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An Application of the IPS Fidelity Scale in the Planning Process to Implement Supported Employment in Flanders

Knaeps J.*[a], DeSmet A.* and Van Audenhove Ch.*
* LUCAS, KULeuven, Belgium

[a] Address for correspondence: Knaeps J., LUCAS (Center for Care Research and Consultancy), Catholic University of Leuven, Kapucijnenvoer 39, bus 3510, B-3000 Leuven, Belgium. TEL.: +32 16336929; FAX: +32 16336922; E-mail: jeroen.knaeps@med.kuleuven.be.

Abstract

Objective: Despite the wish of many people with SMI to work in a competitive job, employment rates are low. IPS is more effective than other vocational rehabilitation methods in achieving employment and its use should be extended to bridge the gap between user wish and reality. This study measures possibilities to implement IPS in Flanders, by investigating current use, barriers and facilitators across a wide range of services.

Method: Semi-structured interviews with 17 vocational rehabilitation agencies were conducted, using the IPS Fidelity Scale and a list of open-ended questions on perceived barriers and opportunities. Results were analyzed via thematic analysis.

Results: Results show an overall lack of implementation of IPS in Flanders, especially on the four core elements for which most evidence exists. An external style of attributing barriers to environment factors or client characteristics is apparent which could lead to a sense of resignation among counselors.

Conclusions: The use of the IPS fidelity scale and open-ended questions has provided concrete levers to prepare for implementation: a strong leadership in the agencies to encourage optimism towards regular employment for people with SMI; closer co-operations between employment agencies, care agencies and employers; and a more facilitating legislation concerning using IPS.

Key Words: Individual Placement and Support, IPS Fidelity Scale, Barriers, Implementation

1. Introduction

Work is an essential part of life. Besides the monetary value, it improves self-esteem, establishes social relationships and offers a goal in life [1]. Most of these benefits do not result from keeping oneself busy, but lie in the societal meaning of having a regular, valued and competitive job [2].

For people with severe mental illness (SMI) competitive jobs, which pay at least minimum wage and are open to any person regardless of disabilities [3], are hard to obtain and keep [4]. Employment rates in the US among people with SMI are as low as 10 to 20% [5] and around 20 to 30% in Europe [6,7]. And this while the majority of people with SMI wants to work in a competitive job and can achieve this with ongoing support [8]. Similar trends in employment rates and user preferences are observed in Flanders, with its six million inhabitants the largest region in Belgium [9].

Evidence-based approaches to support people with SMI in employment are grouped under the umbrella of Supported Employment (SE) [8,10], of which the Individual Placement and Support (IPS) model shows the best outcomes [11,12]. The IPS-model is founded on seven principles: (1) zero exclusion, (2) integration with mental health treatment teams, (3) start from consumers' preferences, (4) rapid job search, (5) competitive employment as goal, (6) time-unlimited follow-up and (7) benefits counseling [13]. The IPS-model is the standardization of SE-principles [3], the terms SE and IPS will therefore be used as synonyms throughout the article.

IPS has shown its value in both US and Europe by helping roughly twice as many people with SMI in finding a regular paid job as traditional vocational services do [8]. The Eqolise trial in six European countries [12,14,15] demonstrated that these superior employment outcomes can be achieved in countries with very different employment contexts, health care policies and benefits systems.

Flanders has a highly protective benefit system and resulting benefits traps for users, as well as a fragmentation of the offer across several (pre-)vocational services and different policy levels with inconsistent regulations [16]. Furthermore, employment outcomes of these services are poorly registered. This background does not provide sufficient incentives for people with SMI to return to work [17].

Vocational rehabilitation in Flanders relies strongly on traditional psychiatric rehabilitation, with a large offer of sheltered work for people with SMI. Although for some, sheltered workplaces are helpful in developing work attitudes and increasing resilience to experiences of failure [18], there is a great number of users in sheltered workplaces, ranging from 25% to 70%, who prefer to work in regular paid employment [9,19,20]. In order to bridge this substantial gap between preference and employment reality, effective methods in supported employment should be further disseminated in Belgium and possibly other countries with a strong reliance on sheltered work [21].

Thanks to a recent mental health care reform in Belgium, policy makers strive towards more community care and user empowerment [22]. This reform is the next phase in deinstitutionalization of the mental health care offer by reducing the number of psychiatric beds and putting a solid outpatient alternative in place [23]. As an increasing number of people with SMI in Belgium will live in the community in the next coming years, regular paid employment will become more important as a way to attain social inclusion. The reorganization of care in Belgium has currently started in 19 regions (www.psy107.be). In these regions, psychiatric hospitals have formed cooperative networks with e.g. primary care, low-threshold social services, supported housing initiatives and employment services to provide a full mental health care offer that can meet the person's needs and allows for maximum community integration. Rather than closing the existing institutions and setting up new facilities that are more community-oriented, policy makers have chosen to reorganize the existing different care forms in collaborative networks and to retrain staff in using evidence-based methods consistent with balanced care. Supported employment is one such method that staff currently working in day activity centers or sheltered workplaces may need to master in the future. In fact, some of the Flemish regional reorganization projects are already investigating the potential of working together with the Flemish Employment Service to add an employment specialist to their newly set up mobile teams. It is evident that a change towards community care should start with supporting competitive employment, as work provides many benefits that are crucial in a person with SMI's recovery process [24].

This study was set up to provide guidelines for SE implementation to employment and health care professionals in Flanders, and in generalization to those in other countries with a high reliance on sheltered or pre-vocational forms of employment support, desiring to change to more community care.

A first objective of the study is to investigate the extent to which vocational rehabilitation services in Flanders currently apply IPS-principles. The second objective is to understand what hinders and facilitates the future use of IPS, which is essential when considering starting to use SE [25,26].

