Published online: *Rehabil Couns Bull May 2, 2014*
doi: 10.1177/0034355214531075

Beliefs Of Vocational Rehabilitation Counselors about Competitive Employment for People with Severe Mental Illness.

Knaeps Jeroen[a]*, Neyens Inge[a], Donceel Peter[b], van Weeghel Jaap[c], Van Audenhove Chantal[a]

[a] *LUCAS Center for Care Research and Consultancy, KU Leuven,*
[b] *Research Unit Social and Preventive Health Care, KU Leuven, Leuven, Belgium*
[c] *Phrenos Centre of Expertise, The Netherlands*

contact information: Jeroen.knaeps@med.kuleuven.be

Abstract

Vocational Rehabilitation (VR) counselors not always focus on competitive employment for people with severe mental illness. Based on the Theory of Planned Behavior (TPB), this study examines how three types of VR counselors (i.e. gatekeepers, case managers and specialists) vary in their underlying beliefs about regular employment.

VR counselors (n=286) completed an online TPB-survey measuring behavioral, normative, control and self-efficacy beliefs. Differences in beliefs were analyzed by one-way ANOVA's and post-hoc comparisons using Bonferroni correction.

Results indicate that counselors differ in their beliefs about competitive employment for people with SMI. More specialized counselors are stronger convinced that competitive employment results in latent benefits (e.g. increased integration and self-confidence). In contrast, gatekeepers consider income as the most recurrent and positive effect. The more specialized VR counselors are, the more often they perceive significant others valuing competitive employment and the more often they are inclined to comply with these norms. Finally, specialized counselors experience fewer barriers, more control and more self-efficacy in dealing with problems compared to less specialized counselors.

The differences in beliefs determining the focus on competitive employment might result in a lack of an integrated approach. Training, outcome feedback and intersectoral communication can enhance consistency between specialized and less specialized VR services.

Keywords

Theory of Planned Behavior, Vocational Rehabilitation, counselors, attitudes

Introduction

Despite the positive effects of competitive employment on peoples' social, emotional and financial life (Rosso, Dekas, & Wrzesniewski, 2010), many people with SMI have difficulties with obtaining and retaining a competitive job (Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009; OECD, 2013). Therefore, several vocational rehabilitation programs (e.g. Supported Employment, Transitional Employment) have been developed. The Individual Placement and Support model (IPS) of Supported Employment (SE) is the best-researched model and is generally acknowledged as an evidence based practice (Crowther, Marshall, Bond, & Huxley, 2001; Fleming, Del Valle, Kim, & Leahy, 2013; Rogers, Anthony, Lyass, & Penk, 2006; Nithsdale, Davies, & Croucher, 2008). IPS stresses seven principles: (1) zero exclusion, (2) integration with mental health treatment teams, (3) focus on clients' preferences, (4) rapid job search, (5) competitive employment as a goal, (6) time-unlimited follow-up and (7) benefits counseling (Becker & Drake, 1994; Bond, Drake, & Becker, 2008; Crowther et al., 2001; Burns & Catty, 2008). A recently added principle states the importance of building relationships with employers (2013).

In several countries, different types of VR counselors, i.e. (1) gatekeepers, (2) case managers and (3) VR specialists, support the VR process (Becker et al., 1998; Fleming et al., 2013; Premuda-Conti & Lewis, 2011). First, gatekeepers, working in for example state-federal VR agencies in the US (Premuda-Conti & Lewis, 2011) and Europe (e.g. Public Employment Service in Finland or Jobcentres in the UK), are responsible for the intake, global assessment of competences and referral to more specialized services. If gatekeepers do not believe in the value of competitive employment and perceive too many barriers for obtaining and retaining such jobs, it can be expected that referral to IPS services will be low (Casper & Carloni, 2007). Moreover, as they are the first contact person of the clients with SMI, their focus on competitive employment might influence the first intentions of the person with SMI to search for and retain a competitive job. Second, VR case managers assess competences of clients, plan and monitor their VR process and look for jobs (Rapp & Gosha, 2004). They connect the person with VR specialists or other services (OECD, 2013; Rosenthal et al., 2012; Gowdy, Carlson, & Rapp, 2004). VR case managers thus have a mixed profile of generalist and specialist functions (Harries & Gilhooly, 2003). It can be expected that if case managers' intentions are not focused on competitive employment, referral to IPS services will be low (Casper & Carloni, 2007). Moreover, as they have a moderately intensive contact with clients, their intentions might impact those of clients with SMI to search for regular jobs as well. Third, specialized or field VR counselors (Premuda-Conti & Lewis, 2011) offer on-the-job support for clients (with SMI) and employers and are responsible for follow-up (Abraham & Stein, 2009). They often work in Community Mental Health Centers, in psychosocial rehabilitation agencies, or in psychiatric hospitals (Corbière et al., 2010; Rinaldi & Perkins, 2007). As their contact with clients is intensive, their focus on competitive employment is crucial and might strongly impact the intentions of clients to engage in competitive employment.

Differences in the focus on competitive employment between the three types of VR counselors might result in a fragmented VR counseling process. When clients meet counselors with different attitudes and expectations, they can experience ambiguity and instable and less integrated support (Henry,

2004). This can in turn affect the working alliance with the VR counselor. Even more, poor communication between the practitioners, i.e. the gatekeeper, the case manager and the VR specialist and the client may increase non-attendance to meetings with the VR counselor (Mitchell & Selmes, 2007).

Rehabilitation counselors working in different employment settings can differ, e.g. in how and which information needs to be gathered (Leahy, Muenzen, Saunders, & Strauser, 2009; Fleming et al., 2013). This study aims to investigate the potential differences between gatekeepers, case managers and VR specialists in their intentions to focus on competitive employment. In specific, the study offers new insights in their intentions by examining the underlying beliefs of these three groups of counselors. A more thorough understanding of the underlying determinants of VR counselors' intentions might improve training by tailoring it to the specific needs of the counselor. Furthermore, aligning the intentions of different types of VR counselors can encourage integration of the VR counseling process.

