

UNIVERSITÉ DU QUÉBEC À MONTRÉAL

CERVEAUX AU TRAVAIL : UNE INTERVENTION INTÉGRATIVE VISANT À
AMÉLIORER LE MAINTIEN EN EMPLOI DES PERSONNES VIVANT AVEC
UN TROUBLE PSYCHOTIQUE

ESSAI

PRÉSENTÉ

COMME EXIGENCE PARTIELLE

DU DOCTORAT EN PSYCHOLOGIE

PAR

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AVRIL 2021

UNIVERSITÉ DU QUÉBEC À MONTRÉAL
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REMERCIEMENTS

J'aimerais tout d'abord remercier mes directeurs de recherche, Dr. Marc Corbière (UQÀM, Département d'éducation et de pédagogie) et Dr. Martin Lepage (Université McGill, Département de psychiatrie) pour leur soutien et leur confiance à travers cette nouvelle aventure. C'est toujours un immense plaisir de travailler auprès de ces deux personnes si généreuses et talentueuses. Merci de m'avoir encouragée à prendre cette voie, d'avoir cru en moi et d'avoir su m'épauler et me conseiller pendant toutes ces années. J'espère pouvoir continuer à travailler auprès de vous pour encore longtemps.

Je tiens aussi à remercier mes professeurs du département de psychologie et de l'École des Sciences de la Gestion de l'UQÀM, et les membres du jury de mon examen doctoral, Drs. Thomas Saïas et Jacques Forest, qui ont su me guider dans le cadre de ce travail de recherche.

Je remercie également mes superviseurs cliniques du Centre de Services Psychologiques (CSP) de l'UQÀM, Dre Pascale Brillon, et du Centre Universitaire en Santé McGill (CUSM), Drs Sylvie Goulet, Debbie Sookman et David Sinyor. Leurs enseignements cliniques et leur passion pour leur travail ont su faire de moi la clinicienne que je suis aujourd'hui.

Merci aussi à tous mes collègues de laboratoire, du département de psychologie de l'UQÀM et du CUSM, Karyne Anselmo, Marie-Christine Boulianne, Gabriella Buck, Gabrielle Pochiet, Dre Delphine Rauché-Chéné, Dre Katie Lavigne, Danielle Penney, Casandra Roy-Gelencser, Laura Moro, Ana Elisa Farias de Sousa, Charlie Bellemare, Olivier Percie du Sert, Dre Carolina Makowski, Dre Catherine Otis, Jean-Philippe Lachance, Marie-France Bastien, Élyse Charrette-Dussault, Marilou Lépine, Isabelle

Assouline, Dre Krista Pratte, Gabrielle McNicoll, Élisabeth Camirand, Dre Molly Moroz, Dre Jennifer Russell, Zoey Walden, Amanda Ravary, Warren Caldwell, Paige Ethridge, Sarah Schell, Micheline Khouzam, Dre Annette Granich, Dre Pasqualina DiDio, Dr Marc Hamel, Dre Marie-Jsoée Brouillette, et j'espère ne pas avoir oublié personne!

Encore merci à mon amoureux Jean-Marc qui est toujours partant pour me suivre dans mes aventures et qui sait constamment me soutenir et m'épauler. Merci à ma famille Papa, Maman, Fred, Nath, Pauline, Jean-Paul, Lucie, Yves & Manon.

Et finalement, merci à la Fondation de l'UQÀM, à la Fondation J.-A. De Sève et à la Faculté des sciences humaines pour leur soutien financier.

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LISTE DES ABRÉVIATIONS, DES SIGLES ET DES ACRONYMES

IPS : Individual Placement and Support

M@W: Minds@Work

PRISMA : Preferred Reporting Items for Systematic Reviews and Meta-Analyses

SE : Supported Employment

SE+ : Augmented Supported Employment

RÉSUMÉ

Contexte : Les troubles du spectre de la schizophrénie et autres troubles psychotiques ont des impacts importants sur le fonctionnement au travail des individus. Ainsi, une proportion significative de cette population est sans emploi, bien que la plupart d'entre eux désirent travailler. Différents programmes d'intervention de soutien à l'emploi qui semblent démontrer une efficacité satisfaisante pour aider ces personnes à obtenir un emploi. Malheureusement, le maintien en emploi demeure un défi important puisque la durée moyenne de leur emploi est bien en-deçà de la population générale. Le présent projet a pour objectif d'effectuer une recension systématique des écrits et d'en modéliser les résultats afin d'informer le développement d'une nouvelle intervention visant spécifiquement l'amélioration du maintien en emploi des personnes vivant avec un trouble psychotique.

Méthodologie : Une recension des écrits suivant les lignes directrices PRISMA et portant sur les prédicteurs du maintien en emploi a été effectuée. Les résultats ont été modélisés selon la méthodologie des modèles logiques suivant les lignes directrices de la fondation W. K. Kellogg, ce qui a permis d'informer le développement d'une nouvelle intervention.

Résultats : Un total de 93 articles a été inclus dans la recension et les analyses. La modélisation des résultats a été faite selon les catégories suivantes : les typologies des interventions, mécanismes d'action, prédicteurs du maintien en emploi, conséquences occupationnelles désirées et modérateurs contextuels. Une nouvelle intervention psychosociale visant à améliorer le maintien en emploi a par la suite pu être développée en misant sur les mécanismes d'actions et les prédicteurs identifiés dans le modèle logique proposé.

Conclusions : Le présent projet a permis d'identifier les mécanismes permettant l'amélioration du maintien en emploi des personnes ayant vivant avec un trouble psychotique. Une nouvelle intervention qui est prête à être utilisée par des professionnels de la santé a également été développée, bien que son efficacité demeure à être vérifiée empiriquement.

Mots clés : modèle logique, recension systématique des écrits, programme, schizophrénie, troubles mentaux graves

ABSTRACT

Context : Psychotic disorders, including schizophrenia, have important impacts on occupational functioning. In fact, a large proportion of this population is unemployed, even though the majority wants to work. Different intervention programs of supported employment have demonstrated their efficacy in helping people living with a psychotic disorder to gain employment. Unfortunately, maintenance at work remains an important challenge since the average duration of their employment is still well under that of the general population. The present project aims to conduct a systematic literature review and to model the results in order to inform the development of a new intervention targeting the improvement of job tenure for people living with a psychotic disorder.

Methods: A systematic literature review focusing on predictors of job tenure was conducted following the PRISMA guidelines. Results were modelled according to the logic models methodology following the best practice guidelines of the W. K. Kellogg Foundation, which informed the development of a new intervention.

Results: A total of 93 articles were included in the review and analyses. Modeling of results was performed according to the following categories: intervention typologies, putative mechanisms of action, predictors of job tenure, desired occupational outcomes and contextual moderators. Based on these results, a new psychosocial intervention aimed at improving job tenure was developed by capitalizing on mechanisms of action and predictors identified in the proposed logic model.

