A Demonstration Project Involving Peers as Providers of Evidence-Based,
Supported Employment Services

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Objective: The present demonstration project involved development of a training program designed to teach recovering consumers employed as peer advocates how to provide evidence-based supported employment services to consumers with severe mental illness. Methods: A training curriculum was developed to teach the core competencies of the Individual Placement and Support (IPS) model of supported employment. Three peers participated in training and provided work outcome data from their caseloads. Assessments were conducted of peers’ competence in implementing IPS and effectiveness in promoting job placements. Peer competency was assessed by the following: (a) a formal IPS fidelity review performed by two external reviewers to evaluate service implementation, and (b) the Kansas Employment Specialist Job Performance Evaluation, an objective measure of employment specialist attitudes and skills. Program efficacy was assessed by examining the number of job placements and corresponding tenure. Results: The fidelity review revealed that peers met IPS standards of implementation on 7 of 14 items assessing service delivery. The Kansas scale results revealed attitudes to be a relative strength and job performance competency ratings fell in the average to above average range across skill areas assessed (e.g., vocational assessment, job development). Thirty-three percent of consumers from the peers’ caseloads got competitive jobs; mean tenure was 26.1 weeks. Conclusions and Implications for Practice: This demonstration project provides a starting point for future efforts aimed at expanding the role of peers as providers of evidence-based mental health services and provides a measured degree of optimism that this is a realistic, attainable goal.
Peer participation in the delivery of services is recognized at national, state, and local levels as a key component to a recovery-oriented model of care for persons with schizophrenia (Campbell, 2005; Cook et al., 2012; Druss et al., 2010; Mowbray, Moxley, Jasper, & Howell, 1997; New Freedom Commission on Mental Health, 2003; Pickett et al., 2012). Peer providers are individuals who have achieved functional recoveries from a mental disorder, continue to receive mental health services themselves, and are employed by mental health programs to work alongside professionally prepared staff members. Peer support is based on the assumption that individuals with mental illnesses are uniquely positioned, based on their personal experience of having lived with a mental disorder, to provide support and encouragement to others who are in the process of recovery.

An increasing number of clinical and rehabilitation programs employ peer providers to furnish a variety of services to individuals with severe mental illness (SMI; Goldstrom et al., 2006). Peer provider roles include case manager aides, community aides that connect hospitalized consumers to continuing outpatient services, counselors and advocates, outreach workers, providers of self-help educational services, and vocational counselors (Clay, Schell, & Corrigan, 2005; Sledge et al., 2011). Most data on the use of peers as service providers have come from descriptive studies indicating comparable benefits for individuals with SMI receiving services from peer versus nonpeer providers (Clarke et al., 2000; Davidson, Chinman, Sells, & Rowe, 2006, Davidson et al., 2004; O’Donnell et al., 1999; Schmidt, Gill, Pratt, & Solomon, 2008; Sherman & Porter, 1991; Solomon & Drake, 1995). Two randomized, controlled studies found that peers serving as health or personal assistants to case managers resulted in increased service engagement, level of social participation, and quality of life among the consumers served (Craig, Doherty, Jamieson-Craig, Boocock, & Attafua, 2004; Felton et al., 1995).

More recent efforts have examined the efficacy of peer delivery of evidence-based practices in education training programs focusing on illness self-management. In a randomized, controlled trial Cook et al. (2012) found that an 8-week, peer-led educational training program on mental illness self-management reduced consumers’ levels of depression and anxiety and improved their self-perceived recovery compared to a group that received usual care. Similarly, Druss et al. (2010) found that peer-led education about management of chronic illnesses resulted in improvement in patient activation and rates of making primary care visits compared with a usual care group. Pickett et al. (2012) found that consumers randomized to receive peer-led education to increase their empowerment over their own health care showed increases in overall empowerment, self-esteem, and self-advocacy-assertiveness, and level of improvement was maintained over a 6-month follow-up.

A unique service provider role that may be particularly germane to peer involvement is supported employment. For individuals with SMI, employment failure in the community workforce has been a historically intractable problem. Estimates of those not competitively employed range from 65% to 90% in studies and reviews conducted over the past 25 years (Anthony & Jansen, 1984; Baron & Salzer, 2002; Lehman, 1995; Rosenheck et al., 2006). Using the U.S. Bureau of Labor Statistics definition that is based on individuals actively seeking work in the last 4 weeks, SMI unemployment rates generally fall around 25%–27%, which is still 3 to 4 times greater than current national levels (Cook, 2006).

