Leaving the sheltered workshop

■ **J. Modestin, M. Lieb**

Psychiatric University Hospital Zurich

Summary

Modestin J, Lieb M. Leaving the sheltered workshop. Schweiz Arch Neurol Psychiatr 2002; 153:214–20.

Occupational activity is an important part of the psychosocial adjustment even in those mental patients who cannot be fully rehabilitated and integrated into the competitive labour market. Yet some patients do not adhere to the occupational programmes and quit. We studied a group of chronic patients who had left after an average stay of 6.4 months a sheltered workshop designed specifically for seriously disabled patients with mental disorders. We compared these patients with two groups of control patients who remained in the workshop for a shorter (11.9 months on average) or longer (7.4 years on average) time, assessed possible reasons for the patients' leaving the workshop and inquired about their later occupational status. The purpose was to obtain information which could help to improve the patients' work adherence and thus promote their psychosocial adjustment. All patients, 16 in each group, were assessed using three instruments: (1) a self-devised interview schedule with items related to sociodemographic and clinical data, circumstances of patients' entry in the workshop and, if appropriate, situation at the time of their leaving the workshop and afterwards; (2) the ABB ("Arbeitsbeschreibungsbogen") questionnaire measuring patients' work satisfaction; (3) the Work Importance List ("Bedeutungsliste Arbeit") assessing the importance ascribed by the patients to 17 different aspects of work. Regarding sociodemographic and the majority of clinical variables, there were no significant differences between the three groups. All patients entered the workshop relatively late in their illness career at the average age of 39 years. The diagnosis schizophrenia was given to 75% of patients in the long stay group, 50% in the short stay group and to only one patient in the study group. The patients of the study group were mostly diagnosed with personality (borderline) and substance use disorder. They had received higher school education, spent less time in inpatient treatment and were more intensively cared for as outpatients. By all patients the highest values of satisfaction in ABB were given to superiors, the lowest values to payment and career perspectives, however, the patients of the study group indicated less satisfaction in all ABB dimensions. Structuring of the day, possibility to be active and to do something meaningful were indicated as the most important aspects of work in all three groups. There were no significant differences between the groups with regard to the item means and rankings. After leaving the workshop, 5 of 16 patients pursued another rehabilitation programme. However, the majority stayed at home without any occupation and they were not able to give a precise reason for their leaving the workshop. The results indicate that only a small minority of vocationally disabled chronic mental patients who leave a low entry threshold sheltered workshop after a relatively short time do so in order to progress in their rehabilitation process. The majority stay at home without being sufficiently occupied, and they are not able to find an adequate alternative without specialised help. Production oriented simple serial industrial activity in the workshop appears appropriate for the schizophrenic patients, but obviously it did not meet the needs of the study group patients with a higher previous school education. For these patients alternative options in the sheltered workshop itself must be considered along with the new approaches in general, better tailored to their needs and preferences.

Keywords: psychiatric outpatients; sheltered workshop; psychiatric rehabilitation; chronic patients

Correspondence:
Prof. J. Modestin
Psychiatrische Universitätsklinik
Lenggstrasse 31
CH-8029 Zürich
e-mail: modestin.sek@puk.zh.ch

Introduction

Occupational activity is one of the most important parts of the psychosocial rehabilitation, and this is also true for patients whose societal integration remains marginal [1]. Work fosters social interactions, helps to structure time usefully, provides the patient with an opportunity for socially productive behaviour, and strengthens the appraisal of himself and reality [2]; and this also applies to patients who cannot be placed in the open labour market and receive a disability pension.

In the population of chronically mentally ill the vocational integration into the open competitive labour market is a desirable and realistic objective only for some individuals [3]. In others the employment does not aim at full rehabilitation but at a promotion of the patient in the frame of his or her possibilities [4]. Most of a larger group of patients in sheltered employment intended to remain there; only 20% hoped to change to the open labour market [5]. Accordingly, we have to differentiate between work as a gainful employment – optimally realised in the free labour market – and work as an occupational activity – most frequently realised in specialised sheltered workshops [6]. The latter must not be underestimated: everyday occupation can be effective for decreasing dysfunctional behaviours [7].