Conclusions: The current project allowed to identify putative mechanisms of actions underlying the improvement of job tenure for people living with a psychotic disorder. A new intervention readily available for health professionals has also been developed, although its efficacy remains to be empirically verified.

Keywords : logic model, systematic literature review, program, schizophrenia, severe mental disorders

INTRODUCTION

Les troubles du spectre de la schizophrénie et autres troubles psychotiques (*ci-après* troubles psychotiques) sont des diagnostics psychiatriques, principalement caractérisés par des symptômes dits positifs, qui incluent les hallucinations, les idées délirantes et les comportements étranges (Owen *et al.*, 2017). Bien que ces symptômes puissent être adéquatement traités par pharmacothérapie et psychothérapie dans la majorité des cas, les personnes ayant un trouble psychotique conservent plus souvent qu'autrement d'importantes limitations fonctionnelles, cognitives et sociales (Galling *et al.*, 2017; Hopper *et al.*, 2014; Turner *et al.*, 2014). De plus, le portrait clinique associé aux troubles psychotiques est très hétérogène, et une grande proportion de ces personnes présentent des symptômes résiduels, tels que les symptômes négatifs (p. ex., amotivation, anhédonie) et les déficits cognitifs (Dickinson *et al.*, 2017; Galderisi *et al.*, 2013; Heinrichs *et al.*, 2013).

En 2016, l'Organisation Mondiale de la Santé a estimé qu'environ 21 millions de personnes à travers la planète avaient un diagnostic de schizophrénie, représentant un taux de prévalence d'environ 1% (Organisation Mondiale de la Santé, 2016; Saha *et al.*, 2005). On estime également que l'incidence des troubles psychotiques oscille autour de 0,02% par année, suggérant qu'on recense annuellement environ 16 nouveaux cas par 100 000 individus de la population générale (McGrath *et al.*, 2004). Les coûts annuels associés aux troubles psychotiques varient entre 94 millions et 102 milliards de dollars américains selon la région géographique (Chong *et al.*, 2016). La moitié de ces coûts seraient notamment liés à la perte de productivité due au faible taux d'insertion et de maintien en emploi chez cette population et laissent dans

l'ombre la souffrance vécues par les personnes vivant avec un trouble psychotique et leurs proches (Allott *et al.*, 2012).

L'évolution temporelle des troubles psychotiques peut se diviser en différents stades. Selon le modèle de McGorry *et al.* (2014), les troubles psychotiques se présentent d'abord de manière atténuée et non-spécifique (p. ex., idées étranges, légers symptômes dépressifs ou anxieux), généralement durant l'adolescence et même plusieurs années avant de recevoir un diagnostic (Nelson *et al.*, 2013). Une réduction du fonctionnement peut s'observer durant cette période, la sévérité des symptômes peut s'intensifier et de nouveaux symptômes plus distinctifs des troubles psychotiques peuvent apparaître (e.g., anomalies perceptives). On réfère généralement à cette période comme étant le *stade à haut risque clinique* ou à la phase prodromique (Yung et Nelson, 2013). Lorsque la progression se poursuit et que la sévérité des symptômes atteint un seuil clinique (p. ex., hallucinations franches, idées délirantes), typiquement au début de l'âge adulte, on considère alors que l'individu vit un *premier épisode psychotique* (Fusar-Poli *et al.*, 2013; Liu *et al.*, 2013). C'est habituellement à ce moment qu'on offre à l'individu de débiter un traitement pharmacologique (Alvarez-Jimenez *et al.*, 2016). Dans les cliniques spécialisées en premier épisode psychotique, on combine à ce traitement des interventions psychologiques et psychosociales, incluant la thérapie cognitive-comportementale, dans le but de minimiser les impacts à long-terme de la maladie en accompagnant les personnes dans la reprise des activités développementalement normatives (Cotton *et al.*, 2016; Iyer, S. *et al.*, 2015). L'accès et l'adhésion à ces traitements n'est pas toujours facile; on estime ainsi qu'environ 82% de ces personnes vivront un ou plusieurs autres épisodes dans les cinq ans suivant leur premier épisode de psychose (Alvarez-Jimenez *et al.*, 2012). Cette chronicité des symptômes peut persister pendant plusieurs années, auquel cas on réfère alors au *stade d'épisodes de psychose multiples* (Gillespie *et al.*, 2017).

Toutefois, les difficultés sociales, l'isolement, les symptômes négatifs et les troubles cognitifs auront souvent plus d'influence sur le fonctionnement de ces individus que des symptômes en apparence plus incommodants, comme les hallucinations et idées délirantes (Grau *et al.*, 2016; Rabinowitz *et al.*, 2012; Stouten *et al.*, 2014). Par conséquent, même si leurs symptômes psychotiques sont bien contrôlés, une très faible proportion de personnes vivant avec un trouble psychotique retourneront sur le marché du travail de façon pérenne (Marwaha et Johnson, 2004; Suijkerbuijk *et al.*, 2017).

Plusieurs facteurs peuvent expliquer la sous-représentativité de cette population sur le marché du travail. Bien que la grande majorité des individus vivant avec un trouble psychotique désirent travailler (Westcott *et al.*, 2015), les déficits cognitifs, les symptômes négatifs (p. ex., l'amotivation), la stigmatisation, et le manque de soutien en milieu de travail sont des barrières importantes au fonctionnement au travail (Stouten *et al.*, 2017).

Différents types d'interventions ont été mis sur pied pour accompagner les personnes vivant avec un trouble psychotique dans leur cheminement professionnel. On compte notamment parmi ceux-ci les programmes pré-vocationnels, et les programmes de soutien à l'emploi, dont le programme de placement et soutien individuel (traduction libre de « *Individual Placement and Support* » IPS) développé par Deborah Becker et Robert E. Drake (Bond *et al.*, 2020), qui est le modèle le plus reconnu et validé auprès de plusieurs populations ayant divers troubles psychiatriques, incluant les troubles liés à une substance et troubles addictifs (Carmona *et al.*, 2017). Si certaines interventions sont plus efficaces que d'autres concernant l'obtention d'un travail, la courte durée du maintien en emploi demeure un frein important à l'insertion sociale et au rétablissement des personnes vivant avec un trouble psychotique (Suijkerbuijk *et al.*, 2017). Compte tenu du contexte économique actuel de pandémie due à la COVID-19 où les taux de chômages ont rapidement augmenté, il est par conséquent

plus primordial que jamais d'élaborer de nouvelles stratégies cliniques pour améliorer le *maintien* en emploi de ces individus.