The Theory of Planned Behavior

The Theory of Planned Behavior (TPB) has been applied within different research domains (Harakeh, Scholte, Vermulst, de Vries, & Engels, 2004; Fila & Smith, 2006) including vocational rehabilitation (Brouwer et al., 2009; Hergenrather, Rhodes, & McDaniel, 2005; Corbière et al., 2011). Within the TPB, intentions to perform a behavior (i.e. focus on regular jobs) are determined by the attitude, subjective norms and perceived behavioral control (PBC) towards the behavior (Ajzen, 1991). These are in turn determined by behavioral, normative and control beliefs (Figure 1).

The attitude towards a behavior reflects the individual's global favorable or unfavorable evaluation of performing the behavior (Ajzen, 2002a). It consists of two components: behavioral belief strength and outcome evaluation. Behavioral belief strength is defined as the perceived probability that an outcome occurs, whereas outcome evaluation refers to how positive/negative each outcome is perceived (Ajzen, 2002a).

Subjective norms are a person's estimate of the social pressure to (not) perform the behavior. Subjective norms are determined by beliefs about how groups of significant others (e.g. partners, supervisors, colleagues, friends) would like them to behave, i.e. normative belief strength and by the motivation to comply with the beliefs of others.

The TPB incorporates perceptions of control over the performance of the behavior (Conner & Armitage, 1998). Perceived behavioral control refers to the person's perception of the extent to which performing a behavior is under control (Sheeran, Trafimow, & Armitage, 2003). The underlying control beliefs are characterized by (1) the likelihood that barriers occur, i.e. control belief strength and (2) the extent to which a barrier hinders performing the behavior, i.e. control belief power (Terry & O'Leary, 1995; Shook & Bratianu, 2010).

Self-efficacy (SE) can be defined as a personal judgment of one's capabilities to organize and perform behaviors to attain goals and overcome barriers (Shook & Bratianu, 2010; Bandura, 1977). Beliefs about the own level of self-efficacy are included in the study as research demonstrates that SE is a strong predictor of intentions and behaviors above the other TPB-components (Povey, Conner, Sparks, James, & Shepherd, 2000; Ajzen, 2002b; Miller & Miller, 2011; Montano & Kasprzyk, 2008).

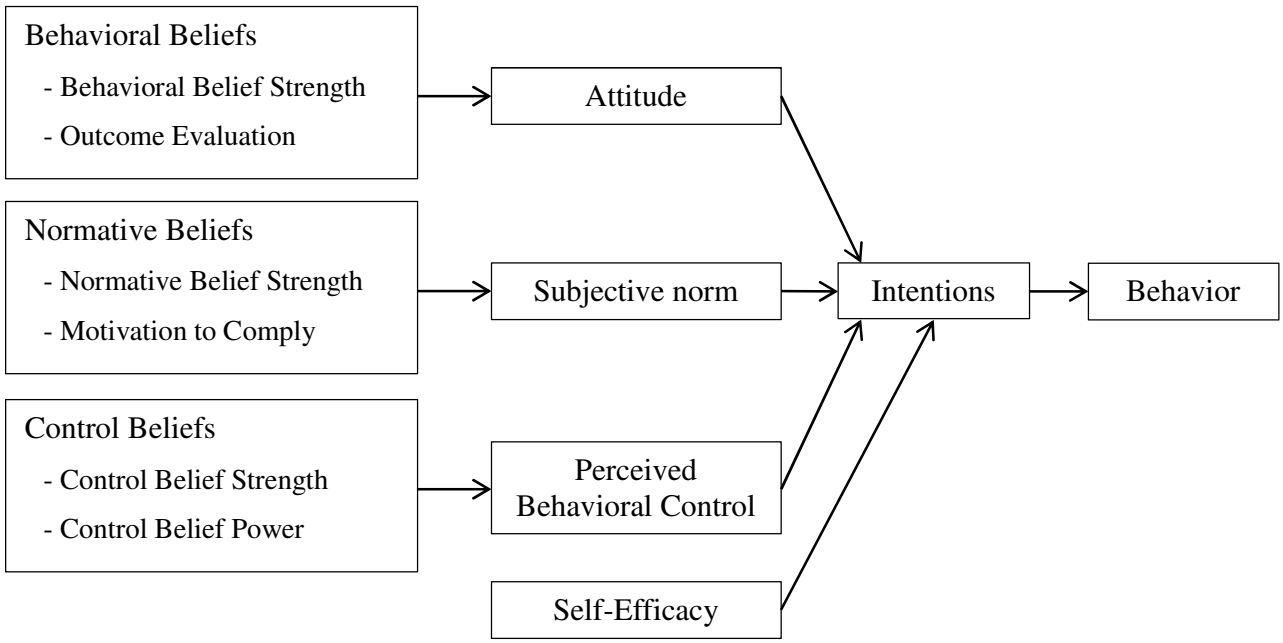

Figure 1. The Theory of Planned Behavior and its underlying beliefs

Method

Sample description

To study the beliefs of the three different groups of VR counselors in their intentions to focus on competitive employment, cross-sectional data was gathered in an adult sample comprising of 286 VR counselors in Flanders, the largest semi-autonomous part of Belgium. The sample comprised gatekeepers of the Flemish Public Employment Service, case managers of the Vocational Training Agencies and VR specialists of the Vocational Counseling Centers, all of them working with people with SMI (total response rate=55%).

Gatekeepers of the Flemish Public Employment Service are responsible for the first contact with the client and the referral to more specialized services and assessment centers. In order to keep demands reasonable, a random sample of 155 counselors of all 1284 gatekeepers of the Flemish Public Employment Service was selected. There were 69 gatekeepers who filled in the questionnaire (response rate=45%).

VR case managers of Vocational Training Agencies set up an individual action plan for people with severe disabilities, search for jobs and bring the person in contact with other specialists (OECD, 2013). They also offer of-the-job support and they facilitate the search for jobs. All 158 case managers of the specialized Vocational training agencies in Flanders received a questionnaire. It was filled in by 110 case managers (response rate=70%).

VR specialists of Vocational Counseling Centers offer even more support in attaining and holding a job. More concretely, they offer on-the-job support to clients and employers and follow-up (Abraham & Stein, 2009). Of all 154 VR specialists of the Vocational Counseling Centers, 107 VR specialists (response rate=69%) filled in the questionnaire.