Findings from supported employment (SE) programs are typically associated with more favorable outcomes (Bond, Campbell, & Drake, 2012). Aimed at returning persons with SMI to work in competitive jobs in community businesses, this approach is based on rapidly moving the mentally ill consumer into the job finding process, bypassing prevocational training, followed by indefinite, in vivo support as needed. An evidenced-based approach for SE of mentally ill persons, Individual Placement and Support (IPS), integrates the role of employment specialist within a multidisciplinary treatment team (Becker & Drake, 2003; Drake, Bond, & Becker, 2012). IPS emphasizes an integrative, collaborative working relationship among clinicians, employment specialists, employers, and consumers with the aim of helping the consumer attain his or her vocational goals. The duties of an employment specialist under this model are multifaceted, requiring comprehensive vocational assessments of each consumer, initiating a rapid job or school search, and continued monitoring, support and problem-solving after job or school placement.

Our primary aims in this preliminary report of an National Institutes of Mental Health (NIMH)-sponsored, rehabilitation research project in an urban community mental health center were to: (a) describe our novel training program designed to teach peers the personal and professional skills of employment specialists under the IPS model, (b) assess the peers’ competencies in implementing IPS, and (c) examine early data on job placement rates and tenure from the peers’ caseloads. Education was a proximal goal for many consumers at this mental health center because they were young with recent onset of schizophrenia and in need of additional skills to be competitive in the job market. However, to be consistent with the IPS literature and the primary focus of this model on employment outcome, we treat educational outcomes separately and in a more limited way.

**Method**

**Participants**

Three newly hired peer advocates (two Caucasian and one Latina) participated in the IPS employment specialist training and provided work outcome data from their respective caseloads. Each had a history of SMI, ranged in age from 40–59 years, and had educational attainment ranging from 10th grade to 1 year of college (Table 1). Each had been hired as a peer advocate by a Los Angeles County Department of Mental Health clinic. Originally, their primary responsibilities were to assist with case management needs and to perform other assigned tasks which included assisting with group therapy sessions, gathering survey data, and planning social events (e.g., birthday celebrations). As part of this NIMH-
supported study on supported employment, the peers were subsequently offered a training opportunity to learn how to provide IPS-supported employment services for consumers with SMI at the clinic’s Wellness Center. During and after the formal period of training, the peers continued to perform some clinic duties that were not employment service related.

Training

Training began with a 2-day, didactic overview of vocational services for persons with SMI, and then included weekly 60- to 90-min sessions that provided information about caseload development, community-based job development, staff and SE roles within a multidisciplinary treatment team, follow-along support for newly hired consumers, and chart documentation. After 6 months, it became clear that this primarily didactic, information-providing approach was largely ineffective. The peers expressed high levels of uncertainty about the priority of developing vocational skills as a core component of their current postions, as well as their ability to carry them out. Our two lead instructors with prior experience training professionally prepared SE staff at other agencies acknowledged the need to shift to a more detailed, skill-focused, training approach to facilitate peer competency in implementing SE.

A training curriculum was developed that covered four key areas of competence required by employment specialists under the IPS model: (a) developing a professional working relationship with a consumer, (b) job development, (c) job support/maintenance, and (d) integration of employment services with a multidisciplinary mental health treatment team. The training curriculum was consistent with the field-based training used by IPS trainers and supervisors (Swanson & Becker, 2011 manual), though the peer training was considerably more intensive and covered a longer period of time than the typical 6-month period required for training mental health professionals. Training procedures for the peers were based on behavioral and social learning principles used in the UCLA Social and Independent Living Skills modules (Liberman et al., 1993), and included:

- didactic instruction about specific skills required of employment specialists within each skill area (based on task analysis)
- clinic-based role-plays of simulated situations based on real-world scenarios
- application of supported employment skills in community settings with performance-based supervision
- modeling, social reinforcement, a rigorous practice schedule, prompting and cueing, corrective feedback, and homework assignments.