CHAPITRE I

CADRE CONTEXTUEL

1.1 Les avantages à travailler

Dans la population générale, les avantages financiers et psychologiques à travailler sont nombreux. Outre l'indépendance financière, le travail permet en général de développer des sentiments de compétence, d'autonomie et d'affiliation sociale, qui sont trois besoins psychologiques fondamentaux (Ryan et Deci, 2000). Ainsi, il en va de même pour les personnes vivant avec un trouble psychotique, et une récente recension des écrits scientifiques indique qu'il ne leur est pas nuisible et même bénéfique d'occuper un emploi (Luciano *et al.*, 2014). Ces avantages individuels à maintenir un emploi, comme l'amélioration des symptômes, de la qualité de vie, et de l'estime de soi, sont soutenus par des bénéfices sociétaux, notamment en ce qui concerne la réduction des coûts de santé (Burns *et al.*, 2009; Kinn *et al.*, 2014; Sultan-Taïeb *et al.*, 2018; Üçok *et al.*, 2012).

La Commission de la santé mentale du Canada a publié un rapport exhaustif relatant de nombreux avantages financiers et organisationnels pour les employeurs à embaucher des individus vivant avec un trouble de santé mentale sévère (Commission de la santé mentale du Canada, 2018). Parmi ceux-ci, on retrouve des taux de roulement et d'absentéisme moins élevés, et une productivité accrue au travail. De plus, recruter et maintenir en poste des personnes vivant avec un trouble de santé

mentale représenterait selon le rapport de la Commission un retour sur investissement intéressant pour les organisations, puisque les avantages économiques seraient de 2 à 7 fois plus élevés que les coûts associés aux mesures d'accommodement mises en place.

1.2 La sous-représentativité sur le marché du travail

L'Organisation Mondiale de la Santé estime qu'entre 70 à 90% des personnes vivant avec un trouble de santé mentale sévère demeurent sans emploi (Harnois *et al.*, 2000). On évalue également que 85% des personnes vivant avec un trouble psychotique désirent occuper un emploi (Westcott *et al.*, 2015). L'organisation de coopération et de développement économiques (OCDE) rapporte que la sous-représentativité de cette population sur le marché du travail semble généralisée puisqu'elle a été observée dans de nombreux pays (OCDE, 2015). Selon un sondage auprès d'experts à travers le monde, près de 50% des individus vivant avec un trouble psychotique seraient aptes à travailler (Zaprutko *et al.*, 2015). Cependant, cette proportion pourrait probablement être encore plus élevée dans un contexte où un soutien à l'emploi adéquat est offert de manière systématique.

D'un point de vue plus global, il existe plusieurs éléments en faveur de l'inclusion des personnes vivant avec un trouble psychotique sur le marché du travail régulier. La Commission de la santé mentale du Canada a adopté une position claire sur cette question : « Aucun pays ne peut aujourd'hui se permettre de tenir des citoyens productifs à l'écart en raison de programmes mal conçus en matière de santé et de services sociaux » (Kirsh *et al.*, 2013, p. 6). Leurs arguments économiques principaux reposent sur la pénurie de main-d'œuvre qui s'annonce au Canada et les coûts

toujours grandissants des programmes sociaux, notamment les régimes de prestations d'invalidité.

1.3 Interventions existantes et efficacité

Il existe de nombreuses approches pour accompagner les personnes vivant avec un trouble de santé mentale sévère vers l'emploi. Avant les années 1980, ces individus pouvaient occuper un emploi protégé (« *sheltered employment* », c'est-à-dire réservé pour les personnes vivant avec un handicap physique ou psychique) ou compléter une phase d'entraînement pré-vocationnelle et effectuer un travail bénévolement avant de pouvoir avoir accès au marché du travail régulier (Suijkerbuijk *et al.*, 2017). La durée de ces programmes pouvait s'étendre sur plusieurs années. Leurs objectifs étaient généralement d'offrir une occupation aux personnes vivant avec un trouble de santé mentale sévère ou de leur offrir plusieurs étapes de préparation à l'emploi lorsque cette avenue était envisagée (Suijkerbuijk *et al.*, 2017). Par la suite, les programmes de soutien à l'emploi ont émergé. Malheureusement, ceux-ci peinent encore à être instaurés en raison de différentes barrières économiques et organisationnelles (Kinn *et al.*, 2014). Cette approche mise sur la recherche rapide d'un emploi rémunéré sur le marché du travail régulier, tout en offrant des services cliniques continus (Kinoshita *et al.*, 2013). Le programme de placement et soutien individuel (IPS; traduction libre de « *Individual Placement and Support* ») représente une forme spécifique de soutien à l'emploi, qui a reçu énormément d'attention de la part de la communauté scientifique (Drake *et al.*, 2012).

Plus spécifiquement, le programme IPS, qui a été adopté au Québec et à travers le monde, comporte 8 principes directeurs. Brièvement, toute personne désirant travailler est admis dans le programme (1), la recherche d'emploi est amorcée dès que

possible (2), les préférences professionnelles des individus sont prises en considérations (3), on vise l'obtention d'un emploi sur le marché du travail régulier (4), l'équipe clinique établit une collaboration étroite avec l'employeur (5), les conseillers en emploi font continuellement des démarches auprès d'employeurs potentiels (6), un soutien temporellement illimité est offert à l'individu, même lorsqu'il demeure en emploi (7), et on offre aux participants des conseils concernant la gestion des prestations sociales (8) (Drake *et al.*, 2012).

Depuis peu, un intérêt grandissant se développe pour les programmes de soutien à l'emploi augmentés par d'autres composantes (SE+). Celles-ci peuvent par exemple prendre la forme de remédiation cognitive ou d'entraînement des habiletés sociales, deux interventions qui utilisent une approche de psychoéducation et de développement de stratégies pour améliorer les fonctions cognitives (p. ex., concentration, mémoire) et les interactions sociales (McGurk *et al.*, 2007; Zhang *et al.*, 2017). La durée de ces programmes est souvent déterminée par la portion occupée par les autres composantes (p. ex., 16 semaines pour la remédiation cognitive). On considère alors que ces composantes sont reliées aux symptômes des troubles sévères de santé mentale plutôt qu'au savoir-faire professionnel (p. ex., savoir remettre la monnaie) (Suijkerbuijk *et al.*, 2017). Selon deux méta-analyses, les programmes de soutien à l'emploi augmentés par une intervention de remédiation cognitive semblent améliorer le taux d'obtention d'un travail, sans pour autant augmenter la durée du maintien en emploi (Chan *et al.*, 2015; Sauvé, Lepage, *et al.*, 2019). Parallèlement, Au *et al.* (2015) ont ajouté une composante d'entraînement aux habiletés sociales en plus de la remédiation cognitive à leur programme de soutien à l'emploi de 12 semaines et ont obtenu des résultats pilotes encourageants. Bien que les différences entre leurs groupes expérimental et témoin n'aient pas été statistiquement significatives, leur programme de soutien à l'emploi intégré a mené à un moins grand nombre de résiliation d'emploi après environ 1 an de suivi et à l'obtention d'emplois

ayant un meilleur salaire-horaire. Ainsi, la combinaison de plusieurs approches/interventions semble prometteuse.

