A Hybrid Supported Employment Program for Persons With Schizophrenia in Japan

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Introduction by the column editors: **Because the mental health system in Japan has emphasized hospital-based treatment (1), patients with schizophrenia often remain institutionalized for long periods, even after their symptoms have stabilized. In addition, the introduction of modern community-based methods of treatment and rehabilitation was delayed by an antipsychiatry movement in the 1970s and the ascendance of a reductionistic biological approach to services (2).**

Lack of adequate outpatient services and community residential care in Japan has been a serious obstacle to destigmatization of mental disorders and has contributed to the heavy burden and stress experienced by families of mentally ill persons (3). More than 80 percent of patients discharged from mental hospitals return to live with their families, who are ill prepared to provide the supportive services required for community tenure.

Involvement in work activities can facilitate community reentry for people with serious and persistent mental illness because employment displaces symptoms, provides structure and meaning in daily life, offers socialization with peers, and permits workers to earn income for shelter and food. In this issue's Rehab Rounds column, the authors describe an innovative vocational rehabilitation program for patients with schizophrenia that was designed to overcome obstacles to discharge and community adjustment. The program at Yabuki Prefecture Psychiatric Hospital, in the northern prefecture of Fukushima, Japan, has been successful in training patients for competitive work while capitalizing on the importance of work in Japanese culture and its traditionally supportive employer-employee relationships. The program is termed "hybrid" because it combines elements of transitional employment with supported employment (4).

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The Yabuki Prefecture Psychiatric Hospital, located in Fukushima Prefecture, Japan, was established in November 1955. Initially Yabuki Hospital provided milieu therapy that focused on teaching hygiene skills, recreation therapy, and diversional occupational therapy conducted by nurses. In 1974 a change in mental health policy allowed reimbursement for occupational therapy services by insurance. Yabuki Hospital soon became the first in the prefecture to obtain government approval to provide reimbursable occupational therapy services, and the hospital hired several licensed occupational therapists and significantly expanded its array of occupational therapy services.

As part of the expansion of services, the hospital created a vocational rehabilitation program for patients with schizophrenia that integrated the clinical team with hospital-based occupational therapy, followed by supported employment (5). Patients were placed in competitive jobs, where they received individual job coaching, advocacy, support, and long-term follow-up by the clinical team to help them maintain their jobs. The clinical team consisted of a psychiatrist, a psychologist, a social worker, a nurse, and an occupational therapist.

The hybrid model of vocational rehabilitation

Soon after hospitalization, the patients were enrolled in occupational therapy groups. Group sessions were offered six days a week, and patients attended for two to six hours each

day, depending on their clinical status and cognitive functioning. Occupational therapy activities included gardening, agricultural work (pig, cow, and vegetable farming), handicrafts (Japanese paper art and knitting), and making paper products such as gift bags and envelopes. The average patient-to-therapist ratio in the occupational therapy groups was 10 to 1.

Patients who did well in occupational therapy proceeded to the next phase, in which clinicians worked with local businesses to find employment for them. The employers and the clinicians collaborated in placing patients in jobs according to the patients' abilities and preferences. The clinicians then developed a supported employment component that grew out of the occupational therapy program, creating a hybrid model of vocational rehabilitation (6) containing elements of transitional and supported employment.

These early efforts led to the establishment of the first Japanese Vocational Helper Liaison Council in 1977. The helpers, or members, of the council were employers who made jobs available for psychiatric patients at the hospital. The number of employers offering job placements for hospitalized patients immediately increased from 12 to 23. All companies offered a competitive work environment, with the exception of one clothing manufacturer that predominantly hired disabled workers. At this site, patients had contact with smaller numbers of nondisabled workers, but all other conditions of employment were similar to those of the competitive sites.

Clinicians from the hospital held meetings to educate council members about schizophrenia and other serious mental illnesses, to answer any questions or concerns held by members, and to point out the advantages of hiring psychiatric patients. The advantages for employers included rehabilitation readiness of patients through their training in occupational therapy, partial government support for wages paid to psychiatric patients (up to 10 percent), and patients' acceptance of lower wages. Although lower wages might be seen as a disadvantage to workers, program participants did not think so, as these jobs were often the first paid work the patients had done. The lower wages also gave the patients a competitive edge in the employment market, enabling them to leave the hospital, obtain jobs, and receive vocational experience that promoted their future employment prospects.

Once a council member had a job opening, the employer consulted with the clinical team to find a patient who was appropriate for the position and interested in taking the job. Because of limited job openings and resources, positions were offered only to patients who were psychiatrically stable and who were otherwise unable to leave the hospital– that is, the family was unwilling or unable to take the patient back into their home or provide the patient with other housing. The conditions of employment were established before the patient was placed. One mandatory condition was that the patient could be readily rehospitalized if relapse occurred.

A vocational helper was assigned to each patient at the time of job placement– a nonprofessional who was an employee or employer at the job site and who volunteered to provide assistance to patients working in the community. The role of the vocational helper included job orientation, training the patient to perform all work tasks, giving advice, and being available to the patient for problem-solving and crisis situations, in consultation with the clinical team.

After being placed in a job, patients were generally discharged from the hospital to live in company-owned housing or to live independently in a house or an apartment. Another housing option was the Akebono-so residential home. Akebono-so was the first community residential home in Fukushima, established in 1978 by the Family Association of Yabuki Hospital with cooperation from the Vocational Helper Liaison Council. The residential home was a ten-bed, independent living facility with one part-time staff member who would prepare one meal a day. All other food preparation, laundry, and cleaning were performed by the residents.