2. Methods

Studies on implementing or evaluating IPS often follow a quantitative research method using Fidelity Scales [27-29] whereas other studies use qualitative approaches [30]. This study combines both quantitative and qualitative research methods, similarly to studies by Bond et al. (2008) [31] and Porteous and Waghorn (2007) [32]. In both studies, qualitative data collected in interviews with occupational therapists or implementation monitors enrich the quantitative data and give insight in the implementation progress as experienced by counselors [31,32].

2.1 Sample

We aimed to interview approximately 20 agencies to keep data collection feasible in the time available, while also striving for a maximum geographical spread in Flanders and representation over different agency types. As the mental health care reform in Belgium may urge current sheltered workplaces or activation programs to adapt and (also) offer Supported Employment when called for by the needs of the service user, we have chosen to include a broad range of agency types, such as sheltered workplaces and pre-vocational training agencies, that are not usually included in IPS implementation studies. Recommendations for future implementation should not only consider those agencies that are already closest aligned with the SE philosophy, but also those who are less familiar with evidence-based methods in supporting people in competitive employment and who might face different challenges in implementation.

The Flemish Employment Service provided a list of contact details for agency types which are under their authority (e.g. SE agencies, pre-vocational training) as well as some contacts for other types of agencies (e.g. vocational rehabilitation offered via mental health care institutions), known to them through networks, conferences or cooperation projects. As this first list was not comprehensive, it was further completed by searching on websites of official umbrella or government organizations, resulting in a list of 231 officially registered agencies

providing vocational rehabilitation to people with SMI. A purposive sample of contacts with explicitly mentioned coordinates on the list or official websites was chosen as this was considered a sign of their personal expertise in vocational rehabilitation. This is an appropriate method for qualitative research to guarantee that the subjects will be good informants for the study [33].

The list was organized by agency type and province and the first-occurring agency with contact details was iteratively selected. Twenty-three agencies were thus selected over several agency types and contacted by telephone or e-mail. Seventeen were willing to participate (response rate 74%). Participating services included are: regional job coaching centers, vocational counseling centers, vocational training agencies, day-activity centers, sheltered or social workshops, vocational units in psychiatric hospitals, and pre-vocational counseling agencies (Table 1). Those declining did so because of lack of time or perceived lack of experience on the subject.

Participants were interviewed between Oct-Dec 2010 in a private work office. Interviews lasted between 60 to 120 minutes and were audio-taped for later scoring. All participants provided written informed consent. On three of the seventeen interviews two persons were present. Of the total of 20 interviewees, there were 11 women and 9 men, aged between 24 and 56 years old (M: 36, SD: 9.13), with on average 7.6 years experience in vocational rehabilitation (SD: 6.19). All interviewees worked with persons with mental illnesses.

The unit of analysis is the participating service, therefore agencies are grouped in three categories. The first is the category of Sheltered Workshops which includes agencies focusing on developing work habits and skills. A second is that of SE-programs. These strive towards assisting individual placement in competitive employment as quickly as possible [18]. A third category is that of pre-vocational training centers. This type of 'activation' program is a pilot project currently being evaluated in Flanders and consists of a combination of mental health care interventions and 'vocational empowerment' sessions [34]. It is similar to sheltered workshops in that it aims to improve skills, but these programs are strictly therapeutic individual encounters for a maximum of 18 months and do not necessarily provide any work experience

Table 1 Categorization of employment services for people with SMI

Category	Goal	Vocational Services	Number of agencies in sample	Number of agencies in Flanders
Supported Employment	Regular paid employment			
		Regional job coaching centers	4	4
		Vocational training agencies	3	12
		Vocational counseling centers	1	6
Sheltered Employment	Focus on latent benefits of work			
		Day-activity centers	1	n.o.d.*
		Sheltered or social workshops	2	164
		Vocational units in psychiatric hospitals	2	n.o.d*
Pre-vocational counseling agencies	Focus on empowerment and counseling			
		Pre-vocational counseling agencies	4	45

** No official data is known*

2.2 Instruments

2.2.1 IPS fidelity Scale

High fidelity to IPS is a prerequisite to successful vocational outcomes [35,36] and can be assessed by the IPS Fidelity Scale [37], which differentiates between IPS programs and other vocational approaches [37] and has good content and concurrent validity [38]. Content validity was established by practitioners employed on supported employment teams and experts in vocational rehabilitation who endorse that critical ingredients of supported employment are comprehended by the IPS Fidelity Scale [38]. Concurrent validity was proven by a correlation of 0.85 between the Quality of Supported Employment Implementation Scale (QSEIS) and the IPS Fidelity Scale [39]. Internal consistency of the total scale is high (0.92) and interrater reliability is very good with intraclass correlations for individual items ranging from 0.67 to 0.99 [38].

The IPS fidelity Scale is considered a useful tool in guiding the planning process when considering implementing IPS [39]. The Dutch version of the IPS Fidelity Scale was previously used in the Netherlands [40] and is used in this study as well. It consists of 15 items divided in four factors [41] (Table 2). Each item is scored on a scale from 1 to 5 using

mainly quantifiable descriptive anchors [37]. Total scores range from 15 to 75 with scores between 66 and 75 indicating high implementation, scores between 56-65 fair implementation and scores below 55 no implementation [37]. To examine mean item scores, we used the criteria formulated by Bond et al. (2008) [31]. A mean item score below three reflects very low fidelity, while a mean item score between three and four indicates low fidelity. A mean score of four or higher reflects high fidelity.

2.2.2 Barriers and opportunities for implementation

To prepare for implementation, barriers and opportunities need to be examined. According to Bond and Drake (2008) predictors of successful vocational rehabilitation can be divided in three categories: 1) barriers on the client level, 2) on the environmental level of legislation and society and 3) on the organizational level. Predictors on the client level are for example work history and cognitive impairments. Environmental factors can be inadequate co-operation between organizations [3]. Intervention-factors are for example high caseload [3,42]. Perceived barriers and opportunities were assessed via open-ended questions reflecting these three categories. Examples of the open-ended questions used are: "Which barriers do you experience in finding competitive employment for people with psychiatric disabilities?", "Thinking back of success stories in your organization for people with psychiatric disabilities, what really made the difference for them, that helped them find and keep a regular paid job?" "Which difficulties do you experience in finding regular paid employment for people with SMI that you would say are related to the approach that is used within your organization or from the program that is used?" and "Which hurdles do you come across in legislation or the society at large that make finding and keeping regular paid employment for people with SMI more difficult?".