The mean age of respondents is 36.1 years (SD=9.0, range, 21-59), with a mean length of service of 7 years (SD=5.8, range 0-30). Most of the respondents were women (n=237, 82.9%) and have daily (n=83, 29%) to weekly (n=152, 53%) professional contact with people with SMI. Significant differences between gatekeepers, case managers and VR specialists emerged on age ($F=26.39$, $p<.01$) and length of service ($F=10.79$, $p<.01$). Case managers are significantly younger (M=32.1, SD=6.9) than VR specialists (M=37.0, SD=9.0) who are in turn significantly younger than gatekeepers (M=41.2, SD=9.2). Gatekeepers (M=8.9, SD=7.3) and VR specialists (M=7.1, SD=5.9) have had their jobs longer compared to case managers (M=4.9, SD=3.9). Significant differences between gatekeepers, case managers and VR specialists also emerged on amount of professional contact with target group ($F=25.56$, $p<.01$) with gatekeepers saying to have mostly weekly/monthly contact and the other two groups stating to have daily/weekly contact. The three groups did not differ significantly on personal contact with clients with SMI ($F=1.49$, $p=.227$).

Survey instrument

The recommendations of Ajzen (2002) to develop TPB-questionnaires were used. The results of a study describing the possibilities and barriers experienced by VR counselors to implement IPS (Knaeps, DeSmet, & Van Audenhove, 2012) were used to generate items. One expert in constructing TPB-questionnaires revised the instrument. Face validity of the instrument was ensured by offering and discussing the 46-item questionnaire to an expert panel consisting of five VR counselors working with people with SMI. The questionnaire was electronically distributed and anonymity was guaranteed.

Attitude

The assessment of behavioral beliefs towards competitive employment is based on seven reported outcomes of competitive employment (Knaeps et al., 2012): (1) integration in society, (2) higher income, (3) more self-confidence, (4) higher level of autonomy/independency, (5) more stress, (6) less prejudices/stigma in society, and (7) temporary worsening of psychiatric symptoms. As these seven outcomes were used to measure belief strength and outcome evaluation, the measurement of behavioral beliefs included 14 items. ‘Belief strength’ is measured by asking how often each of the seven outcomes of competitive employment occurs on a 6-point Likert scale (‘not at all likely’ to ‘very likely’). An example of an item is “How often competitive employment increases a persons’

autonomy". 'Outcome evaluation' is the desirability of each outcome of competitive employment. Respondents rated on a 6-point Likert scale ranging from 'very negative' to 'very positive' whether each outcome is rather positive or negative for the person (Ajzen, 2002a). An example is: "How positive is achieving more autonomy for most people with SMI?".

Subjective Norm

Subjective norms constitute of normative belief strength and motivation to comply. To measure normative belief strength, respondents rated for each of four groups (client, colleagues, supervisor/boss and others outside work, e.g. partner, friends, parents) how often a particular group considers competitive employment important (e.g. "The client with SMI thinks I should focus on competitive employment."). A 6-point Likert scale was used ranging from 'never' to 'always'. Respondents subsequently registered on a 6-point Likert scale whether they are motivated to comply with the opinion of each of the four groups. In total, the assessment of subjective norms includes 8 items.

Perceived Behavioral Control and Self-Efficacy

Previous research identified eight barriers that might interfere with focusing on competitive employment (Knaeps et al., 2012): (1) socio-economic problems (housing, transportation, debts …), (2) instable psychiatric symptoms, (3) lack of time for follow-up, (4) negative internal organizational affairs (e.g. downsizing, lack of support), (5) insufficient contact with employers, (6) incompatible legislation, (7) lack of motivation of the client and (8) insufficient collaboration with other services (e.g. with mental health services, or local governmental organizations). These eight barriers were used three times in order to measure control belief strength, power and self-efficacy. 'Control belief strength' is assessed by rating the likelihood each of these barriers occurs (6 point Likert-scale from 'never' to 'always'). An example of an item is "How often is there a lack of time for follow-up?" 'Control belief power' is measured by the difficulty each barrier poses on rehabilitation (6 point Likert-scale from 'very difficult' to 'very easy'). An example of an item is "How difficult is it to focus on competitive employment when there is a lack of time for follow-up?" 'Self-efficacy' was also rated on a 6 point Likert-scale with each respondent indicating his/her confidence to overcome each barrier.

Data analysis

For each of the determinants of intention, data was analyzed by one-way ANOVA's. When significant differences occurred, post-hoc comparisons were carried out using Bonferroni correction for multiple comparisons (Zar, 1984). All analyses were conducted using SPSS statistics version 17.0 (Chicago: SPSS Inc).

Results

One-way analysis of variance showed a number of differences regarding attitude, normative beliefs, perceived barriers and self-efficacy of the three groups of counselors. Age, contact with the target

group and length of service had no significant effect on the outcomes and are therefore not further described.

Attitude

Concerning behavioral belief strength, all counselors specify that competitive employment results in more integration in society (M=4.47, SD=.90) more self-confidence (M=4.30, SD=.91), a higher income (M=4.27, SD=.96) and more autonomy (M=4.03, SD=.90) for people with SMI (Table 1). It sometimes results in higher levels of stress (M=3.79, SD=.77) and worsening of symptoms (M=3.20, SD=.55). Yet, the three groups of VR counselors differ in their behavioral belief strength. VR specialists and case managers think competitive employment will (very) often lead to self-confidence (F=7.69, p=.001), autonomy (F=11.92, p<.001) and integration in society (F=7.08, p=.001) whereas gatekeepers indicate that these results occur only occasionally and that income is the most prevalent effect.

Regarding the outcome evaluation, all three types of counselors rate the worsening of symptoms (M=2.57, SD=0.87) and increased levels of stress as the most negative outcomes of competitive employment. In contrast, more integration in society (M=4.76, SD=.76), income (M=4.78, SD=.75) and self-confidence (M=4.84, SD=.73) are evaluated as rather positive. Case managers and VR specialists rate higher levels of autonomy (F=6.16, p=.002) and self-confidence (F=7.63, p=.001) more positive than gatekeepers.

