been longer-term declines in cost as the programs mature (Salkever, 2012, p. 7). Please see Table 1 for a break-down of IPS costs at the CMHA. The CMHA provides a high-fidelity IPS program.

Table 1: Cost of IPS within CMHA Fiscal Year 2015-16 (CMHA, December 2015)

CMHA IPS Program Fiscal year 2014-15	Cost of program	Number of clients served	Employment outcome rate within first year	Average cost of service per client fiscal year 2015- 16	Cost per client that was successfully employed in competitive employment fiscal year 2014/15
	\$838,421	461	51%	\$1,819	\$3,583

The other cost-benefit of IPS is in the decrease of societal costs such as shelter, outreach, hospital, police and justice services (Streethome Foundation, 2011). The studies also showed that IPS undoubtedly showed an increase in earnings (Salkever, 2012, p. 5-6), and the costs of welfare benefits, loss of income tax and CPP contributions, and lost production (Off the Streets and into Work, 2006, p. 18).

5.1.1 Lowered cost of health care

IPS has shown to produce better outcomes than alternative vocation services at a lower cost overall to health and social care systems (Knapp et al., 2013, p. 60; Burns et al., 2009, p. 949).

According to one study of 100 IPS participants whose competitive work and hospital stays were tracked over five years, IPS can produce a higher social return on investment (Hoffmann, Jäckel, Glauser, Mueser & Kupper, 2014, p. 1183). The IPS participants who took part in this randomized controlled study were significantly less likely to be hospitalized, had fewer psychiatric hospital admissions, and spent fewer days in the hospital than the control group, who received traditional vocational rehabilitation (Hoffmann, Jäckel, Glauser, Mueser & Kupper, 2014, p. 1183). According to Hoffmann, Jäckel, Glauser, Mueser and Kupper, “[t]he social return on investment was higher for supported employment participants, whether calculated as the ratio of work earnings to vocational program costs or of work earnings to total vocational program and mental health treatment costs (Hoffmann, Jäckel, Glauser, Mueser & Kupper, 2014, p. 1183).”

Another study of IPS participants in 6 European cities who had not worked for at least one year before taking part in the program considered the various medical, social care and vocational rehabilitation costs that a person with mental illness may incur throughout the year, and showed that IPS was more cost-effective overall than other vocational services (Knapp et al., 2013, p. 60).

David Salkever, however, reviewed a total of 27 studies to bring together evidence of the social impacts of providing IPS programs, and showed that the health care offsets were about equal to the costs for IPS for most of the programs. This means that the research showed little difference in non-vocational outcomes such as rehospitalisation, even though there was a cost-benefit to vocational rehabilitation costs (Salkever, 2012, p. 7). In fact, Salkever states that,

“...review summaries of research findings have uniformly failed to support the proposition that IPS-SE leads to substantial treatment cost savings.”

At the same time, however, Salkever reported that Eric Latimer cited one small-scale study of 19 IPS participants who showed a substantial reduction in hospital use compared to their hospital use before they participated (Salkever, 2013, p.5). Salkever also showcased the findings of the six-site European controlled study mentioned above, which shows significantly less hospital use for the IPS participants than for the control group (20% versus 31%) and less time spent in hospital for the IPS group (4.6% versus 8.9%). It is worth noting, as Salkever has in his paper, that the European study may have been more successful than some of the American studies of IPS because the participants may have had a greater overall use of inpatient care. Therefore, it is difficult to generalize the results of the 27 studies considering that the USA, Europe, and Canada have different health care systems. Further cost analysis studies should be conducted with regards to the Canadian context. In addition, although there are a number of components of social cost impacts, the studies mainly reviewed the providers' costs of running the programs, the cost benefits in the reduction of traditional rehabilitation services because of increased employment, and how IPS affected clients' earnings (Salkever, 2012, p. 1). Please see Figure 4 below for a more comprehensive list of social cost impacts according to Salkever, which may be considered in further cost-benefit analyses.

Figure 4: Possible components of social cost impacts (Salkever, 2013, p. 3)

Components of Social Cost Impacts of Expanding Access to Evidence-Based Supported Employment^a

1. Implementation costs for establishing and providing supported employment services based on the individual placement and support model of supported employment (IPS-SE).
 - A. Costs of public-sector “overhead” activities for expanded IPS-SE programs (for example, recruiting more IPS clients and providers, training additional IPS-SE agency staff, overseeing and paying additional providers, and quality assurance).
 - B. Resource costs of provider agencies implementing expanded IPS-SE services.
2. Cost offsets of other mental health treatment and rehabilitation services.
 - A. Reduced costs for provision of other psychiatric vocational rehabilitation services.
 - B. Program impacts on costs for clients’ other mental health treatment and rehabilitation services.
3. Program impacts on costs for clients’ somatic health services.
4. Program impacts on costs for clients’ consumption of other goods and services not purchased directly by clients.
 - A. Program impacts on costs of other government-provided goods and services minus impacts on client tax payments.
 - B. Program impacts on costs of other goods and services from charitable organizations minus client contributions.
5. Program impacts on net private consumption of other goods and services purchased by clients directly with their own funds (items A–C below).
 - A. Impacts on clients’ income available for private consumption (for example, earnings, transfer income support from governments, help from family members, and cash gifts from others).
 - B. Impacts on clients’ earnings.
 - C. Impacts on clients’ savings.

^aItems 1, 2, and 3 may include both public and private third-party payments and out-of-pocket costs. For simplicity, the discussion assumes that all these costs are paid by governments.

5.2 Other employment programs available for people who have multiple barriers in B.C.

As of April 2012, the Ministry of Social Development & Social Innovation (SDSI) replaced all Labour Market Development Agreement (LMDA) employment programs and services and all provincial employment programs for B.C. Employment Assistance (BCEA) recipients with one core program - the Employment Program of BC (EPBC). The EPBC was developed to provide a

one-stop shop for the full range of employment services and programs available in the province (John Coward Consulting, 2013; WorkBC, 2014).

Within the EPBC program, which provides the WorkBC sites that are situated around the province, multi-barrier individuals (people who have two or more barriers to employment such as housing, addictions, and mental health) are considered a Targeted Population requiring specific services. The program is designed so that contractors can provide specific programming designed for their particular needs.

WorkBC was developed to provide access to employment-finding support to all individuals in need of help finding employment. According to a Province of British Columbia report, *specialized populations* account for 74 per cent of all active case managed episodes (Province of British Columbia, 2015, p. 3). In August, 2015, 9,699 people who identified as having *multiple barriers*, which made up about 22% of the case managed episodes for the month, utilised WorkBC's services.

Chart 1 shows some of the specialized programs that are aimed at targeted populations. Depending on the number of multi-barrier clients in a geographic location, EPBC will decide whether to contract an organization to provide employment services or designate an experienced case manager or a case manager with specific training to work with multi-barrier clients (John Coward Consulting, 2013, p. 21).

Figure 5: WorkBC Programs Targeted at Clients who have Multiple Barriers (McEown, 2015, p. 3-4)

- Aboriginal Business Entrepreneurship Skills Training;
- Aboriginal Training and Employment Program;
- Bladerunners;
- Employment Skills Access Initiative;
- Immigrants in Trades Training;
- Job Options BC;
- Job Options BC - Urban Older Workers;
- Labour Market Sector Solutions;
- Skilled Trades Employment Program;
- Skilled Trades Employment Program - Job Match Services;
- Skills Connect for Immigrants;
- Targeted Initiative for Older Workers;
- Targeted Skills Shortage Pilot Program;
- Trades Training for Aboriginal People;
- Women in Trades Training;
- Women's Mentorship Programs;
- Youth Skills BC - Workplace Programs; and
- Youth Skills BC - Entrepreneurship.

According to John Coward Consulting, the only alternative programming to WorkBC for people facing multiple barriers is the Specialized Community Assistance Program (SCAP) funded through the Labour Market Agreement and administered by the Ministry of Social Development (MSD) (John Coward Consulting, 2013, p. 22). The program provides long-term case management for chronically homeless individuals. However, this program has limited influence on facilitating entry into the mainstream labour market (McEown, 2015, p. 2). Table 2 shows the estimated cost per client for WorkBC for specialized populations.

5.2.1 Cost of WorkBC for Tier 3 and Tier 4 Client Classification

The clients that the CMHA currently provides IPS to, and to whom they propose to provide future programming to, would likely be considered Tier 3 and Tier 4 clients within the WorkBC framework. The categories are not defined clearly, however, because according to a WorkBC representative, WorkBC provides individualized services and supports to all unemployed British Columbians. Tier 3 and Tier 4 refers to the complexity of the barriers that some clients face in relation to the employment continuum. Correspondence with a representative of EPBC showed that EPBC was not able to specify the criteria used to assign clients to Tier 3 and 4 because each case is highly individualized. The representative stated that each person would be eligible for different services based on a myriad of criteria.

The vision for WorkBC is to provide individualized support to every person. Their programming options are based on complex eligibility, and when they do not have the programming resources that they need, they connect with organizations within the community who can provide these resources.

Below is a summary of the costs of WorkBC services for people who are considered Tier 3 and Tier 4.

Table 2: Cost of WorkBC Programs in BC from April 2012 to November 2015 (EPBC, December 22, 2015)

WorkBC Programs	Number of case managed episodes	April 2012 to November 2015 – Spent on Tier 3 and Tier 4)	Employment outcome success rate	Average cost of service per client fiscal year 2014/15	Cost per client that was successfully employed in competitive employment fiscal year 2014/15
Tier 3 Clients	89,811	\$106,515,846	34%	\$1,186	\$3,468.67
Tier 4 Clients	29,369	\$39,413,198	17%	\$1,342	\$7,812.33

5.3 Summary

The tables above show that, according to the Government of British Columbia's WorkBC statistics, since the launch of WorkBC, 34% of Tier 3 and 17% of Tier 4 clients, found work in competitive employment. In contrast, the CMHA has been able to reach a 51% success rate with its clients within their first year of receiving services.

This review shows that the costs associated with finding employment through IPS are only slightly higher to WorkBC on a per client basis for Tier 3 clients, and about half the cost of WorkBC in assisting a person in their Tier 4 classification. The CMHA cost per successfully employed client (Tier 3 or 4) is \$3,583 per person. The WorkBC cost of helping people who are considered Tier 3 clients to secure competitive employment is \$3,468.67 per person, and the cost for Tier 4 is \$7,812.33 per person.

The literature also shows that employment generally has a diminishing effect on social costs for people with severe mental illness in some circumstances, such as a decrease in hospital use. The CMHA should therefore consider ways to expand IPS services to people who have experienced homelessness in order to decrease mental health treatment and other social costs including shelter, outreach, justice and police in the Vancouver Coastal and Fraser Health regions, and increase employment income, income tax and CPP contributions.

6.0 Findings: Interviews and Focus Group

This section of the report will provide an overview of key findings obtained through one-on-one interviews and one focus group of supported employment and supportive housing experts. A total of 12 interviews were conducted, and the focus group included 7 participants. Nine of the interviewees were IPS specialists and 3 were IPS researchers. The focus group participants were employment specialists (IPS or other), funders of employment programs, or supportive housing specialists. All of them work in Canada and the U.S.A.

All interviewees had rich experience to share, and 5 key themes emerged. These included a general satisfaction with the IPS program, and many confirmed the benefits and alignment with the principles of IPS with stories about their own clients. As with other grounded research studies, the interviews were initially semi-structured with some set questions, but the researcher allowed room for discussion and later, as the theory was developing, questions that were more focussed on the emerging themes were asked (Grounded Theory Online, n.d.).

While the initial intention was to only interview housing and supported employment specialists, it became apparent that it would benefit the research to also interview researchers who understand that, while IPS is considered the evidence-based employment practice that works best for people with serious mental health concerns and issues with chronic homelessness, the research may also show some challenges in setting up the IPS group in an ACT or ICM team.

The CMHA's main concern was to maintain the fidelity of its IPS program, as it has been successful at providing a successful and robust IPS program over the last 15 or so years. We started by reviewing the possible ways in which an IPS program can be part of Assertive Case Management (ACT) and Intensive Case Management (ICM) teams that already exist within the supportive housing and Housing First models that currently exist in Vancouver, and found additional possibilities.