2.3 Analysis

The IPS Fidelity Scale was analyzed using the Implementation Resource Kit [43]. Scoring was based exclusively on information from the program manager or a vocational rehabilitation counselor, an approach that is also used by Latimer (2006) [28]. Two researchers independently examined a subsample of 9 interviews. Inter-rater reliability for the total scale is .687 (ICC) based on a one-way random-effects analysis of variance model for agreement between the two assessors. Differences in ratings were discussed until full consensus was reached.

The open-ended questions were analyzed using a hybrid approach of thematic analysis [44] combining data-driven inductive approach and an a priori template of codes based on Bond and Drake's categories of barriers (2008) [45,46]. Data was coded with NVivo 8.0 (2008).

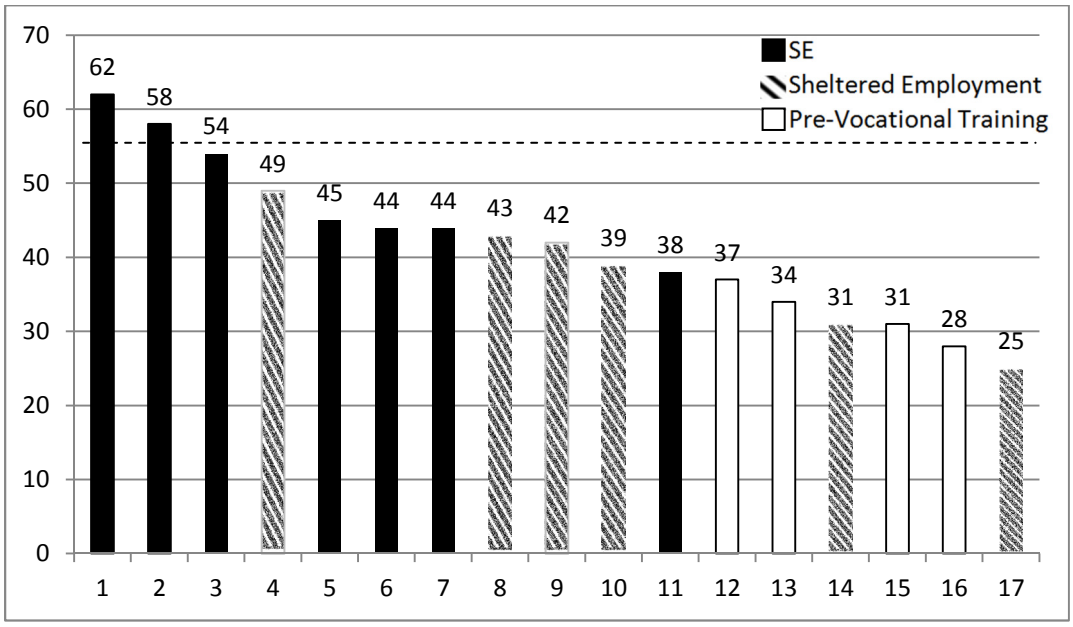
3. Results

3.1 Extent of implementation of IPS

Scores for vocational agencies in Flanders ranged between 25 and 62 (Figure 1). Most agencies score under 55, indicating no implementation of IPS.

SE-agencies score between 38 and 62 on the IPS Fidelity Scale, with an average of 49 (SD: 8.77). Within this group, two agencies score above the no-implementation level of 55 and are rated as providing IPS on a moderate level. The six agencies in the Sheltered Employment group score between 25 and 49 (M: 38, SD: 8.73). The four agencies offering pre-vocational training reach a score between 28 and 37, with an average of 32.5 (SD: 3.87).

Figure 1. Scores on the IPS Fidelity Scale in categories of services



Of the 15 individual items, only two received overall high fidelity: 'Vocational Services Staff', employment specialists providing only vocational services and 'Vocational Generalists', each employment specialist carries out all phases of vocational service (Table 2). As the two other items composing this factor also score relatively high, 'Vocational Staffing'

can be considered the best implemented in Flanders. This indicates that counselors work as a unit, have a manageable caseload and carry out most phases of vocational rehabilitation. However, the relatively high average scores on 'Caseload' are greatly influenced by a small number of outliers, i.c. agencies with a caseload of 25 or less, especially within SE-agencies. One other item that received a reasonably high score was 'Assertive Engagement and Outreach'.

The remaining ten items are rated very low, especially "Integration of rehabilitation teams with mental health". Even in the Pre-Vocational Training agencies that have a combined focus on care and vocational rehabilitation, integration between services is very low. Another component that proved difficult to apply in all organizations was the rapid search for competitive jobs, even in SE-agencies. As the other items within the 'Job Selection' factor also showed a low implementation, the overall score on this dimension was low.