Selon une recension systématique des écrits scientifiques effectuée par le groupe Cochrane, les programmes de soutien à l'emploi et ceux de type SE+ offriraient une efficacité comparable concernant l'obtention d'un emploi (Suijkerbuijk *et al.*, 2017). Pour le maintien en emploi à court terme (c.-à-d., moins d'un an), les analyses suggèrent que ce sont les programmes de soutien à l'emploi qui seraient les plus performants. Néanmoins, lorsqu'on s'attarde aux analyses de maintien en emploi à plus long terme (plus d'un an), les programmes SE+ semblent alors plus profitables. Ainsi, ces programmes offrent un avantage important en ce qui a trait au maintien en emploi comparativement aux autres approches interventionnelles.

Malgré tout, la durée de maintien en emploi pour les personnes vivant avec un trouble psychotique, qui est estimée à environ 8 mois, demeure sous la moyenne de la population générale non-clinique, qui a frôlé les 9 ans au Canada en 2017 (Statistique Canada, s.d.; Suijkerbuijk *et al.*, 2017). La réalité d'une importante proportion de personnes vivant avec un trouble sévère de santé mentale est alors illustrée par un cycle défavorable où ils obtiennent un emploi, le conserve seulement pour une courte période de temps, et doivent ensuite recommencer un processus de recherche d'emploi (Côté, 2014). Ces pertes d'emplois peuvent être perçues comme des échecs par la plupart des individus vivant avec un trouble de santé mentale sévère. Ainsi, l'accumulation de ces déceptions professionnelles ont sans aucun doute un grand impact non seulement sur l'estime de soi, mais également sur les symptômes et la santé mentale déjà délicate de ces individus (Kinn *et al.*, 2014). C'est pour ces raisons, et bien d'autres, qu'il est important de développer des solutions pour aider les personnes vivant avec un trouble mental sévère à se maintenir plus longtemps en emploi.

1.4 Déterminants du maintien en emploi

Le concept du maintien en emploi a été opérationnalisé de diverses façons à travers les études. Par exemple, Kinoshita *et al.* (2013) utilisent dans leur recension systématique des écrits scientifiques *l'ancienneté* comme indicateur de maintien en emploi et la définissent comme étant le nombre de semaines travaillées par emploi par individu. Dans une autre recension systématique des écrits, Suijkerbuijk *et al.* (2017) opérationnalisent le maintien en emploi simplement comme étant le nombre de semaines passées au travail sans tenir compte du nombre d'emplois que la personne a occupé durant la période de suivi (p. ex., 2 ans). Un consensus concernant la définition et les mesures pour étudier le maintien en emploi reste ainsi à établir.

Néanmoins, Williams *et al.* (2016) ont récemment identifié, de manière systématique à travers la littérature, différents facteurs qui peuvent freiner ou faciliter le maintien en emploi des personnes vivant avec un trouble de santé mentale sévère. Les auteurs ont divisé ceux-ci en trois thèmes, nommément l'expérience antécédente du travailleur dans le type d'emploi, les soutiens naturels au travail et les stratégies utilisées pour intégrer l'emploi dans un contexte de rétablissement et de bien-être. Plus spécifiquement en lien avec les troubles psychotiques, Cougnard *et al.* (2009) indiquent également qu'un niveau de scolarité plus élevé et qu'une plus longue période en emploi avant le premier épisode psychotique est associé à un meilleur maintien professionnel. Par ailleurs, une étude menée par Lanctôt *et al.* (2013) rapporte que 73% de leur échantillon de personnes vivant avec un trouble psychotique et participant à un programme de soutien à l'emploi ont volontairement décidé de terminer leur emploi. Parmi les raisons les plus communes rapportées par les participants de cette étude pour expliquer leur perte d'emploi, on retrouve : des

problèmes reliés aux tâches, les symptômes psychiatriques, les difficultés à accomplir le travail demandé, la relation avec l'employeur et les conditions de travail inadéquates.

Un autre pan de la littérature concerne le fonctionnement professionnel général, qui inclut le maintien en emploi. Ainsi, plusieurs autres facteurs plutôt cliniques pouvant potentiellement influencer le maintien en emploi ont été identifiés. On compte parmi ceux-ci des variables démographiques, cliniques, sociales, motivationnelles et cognitives (p.ex., Galderisi *et al.*, 2018; Llerena *et al.*, 2018; Reddy *et al.*, 2016; Strassnig *et al.*, 2018; Strassnig *et al.*, 2015). Il apparaît donc qu'une approche clinique multi-dimensionnelle pourrait potentiellement agir sur cette variété de déterminants du fonctionnement professionnel.

1.5 La nécessité d'une nouvelle approche clinique

Tel que brièvement illustré précédemment, le fonctionnement professionnel demeure sous-optimal pour les personnes ayant un trouble psychotique et ce, malgré l'existence d'une diversité d'interventions. Le nombre important de variables ayant une influence sur l'obtention et le maintien en emploi complexifie davantage la planification des soins. Néanmoins, les bénéfices individuels et sociétaux de l'intégration des personnes vivant avec un trouble psychotique sur le marché du travail surpassent largement les coûts associés au développement d'interventions à cet effet. Ainsi, compte-tenu de l'absence d'efficacité claire des interventions existantes concernant le maintien en emploi des personnes vivant avec un trouble psychotique, il apparaît nécessaire de développer une nouvelle approche clinique.

La combinaison de certains éléments clés, compris dans des interventions déjà développées, semble être une approche prometteuse. L'intégration de différentes composantes aux programmes de soutien à l'emploi semble être préférable comparativement à des programmes similaires sans ajouts (Suijkerbuijk *et al.*, 2017). Cependant, ces interventions sont pour la plupart très spécifiques (p. ex., remédiation cognitive ou entraînement des habiletés sociales) et n'adaptent pas leur contenu à des contextes précis, comme l'insertion en emploi. Une des limites principales de ces composantes additionnelles, comme la remédiation cognitive, est la faible généralisation des acquis et l'absence de transfert des apprentissages à d'autres contextes (Keefe *et al.*, 2016; Medalia et Saperstein, 2013).

Le développement d'une nouvelle approche clinique basée sur les données probantes apparaît alors doublement avantageux : d'un côté, les interventions existantes pourront être optimisées en agissant directement sur leurs limites, et de l'autre côté, le fonctionnement au travail pourra être amélioré grâce à la combinaison des mécanismes d'action déjà identifiés dans le cadre de différentes interventions. Par exemple, un des éléments clés de la thérapie par remédiation cognitive semble être l'enseignement des stratégies à utiliser pour résoudre différentes tâches cognitives (Krabbendam et Aleman, 2003). Dans le cadre d'une thérapie de remédiation cognitive traditionnelle, c'est-à-dire sans égard à l'emploi, diverses stratégies pour réussir à compléter des tâches cognitives sont enseignées. Or, ces stratégies peuvent être utilisées pour de multiples tâches présentées lors de différentes séances. Ainsi, enseigner seulement les stratégies qui pourraient être utiles dans le cadre d'un emploi permettrait potentiellement de mettre à profit les mécanismes d'action qui ont une influence directe sur les conséquences positives observées (traduction libre de « *outcomes* »).