Table 1

Behavioral belief and outcome evaluation (1-6) (M±SD)

Items	All	Gatekeepers (1)	Case managers (2)	VR specialists (3)	F	P	Bonferroni Post hoc Correction[a]
Behavioral belief strength							
Integration in society	4.47 ± 0.90	4.13 ± 0.91	4.53 ± 0.91	4.63 ± 0.83	7.082	.001	1<2, 1<3
More self confidence	4.30 ± 0.91	3.96 ± 1.02	4.32 ± 0.85	4.50 ± 0.85	7.692	.001	1<2, 1<3
Higher income	4.27 ± 0.96	4.35 ± 0.97	4.25 ± 0.90	4.24 ± 1.01	0.306	.736	
Higher level of autonomy	4.03 ± 0.90	3.64 ± 0.80	4.02 ± 0.88	4.29 ± 0.89	11.920	<.001	1<2, 1<3
More stress	3.79 ± 0.77	3.75 ± 0.79	3.85 ± 0.78	3.76 ± 0.75	0.458	.633	
Less prejudices, stigma in society	3.79 ± 1.05	3.67 ± 0.97	3.86 ± 1.07	3.80 ± 1.09	0.746	.475	
Temporary worsening of symptoms	3.20 ± 0.55	3.17 ± 0.62	3.23 ± 0.48	3.18 ± 0.58	0.289	.749	
Outcome evaluation							
Integration in society	4.76 ± 0.76	4.57 ± 0.78	4.85 ± 0.77	4.79 ± 0.74	3.083	.047	N.L.S
More self confidence	4.84 ± 0.73	4.55 ± 0.88	4.95 ± 0.66	4.93 ± 0.64	7.630	.001	1<2, 1<3
Higher income	4.78 ± 0.75	4.71 ± 0.81	4.86 ± 0.71	4.74 ± 0.74	1.158	.315	
Higher level of autonomy	4.50 ± 0.68	4.26 ± 0.72	4.53 ± 0.63	4.62 ± 0.67	6.158	.002	1<2, 1<3
More stress	2.68 ± 0.87	2.70 ± 0.88	2.60 ± 0.86	2.75 ± 0.87	0.803	.449	
Less prejudices, stigma in society	4.45 ± 0.92	4.36 ± 0.91	4.53 ± 0.89	4.43 ± 0.97	0.721	.487	
Temporary worsening of symptoms	2.57 ± 0.87	2.54 ± 0.80	2.51 ± 0.82	2.65 ± 0.96	0.820	.441	

[a] Mean differences are significant at the .01 level

N.L.S: no longer significant after Bonferroni correction

Subjective norms

Concerning the normative belief strength, counselors think that their clients (M=4.11, SD=1.00) and supervisors (M=3.91, SD=.77) would appreciate it that they focus on regular jobs (Table 2). Of the three types of counselors, VR specialists are most convinced that their clients, colleagues and supervisor value a focus on competitive jobs.

The three types of counselors are most motivated to comply with the desires of their clients (M=5.14, SD=.77). Especially VR specialists are likely to comply with their desires (F=41.19, p<.001). Moreover, VR specialists are -compared to gatekeepers- more inclined to take into account the opinions of their supervisor and colleagues, albeit not significantly more than case managers.

Table 2

Subjective norms and differences between subjective norm beliefs (1-6) (M±SD)

Items	All	Gatekeepers (1)	Case managers (2)	VR specialists (3)	F	P	Bonferroni Post hoc Correction[a]
Normative belief strength							
Client	4.11 ± 1.00	3.33 ± 1.02	4.16 ± 0.84	4.56 ± 0.82	41.191	<.001	1<2<3
Supervisor, boss	3.91 ± 1.16	3.14 ± 1.09	3.67 ± 0.94	4.64 ± 0.99	51.713	<.001	1<2<3
Colleagues	3.61 ± 1.17	2.90 ± 0.96	3.31 ± 0.91	4.38 ± 1.10	54.798	<.001	1<2<3
Partner, significant others outside work	2.79 ± 1.26	2.62 ± 1.16	2.69 ± 1.13	2.99 ± 1.42	2.314	.101	
Motivation to comply							
Client	5.14 ± 0.77	4.96 ± 0.93	5.03 ± 0.70	5.38 ± 0.67	8.935	<.001	1<3, 2<3
Supervisor, boss	4.52 ± 0.77	4.16 ± 0.85	4.61 ± 0.71	4.67 ± 0.71	11.123	<.001	1<2, 1<3
Colleagues	4.52 ± 0.81	4.16 ± 0.92	4.59 ± 0.75	4.68 ± 0.72	10.092	<.001	1<2, 1<3
Partner, significant others outside work	2.44 ± 1.31	2.26 ± 1.35	2.31 ± 1.21	2.69 ± 1.36	3.221	.041	NLS

[a] Mean differences are significant at the .01 level

N.L.S: no longer significant after Bonferroni correction

Perceived Behavioral Control and Self-efficacy

Regarding the control beliefs, all three groups of counselors indicate that socio-economic problems (M=3.94, SD=.69) and instable psychiatric problems (M=3.80, SD=.67) are important impediments for attaining competitive employment (Table 3). The counselors perceive sufficient collaboration with other services (M=2.77, SD=.92). Furthermore, the three groups of counselors differ significantly in their control belief strength. Gatekeepers and case managers perceive more lack of time for follow-up (F=14.24, p<.001) and insufficient collaboration with employers (F=32.41, p<.001) compared to VR specialists. Gatekeepers also perceive a significant higher rate of unmotivated clients (F=14.19, p<.001) and incompatible legislation (F=5.00, p=.007) in contrast with case managers and employment specialists. Finally, gatekeepers perceive more negative internal barriers (e.g. downsizing, lack of support) compared to VR specialists (F=9.10, p<.001).

With respect to the control belief power, all counselors believe that instable psychiatric symptoms (M=1.67, SD=.68) and a lack of motivation (M=1.64, SD=.74) mostly hinder them in guiding and supporting the person with SMI towards competitive employment. A lack of time for follow-up (F=15.43, p<.001), insufficient contact with employers (F=5.18, p=.006) and incompatible legislation (F=9.74, p<.001), are more hindering for gatekeepers compared to case managers and VR specialists.

All counselors indicate relatively high levels of self-efficacy on collaboration with other services (M=4.40, SD=.92) and working with people with less stable psychiatric symptoms (M=4.20, SD=.81). Negative internal affairs in the own organization (e.g. downsizing, lack of support) (M=3.70, SD=.95) and incompatible legislation (M=2.65, SD=1.03) are harder to overcome.