6.1 Integration within a mental health team

Corresponding with the literature, all of the participants in the study agreed that obtaining high fidelity to the IPS program would ensure greatest success in measurement outcomes. Rapid job search, integration with a mental health team and ensuring the hardiness of the IPS workers were cited as the key components of a good IPS program.

According to most interviewees, working within a mental health team is a requirement and the hallmark of IPS. There are a number of reasons why an IPS specialist cannot work within a stand-alone clinic program, but the main reason is that the mental health team and the IPS specialist need to communicate. This helps in occasions where the clinical team is aware of something that can potentially have an impact on the work of the client, or when the IPS specialist sees a need to adjust a client's medication. The clinical team itself also needs to see the value of supported employment as a concept, and the effects that employment has on their client. An IPS specialist that is embedded in a team can consistently communicate the efficacy of the program.

6.2 IPS for people who have experienced homelessness

The interviewees agreed that IPS is the best program for employing people with serious mental health concerns, including people who have experienced homelessness. One of the reasons cited was that the program has no restrictions compared to the one-stop employment centre model, which may restrict their employment specialists from being able to use their skills in a way that brings some of the most marginalized people along in their employment journey. For example, time is essential when working with people who have experienced homelessness, and an IPS specialist will work on finding connections for people and work with people on their self-esteem issues right away instead of advising the client to take work preparedness workshops.

There are circumstances, however, in which IPS may be restricted. One interviewee mentioned that a randomized control study hasn't been conducted to analyse whether IPS meets its outcome measurement goals with people who are *currently* homeless (although there are IPS programs for clients who are currently homeless). The research has shown IPS to be effective with people who are currently housed and receiving medical and mental health treatment through a mental health team.

There are many additional barriers to trying to get a job for people who have experienced homelessness. Hence, there might be some wisdom in thinking that an IPS program that worked with people who had been recently homeless will itself need to adapt, and need time to understand what clients' needs are on an individual level. One interviewee said that a client may think, 'Work is good for me but there are things that I need to do to maybe make myself ready for it.' There are things you need to relearn to do once you are housed. Since an immediate job search is a component of IPS, a number of key wellness domains will need to be addressed simultaneously with employment.

6.3 Developing the culture of IPS within an ACT or ICM team

The culture of the integrated mental health team is very important. Clinicians need to believe that their clients can and will obtain competitive employment.

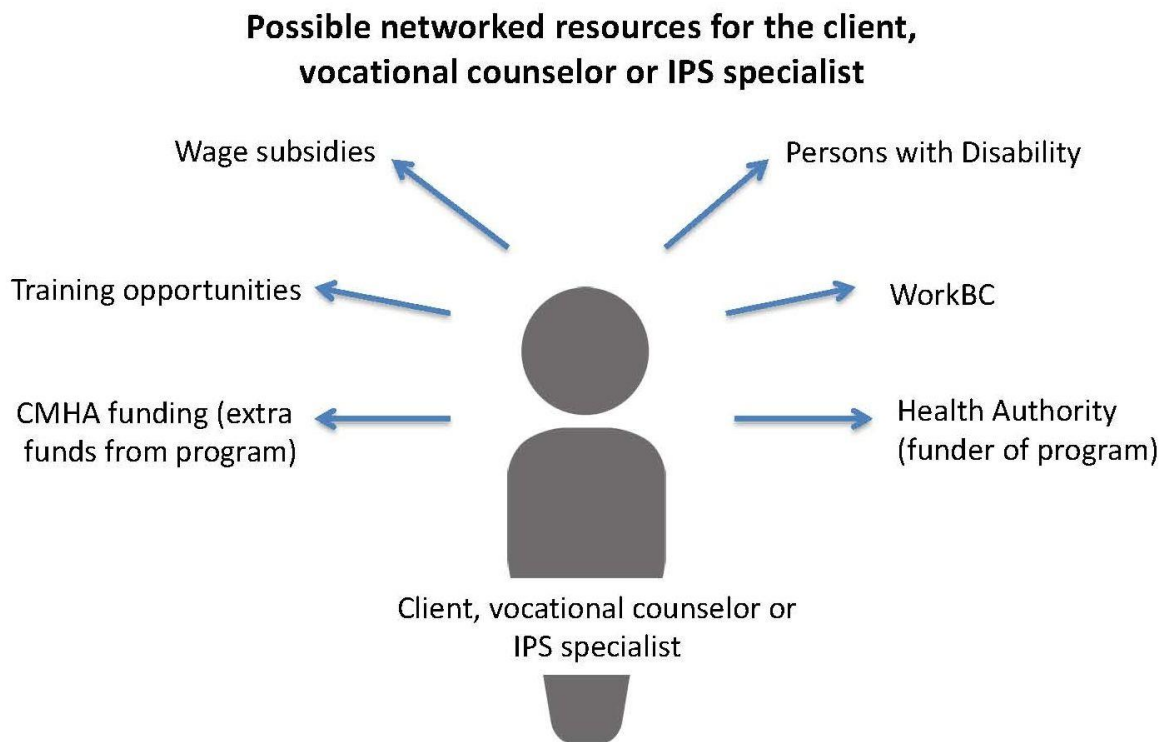
Many respondents thought that working within an ACT or ICM team could be difficult for an IPS specialist, because the case managers who work on the team, whether they are an occupational therapist or social worker or psychiatrist, work in a trans-disciplinary way. On these teams, case management takes precedence and everyone is expected to contribute to the overall wellness of each individual as required. The IPS specialist may, therefore, be expected to deal with crisis situations outside the employment domain.

Another problem that an IPS employment specialist often faces is that staff members of the team they work with feel that their clients need to complete other goals before they are ready for competitive employment, such as dealing with their substance use through a treatment program.

Finding the right mental health team to work with is therefore important. An ACT or ICM team that works well with an IPS specialist can help by providing some of the resources that their clients would need to find and retain employment. The employment piece cannot work without the case managers, as they set up appointments and know what medications their clients are taking. IPS specialists need to work alongside them. For example, the Occupational Therapist could look for funding for one- or two-day course that would help the client obtain a job in the industry that they would like.

Finally, IPS employment specialists require strong, focused leadership and direct support and supervision from IPS trained supervisors to avoid program drift and to keep IPS on track.

Figure 6: Possible Funding and Training Resources Available to Client, Vocational Counsellor and IPS Specialist



6.4 IPS compared to one-stop employment centres

The focus group discussed the restrictive protocols that the one-stop employment centres have, such as asking clients to attend job search or other types of workshops before they start. Some of the interviewees agreed that the architectural arrangement of a one-stop employment centre is daunting for some people who live in supportive housing. One-stop employment centres can feel clinical, as they are set up as a social enterprise. Another way that the IPS model differs is that, while an employment specialist at a one-stop centre may propose a number of unique and innovative ideas that involve creating an action plan and going through

the processes of vocational planning, IPS will just start looking at the skills and possibilities for employment.

6.5 Other possibilities for working with people who have been homeless

There may be possibilities for an IPS specialist to work within a medical team that wasn't an ACT or ICM team, as long as there is a mental health component to the team. The reasons as to why we would want to develop additional opportunities differed within the group. One interviewee noted the benefit of being able to reach a larger number of people. IPS might be a key to employment for people who have experienced homelessness, but it cannot be the only piece as it has been developed for people with severe mental health concerns.

One possibility is working with clients who are attending integrated out-patient clinics to receive physical and mental health treatment, such as Vancouver Coastal Health's proposed Integrated Care Teams which are being developed to start in the Fall of 2016. According to one interviewee, it's difficult to know how this would be managed because many people who have experienced homelessness and who are living in Housing First are in need of a more intensive follow-up. On the other hand, if a client who had been part of a mental health team is stable, they may or may not continue to need the intensive case management of that team. Another concern is how an IPS specialist would be connected to the clinicians of such a team, and if there will be a process for linking them and if the MD or Psychiatrist will actually make the necessary referrals.

6.6 Stakeholder Analysis

A stakeholder analysis in Table 3 was conducted to assist the CMHA in its project development and implementation stage by ensuring that the people and organizations that will be effected and can affect the new program will be consulted regularly and sent appropriate and timely communication.

According to John M. Bryson, leaders need to pay close attention to the concerns of their organizations' key stakeholders (Bryson, 2011, p. 48). A stakeholder analysis is a way for an organization's leaders and staff to incorporate the networks and politics of their organization (Bryson, 2011, 48).

The CMHA's core funding comes from Vancouver Coastal Health and Fraser Health Authorities and the CMHA has a strong relationship with both of these organizations. A stakeholder analysis is important here because the satisfaction of key stakeholders is the key to success. The CMHA's stakeholders will help drive the organization's potential new IPS projects through support, resources, and funding.

Table 3: Stakeholder Influence Chart

Stakeholder Group	Description of Group	Impact (your view on how you impact their aspirations)	Level of Influence / Power	Buy-In and Involvement Strategies	Action Owner	Time Frame
Housing providers and service providers to people who were formerly homeless (including organizations with safe spaces, drop in centres, Assertive Community Treatment teams, Intensive Case Management teams, and youth services)	Our partners within this group will provide Housing First and potentially have an ACT or ICM team.	High - IPS will impact this group in a number of ways such as helping their clients find employment.	High - This group has a high influence because we would have the same clients. Their relationship could help negotiate funding and project development, especially if their management thought we would be a good fit for their ACT or ICM team.	Start building stronger alliances with organizations that we do and do not have relationships with through digital communications, personal communication, meetings, and networking.	IPS staff; CMHA Leadership Team; CMHA Communications	Project funding/development stage
Police community outreach, bylaw enforcement and drug court	Police and justice personnel who engage with people who are currently or have been homeless	High - higher employment rates could mean a reduction in policing and justice needs	Low - Influencers in the development or sustainability of the project except for Option 3. They could potentially fund Community Support Workers to help people who have experience with the justice system to find employment.	Emails and social media that communicates about the project. If the CMHA goes with Option 3, meetings with police and court administrators would promote the project so that we could eventually ask for funding.	CMHA Communications	Project funding/development stage

Primary care providers (doctors and medical clinics)	Provide the first point of contact with a health care provider for prevention, diagnosis, treatment, followup and long-term management of health concerns.	Medium - An employment program would impact their clients' health and potentially lower costs to the health care system.	Low -They cannot help the CMHA obtain funding. They can, however, influence clients once the project is underway (and in that case their influence will change)	We will need to consult with medical associations and doctors groups, particularly in the Strathcona and DTES areas but also any clinic or medical office where someone who lives at a Housing First building might attend to.	IPS Staff; CMHA Communications	Project funding/development stage
Integrated Care Teams, mental health teams such as ACT and ICM	IPS is situated in these teams. Finding the right team to work with is important, as team culture can influence outcomes.	High - If they were to include IPS in their models, they and their clients would be impacted greatly	High - Existing teams that want to work with us may be able to obtain funding.	Continuous and strategic communications efforts through one-on-one discussion, group meetings and networking opportunities.	Program Director	Project funding/development stage, work with ICT and/or ACT and ICM teams to develop a strong IPS/employment culture within the team.
BC Housing	BC Housing is the housing funder for services and response to homelessness in B.C.	High - Many potential IPS clients utilize BC Housing services	High - They have both a high political influence and influence on the program funding.	Michael will communicate with the relevant BC Housing management staff in order to let them know of our intent to begin the project, as well as discuss the	Michael Anhorn	Project funding/development stage

				background and resources required.		
Policy organizations such as City of Vancouver, Ministry of Social Development and Social Innovation, Ministry of Health, and Employment and Social Development Canada (ESDC)	As government bodies, these groups have a vested interest in solving homelessness and providing employment support to people. MSDSI already funds WorkBC for example and CMHA is receiving funding from ESDC at the moment.	High- We will be helping these organizations meet some of its targets on street homelessness.	High - They are influencers on the development and sustainability of the project.	We will be asking these organizations to help us in our project development, and once we implement the project we will meet with each of these groups to discuss support and funding.	Michael Anhorn	Project funding/development stage
Local businesses	Potential employers	Medium - businesses will provide employment, and they will therefore find suitable employees to work for them. Some may also be fulfilling their Corporate Social Responsibility goals by employing our clients	Low	Newsletter, email.	CMHA Communications	Project implementation stage