Ainsi, la remédiation cognitive offre une structure intéressante pour le développement d'une nouvelle approche visant à améliorer le fonctionnement professionnel, mais plusieurs autres variables devraient également être prises en considération. Pour n'en nommer que quelques-unes, la motivation, les biais cognitifs (p. ex., attitudes défaitistes), l'estime de soi, et les habiletés sociales pourraient représenter des cibles thérapeutiques additionnelles traitées dans le cadre d'une nouvelle approche clinique intégrative (Cardenas *et al.*, 2013; Couture *et al.*, 2011; Grant et Beck, 2009; Yanos *et al.*, 2010).

Par conséquent, il semble important de combiner différentes approches, mais aussi d'adapter le contenu de l'intervention au contexte de retour en emploi. Le tout devrait être justifié par des données probantes et devrait tirer profit du matériel contenu dans les interventions déjà existantes. L'idée générale est qu'une (ré-)insertion en emploi réussie nécessite divers éléments, et qu'une intervention combinant certains mécanismes d'action agissant sur ces derniers dans un cadre adapté au contexte du retour en emploi devrait atteindre des niveaux d'efficacité plus optimaux.

1.6 Comment développer un nouveau modèle d'intervention?

Bien qu'il existe peu de guides à l'intention des chercheurs et cliniciens sur la méthodologie à adopter pour développer une intervention psychosociale, quelques approches ont été documentées dans la littérature scientifique. Par exemple, l'approche de *mappage d'intervention* (traduction libre de : « Intervention Mapping ») propose un protocole rigoureux en six étapes permettant de planifier des programmes de promotion de la santé (Bartholomew *et al.*, 2016). Si cette approche

est vastement utilisée et acceptée, elle demande un important investissement de ressources et adopte une posture qui est considérée comme trop prescriptive par certains (Wight *et al.*, 2016). Ainsi, d'autres cadres méthodologiques ont été proposés et on compte notamment parmi ceux-ci *l'approche du Conseil Médical de Recherche* (traduction libre de « Medical Research Council Framework ») développée au Royaume-Uni et qui soutient le développement d'interventions complexes (Bleijenberg *et al.*, 2018); le *modèle précède-procède* (traduction libre de « PRECEDE-PROCEED model »), qui suggère de catégoriser les différents déterminants du changement (Green et Kreuter, 2005); et le *cadre des domaines théoriques* (traduction libre de « Theoretical Domains Framework ») combinant plusieurs théories du changement (Cane *et al.*, 2012).

Ces approches ne répondent cependant pas aux besoins actuels, qui demandent de combiner et d'adapter plusieurs interventions existantes dont l'efficacité a déjà été démontrée à travers de nombreux essais contrôlés randomisés. En effet, les approches mentionnées ci-haut ont tout d'abord été développées en majorité pour mettre sur pied des programmes d'intervention complexes, impliquant de nombreux intervenants à différents niveaux organisationnels. De plus, ces méthodologies visent également la planification de l'implantation d'un programme d'intervention dans des contextes et milieux très spécifiques.

Ainsi, pour développer un nouveau modèle d'intervention, il apparaît judicieux de plutôt combiner les méthodologies de la recension systématique des écrits et des *modèles logiques* (traduction libre de « logic models method »). Il existe des lignes directrices pour les recensions systématiques des écrits scientifiques, nommées PRISMA (Moher *et al.*, 2009). Celles-ci sont largement utilisées par la communauté scientifique et ont pour but de guider les chercheurs à travers les étapes d'une recension des écrits. Il existe également des lignes directrices pour l'élaboration de protocoles de recensions systématiques des écrits (Shamseer *et al.*, 2015). La *méthode*

des modèles logiques a été utilisée pour faciliter la synthèse d'information recueillies à la suite d'une recension systématique des écrits (Chen, 1990; Winsper *et al.*, 2020). Globalement, un modèle logique réfère à une représentation graphique d'un programme d'intervention ou de services en y décrivant de manière explicite les liens entre les différentes composantes et les résultats attendus (Conrad *et al.*, 1999). Une approche similaire a été adoptée par Baxter *et al.* (2014) et leur a permis de synthétiser des connaissances provenant d'études interventionnelles, corrélationnelles et qualitatives pour ultimement développer une intervention. Suivant une recension systématique des écrits scientifiques classique, l'information a été résumée dans un format graphique modélisant les différentes composantes d'une intervention, incluant les mécanismes de changement, et les liens avec les résultats anticipés (« *outcomes* »). Cette méthode a permis aux auteurs de catégoriser les interventions recensées dans la littérature par typologie, d'identifier les variables médiatrices et modératrices, et d'explicitier les liens avec les résultats à court- et long-terme anticipés.

Ainsi, les résultats de la recension des écrits sont approchés de manière qualitative plutôt que quantitative afin d'identifier les différents éléments du modèle. L'objectif de la méthode des modèles logiques n'est donc pas d'estimer une taille d'effet, mais plutôt de résumer les bases théoriques et le raisonnement derrière les liens existant entre les composantes d'une intervention et les résultats attendus (Baxter *et al.*, 2014). Cette méthode flexible permet ainsi de développer un modèle d'intervention basé sur les données probantes (Glenton *et al.*, 2013). De plus, le développement de modèles logiques faciliterait la communication entre les intervenants et la mise en place de nouvelles politiques et collaborations (Lal, 2001).

Tout comme pour les recensions systématiques des écrits, il existe des bonnes pratiques pour la méthodologie des modèles logiques. Elles sont décrites dans le guide sur le développement des modèles logiques, publié par l'équipe de la W. K.

Kellogg Foundation (W. K. Kellogg Foundation Team, 2004). Brièvement, ces auteurs proposent de procéder en trois étapes. Un premier modèle logique est d'abord développé pour la phase de conception et planification du programme d'intervention. C'est à cette étape que les écrits scientifiques sont recensés afin d'identifier les données probantes justifiant l'inclusion des différentes stratégies interventionnelles constituant le programme. Un deuxième modèle logique est ensuite développé pour l'étape de l'implantation ainsi qu'un troisième pour la portion d'évaluation. Bien que la méthode des modèles logiques ne dicte pas de format spécifique, des canevas de modèles logiques standards ainsi que des grilles d'analyse sont proposés dans ce guide.

1.7 Objectifs et hypothèses

1.7.1 Objectifs

Le présent essai aura pour objectif d'effectuer une recension des écrits scientifiques afin de développer un modèle logique d'intervention basé sur les données probantes qui tentera d'améliorer le maintien en emploi des personnes vivant avec un trouble psychotique .