Table 2 Average Scores on IPS Fidelity Scale-items

	Supported Employment (7)		**Sheltered Employment (6)**		**Pre-Vocational Training (4)**		**Total (17)**	
	M	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Factor 1: Job selection	**3.46**	**1.48**	**1.73**	**1.23**	**1.30**	**0.92**	**2.16**	**1.59**
Permanence of jobs developed	3.00	1.41	1.83	1.33	1.00	0.00	2.12	1.41
Ongoing. work-based vocational assessment	3.00	1.91	2.00	0.89	2.50	1.73	2.53	1.55
Individualized job search	4.00	1.41	1.67	1.63	1.00	0.00	2.47	1.84
Diversity of jobs developed	4.00	1.41	1.50	0.84	1.00	0.00	2.41	1.70
Jobs as transitions	3.29	1.25	1.67	1.63	1.00	0.00	2.18	1.55
Factor 2: Integration with treatment team	**2.39**	**1.26**	**2.83**	**1.40**	**2.44**	**0.89**	**2.55**	**1.24**
Zero-exclusion criteria	1.86	1.25	2.33	1.03	2.00	0.00	2.06	0.66
Assertive engagement and outreach	3.71	0.76	4.67	0.52	3.00	0.00	3.88	0.86
Integration of rehabilitation with mental health treatment	1.00	0.00	2.00	1.10	2.25	1.50	1.65	1.06
Follow-along supports	3.00	1.15	2.33	1.03	2.50	1.00	2.65	1.06
Factor 3: Job development	**3.62**	**1.24**	**2.22**	**1.40**	**2.50**	**1.51**	**2.78**	**1.48**

Vocational services staff	4.86	0.38	3.17	1.33	4.25	0.50	4.12	1.11
Rapid search for competitive jobs	2.86	0.90	1.00	0.00	1.00	0.00	1.76	1.09
Community-based services	3.14	1.21	2.5	1.38	2.25	0.96	2.71	1.21
Factor 4:Vocational staffing	**3.86**	**1.31**	**3.72**	**1.32**	**2.92**	**1.24**	**3.50**	**1.33**
Vocational unit	3.57	0.79	4.00	1.67	3.00	0.00	3.59	1.12
Caseload	3.29	1.89	3.83	0.98	2.00	1.41	3.18	1.59
Vocational generalists	4.71	0.79	3.33	1.37	3.75	1.26	4.00	1.17
Total M	3.29	1.44	2.63	1.50	2.29	1.26	2.76	1.51

3.2 Factors inhibiting and facilitating implementation of evidence-based principles

In total, 168 reports of barriers were coded, divided in 3 categories and 22 different basic themes (Table 3). Opportunities were often mentioned as the absence of barriers, they are therefore discussed together.

Barriers and opportunities at the environmental level were most often mentioned (n: 70, 10 themes). There were no major differences in the number of barriers at the environmental level that were mentioned by counselors of SE agencies (M=4.3), sheltered workplaces (M=4.8) or pre-vocational training agencies (M=4.0). At the client level 64 barriers and facilitators were mentioned (8 themes). Client-related barriers were mentioned least by sheltered workplaces (M=3.6), moderately by SE agencies (M=4.0) and most by pre-vocational training agencies (M=4.5). Least often reported were barriers and opportunities at the organizational level (n: 34, 4 themes). Counselors of SE-agencies report these barriers the least (M=2.0) as do counselors of sheltered Workplaces (M=2.0). Counselors of pre-vocational training agencies mentioned slightly more barriers on this level (M=2,5). Barriers only mentioned once were classified under the theme ‘other’ (n: 19).

These results suggest that no differences in perceived barriers exist between the three types of agencies, but the small sample precludes more in-depth statistics analyses per subtheme or on the precise content of the mentioned barriers and facilitators. Therefore no firm conclusions can be drawn on differences in the qualitative data between agency types. Because of the apparent lack of variation between agency types, perceived barriers and facilitators will be discussed for all agency types together in what follows.

3.2.1 Environmental level

Agencies state that employers are reluctant to offer customized internships and jobs. Also, lack of financial stability due to short-time financing of agencies is hindering the implementation of high quality rehabilitation programs. Other factors frequently mentioned are the difficult collaboration between governmental agencies for unemployment services and other services, stigma and benefit traps. Some agencies perceive the numerous legal regulations for unemployed persons with SMI as no longer adapted to the current labor market.

3.2.2 Client level

The most often mentioned facilitator overall is stability of psychiatric problems. Agencies perceive people with schizophrenia and personality disorders as the most difficult to reintegrate in work. Lack of motivation of service users is also said to hinder their employment, together with a poor work-attitude and lack of punctuality or positive working relationships with co-workers. Agencies do not want to burn their bridges with an employer because of a bad experience with an unmotivated client, they prefer to play safe and favor pre-vocational training.

Other barriers are a lack of disease insight and financial problems. Reasons why clients may not be motivated are e.g. co-morbidity and long-time absence on labor market.

3.2.3 Organizational barriers

Organizational barriers and opportunities were least often reported. Agencies find the caseload and administrative workload too high which inhibits a trusting and continuous relationship with clients. High workload of both vocational rehabilitation services and mental health agencies impedes successful collaboration between both organizations. Vocational rehabilitation counselors also experience different values between employment agencies and mental health organizations (6/17). Mental health teams are considered to offer relatively slower recovery processes while vocational rehabilitation counselors say they favor quick integration in work.

Table 3 Perceived barriers by counselors in decreasing rank order of times mentioned

Level	**Number of barriers mentioned**	**Example**

Environmental level	**70**	
• Employers	11	"I don't understand why employers are not willing to hire our clients."
• Financial support	11	"We receive financial support to offer services, but they are not sufficient for small organizations as ours. The big organizations can rely on their own financial backbone, but we are too small for that".
• Collaboration with other agencies (state)	10	"The Public Employment and vocational Training Service needs to communicate more with us: who is the person in charge of a project, who is the person we can go to with questions…"
• Crisis and local labor market	8	"…our services depend on the local labor market and what is available on the market."
• Stigma and need for awareness campaigns	6	"Employer's willingness to hire them is restricted by fears, lack of knowledge…"
• Benefit traps	6	"There are the benefit traps… try to motivate someone to go to work for €1200 when he receives €1100 on benefits!"
• Incompatible regulations (law)	5	"The role of internships is not well defined, so people have to do job interviews while in an internship."
• Being known in the area	5	"It's a complex organization and all the names of agencies and rehabilitation programs keep changing"
• Other	5	"We don't find enough people that can work in the jobs that are available in our agency."
• Waiting lists	3	"There is no space anymore in Sheltered Workplaces."
Client level	**64**	
• Psychological problems and stability	15	"Some people experience too much anxiety to come"
• Motivation and attitude	12	"People with psychiatric problems often do not want to work at the start of the program."
• Socio-economic problems	11	"Some have a lot of unpaid bills."
• Social skills	7	"It is important that they can deal with the different personalities of the co-workers on the job…"
• Insight	7	"It's difficult to offer services when the person has no idea which direction he wants to proceed in, if he has no insight in his abilities."