Thus the chronic patients' continuous work engagement appears highly desirable; yet some of these patients do not adhere to the programmes and quit. In the present investigation we studied a group of chronic patients who left a sheltered workshop designed specifically for seriously disabled patients with mental disorders. We compared these patients with control patients who stayed in the workshop for a shorter or longer time, assessed possible reasons for the patients' leaving the workshop and inquired about their further occupational status. The purpose was to obtain information which could help to improve the patients' work adherence and thus promote their psychosocial adjustment.

Subjects and methods

The study was carried out in a sheltered workshop run by a non-profit organisation and supported by the State. It provides persons with serious mental problems and a high degree of vocational disability with work opportunities. The workshop has a low entry threshold. For the minority of patients the work in the workshop represents the first step in the rehabilitation programme; to the majority it gives the long-lasting or even permanent occupation in the form of a production-oriented, simple serial industrial activity. At the beginning of their engagement in the workshop, patients sign a work contract and they receive for their work a modest remuneration which partially depends on their achievements.

The study covered the time period from July 1, 1995 to June 30, 1997; the interviews started at the beginning of 1998 and all were carried out within 4 months. At the time of the study the number of work opportunities in the workshop increased from 80 (1995) to over 100 (1997). About 30% of patients worked fulltime, about 70% had a part-time employment.

Three groups of patients were included in the study:

1 The study group consisted of patients who entered the workshop in the course of the two-year study period (July 1, 1995–June 30, 1997) but who left the workshop during the second half of this period (July 1, 1996–June 30, 1997). Thus, the duration of the patients' employment could last from several days to two years. In fact, it lasted 6.4 months (SD = 4.5) on average.
2 The first control group consisted of patients who entered the workshop during the same time period (July 1, 1995–June 30, 1997) and who kept their jobs; they all were still employed in the workshop by June 30, 1997. The duration of their employment could also last several days to two years. In fact, it was significantly longer and lasted 11.9 months (SD = 6.2) on average (Kruskal-Wallis test, $\chi^2 = 8.42$, df = 1, $p = 0.004$).
3 The second control group consisted of patients who all entered the workshop before July 1, 1995, and who were still employed by June 30, 1997; thus, they all were employed in the workshop for longer than two years. On average, the duration of their employment in the workshop was 7.4 years (SD = 5.1).

Table 1 presents the recruitment of the patients. In the workshop there were 275 patients. The intention was to contact and include all patients of the study group (5 could not be traced and one died), as well as one third of the patients of both control groups to obtain three groups of approximately the same size – a lower drop-out rate was expected in both control groups. All patients were asked twice about participation in writing by the personnel manager of the workshop. Once they gave their written informed consent, the patients were contacted by the interviewer (ML) who carried out all interviews. A total of 48 patients – 16 in each of the three groups – agreed to participate. Four patients of the study group and all control patients were

Table 1 Recruitment of the patients.

	all patients	approached	consented and interviewed
study group (left)	51 (100)	45 (88/100)	16 (36)
1st control group (short-term employed)	106 (100)	35 (33/100)	16 (46)
2nd control group (long-term employed)	118 (100)	39 (33/100)	16 (41)
total	275 (100)	119 (43/100)	48 (40)

Percentages are given in parentheses.

interviewed in the workshop itself; 6 study patients at their homes, 4 in a public restaurant and 2 in a psychiatric facility.