1.7.2 Hypothèses

Il est difficile de poser des hypothèses de recherche dans le cadre de recension systématique des écrits scientifiques. Néanmoins, nous pouvons poser l'hypothèse que nous trouverons des études qui seront pertinentes à notre objectif et qui nous serviront ainsi de base pour développer notre modèle d'intervention.

CHAPITRE II

MINDS@WORK – A NEW MANUALIZED GROUP PSYCHOSOCIAL INTERVENTION TO IMPROVE JOB TENURE IN PSYCHOSIS

Sauvé, G., Buck, G., Lepage, M. et Corbière, M. (en révision) Minds@Work – A new manualized group psychosocial intervention to improve job tenure in psychosis.

2.1 Abstract

A significant proportion of people living with psychosis are unemployed, despite a strong desire to work. Current supported employment programs (SE) appear effective in helping people living with psychosis obtain employment, yet job tenure remains an arduous contemporary clinical challenge. We present a new manualized group psychosocial intervention – named ‘*Minds@Work*’ – developed specifically to improve job tenure in psychosis. This novel program was developed using systematic literature review and logic models methodologies. The literature was comprehensively searched for predictors of job tenure in psychosis and existing occupational psychosocial interventions. A total of 93 studies were included and their findings were modeled using different categories: intervention typologies, mechanisms of action, predictors of job tenure, outcomes and contextual moderators. The ‘*Minds@Work*’ program was built based on these modeled findings and aimed to target specific predictors of job tenure while addressing some of the limitations of existing interventions. The program uses evidence-based techniques and is divided into 9 modules covering 4 themes: positive psychology (motivation, character strengths, self-compassion), neurocognitive remediation (attention, memory, problem-solving), cognitive biases training (jumping to conclusions, defeatist beliefs, theory of mind, attributional styles) and socioemotional coping skills (emotion recognition & regulation, verbal & non-verbal communication). Once validated, this novel program is meant to be used either as a stand-alone intervention or integrated in SE initiatives, and by employment specialists or healthcare workers.

2.2 Introduction

Psychotic disorders, which include schizophrenia, are pervasive psychiatric conditions that greatly impact functioning. It has been observed that the vast majority (80%) of people living with psychosis are unemployed despite a strong desire to work (Harnois, Gabriel et World Health Organization & International Labour Organization 2000, Westcott, Waghorn *et al.* 2015). Further, job tenure currently represents an arduous challenge since the average duration of employment for people living with psychosis is 8 months, compared to 9 years in the general population (Suijkerbuijk, Schaafsma *et al.* 2017, Statistique Canada s.d.). Current psychosocial interventions aimed at improving occupational functioning in psychosis have yet to increase these unsatisfactory figures (Carmona, Gomez-Benito *et al.* 2017, Suijkerbuijk, Schaafsma *et al.* 2017, Sauvé, Lepage *et al.* 2019). Therefore, there is a pressing need to develop novel interventions that integrate the most effective components of existing psychosocial approaches. In this paper, we present a new manualized group psychosocial intervention specifically aimed at improving job tenure in psychosis. This novel program, entitled ‘*Minds@Work*’, was developed with the objective of addressing some of the limitations of current occupational interventions.

Over the past decades, many types of supported employment (SE) programs have been developed and tested. Traditional SE, such as *Individual and Placement Support* (IPS), focus on rapid job search in the competitive market and include continuous clinical support (Drake, Bond *et al.* 2012). More recently, SE programs have been augmented (SE+) with additional components, like *Cognitive Remediation Therapy* (McGurk, Mueser *et al.* 2016) or *Cognitive Behavioral Therapy* (Lecomte, Corbière *et al.* 2020). These research and clinical efforts have emerged following the consistent observation that multiple factors appear to impact job tenure in psychosis. Among others, these predictors include: cognitive and social skills deficits, negative symptoms (e.g., amotivation), scarcity of work accommodations, and lack of support

inside and outside the workplace (e.g., Huff, Rapp *et al.* 2008, Rollins, Bond *et al.* 2011, Rajji, Miranda *et al.* 2014, Ergül and Üçok 2015, Milfort, Bond *et al.* 2015, Corbière, Villotti *et al.* 2019). Interestingly, a recent Cochrane review suggested that SE+ outperform traditional SE programs in terms of job tenure (Suijkerbuijk, Schaafsma *et al.* 2017).

However, these reviewed SE+ programs present several limitations. *First*, they are most often augmented with stand-alone therapies (e.g., cognitive remediation therapy), for which the exercises have not necessarily been adapted to the occupational context. For example, some SE+ programs consist of traditional vocational aid (e.g., IPS) supplemented by weekly sessions of typical computer-assisted cognitive remediation therapy (i.e., pre-programmed exercises designed to improve elementary neurocognitive functions; Bowie, Bell *et al.*, 2020). It has been argued that such interventions limit participants' knowledge and skills transfer to their work environment (Medalia and Saperstein 2013, Keefe, Haig *et al.* 2016). *Second*, interventions most often combined SE programs with only one stand-alone therapy, thereupon limiting their scope. A common combination, SE and cognitive remediation therapy, have yielded positive results for obtaining a job, but not for maintaining it (Chan, Hiraï *et al.* 2015, Sauvé, Lepage *et al.* 2019). *Third*, the pre-formulated format of these stand-alone therapies precludes therapists from personalizing these exercises to participants' subjective (work) experiences. In addition to limiting skills transfer, this can curtail participants' motivation to complete the program (Rose, Wykes *et al.* 2008, Best, Milanovic *et al.* 2020).

As previously stated, the combination of additional clinical components with SE programs appears to be a promising avenue. We therefore argue that the integration of multiple clinical components, that are adapted to the occupational context and that can be personalized to participants' subjective experiences, could represent a profitable endeavor. Further, we suggest that these additional clinical components be

anchored in evidence-based research in order to both optimize existing interventions and capitalize on established mechanisms of actions (e.g., teaching of problem-solving strategies; Bowie, Bell *et al.* 2020).

For the purpose of developing such a clinical approach, we opted for a systematic procedure using the logic models method. This methodology has been used to synthesize literature and develop intervention programs based on scientific knowledge (e.g., Baxter, Blank *et al.* 2014). In brief, it consists of conducting a systematic literature review and summarizing the information in graphical format, thus modeling the links between the intervention's components, anticipated outcomes, mediators, and moderators (Chen 1990, Winsper, Crawford-Docherty *et al.* 2020). This method has been deemed flexible and guidelines for good research practices have been developed by the *W.K. Kellogg Foundation* (W. K. Kellogg Foundation Team 2004, Glenton, Colvin *et al.* 2013).

The aims of this paper were therefore (1) to conduct a systematic review of the literature on job tenure in psychosis, (2) to model the results via logic models methodology, and (3) to describe the resulting novel manualized group psychosocial intervention specifically aimed at improving job tenure in psychosis.