The primary on-site instructor, who subsequently served as coordinator and supervisor of the peer employment specialists, was a clinical psychologist with assistance from a Master’s level research associate. This latter period of training covered 12 months with instructional activities conducted 1–2 hr per day up to 3 days per week depending on the peers’ availability vis-à-vis other clinic responsibilities. Our research team’s experienced SE researchers provided oversight of the training conducted by the clinical psychologist and 1.5–2.0 hr weekly in-person training of the peers directly. Our senior consultant made quarterly visits to the clinic to provide specialized instruction on implementation of SE skills based on his years of experience using behavioral and social learning principles for skill acquisition.

Training Procedures for Each Skill Area

For Skill Area 1, “Developing a Professional Working Relationship with a Consumer,” training focused on peers’ development of active listening skills and their ability to elicit consumers’ vocational or educational interests and goals, as well as concerns, ambivalence, and fears about working. Prepared handouts provided brief descriptions of desirable and undesirable verbal and nonverbal communication which the peers used during role-play exercises to cue them about specific skills they were expected to demonstrate. Initially, role-play exercises were performed with research staff to facilitate acquisition, and then later transitioned to inclusion of consumers with SMI to promote generalization.

For Skill Area 2, “Job Development,” peers were provided written information about the functional role of the SE program and how its services might be useful to managers of businesses seeking prospective employees. For an initial meeting with a manager or human resource official, the aim was defined as being able to clearly state the primary purpose of the contact and establish short-term and longer-term goals toward developing a respectful relationship. Initially, peers participated in role-play exercises in the clinic where they practiced interacting with would-be hiring managers and received corrective feedback on their performance.

Training then moved to community settings with our experienced SE researchers modeling how to initiate a conversation with hiring managers at local businesses. Peer participation was structured at this stage. After the team’s SE researchers spoke with a hiring manager, the peers asked their own prepared questions. These interactions served a twofold purpose in providing: (a) real world experience for the peers to interact with hiring managers under conditions optimal for success, and (b) an opportunity to gather information about employment opportunities for their consumers with SMI. In subsequent training sessions each peer took

Table 1
Demographic Characteristics and Work Histories for the Three Peer Providers

<table>
<thead>
<tr>
<th></th>
<th>Peer I</th>
<th>Peer II</th>
<th>Peer III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>40</td>
<td>52</td>
<td>59</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>Caucasian</td>
<td>Caucasian</td>
<td>Latino</td>
</tr>
<tr>
<td>Education (years)</td>
<td>10</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Work experience</td>
<td>Case manager, bakery clerk, cashier, server, printing shop clerk</td>
<td>Board-and-care home activities director, office manager for storage company, purchaser, technical support provider</td>
<td>Lab assistant, parts inspector for aircraft company</td>
</tr>
</tbody>
</table>
the lead in initiating contact and speaking directly with a hiring manager. Immediately following each community outing, the trainers and peers met at the clinic to review the outcome of the interaction with the hiring manager(s) and to go over the observed strengths and weaknesses in the peers’ performance.

For Skill Area 3, “Job Support and Maintenance,” training included viewing examples of job support from IPS training videos, performing role-play exercises, and weekly review of the status of consumers from each peer’s caseload. Information provided to peers emphasized that job support should be related to a consumer’s specific work history, personal preferences, and individual strengths and weaknesses. In one example, it was shown how a meeting with a consumer can be arranged over a lunch break at a location near his or her job to talk about how having a mild return of symptoms might be interfering with work performance. Information was provided about the broad array of services involved in follow-along support. Examples included benefits planning (which may require assistance from an outside agency), providing positive feedback about work accomplishments, giving morning wake-up calls, coordinating transportation issues, and linking consumers to relevant members of the multidisciplinary team for medication or psychotherapeutic interventions.