• Length of absenteeism	4	"A lot of people haven't worked for a long time. And to change that, it isn't easy."
• Co-morbidity	3	"People often have behavioral problems in addition to their mental disabilities."
• Other	5	"Some are too highly educated for the jobs we offer."
Organizational level	**34**	
• Caseload	12	"I have a caseload of more than 100 clients."
• Other	9	"The distance to our centre is for some people too far"
• Administrative work	7	"Before someone can start in the rehabilitation process, 25 signatures need to be placed on different documents."
• Collaboration with other agencies	6	"Our trajectories do not always parallel those of the psychologist in mental health care."

4. Discussion

The main objective of this study was to measure the current use and potential for future implementation of IPS in vocational rehabilitation services in Flanders. In order to achieve high competitive employment rates [36,47] high IPS-fidelity is crucial. Yet, most Flemish agencies are not implementing enough IPS-principles to be considered as offering SE.

There is a strong lack of integration with mental health teams which is a major barrier to IPS implementation [27,41,48]. Australia, where responsibilities for mental health care and employment services are also situated at different governmental levels which makes the implementation of IPS more challenging, can provide good examples on how IPS can be implemented via close inter-sectoral links without reaching full integration [49].

Another shortcoming in current vocational services in Flanders is delaying the search for competitive jobs. A reason for this delay is a fear among counselors to jeopardize their relations with willing employers. There is however strong empirical support that a rapid job search increases employment rates for people with SMI [10].

This means that the SE principles for which outcome evidence is strongest [10], are mostly missing in current Flemish vocational rehabilitation.

On the other hand, vocational staffing elements are reasonably well implemented in Flanders. These are however not considered as crucial in effectiveness by experts and practitioners who have experience in providing SE-services [50].

One specific item of the dimension of vocational staffing warrants attention, namely the caseload. The scores on the fidelity scale for this item were modest for both SE and Sheltered Employment services, but the perception of most counselors in these agencies is that caseload and administrative workload are very high. High caseload can have detrimental effects on the quality of counseling [47,51]. Reduction of caseload will create possibilities for time-unlimited follow-up after the program ends. This is crucial since long term employment is correlated with frequency of contacts during follow-up [52]. Because time-unlimited follow-up is also often constrained by funding arrangements [51,53], funding has to be of a more stable nature. Unstable funding is not uncommon as 22% of SE-agencies in Europe has only short-term funding [54]. However, it is a central factor to achieve high fidelity [36,55] and therefore important when developing strategies for implementing SE [25].

Counselors perceive a need to reform unsuitable legislation hindering the chances of people in getting competitive jobs, which has also been documented in other countries [4]. Especially the 'benefits traps', that lower employment rates of people with SMI because additional disability payments result in a higher income than can be obtained by work [56-58].

Psychiatric symptoms and a lack of motivation of clients are still seen as hurdles for regular work by a majority of the counselors in spite of evidence that people with SMI can and want to work [11]. Counselors continue to attribute barriers to external factors such as client's motivation and inconsistent regulations and to a lesser degree question program factors or their own mind set. This external attribution style can lead to pessimistic perspectives and a feeling of hopelessness with the counselor [12,59]. It has been documented that professionals often do not hold very positive views on prognosis and long-term outcomes [60,61]. This stance will have a negative effect on delivered services [12,59,62] as it is noticed by clients and will ultimately affect their employment outcomes [12,63,64]. Although many studies acknowledge the importance of research on interventions that change counselors' attitudes, few exist [60,65,66]. These few studies emphasize the need to team up with a person with lived experience of SMI to changes counselor's attitudes [67].

Earlier research indicates that zooming in on program factors such as counselors' and supervisors' attitudes can overcome some of the reported client and environmental barriers [3,42]. Strong leadership from a supervisor with positive attitudes towards evidence-based principles and competitive work for people with severe mental illness is a crucial facilitator in this change process [68-70].

And lastly, a great reason for concern in Flanders is the low use of individualized job searches in Sheltered Employment. Individualized jobs searches entails starting from the consumers' job preferences and needs rather than looking at which jobs are available. Without taking the consumers' preferences into account, users in Sheltered Employment who wish to work in a regular competitive environment, will not be heard. This is evident from the low transfer rate of 3% from sheltered workshops to competitive employment [71]. Previous research also observed a low focus on consumer preferences in non-SE-programs [39]. In a country where Sheltered Employment is so abundant, guaranteeing an individualized job search should be of high priority to give everyone who wants to work in a regular paid job the chance to do so.

The study had some limitations. The use of the IPS Fidelity Scale includes analyzing agencies' business reports but as these are lacking or not uniform in Flanders, we restricted ourselves to the information provided in the interviews. This is however also consistent with a potential future use of the fidelity scale by the agencies, which will look for the least labor-intensive approach [39]. Secondly, the sample was drawn from a list of agencies favoring contact persons for whom personal coordinates were available, possibly over-representing those with higher visibility, either via meetings, projects and conferences or via the Internet. This may imply that the sample consists of pioneers in the field of vocational rehabilitation and that therefore the scores on current SE implementation are overestimated. However, we believe this not to be the case, since the list provided by the Employment Service was not purely based on SE-related projects or meetings, and since the low scores on IPS fidelity in the sample do not tend to support this overestimation.
Thirdly, differences in amount of barriers experienced by counselors of different agencies can be very interesting. Preliminary results indicate no differences but due to the small sample, we were not able to determine if agencies with a focus on improving work skills perceive similar barriers as agencies assisting individual placement and support in competitive jobs as quick as possible. This could be a valuable direction for future research.