Three instruments were used:

1 A self-devised questionnaire containing items related to basic sociodemographic and clinical data, circumstances of patients' entry in the workshop and, if appropriate, situation at the time of their leaving the workshop and afterwards. The interviewer filled in the questionnaire in the course of a semistructured interview. A special informed consent was obtained from the patients during the interview to consult their clinical charts for ICD 10 diagnosis, previous hospitalisations and present treatment. Three patients refused to give their consent.
2 Using the questionnaire ABB ("Arbeitsbeschreibungsbogen") developed by Neuberger and Allerbeck [8], satisfaction of the patients with the individual aspects of their work situation in the workshop was assessed. Three 4–6-week test-retest reliability studies yielded average reliability coefficients between 0.61 and 0.83 for individual subscales. Correlations between subscales totals and global pictorial Kunin items yielded high Pearson's correlation coefficients 0.69–0.82. Significant differences in ranking of different areas covered by ABB individual subscales were found between a mentally ill and a normal population and a correspondence between subscales means and Kunin items was found in the mentally ill [9]. A shortened version of the questionnaire with 7 global items was used, each of the items having been evaluated by the patients with the help of the pictorial Kunin 4 grades.
3 Work Importance List ("Bedeutungsliste Arbeit") assesses the importance ascribed by the patients to 19 different aspects of work using a 4-grade scale ranging from "very important" to "not important". Tested on a small group of mentally ill employees and compared with other instruments the results indicated a good face validity of the List [10]. As two items of the scale were badly comprehended by our patients, only 17 items were considered. Scale means were calculated and compared.

The study group was compared with the first (short-term employed) and the second (long-term employed) control group. The statistical analysis was carried out using the χ^2-test (with continuity correction) and the Fisher's exact test (two-tailed) for categorical variables and Kruskal-Wallis test for continuous variables. The ABB and the Work Importance List were evaluated using the modified Mann-Whitney U-test; Kendall correlation coefficients were calculated to compare item rankings in the three groups.

Results

First, the representativity of the sample was tested. The study participants (16 in each group) and non-participants (35 in the study group, 90 in the 1st control group and 102 in the 2nd control group) were compared with each other separately within each group with regard to sex, age at entry to the workshop, marital status, nationality and full-time/part-time employment – all variables which could be identified in the personnel files of the workshop. In the study group there were 8 patients of foreign nationality (23%) among non-participants, whereas among participants there were none (Fisher's exact test, 2-tailed, $p = 0.045$). Apart from this single exception there were no significant differences in all comparisons.

Among the 48 patients included in the study, there were 28 men (58%) and 20 women (42%). The mean age of the patients at the entry to the workshop was 39 years (SD = 9). Due to their longer workshop stay, the patients of the 2nd control group were older at the end of the study period than the patients of both other groups (mean 39 years, SD = 10 vs mean 46 years, SD = 11, n.s.). At the time of their entry to the workshop 31 patients (65%) were single and 37 childless (77%). 21 patients (44%) lived on their own, 12 alone (25%). 28 patients (58%) had completed vocational training, 15 (31%) had previously had

Table 2 Demographic and clinical variables with significant differences between the groups.

	1st control group (short-term employed) $n_2 = 16$ (100)	significance n_2 vs n_1	study group (left) $n_1 = 16$ (100)	significance n_1 vs n_3	2nd control group (long-term employed) $n_3 = 16$ (100)
more than basic education	12 (75)	n.s.	15 (94)	Fi p = 0.035	9 (56)
total duration of inpatient treatment (years): MN ± SD	2.9 ± 3.9	n.s.	1.1 ± 0.6	χ^2 (df1) = 4.15 p = 0.041	2.6 ± 2.3
frequent outpatient treatment[a] (≥ once/week)	5 (50)	n.s.	7 (70)	Fi p = 0.045	2 (18)
diagnosis[b]					
schizophrenic disorders	7 (50)		1 (7)		12 (75)
affective disorders	4 (29)	Fi p = 0.024[c]	5 (33)	Fi p = 0.0003[c]	1 (6)
other disorders	3 (21)		9 (60)		3 (19)

Percentages are given in parentheses. Fi = Fisher's exact test, 2-tailed.
[a] $n_1 = 10$, $n_2 = 10$, $n_3 = 11$ for this variable;
[b] $n_1 = 15$, $n_2 = 14$ for this variable;
[c] schizophrenic disorders versus all other disorders.