Many differences exist with regard to self-efficacy between the three groups. First, all groups differ regarding their sense of self-efficacy when there is a lack of time for follow-up (F=20.60, p<.001) and insufficient contact with employers (F=40.40, p.001). In these cases, VR specialists experience the highest self-efficacy levels. Second, case managers and VR specialists experience more self-efficacy compared to gatekeepers in handling socio-economic problems (F=7.71, p=.001), tackling internal affairs (F=13.28, p<.001) and increasing collaboration with other services (F=7.34, p=.001). Finally, there are significant differences in self-efficacy between gatekeepers and VR specialists (F=3.98, p=.020) in coping with clients' instable psychiatric symptoms.

Table 3

Differences between control beliefs and self-efficacy (1-6) (M±SD)

Items	All	Gatekeepers (1)	Case managers (2)	VR specialists (3)	F	P	Bonferroni Post hoc Correction[a]
Control belief strength							
Socio-economic problems	3.94 ± 0.69	3.97 ± 0.77	4.04 ± 0.68	3.81 ± 0.65	2.965	.053	
Instable psychiatric symptoms	3.80 ± 0.67	3.84 ± 0.63	3.87 ± 0.65	3.69 ± 0.71	2.186	.114	
Lack of time for follow-up	3.68 ± 1.19	4.16 ± 1.17	3.79 ± 1.11	3.25 ± 1.14	14.235	<.001	1>3, 2>3
Negative internal organizational affairs	3.53 ± 1.11	3.59 ± 1.06	3.82 ± 1.02	3.20 ± 1.16	9.097	<.001	2>3
Insufficient contact with employers	3.52 ± 1.04	4.01 ± 1.08	3.75 ± 0.88	2.95 ± 0.91	32.409	<.001	1>3, 2>3
Incompatible legislation	3.21 ± 0.97	3.52 ± 1.01	3.09 ± 0.97	3.12 ± 0.90	4.996	.007	1>2, 1>3
Person with SMI is not motivated	3.10 ± 0.67	3.43 ± 0.70	3.09 ± 0.58	2.91 ± 0.67	14.185	<.001	1>2, 1>3
Insufficient collaboration with other services	2.77 ± 0.92	2.90 ± 1.02	2.68 ± 0.91	2.77 ± 0.85	1.188	.306	
Control belief power							
Socio-economic problems	2.12 ± 0.77	2.19 ± 0.91	2.11 ± 0.72	2.08 ± 0.73	0.395	.674	
Instable psychiatric symptoms	1.67 ± 0.68	1.77 ±0.77	1.60 ± 0.64	1.68 ± 0.67	1.308	.272	
Lack of time for follow-up	2.79 ± 0.80	2.35 ±0.74	2.92 ± 0.76	2.94 ± 0.76	15.426	<.001	1<2, 1<3
Negative internal organizational affairs	2.83 ± 0.77	2.59 ±0.69	2.87 ± 0.79	2.94 ± 0.78	4.666	.010	1<3
Insufficient contact with employers	2.55 ± 0.92	2.25 ±0.93	2.68 ± 0.88	2.60 ± 0.92	5.184	.006	1<2, 1<3
Incompatible legislation	2.75 ± 0.84	2.38 ±0.89	2.85 ± 0.83	2.89 ± 0.73	9.744	<.001	1<2, 1<3
Person with SMI is not motivated	1.64 ± 0.74	1.64 ±0.82	1.65 ± 0.72	1.63 ± 0.69	0.041	.960	
Insufficient collaboration with other services	2.77 ± 0.99	2.61 ± 0.97	2.86 ± 1.00	2.77 ± 0.98	1.420	.243	
Self-efficicay							
Socio-economic problems	3.75 ± 0.91	3.39 ± 1.03	3.92 ± 0.81	3.80 ± 0.87	7.714	.001	1<2, 1<3
Instable psychiatric symptoms	4.20 ± 0.81	3.99 ± 0.92	4.19 ± 0.74	4.34 ± 0.80	3.979	.020	1<3
Lack of time for follow-up	3.51 ± 1.03	2.94 ± 1.11	3.50 ± 0.87	3.90 ± 0.96	20.599	<.001	1<2<3
Negative internal organizational affairs	3.70 ± 0.95	3.25 ± 1.01	3.72 ± 0.89	3.97 ± 0.87	13.280	<.001	1<2, 1<3
Insufficient contact with employers	4.01 ± 0.96	3.35 ± 1.04	3.93 ± 0.82	4.51 ± 0.73	40.400	<.001	1<2<3
Incompatible legislation	2.65 ± 1.03	2.45 ± 1.13	2.79 ± 1.02	2.64 ± 0.94	2.374	.095	
Person with SMI is not motivated	4.13 ± 0.70	4.03 ± 0.75	4.11 ± 0.67	4.21 ± 0.69	1.578	.208	
Insufficient collaboration with other services	4.40 ± 0.92	4.06 ± 1.03	4.58 ± 0.86	4.42 ± 0.84	7.335	.001	1<2, 1<3

[a] Mean differences are significant at the .01 level

Discussion

This is the first study that addresses VR counselors' underlying beliefs to focus on competitive employment for people with SMI. The study provides evidence for differences between gatekeepers, case managers and VR specialists in their attitudes, norms, PBC and self-efficacy.

The three types of VR counselors differ in their behavioral beliefs on the benefits of competitive employment. Case managers and VR specialists think competitive employment often results in latent benefits such as increased integration, autonomy and self-confidence. In contrast, gatekeepers consider the manifest function (i.e. income) as the most recurrent and positive effect of competitive employment.

VR counselors also differ in the degree in which they perceive and comply with norms. The more specialized the VR counselor is, the more he/she thinks others (i.e. clients, supervisors and colleagues) value a focus on competitive work (normative belief strength) and the more one is likely to comply with the others' desires. VR specialists even indicate their supervisors value a focus on competitive work more than their clients.

Next, VR counselors differ in the degree in which they perceive behavioral control over barriers. A lack of motivation of the client is more prevalent and hindering for gatekeepers as compared to case managers and VR specialists. Gatekeepers also experience higher rates of meso- and macro-level barriers (i.e. lack of time for follow-up, contact with employers and incompatible legislation). VR counselors report different levels of self-efficacy in handling these barriers. VR specialists experience more self-efficacy in dealing with the clients' socio-economic problems and instable psychiatric problems. VR specialists and case managers also report higher levels of self-efficacy as compared to gatekeepers for barriers on the meso-level (e.g. insufficient contact with employers or lack of time for follow-up).