Despite the company housing and Akebono-so, some patients who were placed in jobs could not obtain housing. In this case, the patient worked during the day and returned to the hospital at night until other living arrangements could be found.

Patients in the vocational rehabilitation program were expected to visit the hospital at least twice monthly for medication maintenance with a psychiatrist and for supportive group therapy with a social worker or psychologist. The patients were also visited by a member of the clinical team at their workplace up to four times a month. During these visits the clinician consulted with the employer and the vocational helper and assisted patients in matters such as solving interpersonal problems and requesting changes in type of work. Limited clinical intervention was also made available to patients who were living in the community house.

Program evaluation

A retrospective study was conducted to evaluate the course of social and vocational adjustment and rehospitalization of patients participating in the program. A chart review and a survey were conducted for 52 patients at Yabuki Hospital (36 men and 16 women) who were consecutively discharged between 1977 and 1990 and placed into the employment program. Before discharge, each patient participated in two to six hours of occupational therapy six days a week, for a period ranging from one to 20 years, with a mean±SD of 4±2.7 years. Follow-up in the community was maintained by a clinical team for a minimum of three years after discharge.

The patients' mean±SD age at the time of the survey was 51±7.2 years, and the mean age at onset of illness was 23±4.2 years. All patients had a diagnosis of schizophrenia according to *DSM-III-R* criteria. Before placement in supported employment, their mean±SD hospitalization time was 8.9±6.8 years.

All available clinical records were reviewed from the time of onset of illness to 1993. Records included detailed interviews conducted when the patient first entered the hospital, inpatient and outpatient psychiatrists' notes, and progress reports filed by nurses, social workers, psychologists,

day treatment therapists, and occupational therapists. Social workers and psychologists also filed progress reports after visiting the job sites and the community residential home. Baseline and follow-up assessment periods varied among individuals, so community tenure was analyzed by comparing the percentage of time spent out of the hospital after enrollment in the vocational rehabilitation program with baseline rates. Vocational outcomes were also reported.

Vocational and community living status

Before the index hospitalization, only two of the patients (3.8 percent) had worked at all while living in the community. In contrast, after entry into the hybrid program all 52 participants successfully worked for varying lengths of time, from three months to 17 years. The follow-up survey conducted in 1993 offered a snapshot of the patients' vocational and community living status at that time. Twenty patients (38.5 percent) were in a competitive employment position and living in the community, 15 patients (28.8 percent) were living with their families and not working, and 17 (32.7 percent) were hospitalized and not competitively employed.

Rehospitalizations and community tenure

Patients were hospitalized an average of 1.5±1.6 times after supported employment, compared with 3.2±1.7 times before supported employment. Nineteen patients (36.5 percent) had no hospitalizations, and the remaining 33 patients were rehospitalized a total of 77 times (an average of 2.33 each) during the follow-up period.

For those who were rehospitalized, the time between discharge into supported employment and first rehospitalization ranged from three months to 12 years and averaged 2.94± 2.71 years. The most commonly reported events associated with discontinuation of employment and rehospitalization were an increase in symptoms because of medication noncompliance and quitting a job because of dissatisfaction.

The proportion of time spent out of the hospital increased significantly after participation in the vocational program. The time patients spent out of the hospital increased from 54.4 percent in the period before supported employment to 67.9 percent in the period after supported employment ($F=4.57$, $df=1, 48$, $p=.038$).

Case vignette

Mr. A, a 41-year-old single male with a high school education, had his first psychotic episode and hospitalization when he was 21 years old. Before that time, he held a series of unskilled jobs, never achieving stable employment. He had a succession of hospitalizations occasioned by family stress and noncompliance with medication.

After Mr. A was admitted to Yabuki Hospital, he received occupational therapy for two years. When the hybrid vocational rehabilitation program was started, Mr. A enrolled and was employed at a local pig farm. He continued to live at the hospital because he had no other options; when Akebono-so community house was established several months later, he was placed there. Mr. A worked at the pig farm continuously for more than two years.

Collaboration between the vocational helper and the clinical team enabled Mr. A to maintain his job, even after he was briefly hospitalized for a relapse. He subsequently obtained work at another community-based pig farm and moved into an apartment owned by the farmer. After three years of sustained employment, he had another relapse, precipitated by an increase in his work hours and work-related stress. Fortunately, early intervention contained the relapse, and he quickly returned to community life and competitive employment. He eventually married a woman he met in the hospital, and he successfully maintained his self-supporting and competitive work status for eight years.

Afterword by the column editors:

The hybrid vocational rehabilitation program at Yabuki Hospital has enabled many patients, including those who have been institutionalized for extraordinarily long periods, to cross the bridge from hospital to community. The success rates in terms of employability and sustained employment are remarkable for a culture in which vocational rehabilitation for persons with serious mental illness is the exception rather than the rule.

It is interesting that the "wrap-around" services offered to patients by the clinical team and the vocational enabler is similar to the model of individual placement and support popularized and validated by Becker and Drake in the United States (5). Because the Yabuki Hospital program began this hybrid form of vocational rehabilitation before supported employment came into vogue in the United States, we can point to a convergent, cross-cultural validity in this approach. As in the case of social skills training (2), we can look forward to continued cross-fertilization of rehabilitation methods between Japan and the United States to the benefit of patients in both countries who have serious and persistent mental disorders. ♦

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