5. Conclusions

The application of the IPS fidelity scale together with an open assessment of perceived obstacles to the use of IPS provides concrete levers in the implementation planning process. Organizational factors are neither in the counselor's opinions nor in the IPS fidelity requirements the most important hindering factors. Rather, the crucial elements lie in building co-operations: between health care counselors and vocational rehabilitation counselors; and between counselors and employers. Better co-operations with mental health care and long-term follow-up are needed to avoid the fear of users 'crashing' on the job without a long preparation phase. Cross trainings and regular personal contact are some potential strategies to improve co-operation between mental health care and the vocational rehabilitation worker. [72,73]. Apart from building networks of services, the re-organized mental health care in Belgium will also need to encourage close partnerships between professionals at all levels in the care process.

Better co-operations with employers should reduce the reluctance for a rapid job search. Counselors need to create win-win situations with employers, by presenting positive qualities of the job applicant in productivity and punctuality [74]. An optimistic view among counselors that competitive employment is a viable option for people with SMI and a strong leadership in the agencies to encourage these positive attitudes, are needed to make IPS work. Interventions to promote these attitudes should be organized in close collaboration with people with lived experience of SMI and emphasize the importance of taking the consumer perspective as the starting point. There are finally some macro-level changes that can benefit a future IPS implementation: a more consistent legislation that overcomes the benefit traps and a more stable funding rather than working with a string of pilot projects.

This study adds to international knowledge on how best to implement evidence-based employment services. Use of the IPS fidelity scale as a management tool gives opportunities to agencies and policy makers to formulate concrete recommendations on how to plan the IPS implementation process. As this study suggests, pre-implementation mapping of agencies' fidelity on IPS and counselors' experiences of barriers, forms a viable strategy for preparing systems change. After implementation, as shown in other studies, measuring the fidelity remains important for agencies in tracking their progress with implementing IPS and in tackling barriers [30].

References

[1] B.D.Rosso, K.H. Dekas and A. Wrzesniewski, On the meaning of work: A theoretical integration and review, *Research in Organizational Behavior* **30** (2010), 91-127.

[2] G.Thornicroft, *Shunned. Discrimination against people with mental illness*, Oxford: Oxford University Press, 2009.

[3] G.R.Bond, D.R. Becker, R.E. Drake, C.A. Rapp, N. Meisler, A.F. Lehman, M.D. Bell and C.R. Blyler, Implementing Supported Employment as an Evidence-Based Practice, *Psychiatric Services* **52**(3) (2001), 313.

[4] G.Thornicroft, E. Brohan, D. Rose, N. Sartorius and M. Leese, Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey, *The Lancet* **373**(9661) (2009), 408-15.

[5] K.T.Mueser, M.P. Salyers and P.R. Mueser, A prospective analysis of work in schizophrenia, *Schizophrenia Bulletin* **27**(2) (2001), 281.

[6] R.Kilian and Th. Becker, Macro-economic indicators and labour force participation of people with schizophrenia, *Journal of Mental Health* **16**(2) (2007), 211.

[7] D.McDaid, Countering The Stigmatisation and Discrimination of People with Mental Health Problems in Europe, Luxembourg: European Commission, 2008.

[8] R.Crowther, M. Marshall, G.R. Bond and P. Huxley, Vocational rehabilitation for people with severe mental illness, *Cochrane Database of Systematic Reviews* (2) (2001).

[9] Ch.Van Audenhove and J. Wilmotte, Evaluatie van de pilootprojecten activering. Eindrapport (in Dutch), Retrieved from: http://www.kuleuven.be/lucas/pub/publi_upload/2004_7_CVA_JW_Pilootprojecten%20Activering%20Eindrapport.pdf

[10] G.R.Bond, Supported employment: evidence for an evidence-based practice, *Psychiatric Rehabilitation Journal* **27**(4) (2004), 345.

[11] R.E.Crowther, Helping people with severe mental illness to obtain work: systematic review, *British medical journal* **322**(7280) (2001), 204.

[12] M.Rinaldi, L. Miller and R. Perkins, Implementing the individual placement and support (IPS) approach for people with mental health conditions in England, *International Review of Psychiatry* **22**(2) (2010), 163-72.

[13] D.Becker and R. Drake, Individual placement and support: A community mental health center approach to vocational rehabilitation, *Community Mental Health Journal* **30**(2) (1994), 193-206.

[14] T.Burns, 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) (2009), 949.

[15] T.Burns and J. Catty, IPS in Europe: the EQOLISE trial, *Psychiatric Rehabilitation Journal* **31**(4) (2008), 313-7.

[16] J.Bollens and V. Heylen, De sluitende aanpak. Een evaluatie van de effectiviteit van de vroegtijdige en sluitende aanpak van de werkloosheid in Vlaanderen (2002-2004)

(in Dutch), Retrieved from: https://hiva.kuleuven be/resources/pdf/publicaties/R1051.pdf

[17] K.Bogaerts and P. Vandenbroecke, Inactiviteitsvallen bij personen met psychische problemen. Welke factoren maken dat mensen met psychische problemen terug aan de slag gaan of blijven werken? (in Dutch), Retrieved Dec 30,2010 from: http://www.expertisepunt be/sites/default/files/200911%20200911120112547LHIG.pdf

[18] M.Corbière and T. Lecomte, Vocational services offered to people with severe mental illness, *Journal of Mental Health* **18**(1) (2009), 38.

[19] E.S.Casper, A self-rating scale for supported employment participants and practitioners, *Psychiatric Rehabilitation Journal* **27**(2) (2003), 151.

[20] J.Secker, B. Grove and P. Seebohm, Challenging barriers to employment, training and education for mental health service users: The service user's perspective, *Journal of Mental Health* **10**(4) (2001), 395.

[21] A. Migliore, Sheltered Workshops, in: *International Encyclopedia of Rehabilitation*, J. H. Stone, M. Blouin, eds, 2011.