People who have experienced homelessness, who live in supportive housing and who wish to find employment.	Some people in this group will be participants in the project(s)	High- they are the program participants	High - Current and potential clients can influence project model	After project implementation, we will be communicating to potential clients through the agencies that support them. If marketing is required, we will develop brochures, website, meetings, events, and other means of communication.	CMHA Communications	Project implementation stage
Advocacy organizations and movements like Carnegie Action project, PLEA, Tenants Rights Action Coalition (Trac), MPA Society.	This group advocates on behalf of people who have experienced homelessness or who have issues with mental health. They help people find housing, apply for benefits, etc.	High - We will be helping their clients find employment.	High - This group can refer clients to the CMHA for mental health (and possibly employment) support.	Inform through emails, personal communication, newsletters, invitations to events	CMHA Communications	Project implementation stage
Addictions services in Vancouver including Vancouver Coastal Health, Provincial Health Services Authority and Fraser Health	Provide point of contact for people who have issues with addictions.	Medium - an IPS project can potentially lower the need for social services such as addictions services	Medium - this group may influence project funding if they felt that employment could influence their outcomes	Inform through email, digital communications	CMHA Communications	Project implementation stage
Politicians and Political Parties	Influencers of our funders.	High - IPS can improve employment outcomes for the city and province	High - Their backing may help us obtain and maintain project funds	Send communications package and follow up with meetings	Michael Anhorn	Project funding/development stage

Banks and financial institutions in the Downtown Eastside (i.e. Pigeon Park Credit Union)	These financial institutions provide support to potential IPS clients; they are the banks that IPS clients will likely use when they are employed	Low impact - they will be impacted by having an increase in clients who are employed	Low influencers in the development or sustainability of the project but high influencers on our participants who engage with the banks more often.	Send emails and brochures	CMHA Communications	Project implementation stage
Health authorities (particularly Fraser Health Authority, Vancouver Coastal Health Authorities)	Fraser Health and Vancouver Coastal health authorities have been funding CMHA's current IPS program and would potentially fund additional program staff	High - IPS influences the health authorities' impact	High - They provide the program funding	Personal communication	Michael Anhorn	Project funding/development stage
Private and corporate funders such as foundations, individuals, and banks	Some funding groups have housing and employment as part of their funding criteria	Low - this group would like to see people who have experienced homelessness in competitive employment but would find other projects to fund if we do not approach them	Medium - they can help CMHA develop and sustain their program financially	Personal communication	Michael Anhorn, Director of Fundraising	Project funding/development stage OR Project implementation stage

6.7 Summary

The interview and focus group participants were very supportive about expanding the CMHA's expertise of IPS from working with people who have serious mental health concerns, to include people who have experienced homelessness. Many of them discussed the perils of having an IPS specialist on an ACT or ICM team, but they also provided recommendations to be able to ensure that the IPS specialist is protected so that he or she can do their job while there might be a crisis or some other important matter that needs to be tended to by the clinical staff.

Some interviewees also spoke of the challenges some of their clients have in using one-stop employment centres. The one-stop employment centres have restrictions that may seem bureaucratic to someone who has lived on the street, and the centres are placed in buildings that are intimidating to some people.

Finally, many interviewees spoke about the possibility of expanding the CMHA's IPS program to reach a greater number of people. One of the possibilities mentioned was to work with clients in an out-patient clinic that is equipped with doctors, nurse practitioners, and psychiatrists, all of whom can prescribe medication.

The next section will discuss these findings in more detail and outline key themes outlined in the literature review, cost-benefit analysis and interviews.

7.0 Discussion and Analysis

The purpose of this section is to review findings and identify common themes as well as differences that arose between from the various methods – the literature review, the cost-benefit analysis, interviews and focus group - in relation to the project’s research questions. The first section provides an overview of some of the common themes that emerged from the findings. The second part of this section discusses the possible strategic opportunities for the CMHA.

7.1 Summary of Findings and Common Themes

The literature review was developed to provide the CMHA with additional background information to be able to adapt their current IPS program. It strengthened the argument that employment is beneficial to people who have experienced homelessness, and showed that IPS is the most researched and most effective model for helping this population obtain and retain employment. The review centred on fidelity as a theme, and noted that organizations that obtained a high fidelity score also had better outcomes.

The cost-benefit analysis showed that IPS was successful at lowering hospital use in some circumstances, resulting in a positive cost-benefit for Government. It also showed a comparable cost to WorkBC in relation to working with Tier 3 clients, and a considerably lower cost to WorkBC in relation to working with Tier 4 clients.

The interviews offered additional information on the strengths of the program, and most interviewees spoke about client readiness, the necessity for IPS to integrate with a mental health team, and ways to ensure the IPS specialist is able to do his or her job considering the case management environment of ACT and ICM teams. The interviewees also recommended new ways to impact a larger group of people, both by using IPS in an Integrated Care Team, and by partnering with WorkBC to provide Community Support Workers who would help Tier 3 and Tier 4 clients to navigate the WorkBC system better.

Additional research and evaluation opportunities may also lead to the modification of the existing fidelity model if required, depending on the outcomes of new possibilities. An adapted program may provide people who have experienced homelessness with additional support or programming, for example.

7.2 Strategic Implications - Adapting the CMHA’s current IPS program for people who have experienced homelessness

7.2.1 The benefits and promising practices of an IPS program that is geared towards people who have been homeless

A top priority for any new program is to build trust with clients. There was a resounding theme of *engagement* in the literature review, interviews and focus group. The literature review focused on 5 research studies, for example, that showed that IPS programs that provide

adequate support and engagement also provide successful outcomes. In cases that engagement and support were not developed, whether it is because the project was new (running for less than 2 years) or the program didn't have high fidelity, the program outcomes in many of the studies were lower than expected or just moderately better than the control groups. Small adaptations to the programs that addressed the specific needs of a particular group, such as including the natural support systems for youth at the Jeff Griffith Youth Center, also increased engagement and support for these individuals. Poremski, Whitley, & Latimer stated that once trust was established a working alliance was able to form and employment specialists were able to motivate their clients and change negative beliefs (Poremski, Whitley, & Latimer, 2015, p. 3-4).

Most of the suggestions that came from the interviews and focus group were also related to engagement. Many of the interviewees spoke at length about the need to integrate IPS within a mental health team and the need to have adequate supervision from an IPS supervisor, as well as support from the other staff members on the mental health team. The other two main principles discussed were a) a rapid job search and b) ensuring the hardiness of the IPS worker, both of which have an underlying benefit of keeping the client motivated and connected. Integration means that the IPS specialist can communicate with the mental health team so that the medical and scheduling needs of the clients can be addressed quickly, a search of funding and training opportunities can be made quickly, and the clinical team becomes aware of the efficacy of the IPS model and the benefits of employment for their clients.

The focus group discussed the restrictive qualities of one-stop employment centres such as WorkBC that may impede people who have experienced homelessness from engaging with them, such as requiring people to attend resume writing and job search seminars. The architectural arrangement was thought to be daunting for some people who live in supportive housing, let alone the process of registering with a receptionist and waiting for an employment specialist to meet with them. Because of the individualized approach at a location/service that Tier 3 and Tier 4 clients already use, a hardy IPS specialist may be able to address some of the barriers for people who have been homeless.

7.2.2 Ways in which IPS can save the provincial government money

IPS is better at helping people with serious mental health concerns obtain employment compared to one-stop employment centres. For example, the CMHA has been effective at helping 51% of its IPS clients, most of whom fit into WorkBC's Tier 3 and Tier 4 classification for service, find employment within the first year, whereas WorkBC was only effective at helping 34% of its Tier 3 clients and 17% of its Tier 4 clients find employment in fiscal year 2014-15.

IPS costs only slightly more to help Tier 3 clients obtain competitive employment within one year than WorkBC, and it costs less than half for Tier 4 clients to obtain employment within one year than WorkBC. If we account for reduced social costs such as hospital stays, the cost-benefit of IPS is further increased. The other cost-benefits of employment in general, including a decrease in shelter, outreach, police and justice service costs, should also be considered.

The higher success rates that IPS has in finding employment for people in the Tier 3 and Tier 4 classifications are important to the individuals and society. The studies showed that employment through IPS resulted in an increase in earnings (Salkever, 2012, p. 5-6) and a reduction in the costs of welfare benefits, lost income tax, and lost CPP contributions (Off the Streets and into Work, 2006, p. 18). While the main benefit of IPS is that it gets people to work, it also helps to offset some of the social costs related to unemployment and health care, making it less expensive, or at least equal to, the costs of leaving someone unemployed.

A more in-depth cost-benefit analysis of IPS and the costs and benefits of competitive employment for people who experience homelessness would provide the CMHA with additional context for increasing IPS project support in the Lower Mainland, and particularly in Vancouver's Downtown Eastside.

7.2.3 Fitting IPS into Vancouver's new Integrated Care Teams

It would be beneficial to more clients if IPS were integrated with additional mental health teams. The CMHA could therefore approach ACT, ICM and VCH's Integrated Care Teams (ICT) to provide IPS employment support to a larger number of people than they would on an ACT or ICM team.

In the case of ICTs, the issue is that the organization would not necessarily meet fidelity in relation to integration. If the CMHA were to work with an ICT, it would need to research the program to ensure the needs of the clients are met and the outcomes are still positive. If the results are positive but the program adjusts significantly away from fidelity due to the research findings, the CMHA may also need to change the name of the program. Another concern was that the ICT and CMHA would need to find ways to connect the client with IPS support, as the ICT mental health team itself may not be as unified as an ACT or ICM team. Whether the Integrated Care Team's mental health client self-referred or was referred by a mental health professional on the team, for example, the client could be invited to informational sessions that they must attend at least twice in order to ensure they are motivated before starting the program. At the same time, the CMHA could also set up training sessions for the clinical staff so that clinicians could learn how to start discussing employment needs with their clients right away and start referring clients to the team's IPS specialist.

7.2.4 Partnering with WorkBC to increase outcomes for people who have experienced homelessness

Many people who have experienced homelessness encounter additional barriers to finding employment when they navigate the WorkBC system. Members of the focus group explained that both employees at WorkBC and the CMHA already understand some of the issues in this regard. In addition, not every person who has been homeless is eligible or wants to be part of an ACT, ICM or community mental health team, and so IPS isn't necessarily available to every person who needs it.

By using some of the principles of IPS, there may be an opportunity for the CMHA to help a larger number of people who have experienced homelessness by collaborating with WorkBC and providing Community Support Workers who help clients navigate the WorkBC system, set up appointments, attend meetings with their client, conduct internet searches and motivate clients.

7.3 Summary

IPS works better for people who have experienced homelessness than other vocational programs because it has been developed to engage and build trust with clients and their mental health teams. When adapting or developing new IPS programs for people who have experienced homelessness, therefore, the CMHA should consider ways in which to maintain this engagement. The CMHA's program already meets high fidelity standards, and they should also continue to make this a priority of their programming.

The program costs are less than WorkBC considering the needs of both Tier 3 and Tier 4 clients together, and therefore the CMHA should find additional opportunities for working with clients with this level of need.

8.0 Options to Consider and Recommendations

This section presents two options for the CMHA to consider as the organization continues to develop its employment programming for people who have experienced homelessness, and an additional third option to adopt and maintain this project's stakeholder analysis, which will help the CMHA assess communications tactics for the project(s) they choose to develop. These stakeholders may be interested in providing the funding and other resources required to implement the following projects.

These options were identified because they had either worked previously or are currently being considered in other parts of North America. In addition, the CMHA has the knowledge base to implement all of these options and therefore, implementation would only require additional staffing and funding resources.

It is worth noting that most of this project's interviewees worked in, or researched, either ACT or ICM teams. In Vancouver, most ACT teams have a vocational counsellor as a permanent position on their teams, and so for now it would benefit clients more if the CMHA found other opportunities to implement IPS. The CMHA could eventually approach the health authorities about working on ICM teams, but in the meantime this project proposes the options below as the most impactful and practical projects to take on this year.