"white collar" jobs, 33 (69%) had been unemployed before starting in the sheltered workshop. 38 patients (79%) had a disability pension, in 17 patients (35%) measures of guardianship had been taken. In all these variables there were no significant differences between the three groups, and also, compared with the time of the inquiry (some 6 months to 13 years later), in all these patients' life situation hardly any changes could be identified, their situation showing a remarkable constancy.

Previous psychiatric hospitalisations were noted in 41 (91%) of 45 patients (3 patients did not provide the information). The patients' average age at their first psychiatric hospitalisation was 31 years (SD = 9), the average number of their psychiatric hospitalisations was 5 (SD = 5). The mean interval between the first psychiatric hospitalisation and the entry to the sheltered workshop was 9 years (SD = 8). 35 patients (73%) saw no other occupational alternative and for 28 (59%) the main motivation for their engagement in the workshop was obtaining a daily structure. Only 10 patients (21%) worked fulltime in the workshop, the majority of them (7 patients) belonging to the 2nd control group of long-term employed. At the time of the study, all but 5 patients (10%) were in psychiatric therapy, the majority, 31 (65%), as outpatients; some attended the workshop while being inpatients or night-patients. A total of 41 patients (85%) were on psychotropics. Again, in all these variables there were no significant differences between the three groups.

Variables with significant differences between the groups are presented in table 2. The patients of the study group had more frequently received better school education, spent less time in psychiatric inpatient treatment and were more intensively cared for as outpatients. There were significant differences between the study group and both control groups with regard to the diagnostic distribution. Among 9 study group patients with "other" disorders, there were 4 patients with personality disorders and 3 patients with substance use disorders.

In table 3 the groups are compared with regard to the ABB dimensions of work satisfaction. Indicated are group means and standard deviations of the respective 4 Kunin grades. The overall range of the means was 1.8 to 3.8. In all groups the highest values of satisfaction were indicated with regard to "superiors", the lowest values with regard to "payment" and "career perspectives", the rankings of the scale items being highly correlated: study group and 1st control group Kendall's tau = 0.95 ($p < 0.01$), study group and 2nd control group Kendall's tau = 0.70 ($p < 0.05$). The patients of the study group indicated less satisfaction in all 7 dimensions.

In all three groups the most important aspects of work on the Work Importance List were "structuring of the day", "possibility to be active" and "to do something meaningful". Comparing items means, there were no significant differences between the groups and also, the items' rankings were similar: study group and 1st control group Kendall's tau = 0.36 ($p = 0.04$), study group and 2nd control group Kendall's tau = 0.49 ($p = 0.005$).

Eleven patients (69%) of the study group gave notice of their work termination as required by the work contract; 5 patients absconded. At the

Table 3 Comparison of the groups with regard to the individual dimensions of work satisfaction.

	1st control group (short-term employed) $n_2 = 16$ (100)	significance[a] n_2 vs n_1	study group (left) $n_1 = 16$ (100)	significance[a] n_1 vs n_3	2nd control group (long-term employed) $n_3 = 16$ (100)
satisfaction with					
superiors	3.5 ± 0.8	n.s.	3.2 ± 0.8	2.07*	3.8 ± 0.5
organisation/management	3.3 ± 0.9	n.s.	2.9 ± 1.0	n.s.	3.2 ± 0.8
co-workers	3.3 ± 0.9	n.s.	2.7 ± 0.7	2.62**	3.4 ± 0.6
work conditions	3.2 ± 0.5	2.43*	2.4 ± 1.0	2.41*	3.3 ± 0.8
work content	2.6 ± 1.0	n.s.	2.4 ± 1.2	2.33*	3.3 ± 0.6
career perspective	2.4 ± 0.9	n.s.	2.1 ± 0.9	n.s.	2.8 ± 0.9
payment	1.9 ± 1.1	n.s.	1.8 ± 1.1	n.s.	2.4 ± 1.0