[22] O.Schmitz, A. Props, V. De Jaegere, C. Antoine and M. Leys, Mental Health Care Reforms: Evaluation Research of 'Therapeutic Projects' - Second Intermediate Report. Health Services Research, Retrieved from: http://kce.fgov be/sites/default/files/page_documents/kce_146a_evaluatieonderzoek_therapeutische_projecten.pdf

[23] G.Thornicroft and M. Transella, *Better Mental Health Care*, New York: Cambridge University Press, 2009.

[24] G.R.Bond, S.G. Resnick, R.E. Drake, H. Xie, G.J. McHugo and R.R. Bebout, Does Competitive Employment Improve Nonvocational Outcomes for People With Severe Mental Illness?, *Journal of consulting and clinical psychology* **69**(3) (2001), 489-501.

[25] D.R.Becker, S.R. Baker, L. Carlson, L. Flint, R. Howell, Sh. Lindsay, M. Moore, S. Reeder and R.E. Drake, Critical strategies for implementing supported employment, *Journal of Vocational Rehabilitation* **27**(1) (2007), 13.

[26] J.Oldman, L. Thomson, K. Calsaferri, A. Luke and G.R. Bond, A case report of the conversion of sheltered employment to evidence-based supported employment in Canada, *Psychiatric Services* **56**(11) (2005), 1436.

[27] M.Corbière, N. lanctôt, T. Lecomte, E. Latimer, P. Goering, B. Kirsh, E.M. Goldner, D. Reinharz, M. Menear, J. Mizevich and T. Kamagiannis, A Pan-Canadian evaluation of supported employment programs dedicated to people with severe mental disorders, *Community Mental Health Journal* **46**(1) (2010), 44.

[28] E.A.Latimer, Generalisability of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial, *British Journal of Psychiatry* **189**(1) (2006), 65.

[29] C.T.Mowbray, M.C. Holter, G.B. Teague and D. Bybee, Fidelity criteria: Development, measurement, and validation, *The American Journal of Evaluation* **24**(3) (2003), 315.

[30] M.Menear, D. Reinharz, M. Corbière, N. Houle, N. lanctôt, P. Goering, E.M. Goldner, B. Kirsh and T. Lecomte, Organizational Analysis of Canadian Supported Employment Programs for People with Psychiatric Disabilities, *Social Sciences and Medicine* **72** (2011), 1028-35.

[31] G.R.Bond, G.J. Mc Hugo, D.R. Becker, C.A. Rapp and R. Whitley, Fidelity of supported employment: Lessons learned from the national evidence-based practice project, *Psychiatric Rehabilitation Journal* **31**(4) (2008), 300.

[32] N.Porteous and G. Waghorn, Implementing evidence-based employment services in New Zealand for young adults with psychosis: progress during the first five years, *Britisch Journal of Occupational Therapy* **70**(12) (2007), 521-6.

[33] L.G.Portney and M.P. Watkins, *Foundations of clinical research: Applications to practice*, 3 ed. Upper Saddle River: NJ. Prencice-Hall, Inc., 2009.

[34] Flemish Employment Services, Tendering Zorgbegeleiding binnen Activering van Werkzoekenden in kader van Meerbanenplan, Retrieved from: http://partners.vdab be/zorgbegeleiding/doc/definitief%20bestek%20TAZ%20versie%20090306.pdf

[35] R.E.Drake, G.R. Bond and C.A. Rapp, Explaining the Variance Within Supported Employment Programs: Comment on 'What Predicts Supported Employment Outcomes?', *Community Mental Health Journal* **42**(3) (2006), 315-8.

[36] D.R.Becker, H. Xie, G.J. McHugo, J. Halliday and R.A. Martinez, What predicts supported employment program outcomes?, *Community Mental Health Journal* **42**(3) (2006), 303-13.

[37] G.R.Bond, D.R. Becker, R.E. Drake and K.M. Vogler, A fidelity scale for the individual placement and support model of supported employment, *Rehabilitation Counseling Bulletin* **40**(4) (1997), 265.

[38] G.R.Bond, D.R. Becker and R.E. Drake, Measurement of Fidelity of Implementation of Evidence-Based Practices: Case Example of the IPS Fidelity Scale, *Clinical Psychology: Science and Practice* **18**(2) (2011), 126-41.

[39] G.R.Bond, A scale to measure quality of supported employment for persons with severe mental illness, *Journal of Vocational Rehabilitation* **17**(4) (2002), 239.

[40] J.Catty, T. Becker, R. Drake, A. Fioritti, M. Knapp, C. Lauber, W. Rössler, T. Tomov, J. van Busschbach, D. Wiersma and T. Burns, Predictors of employment for people with severe mental illness: results of an international six-centre randomised controlled trial, *British Journal of Psychiatry* **192**(3) (2008), 224.

[41] G.R.Bond, K.M. Vogler, S.G. Resnick, L.J. Evans, R.E. Drake and D.R. Becker, Dimensions of supported employment: Factor structure of the IPS fidelity scale, *Journal of Mental Health* **10**(4) (2001), 383.

[42] E.A.Gowdy, L. Carlson and C.A. Rapp, Organizational factors differentiating high performing from low performing supported employment programs, *Psychiatric Rehabilitation Journal* **28**(2) (2004), 150-6.

[43] D.R.Becker and G.R. Bond, *Supported employment: Getting started with Evidence-Based Practices.*, Rockville: MD: Center for Mental Health Services, 2002.

[44] J.Fereday and E. Muir-Cochrane, Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development, *International Journal of Qualitative Methods* **5**(1) (2008), 80.

[45] J.Attride-Stirling, Thematic networks: an analytic tool for qualitative research, *Qualitative Research* **1**(3) (2001), 385.

[46] V.Braun and V. Clarke, Using thematic analysis in psychology, *Qualitative research in psychology* **3**(2) (2006), 77-101.

[47] D.R.Becker, J. Smith, B. Tanzman, R.E. Drake and T. Tremblay, Fidelity of Supported Employment Programs and Employment Outcomes, *Psychiatric Services* **52**(6) (2001), 834-6.