8.1 Option 1: Partner with Vancouver Coastal Health's Integrated Care Teams (ICT)

As employment is an important part of the recovery of persons living with serious mental illness and having experienced homelessness, it would benefit clients of Vancouver Coastal Health's new Integrated Care Teams to be able to access an IPS program.

Many people who have experienced homelessness and who have issues with mental health are not eligible, may not want, or may not be able to access, the intensive case management and mental health support of an ACT or ICM team. Many people in this position would still benefit greatly from the support and motivation of an IPS specialist to help them find and retain employment.

The new Integrated Care Teams in Vancouver will provide primary health care for both physical and mental health. The model is based on the strengths, resiliency and recovery of its clients. This means that the integrated health team will be available to support clients in meeting their own identified health care goals, which will be co-created with the client (Ministry of Health, 2015, p. 2).

Concerns around meeting fidelity and ensuring that the integrated health team connect the client with IPS support would be mitigated by:

- Incorporating a research component to the program to consistently review outcomes and make changes according to the needs of clients

- Providing training to the Integrated Care Team staff so that they understand what IPS is and how it benefits their patients
- Consistently communicating outcomes and client stories with the Integrated Care Team staff so that they can learn about the benefits of IPS and develop a culture of IPS on the team
- Arranging informational sessions each week so that potential clients who are interested in employment can learn about IPS. Clients that attend two sessions will be able to register for the program if there is space available (to reach higher fidelity, IPS specialists should have 18-20 clients at a time).
- Maintaining the independence of the IPS specialist to do what is detailed in his or her job description
- Ensuring adequate supervision and support of the IPS staff.

8.1.1 Developing Training based on project findings

Whether the CMHA joins an ACT, ICM or ICT team, it would benefit the CMHA to develop staff training specific to working with people who have experienced homelessness based on the recommendations from the interviewees and the literature review findings of this project. Here are some examples that this training could be based on:

- It takes longer to develop trust with clients who have complex needs
- Youth in particular need their natural supports such as their friends from the street that they consider family
- The IPS specialist could be trained in motivational interviewing
- Effective management of illnesses could be integral to becoming a client who becomes a consistent worker
- Some barriers may need to be addressed, and they may include: a hesitation to reveal sensitive information; fluctuating motivation from clients; continued substance use or fear of relapse; fears and anxiety around re-experiencing trauma related to when clients had been homeless
- IPS programs can be designed so that clients see the same employment specialist at each visit to build a working alliance and trust
- The quality of training provided to staff is important to the outcomes
- It takes time to build the expertise within an organization, which also yields better results over time.

8.2 Option 2: Partner with one-stop employment centres to provide complementary services for Tier 3 and Tier 4 clients (this is not IPS)

This option recommends that the CMHA develop a program to provide community support workers to provide advocacy and support to people who live in supportive housing by taking them to WorkBC offices and helping them through motivational counselling (please see Appendix C – Washington State’s Employment Strategy Quadrants, for more details).

This option is recommended because many people who have experienced homelessness have challenges approaching a WorkBC office. Yet, as many as 70% of people who experience homelessness want to find competitive employment (Drake, Bond & Becker, 2012, p. 3).

The community workers may have 50 or 60 clients, and their goal would be to increase the WorkBC outcomes for clients who have been homeless and who experience mental health issues.

8.3 Option 3: Adopt and maintain stakeholder analysis and communications plan

In addition to developing their programming, the CMHA can adopt and maintain their stakeholder analysis and create and implement a communications plan to ensure that the people who affect the program, and the people who will be affected by the new program, will be aware and engaged with its development, implementation, and measurement. This will ensure that the program will receive the support and funding it requires to be viable, and also enough interest because of expected results from potential clients who may benefit from it.

8.4 Option 4: Develop an Evaluation Framework

To assess the progress of their new or adapted program(s), the CMHA can build an evaluation framework into their programs, which will state that the organization will conduct an evaluation at least every three years. Regular and ongoing monitoring will take place to feed into the evaluation and key performance indicators will be developed at the outset of the initiative to monitor progress.

8.5 Comparing the Options and Recommended Approach

The CMHA's current IPS programming and resources would allow it to adapt their existing program to implement Option 1, Option 3 and Option 4 right away. They could, as detailed in the findings of this report, review the additional barriers of working with people who have been homeless and adjust their hiring practices to include additional employment specialists who have experience in working with people who have experienced homelessness and who are hardy and resourceful. Option 1 also proposes that the CMHA develops training for IPS specialists that will prepare them for working with clients who have complex needs, such as issues with addictions and homelessness.

While the CMHA is considered a specialist in IPS for people who have serious mental health concerns, it has not necessarily been considered a specialist in working with people who have been homeless. In order to obtain the funding and support they require to be able to implement the programs, they will need to build new relationships with individuals and programs within the health authorities and elsewhere that manage health issues related to homelessness, including mental health teams such as ACT, ICM and ICTs in Vancouver and across the Lower Mainland.

To note, while Options 1, 3, and 4 are the current recommendations, the CMHA may decide to adopt some or all aspects of Option 2 and develop a program to assist people in navigating the WorkBC process.

8.5 Summary

This section provided four options to help the CMHA adapt their current IPS program for people who have experienced homelessness. The first option is to augment their program slightly, and provide employment support to the new Integrated Care Teams being developed by Vancouver Coastal Health. Based on their experience, the interviewees provided some suggestions for ensuring that the CMHA reaches a high fidelity rating, even though full integration within a mental health team may not be possible. The interview and literature review findings also provide a basis for training material to be developed so that IPS specialists can better work with clients with complex needs. The second option acknowledges that IPS is currently not available for everyone who has experienced homelessness, and provides a recommendation for the CMHA to develop a program that helps clients utilize WorkBC services. Finally, the third option is for the CMHA to adopt and maintain the stakeholder analysis that will impact the project's funding and support.

This paper recommends that the CMHA implement Option 1, and also options 3 and 4. Option 3 will help the CMHA acquire the resources and support it needs by ensuring that the people who affect the program, and the people who will be affected by the new program, will be aware and engaged with its development, implementation, and measurement. Option 4 will ensure that the program that they choose to develop will continue to provide the best outcomes for its clients.

9.0 Conclusion

A recovery goal for many people with issues associated with homelessness and mental health is to find competitive employment that is congruent with personal preferences and is personally satisfying (Bond, Salyers, Rollins, Rapp and Zipple, 2004, p. 571). The benefits of work to mental and physical health and the harmful effects of unemployment are also now both widely recognized (Centre for Mental Health, 2014, p. 1).

The purpose of this report was therefore to seek ways to adapt the CMHA's current Individual Placement and Support (IPS) model to benefit people who have experienced homelessness. This included identifying the reasons why IPS might work better for people who have been homeless in comparison to traditional vocational programs, as well as providing recommendations for changing the model as and if required. Responding to this challenge required a review of the literature to gather existing knowledge of IPS programs around the world, one-on-one interviews and one focus group with IPS and housing leaders, to link practice with research and provide new perspectives.

The CMHA currently has an IPS program that employs 13 IPS specialists. Each CMHA IPS specialist is part of a multidisciplinary mental health team that includes a psychiatrist, a social worker, an occupational therapist, and other professional staff, and any client receiving mental health services from the mental health teams can access the program. The CMHA regularly reviews its program to meet and maintain high fidelity.

The CMHA's main concern was to maintain the high fidelity it has achieved with its current programming if possible, while reviewing the most promising ways in which an IPS program can provide support to other existing mental health teams in the region such as Intensive Case Management (ICM) and Assertive Community Treatment (ACT) teams. The interviewees provided a number of suggestions for integrating with the mental health teams, as their experience showed that IPS specialists are often asked to provide case management support in addition to their own job description. If an IPS program is to meet high fidelity, it needs to both integrate within the team and maintain its autonomy by ensuring that other team members understand the importance and value of the program. Other suggestions were to acknowledge and work with people's barriers to employment, and to have the patience and knowledge to build the IPS culture over some time before measuring outcomes. All IPS programs should provide adequate supervision and supports to their IPS specialists.

The research found that IPS works better for people who have experienced homelessness than other vocational programs because it has been developed to engage and build trust with clients and their mental health teams and that the program costs are comparable to, or better than, WorkBC program costs when considering the needs of Tier 3 and Tier 4 clients. Employment for people who have been homeless may bring many potential cost benefits to society, and yet the project's literature review focused mainly on hospital care. Some studies showed that IPS was more cost-effective overall in this regard than other vocational services. Other studies showed that the social benefit costs were about equal to IPS in regards to hospital use, but this study

argues that there are a number of additional benefits and other social factors to consider. In order to make a stronger case for increasing its existing programming, therefore, the CMHA would benefit from a full cost-benefit analysis that considers the full costs and benefits of returning to work for people who have been homeless.

There may also be opportunities for reaching a greater number of people who have been homeless to help them acquire and maintain employment. In addition to possibly integrating with ACT and ICM mental health teams, therefore, this project considered two new possibilities. One possibility is for the CMHA's IPS team to work with new Integrated Care Teams (ICT) that Vancouver Coastal Health (VCH) is planning to open in Fall 2016. Concerns around meeting fidelity and ensuring that the integrated health team connect the client with IPS support would be mitigated by incorporating a research component to the program to consistently review outcomes and make changes according to the needs of clients and provide training and consistent communication to ICT staff and informational sessions to potential clients.

The other option is to partner with WorkBC and other one-stop employment centres, and provide Community Support Workers who will accompany people who have experienced homelessness to employment centres. Community Support Workers would be able to work with up to 60 people at one time, but this would not be considered an IPS program. The experience that the CMHA has gained from meeting high fidelity in IPS, however, will help provide the context for starting this new program.

This study recommends that the CMHA pursues the first option – enquiring about working with Vancouver Coastal Health's Integrated Care Teams. A stakeholder analysis was conducted to help the CMHA select partners and begin appropriate and sustainable communication with relevant parties to garner support and raise funds for the option(s) they choose to pursue. This paper recommends that the CMHA also adapts, maintains and continues to develop the Stakeholder Influence Chart in Appendix B.

In conclusion, IPS would benefit people who have experienced homelessness and therefore the CMHA should pursue programming to adapt and expand their current IPS program for this clientele. This study takes into account that many people who have experienced homelessness and who have issues with mental health are not eligible for, or may not be able to access, the intensive case management and mental health support of an ACT or ICM team, and therefore provides recommendations for the CMHA to consider options that might be regarded as a variance from the IPS model. With strong partnerships and stakeholder engagement, the CMHA can continue to build trust and show its strengths in providing IPS and other employment strategies.