[a] Indicated are U-values; * $p < 0.05$; ** $p < 0.01$.

time of their leaving the workshop, 3 patients (19%) (including the only one with a schizophrenic disorder) intended to pursue a more advanced rehabilitation programme (one of them on the basis of a private study) and 2 patients (12%) decided to attend another sheltered workshop. At the time of the inquiry, 6 to 10 months later, all these patients continued their chosen programmes. One patient stopped working because of a decompensation and a longer psychiatric rehospitalisation, one patient succeeded in finding (and later on, repeatedly so) a temporary job, but the majority of 9 patients (56%) stayed at home without any occupation and they were not able to indicate a precise reason for their leaving the workshop. At the time of the inquiry for 6 of these 9 patients the situation had not changed; 3 patients, however, found some form of engagement, such as voluntary work in a non-profit organisation.

Discussion

Three groups of patients were included in the study: patients who left the workshop after having stayed there for an average time of 6 months and control patients, still working in the workshop; in the 1st control group for an average of one year, in the 2nd control group for an average of 7 years. Of 16 patients of the study group, only a minority of 2 or (questionably) 3 patients pursued a more advanced rehabilitation programme; the majority of 9 patients stayed first at home without any occupation. In contrast, for many control patients the work in the workshop represented a permanent work opportunity. Correspondingly, Reker et al. [3] identified several types of the rehabilitation course including a long-stay in a sheltered workshop and the shift to permanent unemployment. Nevertheless, a few of our patients found some kind of occupation, even when not a regular one, later on. Thus, they demonstrated their motivation for being active.

The patients entered the workshop relatively late in their illness career, at the average age of 39 years, and the majority of them received the diagnosis of a schizophrenic disorder. The frequency of this diagnosis differed significantly between the groups: it was 75% in the long-stay group, 50% in the short-stay group and it was given to only one patient of the study group. Schizophrenic along with affective disorder was diagnosed in 80% of all control patients. As recently shown [11], there were hardly any differences between schizophrenic and bipolar affective patients receiving rehabilitation programmes. In the study group the diagnosis of a personality disorder (most frequently of the borderline type) or a substance use disorder was the principle diagnosis in 7 patients and the additional diagnosis in 3 further patients. On the one hand, it has been repeatedly claimed that diagnosis is irrelevant for the person's future rehabilitation outcome [12]. On the other hand, different working conditions appear to have different effects in patients with different diagnosis [13] and our results confirm that the same working conditions may be suitable for patients with schizophrenic and affective disorders but not for patients with personality and substance use disorders. Incidentally, in psychotic patients occupational handicaps, in patients with neurotic and substance use disorders social handicaps were correlated with the disorder prognosis [14].

The characteristics of the patients of the study group (diagnosis of personality or drug use disorder, short hospital stays, frequent outpatient consultations) indicate that personal instability could well have been their common feature also influencing their work engagement. Personality and social competence correlate with vocational integration [15]. Instability may contribute to a poor employment history and a worse social adjustment, both these factors being negative predictors of future work performance [16].

Patients who leave the work therapy frequently do so for illness-related reasons: lack of drive, feeling of being overstressed [17]. This does not seem to be the case in our patients. The higher school education of the study group patients might have entitled them for higher professional aspirations which, unfortunately, could not be met in the workshop, which offered a serial industrial activity with relatively low demands. Indeed, some patients succeeded in finding an occupation in a social area later on. As a matter of fact, our patients who left or absconded correspond in some characteristics to the type of patients deemed to be potentially successful in the work rehabilitation [3]: they had a better general school education in the absence of specific vocational qualification, spent less time in inpatient treatment, and in jobs under sheltered conditions. Interesting enough, patients who had completed vocational training were found to be just as unable to cope with normal working life after they became mentally ill as those who had had no such training [18] and this was confirmed in our study.