Four factors may explain the differences in beliefs and practices between types of counselors i.e. the structure of the organizations in which VR counselors work, the organizational culture, the focus of supervisors and the task characteristics of the job.

First, differences between types of counselors may be the result of the structure of the organizations in which they work. Gatekeepers work in large and bureaucratic organizations which often operate under influence of political decisions (Holmes & Karst, 1990). Due to the size of these organizations, many hierarchical structures and formal decision-systems, relying on a high administrative efficiency and strict rules, were formed (Parker & Bradley, 2000). These structures and procedures do simplify the job, but seem to affect the perceived behavioral control of employees. Gatekeepers are also more subjected and bound to follow the legislation and procedures. This may explain why gatekeepers experience low self-efficacy in overcoming some barriers such as incompatible legislation. VR specialists experience more control over barriers since they work in smaller organizations which are less strictly monitored.

The results can also be partially explained by the differences between services in their organizational culture. In large federal or state organizations, employees are often less responsive to the wishes of stakeholders, in this case the client with SMI who has a desire to work (Jones, 2007; Parker & Bradley, 2000). The internal focus of federal-state organizations also hinders the collaboration with other organizations and services. In addition, the strict rules and procedures in governmental organizations, imposed by controlling supervisors, have a negative effect on the attitude towards divergent thinking and innovations such as the Individual Placement and Support model (Williams, 2004). Therefore, gatekeepers might be less oriented to focus on regular jobs for people with SMI.

Considering the focus of supervisors of large federal-state organizations, they incorporate a generalist function and thus have to take care of more diverse responsibilities and are less involved with specific clients. Previous research shows that supervisors' behavior and attitudes influence the intentions, norms and attitudes of VR counselors (Bond et al., 2001; Gowdy, Carlson, & Rapp, 2003). This could explain why gatekeepers have a different attitude towards the IPS principle of focusing on competitive employment.

Two task characteristics, i.e. the amount of process- and outcome feedback VR counselors receive and the level of autonomy they experience can explain the results as well. As concerns the process feedback, case managers and particularly VR specialists have more enduring contact with the clients in comparison with gatekeepers. Their intensive contact enables them to develop a clear view on the positive outcomes of employment. Less visible outcomes, such as increased integration in the society, self-confidence and autonomy might thus become more obvious. Specialized counselors indicate that these latent effects of competitive employment may be more valuable than an increase of income. Regarding the outcome feedback, we notice that once the client is referred to specialized services, gatekeepers often lose contact with the person. Therefore, they are rarely informed about the final employment outcome. Information about outcomes is however crucial and contributes to involvement, realistic assessment of the own competences and motivation (Murphy & Cleveland, 1995; Bakker & Demerouti, 2007). When gatekeepers experience a lack of feedback about the final outcomes, they are more likely to rely on the overall -and often less positive- prevailing attitudes (Holmes & Karst, 1990) towards the benefits of employment and the outcomes of VR. Finally, within the smaller and more innovative teams of VR specialists, more training and autonomy to pro-actively handle barriers is offered. The higher level of autonomy may explain why they experience fewer barriers and why their levels of self-efficacy are higher.

Some practical implications emerge from this study. Process- and outcome feedback raise the motivation and involvement of counselors (Bakker & Demerouti, 2007). Therefore, it is recommended to offer feedback on employment outcomes during face-to-face contacts between gatekeepers and specialized counselors. Even more, co-location with specialized services may foster stronger interorganisational links (Campbell et al., 2007; Fox, 2013; Rucci et al., 2012). Receiving feedback makes it possible to have an idea about the real employment successes, benefits of work (e.g. integration, income) and barriers. Another practical implication of this study -which is in line with the IPS-model of Supported Employment- is to merge case managers' and specialists' functions

into one integrated function. As a result, the client doesn't need to form relationships with different counselors. A final practical implication concerns training (Fleming et al., 2013). Since primary care professionals such as gatekeepers are often less trained in specific skills (Szymanski, 1991) and are less aware of evidence based practices (Ayanian et al., 1994), training needs to equip gatekeepers with both generalist and specialist competences (Frost, Morris, Sherring, & Robson, 2010; Ayanian et al., 1994; Gowdy et al., 2004; Marshall, Rapp, Becker, & Bond, 2008). This will result in more positive attitudes towards evidence based practices such as IPS (Gowdy et al., 2004) and ultimately lead to higher referral rates and employment outcomes (Bond et al., 2001; Torrey, Bond, McHugo, & Swain, 2012; Gowdy et al., 2004; Marshall et al., 2008).

Finally, we point to the limitations of this study and make some suggestions for future research. A first limitation of this study is that the distinction between three groups of counselors may not always be applicable to other countries. Nevertheless, in many countries, a multitude of VR services exist and clients often go through a process of different services before evidence based services are offered (Becker et al., 1998; Premuda-Conti & Lewis, 2011). Even more, the results clearly show some differences between the three types of counselors with the case manager holding an in-between position as expected from their mixed role of generalist and specialist. Hence we expect the results of this study will hold in other countries although specific barriers and beliefs can vary. Another limitation concerns the relatively low response rate of gatekeepers which might reflect the lack of importance that is given to participate in this study. Yet, this lower response rate confirms our finding showing that the three types of VR counselors differ in their attitudes. Finally, this study did not explicitly examine the link between VR counselors' intentions to search for competitive jobs and those of clients. We recommend future research to study how differences in attitudes, norms, PBC and self-efficacy of VR counselors affect the motivation and attitudes of clients. This is important because low expectations of VR counselors can lead to the advice not to focus on competitive employment any more (Rinaldi et al., 2008). These low expectations held by counselors may be internalized by their clients, diminishing his/her motivation and hope (Rinaldi et al., 2008).

Conclusions

Using the TPB as a framework, this study shows many differences between three types of VR counselors in their perception of competitive employment. The more specialized counselors are, the more benefits of regular jobs for clients with SMI they perceive and the fewer barriers they experience. To improve the integrated service for clients, offering training to VR counselors, increasing outcome feedback and enhancing intersectoral communication is crucial.