For Skill Area 4, “Integration of Employment Services with a Multidisciplinary Mental Health Team,” training focused on teaching the importance of working with other professionals involved in consumer treatment. This training aim was met by showing examples demonstrated in IPS videos, role-playing, and reviewing each peer’s participation in the weekly multidisciplinary treatment team meetings. Peers were encouraged to generate ideas about support that may facilitate consumer job success in the context of ongoing mental health treatment concerns. An emphasis was placed on working closely with the mental health treatment team. Through the primary supervisor’s established professional relationship with psychiatry staff, he facilitated acceptance of the peers’ role and active involvement in treatment team meetings. One area given a primary focus was teaching the peers to draft progress notes for the consumers’ medical records. These notes described their ongoing activities with their respective consumers, including attempts at engagement, addressing obstacles to employment, and providing follow-along support. These notes served to further integrate their service delivery efforts in supported employment with other services provided by the treatment team.

Assessment

Assessment of peer competency included the following measures: (a) The 25-item Supported Employment Fidelity Scale (Bond, Peterson, Becker, & Drake, 2012), (b) Kansas Employment Specialist Job Performance Evaluation (Carlson, 2008), and (c) Number of job placements and mean job tenure for consumers with SMI from each peer’s caseload.

The 25-item Supported Employment Fidelity Scale measures a supported employment program’s fidelity to implementation of IPS principles and was used to measure the peers’ collective competency in service implementation. The fidelity review involved a 2-day, in-person visit by two external reviewers and included evaluation of staffing, organization, and services. The review consisted of the following activities: (a) observation of an integrated mental health treatment team meeting, (b) interview with the clinic mental health directors and primary peer supervisor, (c) separate observations of the peers conducting job development activities, (d) interviews with case managers and a staff psychiatrist, (e) group interview with family members and consumers, (f) individual interviews with the peers, (g) interview with the clinic’s benefits counselor, and (h) chart reviews. The scale is designed to assess a program’s level of commitment to implementing IPS as institutionalized, and thus includes items that pertain to the employment specialist’s behavior specifically (e.g., speed with which job development begins after a client enters the program) and others that do not (e.g., management use of employment outcomes in quality assurance activities for the agency). Scores on the full 25-item scale range from 25–125 (Not Supported Employment = 25–73; Fair = 74–99; Good = 100–114; Exemplary = 115–125).

For the purposes of assessing peer competency, the section on “Services” from the fidelity scale was most appropriate. This section included 14 items measuring implementation of functions expected of IPS employment specialists. Each item is rated on a 5-point Likert scale ranging from 1 (no implementation) to 5 (full implementation) with intermediate numbers representing progressively greater degrees of implementation. Scores were consensus ratings from the two external reviewers.

To provide an individualized measurement of peer competency according to defined roles as an IPS supported employment specialist, we administered the Kansas Employment Specialist Job Performance Evaluation. This scale measures the skill level and attitudes of supported employment specialists under the IPS model and was administered and scored by our two internal SE experienced researchers. Scores on each item were consensus ratings. This interview- and observation-based measure included subscales which measure an employment specialist’s attitudes toward consuming with SMI, consumer engagement, ability to complete a vocational profile for a consumer, and integration of supported employment services with the mental health treatment team. The scale was developed to capture key competency criteria of an employment specialist under the IPS model and uses a 5-point Likert scale (1 = poor; 3 = average; 5 = superior).

In sum, the fidelity review provided an objective measure of overall peer competency at the level of implementation, whereas the Kansas scale provided an individualized measurement of each peers’ skill level and attitudes as employment specialists. The data on job placement and tenure provide an objective measure of the peers’ ability to help consumers with SMI attain and maintain employment. These data were aggregated over two years from the time of project start-up. Consumers were followed up to 12 months after their initial job placement for the purpose of assessing tenure.

Results

Results from the “Services” section of the Supported Employment Fidelity Scale appear in Table 2. The peers met fidelity standards of implementation (i.e., a score of 4 or 5) on 7 of the 14 items assessing services delivery. The peers showed medium degrees of implementation (a score of 3) on four other items including work incentives planning, individualized job search, individualized follow-along job support, and time-unlimited follow-along job support. Lower scores (1 or 2), considered not implemented, were obtained on items assessing management of disclosure of psychiatric status with employers and coworkers, frequency of
employer contacts, and the degree to which services were provided in community-based settings. Overall, the program received a "fair" classification on its implementation of IPS principles of supported employment with a total score of 87.