References

- Becker, D. R., Smith, J., Tanzman, B., Drake, R.E., & Tremblay, T. (2001). Fidelity of supported employment programs and employment outcomes. *Psychiatric Services*, 52(6), 834-836. Retrieved at: <http://dx.doi.org/10.1176/appi.ps.52.6.834>
- Becker, D.R., Swanson, S., Bond, G.R. & Merrens, M.R. (2011). *Evidence-based Supported Employment Fidelity Review Manual*. Fidelity Dartmouth Psychiatric Research Center. Retrieved at: www.dartmouthips.org.
- Becker, D. R., Xie, H., McHugo, G., Halliday, J. & Martinez, R. A. (2006). What predicts supported employment program outcomes? *Community Mental Health Journal*, 42, 303-313- Retrieved at: [10.1007/s10597-006-9037-8](https://doi.org/10.1007/s10597-006-9037-8)
- Bond, G.R. (2004). Supported employment: Evidence for an evidence-based practice. *Psychiatric Rehabilitation Journal*, 27(4), 345-359. Retrieved from: <http://dx.doi.org.ezproxy.library.uvic.ca/10.2975/27.2004.345.359>
- Bond, G. (2007). International Perspectives on Implementing Supported Employment for People with Severe Mental Illness. *Journal of Vocational Rehabilitation*, 27 p. 1–2. Retrieved at: <http://content.iospress.com/articles/journal-of-vocational-rehabilitation/jvr00378>
- Bond, G. (2013). *Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment*. Retrieved at: http://sites.dartmouth.edu/ips/files/2013/01/Evidence-IPS_11_2013.pdf
- Bond, G.R., Becker, D.R., Drake, R.E., Rapp, C.A., Meisler, N., Lehman, A.F....Blyler, C.R. (2001). Implementing supported employment as an evidence-based practice. *Psychiatric Services* 52(3), p. 313-322. Retrieved at: <http://dx.doi.org/10.1176/appi.ps.52.3.313>
- Bond, G.R., Campbell, K., Drake, R.E. (2012). Standardizing measures in four domains of employment outcomes for Individual Placement and Support. *Psychiatric Services*. 63(8), 751-757. Retrieved at: doi: 10.1176/appi.ps.201100270.
- Bond, G.R., Drake, R.E., & Becker, D.R. (2008). An update on randomized controlled trials of evidence-based supported employment, *Psychiatric Rehabilitation Journal*, 31(4), 280-290. Retrieved at: DOI: 10.2975/31.4.2008.280.290
- Bond, G.R., Drake, R.E. & Becker, D.R. (2012). Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. *World Psychiatry*, 11(1), 32–39. Retrieved from: <http://onlinelibrary.wiley.com/journal/10.1002/%28ISSN%292051-5545>

- Bond, G.R., Salyers, M.P., Rollins, A.L., Rapp, C.A. and Zipple, A.M. (December 2004). How evidence-based practices contribute to community integration. *Community Mental Health Journal*, 40(6), 569-588. Retrieved from: 10.1007/s10597-004-6130-8
- Borgatti, S. (n.d.). *Introduction to Grounded Theory*. Retrieved at: <http://www.analytictech.com/mb870/introtogt.htm>
- Bowen, R. (2011). Performing a Stakeholder Analysis. *Bright Hub Project Management*. Retrieved at: <http://www.brighthubpm.com/templates-forms/3713-performing-a-stakeholder-analysis/>
- Bryson, J.M. (2011). *Strategic Planning for Public and Non-profit Organizations: A Guide to Strengthening and Sustaining Organizational Achievement* (4th ed.). San Francisco: Joseey Bass.
- Burns, T., Catty, J., White, S., Becker, T., Koletsi, M., Fioritti, A., ... for 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(5), 949–958. Retrieved at: <http://doi.org/10.1093/schbul/sbn024>
- Burt, M.R. (2012). Impact of Housing and Work Supports on Outcomes for Chronically Homeless Adults With Mental Illness: LA's HOPE. *Psychiatric Services*, 63, 209–215. Retrieved at: doi: 10.1176/appi.ps.201100100
- CMHA (n.d.). Employment services. *Canadian Mental Health Association*. Retrieved at: <http://vancouver-Fraser.cmha.bc.ca/how-we-can-help/employment-services>
- Calgary Homeless Foundation, and Calgary Inter-Agency Council on Homelessness. (2012). Sustainable Supports for Adult Males: Effective Employment Models to End Homelessness: Research Report of Findings and Recommendations. *Calgary Homeless Foundation*. Retrieved at: <http://calgaryhomeless.com/wp-content/uploads/Employment-Models-Report.pdf>
- Campbell, K., Bond, G.R., & Drake, R.E. (2011). Who benefits from supported employment: A meta-analytic study. *Schizophrenia Bulletin*, 37(2), pp. 370–380. Retrieved at: doi:10.1093/schbul/sbp066
- Centre for Addiction and Mental Health (n.d.). *Statistics on mental illness and addictions*. Retrieved from: http://www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionmentalhealthstatistics.aspx
- Centre for Mental Health (2014). Briefing 48: Employment support & addiction. *Centre for Mental Health*. Retrieved from: www.centreformentalhealth.org.uk

- Charmaz, K. (2014). *Constructing Grounded Theory*. London, UK: Sage Publications
- City of Vancouver (2012). *Downtown Eastside Local Area Plan: Path to a community plan*. Retrieved at: <http://vancouver.ca/files/cov/downtown-eastside-local-area-factsheet.pdf>
- Crain, M., Penhale, C. Newstead, C. Thomson, L. Heah, T., Barclay, K. (2009). The contribution of IPS to recovery from serious mental illness: A case study. *Work - Journal of Prevention Assessment and Rehabilitation* 33(4), 459-464. Retrieved at: DOI 10.3233/WOR-2009-0894
- Creswell, J.W. (1998). *Research Design: Qualitative, Quantitative, and mixed methods approaches*. Sage Publications.
- Culhane, P. (n.d.) A strategic approach to government relations. *Canadian Society of Association Executives*. Retrieved at: <http://www.csae.com/Resources/ArticlesTools/View/ArticleId/1289/A-Strategic-Approach-to-Government-Relations>
- Dartmouth IPS Supported Employment Center (2008). *Supported Employment Fidelity Scale*. Retrieved at: <http://www.dartmouth.edu/~ips/page19/page21/files/se-fidelity-scale002c-2008.pdf>
- DeBeck, K., Wood, E., Qi, J., Fu, E., McArthur, D., Montaner, J., & Kerr, T. (September 2011). Employment amongst people who use drugs: A new arena for research and intervention? *International Journal of Drug Policy*, 22(5), 376–384. Retrieved at: doi:10.1016/j.drugpo.2011.08.004
- Downtown Eastside Neighbourhood House (n.d.). *The Downtown Eastside Neighbourhood House*. Retrieved from: <http://dtesnhouse.ca/>.
- Drake, R.E. & Bond, G.R. (2011). IPS Support Employment: A 20-Year Update. *American Journal of Psychiatric Rehabilitation*, 14(3). Retrieved at: DOI: 10.1080/15487768.2011.598090
- Drake, R., Bond, G., Becker, D. (2012). *Individual Placement and Support*, Oxford University Press, NY.
- Drake, R. E. & Bond, G. R. (2014). Introduction to the special issue on individual placement and support. *Psychiatric Rehabilitation Journal*, 37(2), 76-78. doi:10.1037/prj0000083
- Drake, R.E., McHugo, G.J., Becker, D.R., Anthony, W.A., Clark, R.E. (Apr 1996). The New Hampshire study of supported employment for people with severe mental illness. *Journal of Consulting and Clinical Psychology*, 64(2), 391-399. Retrieved at: <http://www.ncbi.nlm.nih.gov/pubmed/8871423>

- Dunn, E.C., Wewlorski, N.J. & Rogers, E.S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study. *Psychiatric Rehabilitation Journal*, 32(1), p. 59-62. Retrieved at: DOI: 10.2975/32.1.2008.59.62
- Ferguson, K.M. (2013). Using the social enterprise intervention (SEI) and Individual Placement and Support (IPS) models to improve employment and clinical outcomes of homeless youth with mental illness, *Social Work in Mental Health*, 11(5), 473-497. DOI: 10.1080/15332985.2013.764960
- Ferguson, K.M., Xie, B. & Glynn, S. (2011). Adapting the Individual Placement and Support Model with homeless young adults. *Child Youth Care Forum*, 41, 277–294. Retrieved at: DOI 10.1007/s10566-011-9163-5).
- Gowdy, E. A., Carlson, L.S. & Rapp, C.A. (2004) Organizational factors differentiating high performing from low performing supported employment programs. *Psychiatric rehabilitation journal* 28(2). Retrieved at: 10.2975/28.2004.150.156
- Grounded Theory Online (n.d.). *How Do You Do Grounded Theory?* Retrieved at: <http://www.groundedtheoryonline.com/what-is-grounded-theory>
- Grounded Theory Online (n.d.). *What is Grounded Theory?* Retrieved at: <http://www.groundedtheoryonline.com/what-is-grounded-theory>
- Harrison, M.L., Moore, K.A., Young, S., Flink, D., Ochshorn, E. (2008) Implementing the comprehensive, continuous, integrated system of care model for individuals with co-occurring disorders: Preliminary findings from a residential facility serving homeless individuals. *Journal of Dual Diagnosis*, 4(3), 238-259, DOI: 10.1080/15504260802072305
- Hoffmann, H. M. D., Jäckel, D.M., 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(11), p. 1183-1190. Retrieved at: doi: 10.1176/appi.ajp.2014.13070857
- Jacobs P., Dewa, C., Lesage, A., Vasiliadis, H., Escobar, C., Mulvale, G. & Yim, R. (2010). The cost of mental health and substance abuse services in Canada: A report to the Mental Health Commission of Canada). *Institute of Health Economics*. Retrieved at: <http://www.ihe.ca/documents/Cost%20of%20Mental%20Health%20Services%20in%20Canada%20Report%20June%202010.pdf>
- John Coward Consulting (2013). Environmental Scan of BC Employment Programs. *BC Centre for Employment Excellence*. Retrieved at: <http://cfeebc.org/reports/Environmental-Scan-BC-Employment-Programs.pdf>

- Kim, M.M. & Ford, J.D. (2008) Trauma and Post-Traumatic Stress Among Homeless Men, *Journal of Aggression, Maltreatment & Trauma*, 13(2), p. 1-22, Retrieved at: http://dx.doi.org/10.1300/J146v13n02_01
- Knapp, M., Patel, A., Curran, C., Latimer, E., Catty, J., Becker, T.,...Burns, T. (2013). Supported employment: cost-effectiveness across six European sites. *World Psychiatry*, 12(1), 60–68. Retrieved at: DOI: 10.1002/wps.20017
- Larson, J. E., Barr, L. K., Corrigan, P. W., Kuwabara, S. A., Boyle, M. G., & Glenn, T. L. (2007). Perspectives on benefits and costs of work from individuals with psychiatric disabilities. *Journal of Vocational Rehabilitation*, 26, pp. 71-77. Retrieved at: <http://www.iospress.nl/journal/journal-of-vocational-rehabilitation/>
- Latimer, E.A., Bush, P.W., Becker, D.R., Drake, R.E. & Bond, G.R. (2004). The cost of high-fidelity supported employment programs for people with severe mental illness. *Psychiatric Services*, 55(4), p. 401-406. Retrieved at: <http://dx.doi.org/10.1176/appi.ps.55.4.401>
- Linden, I.A., Mar, M.Y., Werker, G.R., Jang, K., & Krausz, M. (2012). Research on a vulnerable neighborhood: The Vancouver Downtown Eastside from 2001 to 2011, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 90(3), 559-573. doi:10.1007/s11524-012-9771-x
- Logsdon, A. (2011). *Competitive Employment – What Is Competitive Employment?* Retrieved at: <http://learningdisabilities.about.com/od/C/g/Competitive-Employment-What-Is-Competitive-Employment.htm>
- McEown, J. (2015). An employment continuum and assessment tool for employing formerly homeless, sheltered and at-risk individuals in Vancouver. *Streetohome Foundation*.
- McGrew, J.H., & Griss, M. (2005). Concurrent and predictive validity of two scales to assess the fidelity of implementation of supported employment. *Psychiatric Rehabilitation Journal*, 29, 41-47. Retrieved at; 10.2975/29.2005.41.47
- Marrone, J. (2005). Creating hope through employment for people who are homeless or in transitional housing. *American Journal of Psychiatric Rehabilitation*, 8(1), 13-35. Retrieved at: DOI: 10.1080/15487760590953939
- Marrone, J. (2015). *The business Case for funding Evidence Based Supported Employment within the Washington Behavioral Health System*.
- Marshall, T., Rapp, C.A., Becker, D.R., & Bond, G.R. (2008). Key Factors for Implementing Supported Employment. *Psychiatric Services*, 59, 886-892. Retrieved at: DOI: 10.1176/appi.ps.59.8.886

Mental Health Commission of Canada (2012). *At Home/Chez Soi Early Findings Report Vol. 2*. Retrieved at: <http://www.mentalhealthcommission.ca/English/node/775>

Mental Health Commission (2014a). *Montréal Final Report: At Home/Chez Soi Project*. Retrieved at: http://www.mentalhealthcommission.ca/English/system/files/private/document/at_home_final_report_montreal_eng_0.pdf

Mental Health Commission of Canada (2014b). *National Final Report: Cross-Site At Home/Chez Soi Project*. Retrieved at: http://www.mentalhealthcommission.ca/English/system/files/private/document/mhcc_at_home_report_national_cross-site_eng_2.pdf

Miewald, C. (2009). *Food Security and Housing in Vancouver's Downtown Eastside*, Centre for Sustainable Community Development, Simon Fraser University. Retrieved from: <http://www.vch.ca/media/FoodSecurityandHousingonDTES.pdf>

Mindtools (n.d.) *Gap Analysis: Identifying What Needs to be Done in a Project*. Retrieved at: <https://www.mindtools.com/pages/article/gap-analysis.htm>

[Mikoluk, K. \(2013\). *Gap Analysis Template: The 3 Key Elements of Effective Gap Analysis*. Retrieved at: <https://blog.udemy.com/gap-analysis-template/>](#)

Ministry of Health (n.d.), *Client Pathway of Care*.