References

Supported Employment Practitioner Skills: Principles of IPS Supported Employment. (2013). *DARTMOUTH PRC*. Retrieved from http://prc.dartmouth.edu/IPS/unit1/html/unit1page8.html

Abraham, K. M., & Stein, C. H. (2009). Case Managers' Expectations about Employment for People with Psychiatric Disabilities. *Psychiatric Rehabilitation Journal, 33*(1), 9-17. CPR.

Ajzen, I. (2002a). Constructing a TPB questionnaire: Conceptual and methodological considerations. http://chuang.epage.au.edu.tw/ezfiles/168/1168/attach/20/pta_41176_7688352_57138.pdf.

Ajzen, I. (1991). The Theory of Planned Behavior. *Organizational behavior and human decision processes, 50*(2), 179-211. Elsevier.

Ajzen, I. (2002b). Perceived Behavioral Control, Self-Efficacy, Locus of Control, and the Theory of Planned Behavior. *Journal of applied social psychology, 32*(4), 665-683. Wiley Online Library.

Ayanian, J. Z., Hauptman, P. J., Guadagnoli, E., Antman, E. M., Pashos, C. L., & McNeil, B. J. (1994). Knowledge and practices of generalist and specialist physicians regarding drug therapy for acute myocardial infarction. *New England Journal of Medicine, 331*(17), 1136-1142. Mass Medical Soc.

Bakker, A. B., & Demerouti, E. (2007). The job demands-resources model: State of the art. *Journal of Managerial Psychology, 22*(3), 309-328. Emerald Group Publishing Limited.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychol Rev, 84*, 191-215. doi:10.1037/0033-295X.84.2.191

Becker, D. R., Drake, R. E., Bond, G. R., Xie, H., Dain, B. J., & Harrison, K. (1998). Job terminations among persons with severe mental illness participating in supported employment. *Community Mental Health Journal, 34*(1), 71-82. Springer.

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

Bond, G. R., Becker, D. R., Drake, R. E., Rapp, C. A., Meisler, N., Lehman, A. F. et al. (2001). Implementing Supported Employment as an Evidence-Based Practice. *Psychiatric Services, 52*(3), 313-322.

Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An Update on Randomized Controlled Trials of Evidence-Based Supported Employment. *Psychiatric Rehabilitation Journal, 31*(4), 280-290.

Brouwer, S., Krol, B., Reneman, M., Bültmann, U., Franche, R.-L., van der Klink, J. J. et al. (2009). Behavioral Determinants as Predictors of Return to Work After Long-Term Sickness Absence: An Application of the Theory of Planned Behavior. *J Occup Rehabil, 19*(2), 166-174. Springer US.

Burns, T., & Catty, J. (2008). IPS in Europe: the EQOLISE trial. *Psychiatric Rehabilitation Journal, 31*(4), 313-317.

Campbell, K., Bond, G. R., Gervey, R., Pascaris, A., Tice, S., & Revell, G. (2007). Does type of provider organization affect fidelity to evidence-based supported employment? *Journal of Vocational Rehabilitation, 27*(1), 3-11. IOS Press.

Casper, E. S., & Carloni, C. (2007). Assessing the underutilization of supported employment services. *Psychiatric Rehabilitation Journal, 30*(3), 182-188. CPR.

Conner, M., & Armitage, C. J. (1998). Extending the theory of planned behavior: A review and avenues for further research. *Journal of applied social psychology, 28*(15), 1429-1464. John Wiley & Sons.

Corbière, M., lanctôt, N., Lecomte, T., Latimer, E., Goering, P., Kirsh, B. et al. (2010). A Pan-Canadian evaluation of supported employment programs dedicated to people with severe mental disorders. *Community Mental Health Journal, 46*(1), 44.

Corbière, M., Zaniboni, S., Lecomte, T., Bond, G., Gilles, P. Y., Lesage, A. et al. (2011). Job Acquisition for People with Severe Mental Illness Enrolled in Supported Employment Programs: A Theoretically Grounded Empirical Study. *Journal of occupational rehabilitation, 21*(3), 342-354. Springer.

Crowther, R., Marshall, M., Bond, G. R., & Huxley, P. (2001). Vocational rehabilitation for people with severe mental illness. *Cochrane Database of Systematic Reviews,*(2). doi:10.1002/14651858

Fila, S. A., & Smith, C. (2006). Applying the theory of planned behavior to healthy eating behaviors in urban Native American youth. *International Journal of Behavioral Nutrition and Physical Activity, 3*(1), 11. BioMed Central Ltd.

Fleming, A. R., Del Valle, R., Kim, M., & Leahy, M. J. (2013). Best Practice Models of Effective Vocational Rehabilitation Service Delivery in the Public Rehabilitation Program A Review and Synthesis of the Empirical Literature. *Rehabilitation Counseling Bulletin, 56*(3), 146-159. SAGE Publications.

Fox, V. (2013). Professional Roles in Community Mental Health Practice: Generalist Versus Specialist. *Occupational Therapy in Mental Health, 29*(1), 3-9. Taylor & Francis.

Frost, B., Morris, A., Sherring, J., & Robson, E. (2010). Vocational Education, Training and Employment (VETE) pilot project report. Psychiatric Rehabilitation Service 2006-2007. *NSW Health Hunter New England*.

Gowdy, E. A., Carlson, L., & Rapp, C. A. (2004). Organizational Factors Differentiating High Performing From Low Performing Supported Employment Programs. *Psychiatric Rehabilitation Journal, 28*(2), 150-156.

Gowdy, E. L., Carlson, L. S., & Rapp, C. A. (2003). Practices differentiating high-performing from low-performing supported employment programs. *Psychiatric Rehabilitation Journal, 26*(3), 232-239. CPR.

Harakeh, Z., Scholte, R. H., Vermulst, A. A., de Vries, H., & Engels, R. C. (2004). Parental factors and adolescents' smoking behavior: an extension of The theory of planned behavior. *Preventive medicine, 39*(5), 951-961. Elsevier.

Harries, P. A., & Gilhooly, K. (2003). Generic and specialist occupational therapy casework in community mental health teams. *The British Journal of Occupational Therapy, 66*(3), 101-109. College of Occupational Therapists.