Results from the assessment of each peer’s competency using the Kansas scale appear in Table 3. Scores were the means for the summed consensus ratings within each subscale. General observation of these results indicated the following. First, peers’ competency ratings were largely reflective of average to above average job performance levels across skill areas (vocational assessment, integration with mental health treatment team, job development, and providing follow-along support). Second, peers’ attitudes (values and engagement) were an area of relative strength.

Following the completion of training, each peer gradually built up a caseload of consumers with schizophrenia or schizoaffective disorder with less than 10% having other severe mental disorders. Results for the number of consumers obtaining competitive job placements per peer are presented in Table 4. In total, 33.3% of consumers (20 of 60) were placed at competitive jobs. Mean job tenure was 26.1 (SD = 18.7) weeks. The rates of competitive employment fell above the 25th percentile compared with quarterly rates observed at established IPS programs (Becker, Drake, & Bond, 2011). As noted earlier, a number of consumers chose academic outcomes (e.g., completion of GED, English as second language) as their proximal goal. The peers helped these consumers find appropriate classes for their academic needs and provided follow-along support after enrollment. Twenty-five percent of the peers’ overall caseload (15 of 60) fell into this category.

To provide a qualitative view of the peers’ IPS work, synopses from two consumers’ successful job outcomes are presented below.

### Consumer #1

A Latina woman in her 20s with a recent history of mental illness had a limited work history and had been unemployed for two years. She admitted ambivalence about working. With a good deal of encouragement and talking through some of the reasons behind her ambivalence (e.g., afraid she might fail and worries about the consequences of work on her disability and health care benefits), the woman agreed to look for a job. The peer employment specialist taught the consumer how to construct a resume, explored sources of job leads, and practiced going on job interviews. Incorporating the consumer’s family into this process was identified as an important consideration given the cohesiveness of many Latino families.

A family friend offered a job lead for employment as a home health care aide. The peer employment specialist accompanied the
consumer to her job interview. She was hired. After the job began, the peer employment specialist met with the consumer twice each week during the first month, providing encouragement and support and assisting her with selected job obstacles identified by the consumer (e.g., speaking with her supervisor when not sure what to do). The consumer performed with increasing confidence and conscientiousness which led to a promotion from part-time to full-time employment and benefits. She continues to meet with her peer employment specialist on a monthly and as-needed basis to solve problems in sustaining her comfort and competence in her job.

Consumer #2

Having been unemployed for over 10 years because of the disability related to her severe mental illness, this consumer’s mental health barriers to employment included recurrent bouts of anxiety and depression superimposed on her schizophrenia. To

Table 3

Peer Competency on the Kansas Employment Specialist (ES) Job Performance Evaluation

<table>
<thead>
<tr>
<th>Competency areas</th>
<th>Mean competency area ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Peer I</td>
</tr>
<tr>
<td>1. Values: (a) Belief that the clients they work with can work. (b) Belief that no person with psychiatric disability should be excluded from employment services based on job readiness, substance abuse, history of violent behavior, intellectual functioning, or symptoms.</td>
<td>5.0</td>
</tr>
<tr>
<td>2. Engagement: (a) Makes multiple, ongoing attempts to engage or reengage with clients despite difficulties/obstacles to connect with them. (b) Ability to effectively build rapport and trust and ability to relate to a wide variety of people.</td>
<td>4.5</td>
</tr>
<tr>
<td>3. Assessment/Vocational Profile/Planning: (a) The ES is able to use a vocational profile to gather relevant information about the client in order to begin identifying a good job match. (b) Ability to take information obtained in the assessment and assist client in finding employment situations in the community that match the desires and needs of the program participant. (c) The ES clearly identifies an employment goal and job options that include clients’ needs and preferences. (d) The ES discusses disclosure with the client.</td>
<td>3.3</td>
</tr>
<tr>
<td>4. Integration of Rehabilitation Mental Health Treatment: (a) ES regularly attends treatment team meetings. (b) The ES is an active participant in team meetings, participating throughout the whole meeting. (c) The ES meets with case managers and other treatment providers regularly regarding needed services to assist clients in achieving their employment goals.</td>
<td>4.7</td>
</tr>
<tr>
<td>5. Job Development: (a) The ES is able to introduce themselves stating clearly who they are, what they do, and what they want from the employer. (b) The ES is able to obtain critical information about the employer’s business. (c) The ES is able to present information to the employer about the program or client that matches the information obtained from the employer about their needs and desires. (d) The ES is able to end the job development call by clearly stating next steps or getting commitment from the employer to move the process forward.</td>
<td>3.8</td>
</tr>
<tr>
<td>6. Follow-Up Supports: (a) The ES meets regularly with clients who are working to assess how the client is doing. (b) Is able to individualize types and frequency of supports depending on the needs of the client and newness of the job. (c) Ability to provide individual follow-up supports to the employer.</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Note. The Kansas evaluation uses a 5-point Likert scale (1 = poor; 3 = average; 5 = superior); competency area ratings were the mean of the summed consensus ratings for items within each skill area.