Ministry of Health (2012). *Integrated models of primary care and mental health & substance use care in the community*.

Ministry of Health (2015). *Proposed Integrated Health Services Delivery Model – Vision and Key Principles*.

Off the Streets and into Work (2006). *The costs and benefits of formal work for homeless people*, *Centre for Economic and Social Inclusion*, Centre for Economic & Social Inclusion. Retrieved at: www.crisis.org.uk

Patton, M.Q. (2003). *Qualitative evaluation checklist*. Retrieved at: http://www.wmich.edu/evalctr/archive_checklists/qec.pdf

Poremski, D. (2014). *Evidence-Based Supported Employment for People with Mental Illness Recently Housed by a Housing First Project: Helping Homeless People Achieve their Goals of Employment*. Doctoral thesis. Department of Psychiatry, McGill University, Montreal. Retrieved at: http://digitool.library.mcgill.ca/R/?func=dbin-jump-full&object_id=130618&local_base=GEN01-MCG02

Poremski, D., Distasio, J., Hwang, S. W., & Latimer, E. (2015). *Employment and Income of People Who Experience Mental Illness and Homelessness in a Large Canadian Sample*.

Canadian Journal of Psychiatry, 60(9), pp. 379-385. Retrieved at:
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4574713/>.

Poremski, D., Whitley, R., Latimer, E. (2014). Barriers to obtaining employment for people with severe mental illness experiencing homelessness. *Journal of Mental Health*, 23(4), pp. 181–185. Retrieved at: DOI 10.3109/09638237.2014.910640.

Poremski, D., Whitley, R., & Latimer, E. (2015, March 30). Building Trust With People Receiving Supported Employment and Housing First Services. *Psychiatric Rehabilitation Journal*. Advance online publication. <http://dx.doi.org/10.1037/prj0000137>

Poremski, D., Woodhall-Melnik, J., Lemieux, A.J. & Stergiopoulos, V. (2015) Persisting barriers to employment for recently housed adults with mental illness. *Journal of Urban Health*. Retrieved at: <http://www.ncbi.nlm.nih.gov/pubmed/26666250>

PSR Provincial Advisory Committee (2014). *Psychosocial Rehabilitation (PSR) Service Framework*. Not available online; please request a copy from the researcher.

Province of British Columbia (2015). Employment Program of BC August 2015 Monthly Report. Retrieved at: <http://www.sdsi.gov.bc.ca/publicat/reports/epbc-monthly-report.pdf>.

Richardson, L., Wood, E., Li, K. and Kerr, T. (2010). Factors associated with employment among a cohort of injection drug users. *Drug Alcohol Review*, 29(3), p. 293–300. Retrieved at: DOI: 10.1111/j.1465-3362.2009.00141.x

Rio, J., Ware, L., Tucker, P., Martinez, J. (2008). Ending chronic homelessness through employment and housing: A program and policy handbook for successfully linking supportive housing and employment services for chronically homeless adults. Corporation for Supportive Housing and Advocates for Human Potential. Retrieved at: www.csh.org/cheta

Robert Wood Johnson Foundation (n.d.). *Grounded theory*. Retrieved at:
<http://www.qualres.org/HomeGrou-3589.html>

Rosenheck, R. A., & Mares, A. S. (2007). Implementation of supported employment for homeless veterans with psychiatric or addiction disorders: Two-year outcomes. *Psychiatric Services*, 58(3), 325-333. Retrieved at: doi:10.1176/appi.ps.58.3.325

Salkever, D. (2012). Social costs of expanding access to evidence-based supported employment: concepts and interpretive review of evidence. *Psychiatric Services, Advance*. Retrieved at: doi:10.1176/appi.ps.201100499

Salkever, D. S., Gibbons, B., Drake, R. E., Frey, W. D., Hale, T. W., & Karakus, M. (2014). Increasing earnings of Social Security Disability Income beneficiaries with serious

mental disorder. *Journal Of Mental Health Policy And Economics*, 17(2), 75-90. Retrieved at: <http://www.ncbi.nlm.nih.gov/pubmed/25163103>

Schnur, C., Warland, C., Young, M. and Zralek, B. (2013). Work matters: Employment as a tool for preventing homelessness and improving health. *The National Transitional Jobs Network and The National Health Care for the Homeless Council*. Retrieved at: <http://www.acphd.org/media/324724/workmatters.pdf>

Serge, L., Kraus, D., & Eberle, M. (2006). What Works: Effective Policies and Programs for the Homeless Population in Canada: Final Report. Gatineau, QC, CA. *Human Resources and Social Development Canada*. Retrieved from <http://www.ebrary.com>

Shaheen, G. & Rio, J. (2007). Recognizing work as a priority in preventing or ending homelessness. *The Journal of Primary Prevention*, 28, 341–358. Retrieved from: DOI 10.1007/s10935-007-0097-5

Streetohome Foundation (2015). *2014 Annual Report*. Retrieved at: <http://streetohome.org/about-streetohome/annual-report>

Streetohome Foundation (2011). *10-Year Plan*. Retrieved at: <http://streetohome.org/about-streetohome/streetohome-plan>

Strickler, D.C., Whitley, R.E., Becker, D.R., & Drake, R.E. (2009). First person accounts of long-term employment activity among people with dual diagnosis. *Psychiatric Rehabilitation Journal*, 32(4), p. 261-268. Retrieved at: <http://dx.doi.org/10.2975/32.4.2009.261.268>

University of Houston (2004). News release: Employment reduces chronic drug use, UH professors find. *University of Houston*. Retrieved at: <http://www.uh.edu/news-events/archive/nr/2004/11nov/113004montoya.html>

Wallace, C.J., Tauber, R., Wilde, J., (1999). Rehab Rounds: Teaching Fundamental Workplace Skills to Persons With Serious Mental Illness. *Psychiatric Services*, 50(9), 1147-1153. Retrieved at: <http://dx.doi.org/10.1176/ps.50.9.1147>

Work BC (2014). The Employment Program of British Columbia's On-line Client Portal. Retrieved at: <https://www.workbc.ca/blog/May-2014/The-Employment-Program-of-British-Columbia-s-On-li.aspx>.

Appendices

Appendix A – Supported Employment Fidelity Scale

SUPPORTED EMPLOYMENT FIDELITY SCALE*			
Rater:	Site:	1/7/08 Date:	Total Score:
Directions: Circle one anchor number for each criterion.			
<u>Criterion</u>	<u>Data Source**</u>	<u>Anchor</u>	
Staffing			
1. <u>Caseload size</u> : Employment specialists have individual employment caseloads. The maximum caseload for any full-time employment specialist is 20 or fewer clients.	MIS, DOC, INT	1= Ratio of 41 or more clients per employment specialist. 2= Ratio of 31-40 clients per employment specialist. 3= Ratio of 26-30 clients per employment specialist. 4= Ratio of 21-25 clients per employment specialist. 5= Ratio of 20 or fewer clients per employment specialist.	
2. <u>Employment services staff</u> : Employment specialists provide only employment services.	MIS, DOC INT	1= Employment specialists provide employment services less than 60% of the time. 2= Employment specialists provide employment services 60 - 74% of the time. 3= Employment specialists provide employment services 75 - 89% of the time. 4= Employment specialists provide employment services 90 - 95% of the time. 5= Employment specialists provide employment services 96% or more of the time.	

*Formerly called IPS Model Fidelity Scale
 **See end of document for key

SUPPORTED EMPLOYMENT FIDELITY SCALE

1

3. Vocational generalists: Each employment specialist carries out all phases of employment service, including intake, engagement, assessment, job placement, job coaching, and follow-along supports before step down to less intensive employment support from another MH practitioner. (Note: It is not expected that each employment specialist will provide benefits counseling to their clients. Referrals to a highly trained benefits counselor are in keeping with high fidelity, see Item # 1 in “Services”.)

MIS, DOC,
INT, OBS

- 1= Employment specialist only provides vocational referral service to vendors and other programs.
- 2= Employment specialist maintains caseload but refers clients to other programs for vocational services.
- 3= Employment specialist provides one to four phases of the employment service (e.g. intake, engagement, assessment, job development, job placement, job coaching, and follow along supports).
- 4= Employment specialist provides five phases of employment service but not the entire service.
- 5= Employment specialist carries out all six phases of employment service (e.g. program intake, engagement, assessment, job development/job placement, job coaching, and follow-along supports).

ORGANIZATION

1. Integration of rehabilitation with mental health treatment thru team assignment: Employment specialists are part of up to 2 mental health treatment teams from which at least 90% of the employment specialist’s caseload is comprised.

MIS, DOC,
INT, OBS

- 1= Employment specialists are part of a vocational program that functions separately from the mental health treatment.
- 2= Employment specialists are attached to three or more mental health treatment teams. OR Clients are served by individual mental health practitioners who are not organized into teams. OR Employment specialists are attached to one or two teams from which less than 50% of the employment specialist’s caseload is comprised.
- 3= Employment specialists are attached to one or two mental health treatment teams, from which at least 50 - 74% of the employment specialist’s caseload is comprised.
- 4= Employment specialists are attached to one or two mental health treatment teams, from which at least 75 - 89% of the employment specialist’s caseload is comprised.
- 5= Employment specialists are attached to one or two mental health treatment teams, from which 90 - 100% of the employment specialist’s caseload is comprised.

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**See end of document for key

2. Integration of rehabilitation with mental health treatment thru frequent team member contact:

MIS, DOC
INT, OBS

Employment specialists actively participate in weekly mental health treatment team meetings (not replaced by administrative meetings) that discuss individual clients and their employment goals with shared decision-making. Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. Documentation of mental health treatment and employment services is integrated in a single client chart. Employment specialists help the team think about employment for people who haven't yet been referred to supported employment services.

1= One or none is present.

2= Two are present

3= Three are present.

4= Four are present.

5= Five are present.

All five key components are present.

- Employment specialist attends weekly mental health treatment team meetings.
- Employment specialist participates actively in treatment team meetings with shared decision-making.
- Employment services documentation (i.e., vocational assessment/profile, employment plan, progress notes) is integrated into client's mental health treatment record.
- Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members.
- Employment specialist helps the team think about employment for people who haven't yet been referred to supported employment services.

3. Collaboration between employment specialists and Vocational Rehabilitation counselors: The employment specialists and VR counselors have frequent contact for the purpose of discussing shared clients and identifying potential referrals.

DOC, INT
OBS, ISP

1= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) less than quarterly to discuss shared clients and referrals. OR Employment specialists and VR counselors do not communicate.

2= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in person) at least quarterly to discuss shared clients and referrals.

3= Employment specialists and VR counselors have client-related contacts (phone, e-mail, in-person) monthly to discuss shared clients and referrals.

4= Employment specialists and VR counselors have scheduled, face-to-face

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**See end of document for key

4. Vocational unit: At least 2 full-time employment specialists and a team leader comprise the employment unit. They have weekly client-based group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed.