[48] M.P.Salyers, D.R. Becker, R.E. Drake, W.C. Torrey and P.F. Wyzik, A ten-year follow-up of a supported employment program, *Psychiatric Services* **55**(3) (2004), 302.

[49] G.Waghorn, L. Collister, E. Killackey and J. Sherring, Challenges to implementing evidence-based supported employment in Australia, *Journal of Vocational Rehabilitation* **27**(1) (2007), 29.

[50] L.J.Evans and G.R. Bond, Expert ratings on the critical ingredients of supported employment for people with severe mental illness, *Psychiatric Rehabilitation Journal* **31**(4) (2008), 318-31.

[51] M.Boyce, J. Secker, M. Floyd, B. Grove, R. Johnson, J. Schneider and J. Slade, Factors influencing the delivery of evidence-based supported employment in England, *Psychiatric Rehabilitation Journal* **31**(4) (2008), 360-6.

[52] G.R.Bond and M. Kukla, Impact of Follow-Along Support on Job Tenure in the Individual Placement and Support Model, *The Journal of Nervous and Mental Disease* **199**(3) (2011), 150.

[53] G.R.Bond and R.E. Drake, Predictors of competitive employment among patients with schizophrenia, *Current Opinion in Psychiatry* **21**(4) (2008), 362.

[54] S.Beyer, F. Jordan de Urries and M.A. Verdugo, A Comparative Study of the Situation of Supported Employment in Europe, *Journal of policy and practice in Intellectual Disabilities* **7**(2) (2010), 130.

[55] R.Pirttimaa and T. Saloviita, A survey of staff opinions on basic values of supported employment, *Journal of Vocational Rehabilitation* **21**(2) (2004), 95-101.

[56] R.Warner, Work disincentives in US disability pension programs, *Journal of Mental Health* **10**(4) (2001), 405.

[57] N.Turton, Welfare benefits and work disincentives, *Journal of Mental Health* **10**(3) (2001), 285.

[58] T.Burns, J. Catty, Th. Becker, R.E. Drake, A. Fioritti, M. Knapp, Ch. Lauber, W. Rössler, T. Tomov, J. van Busschbach, S. White and D. Wiersma, The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial, *The Lancet* **370**(9593) (2007), 1146-52.

[59] M. Rinaldi and R. Perkins, Early intervention: a hand up the slippery slope, in: *New Thinking about Mental Health and Employment*, B. Grove, J. Secker, P. Seebohm, eds, Radcliffe Publishing Ltd, Abingdon, 2005.

[60] M.Hugo, Mental health professionals' attitudes towards people who have experienced a mental health disorder, *Journal of psychiatric and mental health nursing* **8**(5) (2001), 419.

[61] Ch.Rapp, D. Etzel-Wise, D. Marty, M. Coffman, L. Carlson, D. Asher, J. Callaghan and M. Holter, Barriers to Evidence-Based Practice Implementation: Results of a Qualitative Study, *Community Mental Health Journal* **46**(2) (2010), 112-8.

[62] M.Rinaldi, R. Perkins, E. Glynn, T. Monibeller, M. Clenaghan and J. Rutherford, Individual placement and support: from research to practice, *Advances in Psychiatric Treatment* **14**(1) (2008), 50.

[63] D.C.Lustig, D.R. Strauser, N.D. Rice and T.F. Rucker, The relationship between working alliance and rehabilitation outcomes, *Rehabilitation Counseling Bulletin* **46**(1) (2002), 24.

[64] T.S.Peris, B.A. Teachman and B.A. Nosek, Implicit and explicit stigma of mental illness: Links to clinical care, *The Journal of Nervous and Mental Disease* **196**(10) (2008), 752.

[65] D.W.Wong, F. Chan, E. Da Silva Cardoso, C.S. Lam and S.M. Miller, Rehabilitation Counseling Students' Attitudes Toward People with Disabilities in Three Social Contexts, *Rehabilitation Counseling Bulletin* **47**(4) (2004), 194.

[66] H.Stuart, Stigma and work, *HealthcarePapers* **5**(2) (2004), 100-11.

[67] D.Sadow and M. Ryder, Reducing stigmatizing attitudes held by future health professionals: The person is the message, *Psychological services* **5**(4) (2008), 362.

[68] P.W.Corrigan, L. Steiner, S.G. McCracken, B. Blaser and M. Barr, Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness, *Psychiatric Services* **52**(12) (2001), 1598.

[69] A.O'Brien, C. Price, T. Burns and D. Perkins, Improving the vocational status of patients with long-term mental illness: a randomised controlled trial of staff training, *Community Mental Health Journal* **39**(4) (2003), 333.

[70] C.A.Rapp, D. Etzel-Wise, D. Marty, M. Coffman, L. Carlson, D. Asher, J. Callaghan and R. Whitley, Evidence-based practice implementation strategies: results of a qualitative study, *Community Mental Health Journal* **44**(3) (2008), 213.

[71] D.Vanderpoorten, Beleidsbarometer 2010. De Vlaamse Sociale Economie *(in Dutch)*, Retrieved from: http://www.expertisepunt be/sites/default/files/Beleidsbarometer-2010.pdf

[72] H.Boeltzig, J.C. Timmons and J. Marrone, Maximizing potential: Innovative collaborative strategies between one-stops and mental health systems of care, *Work* **31**(2) (2008), 181.

[73] J.C.Timmons, A. Cohen and Sh.L. Fesko, Merging cultural differences and professional identities: Strategies for maximizing collaborative efforts during the implementation of the Workforce Investment Act, *Journal of Rehabilitation* **70**(1) (2004), 19.

[74] R.Fraser, K. Johnson, J. Hebert, I. Ajzen, J. Copeland, P. Brown and F. Chan, Understanding Employers' Hiring Intentions in Relation to Qualified Workers with Disabilities: Preliminary Findings, *Journal of Occupational Rehabilitation* **20**(4) (2010), 420-6.