Table 4

Employment Outcomes for Severe Mental Illness (SMI) Consumers Served by Each of the Peer Providers Over the 24-Month Period Following Training

<table>
<thead>
<tr>
<th>Caseload size</th>
<th>Number employed</th>
<th>Number unemployed</th>
<th>Mean job tenure (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer I</td>
<td>22</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Peer II</td>
<td>21</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Peer III</td>
<td>17</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>

a Mean job tenure = average number of weeks at a competitive job after initial placement; consumers were followed for 52 weeks after their initial job placement.
reduce these obstacles to her employability, the peer employment specialist collaborated with the mental health treatment team. They devised a plan that included reevaluation of her medication and individual therapy to help reduce her anxiety and depression, plus included counseling on medication adherence and peer support in setting vocational goals.

The peer employment specialist helped her construct a resume and, in job interviews, account for her lengthy period of unemployment. After exploring different job leads and going on a number of job interviews, the consumer was hired for a part-time, seasonal job as a cashier and stocking clerk at a store selling housewares. The peer employment specialist met with the consumer two times per week on the job and in her home during her first month at the store. Providing follow-along job support and problem-solving issues that arose on the job made the difference between sustaining employment versus dropping out. After the holiday seasonal employment period ended, the consumer’s capabilities and personal qualities so impressed her store manager that she was hired on a permanent basis with an increase in hours. Now, three months later, the consumer continues to have meetings with her peer employment specialist and stated, “The pay is not that great, but I’m happy to be working and making a few extra bucks that I badly need. My depression and anxiety are pretty much gone and it sure beats staying at home and feeling helpless.”

Parenthetically, some consumers commented that they perceived the peers as successful role models. This gave them optimism that they, too, could achieve their own individual vocational goals.

Discussion

Results of this study suggest that peer advocates with no background experience in providing vocational services can be taught to implement evidence-based SE with a modest degree of fidelity. Although their status as a peer does not make them better or more uniquely capable than professionally trained employment specialists, it does convey a facet of credibility with their consumers in that they can directly relate to the struggles involved in attaining and maintaining employment while managing a mental illness. This demonstration project takes the IPS model of supported employment and psychosocial rehabilitation into a new realm; namely, demonstrating that consumers who are recovering from their clinical disorders can assume the role of employment specialist that heretofore has been primarily fulfilled by mental health professionals. It should be noted that based on the peers’ accomplished performance in this supported employment program, each peer received a promotion. The promotion by the County agency is an external validation of the capacity of recovering peers to provide evidence-based supported employment services for other consumers with SMI.

To place these findings in proper context, it should be noted that both the peers and the program had to overcome a number of challenges. After being hired as peer advocates the peers were asked to “stretch” into the demanding employment specialist role. They were challenged to transition from a role of case manager assistants to performing as employment specialists, a job of much greater complexity and rigor. Indeed, the first 6 months of training required our team to work with the peers to help them understand the value of doing this work and to help instill confidence in their ability to perform a job that was far more demanding than any they had performed before. In light of their limited education and background experience in this area, it is remarkable that they acquired and effectively implemented the employment specialist skills from the training program. All three are still with the program 4 years later. Another formidable barrier that the peer employment specialists had to overcome was a workload that continued to include their previous activities as aides to the mental health center’s case managers. Until the IPS model was fully adopted by clinic administrators, which occurred some three years into the program and was triggered largely by the successful work of the peer specialists, SE activities were superimposed on other clinic duties that limited their availability to engage in community-based job development and follow-along support.