MIS, INT,
OBS

- meetings at least quarterly, OR have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals.
- 5= Employment specialists and VR counselors have scheduled, face-to-face meetings at least monthly and have client-related contacts (phone, e-mail, in person) weekly to discuss shared clients and referrals.
- 1= Employment specialists are not part of a vocational unit.
- 2= Employment specialists have the same supervisor but do not meet as a group. They do not provide back-up services for each other's caseload.
- 3= Employment specialists have the same supervisor and discuss clients between each other on a weekly basis. They provide back-up services for each other's caseloads as needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times monthly with their supervisor by teleconference.
- 4= At least 2 employment specialists and a team leader form an employment unit with 2-3 regularly scheduled meetings per month for client-based group supervision in which strategies are identified and job leads are shared and discuss clients between each other. They provide coverage for each other's caseloads when needed. OR, If a program is in a rural area where employment specialists are geographically separate with one employment specialist at each site, the employment specialists meet 2-3 times per month with their supervisor in person or by teleconference and mental health practitioners are available to help the employment specialist with activities such as taking someone to work or picking up job applications.
- 5= At least 2 full-time employment specialists and a team leader form an employment unit with weekly client-based group supervision based on the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseloads when needed.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

5. Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. All five key roles of the employment supervisor are present.

MIS, INT,
DOC, OBS

1= One or none is present.

2= Two are present.

3= Three are present.

4= Four are present.

5= Five are present.

Five key roles of the employment supervisor:

- One full-time equivalent (FTE) supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than ten employment specialists may spend a percentage of time on other supervisory activities on a prorated basis. For example, an employment supervisor responsible for 4 employment specialists may be devoted to SE supervision half time.)
- Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives.
- Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis.
- Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development.
- Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

6. Zero exclusion criteria: All clients interested in working have access to supported employment services regardless of job readiness factors, substance abuse, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation. These apply during supported employment services too. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. If VR has screening criteria, the mental health agency does not use them to exclude anybody. Clients are not screened out formally or informally.

DOC, INT
OBS

- 1= There is a formal policy to exclude clients due to lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.) by employment staff, case managers, or other practitioners.
- 2= Most clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.).
- 3= Some clients are unable to access supported employment services due to perceived lack of job readiness (e.g., substance abuse, history of violence, low level of functioning, etc.).
- 4= No evidence of exclusion, formal or informal. Referrals are not solicited by a wide variety of sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held.
- 5= All clients interested in working have access to supported employment services. Mental health practitioners encourage clients to consider employment, and referrals for supported employment are solicited by many sources. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held.

7. Agency focus on competitive employment: Agency promotes competitive work through multiple strategies. Agency intake includes questions about interest in employment. Agency displays written postings (e.g., brochures, bulletin boards, posters) about employment and supported employment services. The focus should be with the agency programs that provide services to adults with severe mental illness. Agency supports ways for clients to share work stories with other clients and staff. Agency measures rate of competitive employment and shares this information with agency leadership and staff.

DOC, INT,
OBS

- 1= One or none is present.
- 2= Two are present.
- 3= Three are present.
- 4= Four are present.
- 5= Five are present.

Agency promotes competitive work through multiple strategies:

- Agency intake includes questions about interest in employment.
- Agency includes questions about interest in employment on all annual (or semi-annual) assessment or treatment plan reviews.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

8. Executive team support for SE: Agency executive team members (e.g., CEO/Executive Director, Chief Operating Officer, QA Director, Chief Financial Officer, Clinical Director, Medical Director, Human Resource Director) assist with supported employment implementation and sustainability. All five key components of executive team support are present.

- Agency displays written postings (e.g., brochures, bulletin boards, posters) about working and supported employment services, in lobby and other waiting areas.
- Agency supports ways for clients to share work stories with other clients and staff (e.g., agency-wide employment recognition events, in-service training, peer support groups, agency newsletter articles, invited speakers at client treatment groups, etc.) at least twice a year.
- Agency measures rate of competitive employment on at least a quarterly basis and shares outcomes with agency leadership and staff.

- 1= One is present.
- 2= Two are present.
- 3= Three are present.
- 4= Four are present.
- 5= Five are present.

- Executive Director and Clinical Director demonstrate knowledge regarding the principles of evidence-based supported employment.
- Agency QA process includes an explicit review of the SE program, or components of the program, at least every 6 months through the use of the Supported Employment Fidelity Scale or until achieving high fidelity, and at least yearly thereafter. Agency QA process uses the results of the fidelity assessment to improve SE implementation and sustainability.
- At least one member of the executive team actively participates at SE leadership team meetings (steering committee meetings) that occur at least every six months for high fidelity programs and at least quarterly for programs that have not yet achieved high fidelity. Steering committee is defined as a diverse group of stakeholders charged with reviewing fidelity, program implementation, and the service delivery system. Committee develops written action plans aimed at developing or sustaining high fidelity services.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

- The agency CEO/Executive Director communicates how SE services support the mission of the agency and articulates clear and specific goals for SE and/or competitive employment to all agency staff during the first six months and at least annually (i.e., SE kickoff, all-agency meetings, agency newsletters, etc.). This item is not delegated to another administrator.
- SE program leader shares information about EBP barriers and facilitators with the executive team (including the CEO) at least twice each year. The executive team helps the program leader identify and implement solutions to barriers.

SERVICES

1. Work incentives planning: All clients are offered assistance in obtaining comprehensive, individualized work incentives planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits and any other source of income. Clients are provided information and assistance about reporting earnings to SSA, housing programs, VA programs, etc., depending on the person's benefits.

- DOC, INT
OBS, ISP
- 1= Work incentives planning is not readily available or easily accessible to most clients served by the agency.
 - 2= Employment specialist gives client contact information about where to access information about work incentives planning.
 - 3= Employment specialist discusses with each client changes in benefits based on work status.
 - 4= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a person trained in work incentives planning prior to client starting a job.
 - 5= Employment specialist or other MH practitioner offer clients assistance in obtaining comprehensive, individualized work incentives planning by a specially trained work incentives planner prior to starting a job. They also facilitate access to work incentives planning when clients need to make decisions about changes in work hours and pay. Clients are provided information and assistance about reporting earnings to SSA, housing programs, etc., depending on the person's benefits.

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**See end of document for key

2. Disclosure: Employment specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability.

DOC, INT
OBS

- 1= None is present.
- 2= One is present.
- 3= Two are present.
- 4= Three are present.
- 5= Four are present.

- Employment specialists do not require all clients to disclose their psychiatric disability at the work site in order to receive services.
- Employment specialists offer to discuss with clients the possible costs and benefits (pros and cons) of disclosure at the work site in advance of clients disclosing at the work site. Employment specialists describe how disclosure relates to requesting accommodations and the employment specialist's role communicating with the employer.
- Employment specialists discuss specific information to be disclosed (e.g., disclose receiving mental health treatment, or presence of a psychiatric disability, or difficulty with anxiety, or unemployed for a period of time, etc.) and offers examples of what could be said to employers.
- Employment specialists discuss disclosure on more than one occasion (e.g., if clients have not found employment after two months or if clients report difficulties on the job.)

3. Ongoing, work-based vocational assessment: Initial vocational assessment occurs over 2-3 sessions and is updated with information from work experiences in competitive jobs. A vocational profile form that includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc, is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with

DOC, INT,
OBS, ISP

- 1= Vocational evaluation is conducted prior to job placement with emphasis on office-based assessments, standardized tests, intelligence tests, work samples.
- 2= Vocational assessment may occur through a stepwise approach that includes: prevocational work experiences (e.g., work units in a day program), volunteer jobs, or set aside jobs (e.g., NISH jobs agency-run businesses, sheltered workshop jobs, affirmative businesses, enclaves).
- 3= Employment specialists assist clients in finding competitive jobs directly without systematically reviewing interests, experiences, strengths,

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**See end of document for key

the client's permission, from family members and previous employers.

etc. and do not routinely analyze job loss (or job problems) for lessons learned.

- 4= Initial vocational assessment occurs over 2-3 sessions in which interests and strengths are explored. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes. They do not document these lessons learned in the vocational profile, OR The vocational profile is not updated on a regular basis.
- 5= Initial vocational assessment occurs over 2-3 sessions and information is documented on a vocational profile form that includes preferences, experiences, skills, current adjustment, strengths, personal contacts, etc. The vocational profile form is used to identify job types and work environments. It is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with the client's permission, from family members and previous employers. Employment specialists help clients learn from each job experience and also work with the treatment team to analyze job loss, job problems and job successes.

4. Rapid job search for competitive job: Initial employment assessment and first face-to-face employer contact by the client or the employment specialist about a competitive job occurs within 30 days (one month) after program entry.

DOC, INT,
OBS, ISP

- 1= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average 271 days or more (> 9 mos.) after program entry.
- 2= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 151 and 270 days (5-9 mos.) after program entry.
- 3= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 61 and 150 days (2-5 mos.) after program entry.
- 4= First face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average between 31 and 60 days (1-2 mos.) after program entry.
- 5= The program tracks employer contacts and the first face-to-face contact with an employer by the client or the employment specialist about a competitive job is on average within 30 days (one month) after program entry.

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**See end of document for key

5. Individualized job search: Employment specialists make employer contacts aimed at making a good job match based on clients' preferences (relating to what each person enjoys and their personal goals) and needs (including experience, ability, symptomatology, health, etc.) rather than the job market (i.e., those jobs that are readily available). An individualized job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.

DOC, INT
OBS, ISP

- 1= Less than 25% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc. rather than the job market.
- 2= 25-49% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market.
- 3= 50-74% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market.
- 4= 75-89% of employer contacts by the employment specialist are based on job choices which reflect client's preferences, strengths, symptoms, etc., rather than the job market and are consistent with the current employment plan.
- 5= Employment specialist makes employer contacts based on job choices which reflect client's preferences, strengths, symptoms, lessons learned from previous jobs etc., 90-100% of the time rather than the job market and are consistent with the current employment/job search plan. When clients have limited work experience, employment specialists provide information about a range of job options in the community.

6. Job development - Frequent employer contact: Each employment specialist makes at least 6 face to-face employer contacts per week on behalf of clients looking for work. (Rate for each then calculate average and use the closest scale point.) An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the client is present or not present. Client-specific and generic contacts are included. Employment specialists use a weekly tracking form to document employer contacts.

DOC, INT

- 1= Employment specialist makes less than 2 face-to-face employer contacts that are client-specific per week.
- 2= Employment specialist makes 2 face-to-face employer contacts per week that are client-specific, OR Does not have a process for tracking.
- 3= Employment specialist makes 4 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a monthly basis.
- 4= Employment specialist makes 5 face-to-face employer contacts per week that are client-specific, and uses a tracking form that is reviewed by the SE supervisor on a weekly basis.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

7. Job development - Quality of employer contact:
 Employment specialists build relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer. (Rate for each employment specialist, then calculate average and use the closest scale point.)

DOC, INT,
 OBS

5= Employment specialist makes 6 or more face-to-face employer contacts per week that are client specific, or 2 employer contacts times the number of people looking for work when there are less than 3 people looking for work on their caseload (e.g., new program). In addition, employment specialist uses a tracking form that is reviewed by the SE supervisor on a weekly basis.

1= Employment specialist meets employer when helping client to turn in job applications, OR Employment specialist rarely makes employer contacts.

2= Employment specialist contacts employers to ask about job openings and then shares these "leads" with clients.

3= Employment specialist follows up on advertised job openings by introducing self, describing program, and asking employer to interview client.

4= Employment specialist meets with employers in person whether or not there is a job opening, advocates for clients by describing strengths and asks employers to interview clients.

5= Employment specialist builds relationships with employers through multiple visits in person that are planned to learn the needs of the employer, convey what the SE program offers to the employer, describe client strengths that are a good match for the employer.

8. Diversity of job types: Employment specialists assist clients in obtaining different types of jobs.

DOC, INT,
 OBS, ISP

1= Employment specialists assist clients obtain different types of jobs less than 50% of the time.

2= Employment specialists assist clients obtain different types of jobs 50-59% of the time.

3= Employment specialists assist clients obtain different types of jobs 60-69% of the time.

4= Employment specialists assist clients obtain different types of jobs 70-84% of the time.

*Formerly called IPS Model Fidelity Scale
 **See end of document for key

9. Diversity of employers: Employment specialists assist clients in obtaining jobs with different employers.

DOC, INT,
OBS, ISP

5= Employment specialists assist clients obtain different types of jobs 85-100% of the time.

1= Employment specialists assist clients obtain jobs with the different employers less than 50% of the time.

2= Employment specialists assist clients obtain jobs with the same employers 50-59% of the time.