2.3 Methods

2.3.1 Literature review

The PRISMA guidelines for systematic reviews and meta-analyses were followed (Moher, Liberati *et al.* 2009) and the study was registered on the Open Science

Framework platform (osf.io/he68z). Searches of published sources first took place on September 14, 2018 and were updated on May 1, 2020 using the following databases: Medline, Embase, PsycInfo, and Cochrane Library. There was no restriction regarding the year of publication, but results were limited to studies published in French or English. The following keywords were used for the search: "schiz* OR psychosis OR psychotic*" AND "vocation* OR job* OR employ*" AND "maintenance OR maintaining OR tenure" AND "intervention* OR treatment* OR therap*" AND "cogniti*". Reference lists of selected articles were also screened for identification of additional relevant publications.

Selection of studies was based on the following inclusion criteria: (1) published in a peer-reviewed journal, (2) include participants with a psychosis spectrum disorder or a severe mental health disorder (as defined by the authors), (3) report any data relevant to the development of a psychosocial intervention aimed at improving duration of employment (e.g., predictors of job tenure, occupational interventions, links between interventions and outcomes). Any type of research design (e.g., pilot studies, randomized controlled trials) or data (e.g., quantitative, qualitative) were considered. Sources that were not published in peer-reviewed journals (e.g., books, conference proceedings) were included only if the information presented was not available in another source that met the inclusion criteria. Identified articles were stored in the reference management software Endnote® to automatically remove duplicates. Authors G.S., G.B. and a third person from our lab (Karyne Anselmo, M.Sc.) completed the selection of papers. They performed an initial screening of all identified articles based on titles and abstracts, and then screened full-text articles for inclusion in the final review.

Data from the selected sources were extracted according to a pre-established form. It included bibliographic data (i.e., names of authors, publication year, journal), study details (i.e., study design, sample characteristics, features of the intervention, primary

and secondary outcome measures) and key findings related to job retention, with particular attention dedicated to the underlying therapeutic mechanisms and contextual variables that might play a moderating role on job tenure.

2.3.2 Logic models

Following the literature review portion of this study, we used the logic models methodology to synthesize the results. The logic model was developed following the good practice guidelines described by the W. K. Kellogg Foundation Team (2004). Briefly, a logic model consists of a summary diagram which maps out an intervention and its putative links with anticipated outcomes in order to develop a summarized theory of how a complex intervention works (Conrad *et al.*, 1999). A key part of the model is detailing the mechanisms of change within the pathway, as well as the moderating and mediating factors that might be influencing outcomes. Accordingly, the objective of the logic model method is not to estimate an effect size, but rather to identify the theoretical basis and reasoning behind the links between components of an intervention and the expected results (Baxter *et al.*, 2014). Therefore, combining methodologies of logic models and literature review implies that the extracted data from included studies are treated as qualitative in order to inform the development of the model, as described in a recent paper by Winsper, Crawford-Docherty *et al.* (2020). This flexible method makes it possible to develop evidence-based intervention models (Glenton *et al.*, 2013), in line with our research objective. Logic models also have the added value of diagrammatic representation, lending themselves useful for communicating the results of systematic reviews more clearly and transparently to knowledge users and decision-makers (Anderson *et al.*, 2011).

2.4 Results

2.4.1 Literature review

A total of 2,956 references were initially retrieved and an additional 134 references were identified through other sources (i.e., reference lists, bibliographies of experts in the field). Of these, 468 papers were further assessed for eligibility. After considering these full-text articles, 93 papers were included in the qualitative synthesis, as depicted in Figure 1. The characteristics and main outcomes of each included study is presented in supplementary Table 1.

2.4.2 Description of the logic model

The logic model presented in Figure 2 was systematically developed by synthesizing the information extracted from the literature review described above. Following an iterative procedure, the final logic model represents consensus by all authors. The model reads from left to right and includes: intervention typologies *using* mechanisms of actions to *target* predictors of job tenure *resulting* in desired outcomes, which are *influenced* by contextual moderators. Sections of the model are described below.

2.4.2.1 Intervention types

We identified two main types of interventions, namely SE and SE+ programs. In the first typology, we mainly included interventions falling under the *IPS model*, which follows 8 core principles: rapid job search in the regular labor market, consideration for individual occupational preferences, close collaboration between the clinical team, vocational counsellors and employers, unlimited support to participants, and social benefits counselling (Drake, Bond *et al.* 2012). Interestingly, one study reported on the “*WorkingWell*” smartphone application, which has been developed to provide direct support to participants of IPS programs by tracking progress, setting reminders and taking notes, among other features (Nicholson, Carpenter-Song *et al.* 2017).

The second typology comprised interventions addressing cognitive deficits and/or social skills deficits as well as attitudes and beliefs in the context of a SE program. The interventions comprising the *first sub-section* specifically targeted cognitive deficits either by *cognitive remediation therapy* (Yamaguchi, Sato *et al.* 2017), *compensatory cognitive training* (Twamley, Thomas *et al.* 2017), or *errorless learning* (Kern, Zarate *et al.* 2018). All three interventions aim to improve cognitive capacity in participants by providing cognitive strategies and/or by practicing elementary and complex tasks. Another intervention, called “*Thinking Skills for Work*”, was included and aims to identify cognitive enhancement strategies based on the participant’s cognitive strengths and weaknesses (McGurk, Mueser *et al.* 2007, Ikebuchi, Sato *et al.* 2017). The *second sub-section* of SE+ programs focused solely on *work-related social skills training* to facilitate interpersonal conflict resolution (Tsang, Fung *et al.* 2010). Interventions included in the *third subsection* addressed attitudes and beliefs related to work by using techniques based on cognitive behavioral therapy, such as cognitive restructuring and psychoeducation. These included the *Indianapolis Vocational Intervention Program* (Mervis, Lysaker *et al.* 2016) as well as two adaptations: the *Cognitive-Behavioral Therapy for people*

registered in SE programs (Lecomte, Corbière *et al.* 2020) and the *Cognitive Behavioral Therapy for Work* (Kukla, Strasburger *et al.* 2018). These interventions are delivered in a group setting and notably target work-related self-defeating beliefs, stress, painful emotions, self-assertiveness and problem-solving. In the *last subsection*, we included interventions addressing combinations of the aforementioned elements. Some combined SE programs with cognitive remediation therapy and social skills training (Au, Tsang *et al.* 2015), the ‘Indianapolis Vocational Intervention Program’ with cognitive remediation therapy (Kukla, Bell *et al.* 2018), or the ‘Thinking Skills for Work’ program with an intervention targeting *theory of mind deficits* (Bechi, Spangaro *et al.* 2017). The concept of ‘theory of mind’ is closely related to those of ‘insight’ and ‘mentalization’ (Allen and Fonagy 2006). It pertains to the abilities to reflect on and infer intentions and beliefs in oneself and others (Catalan, Angosto *et al.* 2018). Other interventions of this subsection included the “*Workplace Fundamentals*” and the *PASS* programs. The former notably works on helping people to better manage their psychiatric symptoms, medication and physical health in addition to addressing workplace stressors, motivation and interpersonal issues (Nuechterlein, Subotnik *et al.* 2008). The latter incorporates strategies to address various placement, attitudinal, support, and skills issues (Dorio and Marine 2004).