This peer-driven supported employment program would not have been possible without the strong leadership of a highly competent on-site coordinator and supervisor who provided structure, oversight, and support to help them carry out weekly SE activities and problem-solve as challenges arose with individual consumers. In addition, the program required a high tolerance for medically excused absenteeism resulting from the peers’ physical or mental health problems and appointments with their doctors and therapists. Keeping the peer employment specialists healthy and functional was a high priority, as it is for employees in any workplace. Furthermore, maintaining their own well-being was a key element in serving as role models for consumers with SMI.

In interpreting the overall placement rate from the peers’ caseloads there are a number of points to consider. First, the absence of a control group limits interpretation of these findings. Hence, no definitive conclusions can be drawn about whether the strengths or weaknesses observed in the employment specialists’ work performance can be attributed to their status as peers. In line with this point, it is unknown to what degree contextual factors, such as the extensive training, ongoing supervision, and organizational structure of the environment, served to facilitate their work performance as employment specialists. Second, it should be noted that of the 60 consumers enrolled in the program only 20 (33.3%) got competitive jobs. This falls below the median of 41% employment observed across established IPS programs and the higher 60–70% performance as employment specialists. Second, it should be noted that the 60 consumers enrolled in the program only 20 (33.3%) got competitive jobs. This falls below the median of 41% employment observed across established IPS programs and the higher 60–70% acquisition rates reported in recent independent studies and reviews (Becker et al., 2011; Bond, Drake, & Becker, 2008; Campbell, Bond, & Drake, 2011; Twamley et al., 2012). In part, this reflects the fact that 25% of the consumers identified returning to school (rather than obtaining a competitive job) as their recovery goal, a finding consistent with other efforts to integrate supported employment and education, particularly in recent onset samples (Nuechterlein et al., 2008). Third, the sample predominantly comprised of individuals with schizophrenia might be another consideration in the lower competitive employment rates. However, despite the intuitive linkage, findings from reviews and meta-analyses generally indicate no difference in competitive employment rates between individuals diagnosed with schizophrenia and other severe mental disorders (Campbell et al., 2011; Cook et al., 2008). Fourth, the overall “fair” classification from the fidelity review indicates a less than optimal level of implementation which may be related to job placement success. In fact, findings from recent studies reveal a high correlation between degree of fidelity implementation and employment rates and tenure (Becker et al., 2001; Bond et al., 2008). Fifth, the employment rate results should
be interpreted in the context of the nation’s recession which required the peer employment specialists to swim against the current of the high unemployment rate ranging from 12.3 to 12.6% in Los Angeles County for the period of participant enrollment (U.S. Department of Labor, Bureau of Statistics, 2010, 2011). Among the states, California’s unemployment rates has been third highest in the country with the clients in this program having to compete against recently laid off workers without SMI eager to find work at even lower level paying jobs. Sixth, the competitive employment rate may have been further impeded by the fact that the vast majority of the consumers were from minority ethnic groups—especially Latinos—who potentially had to overcome cultural stigma as well as stigma from having a serious mental disorder (Kopelowicz, 1998).

We would be remiss without addressing the importance of education as a personally relevant goal for consumers with SMI. Although the IPS literature has been largely devoted to competitive employment, more recent efforts have expanded this model to include education (Nuechterlein et al., 2008). Competitive work should not be construed as somehow better or more dignified and building of self-efficacy than fulfilling educational goals. Clearly, in this sample of consumers with SMI at an urban community mental health center, advancing their education was a preferred choice for many of them. Perhaps, future studies of IPS will consider broadening the definition of outcomes to include both competitive employment and education to better capture the range of personally relevant goals common to persons with SMI. This may be particularly appropriate for studies including younger, recent-onset samples.

In conclusion, there is a good deal of interest in the consideration of peers as providers of evidence-based practices. Having work rehabilitation services provided by peers who themselves have experienced mental illness clearly presents certain advantages. On the other hand, peers pose training challenges given the kinds of complex and varied skills necessary to function as a competent employment specialist. Future efforts may wish to further examine the potential use of peers as providers of evidence-based practices in SE and other clinical and rehabilitation service areas. For work rehabilitation, perhaps future efforts may move toward testing of manualized training methods with a larger sample of peers and perhaps including multiple sites to assess the efficacy and generalization of training in this area.

References