3= Employment specialists assist clients obtain jobs with different employers 60-69% of the time.

4= Employment specialists assist clients obtain jobs with different employers 70-84% of the time.

5= Employment specialists assist clients obtain jobs with different employers 85-100% of the time.

10. Competitive jobs: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status, e.g., TE (transitional employment positions). Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use are counted as competitive jobs.)

DOC, INT,
OBS, ISP

1= Employment specialists provide options for permanent, competitive jobs less than 64% of the time, OR There are fewer than 10 current jobs.

2= Employment specialists provide options for permanent, competitive jobs about 65- 74% of the time.

3= Employment specialists provide options for permanent competitive jobs about 75-84% of the time.

4= Employment specialists provide options for permanent competitive jobs about 85-94% of the time.

5= 95% or more competitive jobs held by clients are permanent.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

11. Individualized follow-along supports:

Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Supports are provided by a variety of people, including treatment team members (e.g., medication changes, social skills training, encouragement), family, friends, co-workers (i.e., natural supports), and employment specialist. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. Employment specialist offers help with career development, i.e., assistance with education, a more desirable job, or more preferred job duties.

DOC, INT,
OBS, ISP

- 1= Most clients do not receive supports after starting a job.
- 2= About half of the working clients receive a narrow range of supports provided primarily by the employment specialist.
- 3= Most working clients receive a narrow range of supports that are provided primarily by the employment specialist.
- 4= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialists provide employer supports at the client's request.
- 5= Clients receive different types of support for working a job that are based on the job, client preferences, work history, needs, etc. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. The employment specialist helps people move onto more preferable jobs and also helps people with school or certified training programs. The site provides examples of different types of support including enhanced supports by treatment team members.

12. Time-unlimited follow-along supports:

Employment specialists have face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily, and desired by clients. Clients are transitioned to step down job supports from a mental health worker following steady employment. Employment specialists contact clients within 3 days of learning about the job loss.

DOC, INT,
OBS, ISP

- 1= Employment specialist does not meet face-to-face with the client after the first month of starting a job.
- 2= Employment specialist has face-to-face contact with less than half of the working clients for at least 4 months after starting a job.
- 3= Employment specialist has face-to-face contact with at least half of the working clients for at least 4 months after starting a job.
- 4= Employment specialist has face-to-face contact with working clients weekly for the first month after starting a job, and at least monthly for a year or more, on average, after working steadily, and desired by clients.
- 5= Employment specialist has face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, on average, after working steadily and desired by clients. Clients are transitioned to step down job supports, from a mental health worker following steady employment clients. Clients are transitioned to step down job supports from a mental health worker following steady employment.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

Employment specialist contacts clients within 3 days of hearing about the job loss.

13. Community-based services: Employment services such as engagement, job finding and follow-along supports are provided in natural community settings by all employment specialists. (Rate each employment specialist based upon their total weekly scheduled work hours, then calculate the average and use the closest scale point.)

DOC, INT
OBS

- 1= Employment specialist spends 30% time or less in the scheduled work hours in the community.
- 2= Employment specialist spends 30 - 39% time of total scheduled work hours in the community.
- 3= Employment specialist spends 40 -49% of total scheduled work hours in the then community.
- 4= Employment specialist spends 50 - 64% of total scheduled work hours in the community.
- 5= Employment specialist spends 65% or more of total scheduled work hours in the community.

14. Assertive engagement and outreach by integrated treatment team: Service termination is not based on missed appointments or fixed time limits. Systematic documentation of outreach attempts. Engagement and outreach attempts made by integrated team members. Multiple home/community visits. Coordinated visits by employment specialist with integrated team member. Connect with family, when applicable. Once it is clear that the client no longer wants to work or continue SE services, the team stops outreach.

MIS, DOC,
INT, OBS

- 1= Evidence that 2 or less strategies for engagement and outreach are used.
- 2= Evidence that 3 strategies for engagement and outreach are used.
- 3= Evidence that 4 strategies for engagement and outreach are used.
- 4= Evidence that 5 strategies for engagement and outreach are used.
- 5= Evidence that all 6 strategies for engagement and outreach are used: i) Service termination is not based on missed appointments or fixed time limits. ii) Systematic documentation of outreach attempts. iii) Engagement and outreach attempts made by integrated team members. iv) Multiple home/community visits. v) Coordinated visits by employment specialist with integrated team member. vi) Connect with family, when applicable.

*Formerly called IPS Model Fidelity Scale
**See end of document for key

*Data sources:

MIS Management Information System
DOC Document review: clinical records, agency policy and procedures
INT Interviews with clients, employment specialists, mental health staff,
VR counselors, families, employers
OBS Observation (e.g., team meeting, shadowing employment specialists)
ISP Individualized Service Plan

2/14/96
6/20/01, Updated
1/7/08, Revised

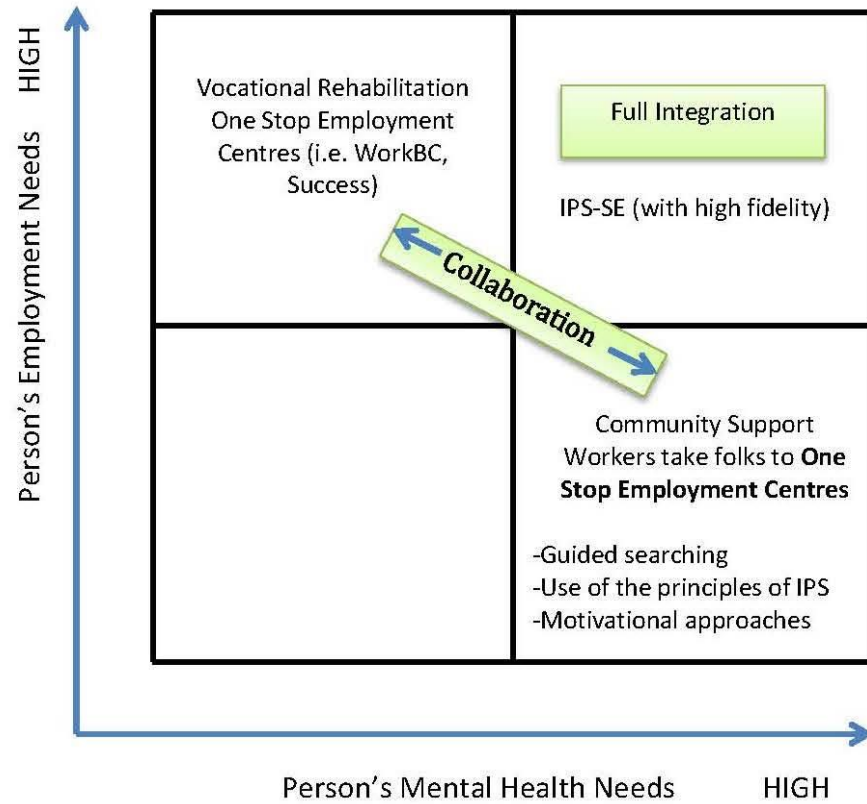
Supported Employment Fidelity Scale Score Sheet

Staffing		
1.	Caseload size	Score:
2.	Employment services staff	Score:
3.	Vocational generalists	Score:
Organization		
1.	Integration of rehabilitation with mental health thru team assignment	Score:
2.	Integration of rehabilitation with mental health thru frequent team member contact	Score:
3.	Collaboration between employment specialists and Vocational Rehabilitation counselors	Score:
4.	Vocational unit	Score:
5.	Role of employment supervisor	Score:
6.	Zero exclusion criteria	Score:
7.	Agency focus on competitive employment	Score:
8.	Executive team support for SE	Score:
Services		
1.	Work incentives planning	Score:
2.	Disclosure	Score:
3.	Ongoing, work-based vocational assessment	Score:
4.	Rapid search for competitive job	Score:
5.	Individualized job search	Score:
6.	Job development—Frequent employer contact	Score:
7.	Job development—Quality of employer contact	Score:
8.	Diversity of job types	Score:
9.	Diversity of employers	Score:
10.	Competitive jobs	Score:
11.	Individualized follow-along supports	Score:
12.	Time-unlimited follow-along supports	Score:
13.	Community-based services	Score:
14.	Assertive engagement and outreach by integrated treatment team	Score:
		Total:

115 – 125	= Exemplary Fidelity
100 - 114	= Good Fidelity
74 – 99	= Fair Fidelity
73 and below	= Not Supported Employment

*Formerly called IPS Model Fidelity Scale
 **See end of document for key

Appendix B – Employment Strategy Quadrants (adapted from Marrone, 2015)



Appendix C – Interview Questions – Individuals

The research objective is to determine whether the Canadian Mental Health Association Vancouver-Fraser branch (CMHA) can adapt their Individual Placement and Support (IPS) program for people who have experienced homelessness or who are at risk of being homeless. The following interview questions consider the main research question: What is the most effective way to adapt the CMHA's current IPS program for people who have experienced homelessness or who are at risk of being homeless?

1. What do you research/what kinds of services do you and your organization provide?
2. Do you research or provide the IPS program or another supported employment program?
3. What clientele does your organization work with? Do you work with people who have experienced homelessness?
4. How does your organization measure the impact of your IPS program?
5. In what ways does your organization ensure that your program maintains fidelity to the IPS model?
6. We would like to list and analyse the stakeholders who would like to know about the IPS program, including people and organizations that can benefit from the program but also funders, government bodies, organizations, and services that may wish to learn about the program. Can you give me some examples of the stakeholders that you work with, that we may consider working with here in Canada?
7. What are the benefits and promising practices of an IPS program that is geared towards people who are homeless or at risk of being homeless?
8. Do you have any recommendations for the CMHA, in how it might be able to provide services in the communities where people who have experienced homelessness now live (instead of a mental health team within the CMHA)?
9. How can the CMHA sustain the fidelity of the IPS while adapting the program for this population?
10. What is the existing literature on IPS programs that have been adapted for this population?
11. Is there anything you would like to clarify from your interview?

12. Can you suggest any other professional/business contacts who work in community service organizations that provide mental health and addictions support, and who may be interested in being interviewed? If so, could you please provide their contact information?

Appendix D – Focus Group Questions

The research objective is to determine whether the Canadian Mental Health Association Vancouver-Fraser branch (CMHA) can adapt their Individual Placement and Support (IPS) program for people who have experienced homelessness or who are at risk of being homeless. The following interview questions consider the main research question: What is the most effective way to adapt the CMHA's current IPS program for people who have experienced homelessness or who are at risk of being homeless?

We will use Community Based Research techniques, which is a partnership approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process and in which all partners contribute expertise and share decision making and ownership (Wikipedia (n.d.). Community-based participatory research Retrieved at: en.wikipedia.org/wiki/Community-based_participatory_research).

I recognize that our organizations may be considered for some of the same funding opportunities. If this is a concern, please feel free to only talk about the qualities of your programs and potential aspects of programs that have already been published or made public, and which are not private to your organization. If you feel that some unpublished information would provide the CMHA with beneficial information for developing a better program, you may wish to say it without jeopardizing your own organization in any way.

1. What do you research/what kinds of services do you and your organization provide?
2. Do you research or provide the IPS program or another supported employment program?
3. What clientele does your organization work with? Do you work with people who have experienced homelessness?
4. How does your organization measure the impact of your IPS program?
5. In what ways does your organization ensure that your program maintains fidelity to the IPS model? (I will bring the fidelity criteria and we can go through it together)
6. We would like to list and analyse the stakeholders who would like to know about the IPS program, including people and organizations that can benefit from the program but also funders, government bodies, organizations, and services that may wish to learn about the program. Can you give me some examples of the stakeholders that you work with, that we may consider working with here in Canada?

7. What are the benefits and promising practices of an IPS program that is geared towards people who are homeless or at risk of being homeless?

7a. What are some of the interventions that have been used by other organizations?

7b. What are some interventions that you believe may be effective for this population?

7c. Do you think we can work with existing Housing First Intensive Case Management (ICM) teams to establish the IPS program out in the community? If so, how do you see this working? Which organizations might this work best with? Why?

8. What are some ways that the CMHA can sustain the fidelity of the IPS while adapting the program for this population?

9. Is there anything you would like to add?