Henry, A. D. (2004). Facilitators and barriers to employment: The perspectives of people with psychiatric disabilities and employment service providers. *Work, 22*(3), 169-182.

Hergenrather, K. C., Rhodes, S. D., & McDaniel, R. S. (2005). Correlates of Job Placement Practice: Public Rehabilitation Counselors and Consumers Living with AIDS. *Rehabilitation Counseling Bulletin, 48*(3), 157. SAGE Publications.

Holmes, G. E., & Karst, R. H. (1990). The institutionalization of disability myths: Impact on vocational rehabilitation services. *Journal of Rehabilitation, 56*(1), 20-27.

Jones, G. R. (2007). Designing Organizational Structure: Authority and Control. In *Organizational theory, design, and change* (5 ed., pp. 117-144) Prentice Hall Upper Saddle River, NJ.

Knaeps, J., DeSmet, A., & Van Audenhove, Ch. (2012). The IPS Fidelity Scale as a Guideline to Implement Supported Employment. *Journal of Vocational Rehabilitation, 37*(1), 13-23.

Leahy, M. J., Muenzen, P., Saunders, J. L., & Strauser, D. (2009). Essential knowledge domains underlying effective rehabilitation counseling practice. *Rehabilitation Counseling Bulletin, 52*(2), 95-106. SAGE Publications.

Marshall, T., Rapp, Ch. A., Becker, D. R., & Bond, G. R. (2008). Key Factors for Implementing Supported Employment. *Psychiatric Services, 59*(8), 886-892.

Miller, W., & Miller, T. (2011). Perceived Behavioral Control and Self-Efficacy of Overweight and Normal Weight Adults Regarding Exercise at a Health Club. *The Internet Journal of Allied Health Sciences and Practice, 9*(2), 1-8.

Mitchell, A. J., & Selmes, Th. (2007). Why don't patients attend their appointments? Maintaining engagement with psychiatric services. *Advances in psychiatric treatment, 13*(6), 423.

Montano, D. E., & Kasprzyk, D. (2008). Theory of reasoned action, theory of planned behavior, and the integrated behavioral model. *Health behavior and health education: Theory, research, and practice, 4*, 67-95. Jossey-Bass San Francisco, CA.

Murphy, K. R., & Cleveland, J. (1995). *Understanding performance appraisal: Social, organizational, and goal-based perspectives* SAGE Publications, Incorporated.

Nithsdale, V., Davies, J., & Croucher, P. (2008). Psychosis and the Experience of Employment. *Journal of occupational rehabilitation, 18*(2), 175-182. Springer.

OECD. (2013). *Mental Health and Work: Belgium* OECD Publishing. Retrieved from: http://dx.doi.org/10.1787/9789264187566-en

Parker, R., & Bradley, L. (2000). Organisational culture in the public sector: evidence from six organisations. *International Journal of Public Sector Management, 13*(2), 125-141. MCB UP Ltd.

Povey, R., Conner, M., Sparks, P., James, R., & Shepherd, R. (2000). Application of the Theory of Planned Behaviour to two Dietary Behaviours: Roles of Perceived Control and Self–Efficacy. *British journal of health psychology, 5*(2), 121-139. Wiley Online Library.

Premuda-Conti, P., & Lewis, A. (2011). Vocational Rehabilitation Counseling in the United States. *Psicologia, Conocimiento y Sociedad, 1*(4), 52-82.

Rapp, C. A., & Gosha, R. J. (2004). The principles of effective case management of mental health services. *Psychiatric Rehabilitation Journal, 27*(4), 319-333.

Rinaldi, M., Perkins, R., Glynn, E., Monibeller, T., Clenaghan, M., & Rutherford, J. (2008). Individual placement and support: from research to practice. *Advances in psychiatric treatment, 14*(1), 50-60.

Rinaldi, M., & Perkins, R. (2007). Implementing evidence-based supported employment. *Psychiatric Bulletin, 31*(7), 244-249. RCP.

Rogers, E. S., Anthony, W. A., Lyass, A., & Penk, W. E. (2006). A randomized clinical trial of vocational rehabilitation for people with psychiatric disabilities. *Rehabilitation Counseling Bulletin, 49*(3), 143-156. SAGE Publications.

Rosenthal, D. A., Hiatt, E. K., Anderson, C. A., Brooks, J., Hartman, E. C., Wilson, M. T. et al. (2012). Facilitators and barriers to integrated employment: Results of focus group analysis. *Journal of Vocational Rehabilitation, 36*(2), 73-86. IOS Press.

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

Rucci, P., Piazza, A., Menchetti, M., Berardi, D., Fioritti, A., Mimmi, S. et al. (2012). Integration between Primary Care and Mental Health Services in Italy: Determinants of Referral and Stepped Care. *International journal of family medicine,* -1. Hindawi Publishing Corporation.

Sheeran, P., Trafimow, D., & Armitage, C. J. (2003). Predicting behaviour from perceived behavioural control: Tests of the accuracy assumption of the theory of planned behaviour. *British Journal of Social Psychology, 42*(3), 393-410. Wiley Online Library.

Shook, C. L., & Bratianu, C. (2010). Entrepreneurial intent in a transitional economy: an application of the theory of planned behavior to Romanian students. *International Entrepreneurship and Management Journal, 6*(3), 231-247. Springer.

Szymanski, E. M. (1991). Relationship of level of rehabilitation counselor education to rehabilitation client outcome in the Wisconsin Division of Vocational Rehabilitation. *Rehabilitation Counseling Bulletin, 35*(1), 23-37. ERIC.

Terry, D. J., & O'Leary, J. E. (1995). The theory of planned behaviour: The effects of perceived behavioural control and self-efficacy. *British Journal of Social Psychology, 34*(2), 199-220. Blackwell Publishing Ltd.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *The Lancet, 373*(9661), 408-415.

Torrey, W. C., Bond, G. R., McHugo, G. J., & Swain, K. (2012). Evidence-based practice implementation in community mental health settings: the relative importance of key domains of implementation activity. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(5), 353-364. Springer.

Williams, S. D. (2004). Personality, attitude, and leader influences on divergent thinking and creativity in organizations. *European Journal of Innovation Management, 7*(3), 187-204. Emerald Group Publishing Limited.

Zar, J. H. (1984). *Biostatistical Analysis* (2 ed.). USA.