Regarding the patients' satisfaction with their work situation in the workshop, a very similar ranking was indicated in all three groups and highly comparable results were found by Weis [9] and Reker et al. [19] assessing other samples of mental patients with the same instrument. Dissimilar results were obtained in a normal working population [8]. The same ranking indicates that all patients experienced the workshop in the same way, being mostly satisfied with their superiors and at least – and quite realistically so – with their payment and career perspectives. In contrast, the patients of the study group rated lower on all items; they were less satisfied than the control patients and comparable populations of sheltered workshops [9, 19]. Subjective appraisal of the work situation is of utmost importance for a successful rehabilitation [20] and successful rehabilitation depends on the attitudes and expectations of the patient and his or her social environment [21]. Lower satisfaction ratings by our study patients as an expression of more negative attitudes may have contributed to their leaving the workshop. However, in the study patients work satisfaction and work importance were assessed retrospectively and the factor of social desirability could have influenced the ratings in the control patients.

Our study is not without weaknesses: only 48 patients (40% of those asked for participation, 17.5% of all potential study candidates) entered the study. As far as the data were available however, we tested the representativity of our study groups and found no substantial differences between study participants and non-participants. There is an overlap between our groups: some patients of the 1st control group stayed in the workshop for a shorter time than some study patients, even though there is a significant difference on the group level. The small member of patients in each group could be responsible for the large amount of non-significant results.

Allowing for these shortcomings, the results indicate that only a small minority of vocationally disabled, chronic mentally ill patients who leave a low entry threshold sheltered workshop after a relatively short time do so in order to take a further step in their rehabilitation process. The majority of these patients stay – and some of them obviously for a longer time – at home without being sufficiently occupied. Without specialised help they are not able to find an adequate alternative. The study demonstrates that the duration of the stay in the workshop positively correlates with the diagnosis of schizophrenic disorder. The patients of the study group mostly suffered from personality and substance use disorders; they had received a higher school education and their needs were apparently not adequately met in the workshop providing them with simple industrial work. Whereas such an offer may be appropriate for many schizophrenic patients, sheltered workshops should be able to offer other kinds of occupation as well. Staying in the sheltered workshop provides the patients with an occupation; however, it also frequently terminates the rehabilitation process at a relatively low level. Thus, not only alternative options in the sheltered workshop itself but also new approaches in general must be considered for suitable patients, such as supported employment in the competitive labour market [22–24]. Nevertheless, we must bear in mind that competitive employment – with its possibility to offer a wider choice of occupations and to adjust better to the patients' qualifications and preferences – represents a realistic objective only for patients with high motivation and favourable preconditions [3].

References

1 Bachrach LL. Psychosocial rehabilitation and psychiatry in the care of long-term patients. Am J Psychiatry 1992;149:1455–63.

2 Bennett D. The value of work in psychiatric rehabilitation. Soc Psychiatry 1970;5:224–30.

3 Reker T, Hornung WP, Schonauer K, Eikelmann B. Long-term psychiatric patients in vocational rehabilitation programs: a naturalistic follow-up study over 3 years. Acta Psychiatr Scand 2000;101:457–63.

4 Eikelmann B. Arbeit – ihre Bedeutung in Therapie und Rehabilitation chronisch seelisch Kranker. Psychiatr Prax 1987;14:8–12.

5 Eikelmann B, Reker T. A second labour market? Vocational rehabilitation and work integration of chronically mentally ill people in Germany. Acta Psychiatr Scand 1993;88:124–9.

6 Weis J, Koch U. Tagesstrukturierende Beschäftigungsangebote für psychisch Kranke im ausserstationären Bereich. In: Hippius H, Lauter H, Ploog D, Bieber H, van Hout, Hrsg. Rehabilitation in der Psychiatrie. Berlin: Springer; 1989. S. 303–15.

7 Holm MB, Santangelo MA, Fromuth DJ, Brown SO, Walter H. Effectiveness of everyday occupations for changing client behaviors in a community living arrangement. Am J Occupation Ther 2000;54:361–71.

8 Neuberger O, Allerbeck M. Messung und Analyse von Arbeitszufriedenheit: Erfahrungen mit dem «Arbeitsbeschreibungsbogen (ABB)». Bern: Huber; 1978.

9 Weis J. Arbeitszufriedenheit und Arbeitsplatzgestaltung bei psychisch Kranken in Einrichtungen der beruflichen Rehabilitation. Z Arbeitsorganisationspsychologie 1993;37:29–32.

10 Weis J. Arbeitsbelastungen und Arbeitsbewältigung bei psychisch Kranken. Eine arbeitsanalytische Studie zur Praxis der beruflichen Rehabilitation. Freiburg i.Br.: Deutscher Studien Verlag; 1989.

11 Dickerson FB, Sommerville J, Origoni AE, Ringel NB, Parente F. Outpatients with schizophrenia and bipolar I disorders: do they differ in their cognitive and social functioning? Psychiatry Res 2001;102:21–7.

12 Farkas MD, Anthony WA. Psychiatric rehabilitation: fiction or fact? In: Hippius H, Lauter H, Ploog D, Bieber H, van Hout L, Hrsg. Rehabilitation in der Psychiatrie. Berlin: Springer; 1989. p.177–83.

13 Vogel R, Bell V, Blumenthal S, Neumann N-U, Schüttler R. Work and psychiatric illness: the significance of the posthospitalization occupational environment for the course of psychiatric illnesses. Eur Arch Psychiatry Neurol Sci 1989;238:213–9.

14 Blumenthal S, Bell V, Neumann N-U, Schüttler R, Vogel R. Berufliche Handicaps als Risikofaktoren für eine Wiedereinweisung von ersthospitalisierten psychiatrischen Patienten – Ergebnisse einer prospektiven Längsschnittuntersuchung. Rehabilitation (Stuttg) 1986;25:112–5.

15 Hoffmann H. Berufliche Integration in den allgemeinen Arbeitsmarkt – Ein realistisches Ziel für chronisch psychisch Kranke? Psychiatr Prax 1999;26:211–21.

16 Anthony WA, Jansen MA. Predicting the vocational capacity of the chronically mentally ill. Am Psychol 1984;39:537–44.

17 Reker T, Eikelmann B. Ambulante Arbeitstherapie. Ergebnisse einer multizentrischen, prospektiven Evaluationsstudie. Nervenarzt 1994;65:329–37.

18 Reker T, Eikelmann B, Inhester ML. Pathways into sheltered employment. Soc Psychiatry Psychiatr Epidemiol 1992;27:220–5.

19 Reker T, Eikelmann B, Hagenbrock M, Inhester ML, Soggeberg C, Spangenberg J, et al. Begleitende Hilfen im Arbeitsleben für psychisch Kranke und Behinderte. Abschlussbericht des Forschungsprojektes. Bonn: Bundesministerium für Arbeit und Sozialordnung; 1996.

20 Sonnentag S. Berufliche Rehabilitation von psychisch Kranken – Ergebnisse einer Untersuchung in Werkstätten für Behinderte. Psychiatr Prax 1992;19:201–6.

21 Ciompi L. Resultate und Prädiktoren der Rehabilitation. In: Hippius H, Lauter H, Ploog D, Bieber H, van Hout L, Hrsg. Rehabilitation in der Psychiatrie. Berlin: Springer; 1989. S. 27–38.

22 Drake RE, Becker DR, Clark RE, Mueser KT. Research on the individual placement and support model of supported employment. Psychiatr Q 1999;70:289–301.

23 Crowther RE, Marshall M, Bond GR, Huxley P. Helping people with severe mental illness to obtain work: systematic review. Br Med J 2001;322:204–8.

24 Latimer EA. Economic impacts of supported employment for persons with severe mental illness. Can J Psychiatry 2001;46:496–505.