Throughout our literature review, we identified several other intervention programs, but because their effects on job tenure predictors were not tested, or because they focused on other components of occupational functioning (e.g., interview skills), they were not included in the proposed logic model (e.g., Roder, Zorn *et al.* 2001, Cameron, Walker *et al.* 2012, Sohn, Hwang *et al.* 2016, Smith, Smith *et al.* 2017).

2.4.2.2 Putative mechanisms of action

Identified mechanisms of action were divided into four categories. They represent variables that are believed to enable interventions to specifically address predictors of job tenure for people diagnosed with a psychosis disorder. The *first* category includes those that foster *connection*, such as a positive therapeutic alliance (Cella et Wykes 2019), a group setting (Kukla, Strasburger *et al.* 2017, Sandoval, Gonzalez *et al.* 2019), as well as frequent contacts with the clinical/employment counselling team (Bond et Kukla 2011, McGuire, Bond *et al.* 2011). *Second*, the results of our literature review indicated that another way for interventions to address job tenure predictors is by cultivating *engagement* of participants in their occupational process via exercises that are rapidly perceived as being useful and by developing attractive interventional material (Bryce, Lee *et al.* 2018). *Third*, identified putative mechanisms of action also included variables related to the *teaching* of strategies, such as problem-solving, cognitive deficits, emotional coping and the promotion of mental health literacy for patients and other stakeholders (e.g., McGurk et Mueser 2006, Phillips, Kaseroff *et al.* 2014). The *fourth* category of variables included *transposition* mechanisms that allow participants to transfer their knowledge to real-world situations (Koren, Seidman *et al.* 2006), to conceptualize work as part of their recovery process (Matthewson, Langworthy *et al.* 2015, Williams, Fossey *et al.* 2016), and to benefit from additional support related to non-vocational aspects of their functioning (Nygren, Markstrom *et al.* 2013).

2.4.2.3 Predictors of job tenure

The predictors of job tenure identified in our literature review were divided according to the classification used by Corbière, Charette-Dussault *et al.* (2020) , which includes individual and environmental predictors. The former category was further divided into 4 sections. First, individual predictors related to the self, like self-esteem (Graham, Jones *et al.* 2010, Corbière, Villotti *et al.* 2014, Kukla, Davis *et al.* 2014), self-efficacy (Pachoud, Llorca *et al.* 2015), and personality traits (Fortin, Lecomte *et al.* 2017) have been identified as predictive of employment duration. The individual's attitude, e.g., flexibility and open-mindedness (Cunningham, Wolbert *et al.* 2000, Dorio et Marine 2004), job skills (Lord, McGurk *et al.* 2014), as well as the fit between the person and the job (Bégin et Corbière 2012, Williams, Fossey *et al.* 2016), have also been included in this section of job tenure predictors. Second, identified individual predictors *related to motivation* included levels of intrinsic motivation (Saperstein, Fiszdon *et al.* 2011) and motivation to keep working (Kirsh 2016). The third section of individual predictors *related to the psychiatric condition* were further subdivided into psychiatric symptoms and cognitive deficits. In the former section, variables like the degree of management of psychiatric symptoms (Lord, McGurk *et al.* 2014), the severity of negative symptoms (e.g., anhedonia, asociality; Evans, Bond *et al.* 2004), social and communication skills (Graham, Jones *et al.* 2010), as well as the level of social functioning (Sumiyoshi, Fujino *et al.* 2018), were identified as predicting job tenure in psychosis. In the fourth section, individual predictors *related to cognitive deficits*, the following domains were identified as most predictive of employment duration: memory (Dickerson, Stallings *et al.* 2007, Allott, Cotton *et al.* 2013, Rajji, Miranda *et al.* 2014, Caruana, Cotton *et al.* 2015, Lystad, Falkum *et al.* 2017), attention (McGurk et Mueser 2006, Franck 2014), executive functions (Jabben, van Os *et al.* 2008, Tsang, Leung *et al.* 2010, Lexen, Hofgren *et al.* 2016) and decline in intellectual quotient since symptom onset (Gold, Goldberg *et al.* 2002).

The second category included predictors of job tenure associated with the *work environment*. They were mainly related to relationships with colleagues and supervisors, in terms of their attitude (Corbière, Villotti *et al.* 2014) and the support they provide (Huff, Rapp *et al.* 2008, Rollins, Bond *et al.* 2011) for tasks (Corbière, Villotti *et al.* 2014) and accommodations (Corbière 2008). The realistic possibility of disclosing one's psychiatric diagnosis was also identified in our literature review as a predictor of job tenure in psychosis (Johannesen, McGrew *et al.* 2009, Corbière, Villotti *et al.* 2014). Further, evolving in a respectful work culture as well as being employed and supervised by people who hold realistic expectations were also identified as predictors of job tenure (Tsang, Angell *et al.* 2007, Williams, Fossey *et al.* 2016).

2.4.2.4 Contextual moderators of outcomes

Some variables identified through our literature search did not specifically predict employment duration, but were believed to have a moderating effect on desired outcomes (i.e., improved job tenure and/or reduced job termination). One was labelled as a *positive contextual moderator*, such as having social support from friends and family (Huff, Rapp *et al.* 2008, Graham, Jones *et al.* 2010, Matthewson, Langworthy *et al.* 2015), because it positively impacts employment duration. And another was classified as a *negative contextual moderator*, such as having family issues (Milfort, Bond *et al.* 2015), because it tends to reduce job tenure or expedite work termination.

2.4.3 Description of the *Minds@Work* program

Based on the findings identified from the literature review and synthesized in the logic model, a new intervention – called Minds@Work – was developed. As previously stated, augmented and integrative approaches appear to be most promising for improving the job tenure of people diagnosed with a psychotic disorder. Therefore, M@W was designed to include the identified putative mechanisms of action and target the predictors of job tenure, as much as possible. The program is available in French and English, and can be obtained upon request. A description of the modules and setting of the program follows.

2.4.3.1 *Modules*

The M@W program is divided into 9 modules of equal duration covered over the same number of sessions, as presented in Table 2. In line with the predictors of job tenure identified in the proposed logic model, modules 1 to 6 focus on the self, while modules 7 and 8 concentrate on others in the work environment (e.g., colleagues, supervisors). The ordering of the modules has been carefully planned so that each one lays the foundation for the next. Given the qualitative focus of the literature review portion of this study, equal weight has been allocated to each module in order to be concise and broad-spectrum at the same time (Chorpita, Daleiden *et al.* 2005, Dunn, Fowler *et al.* 2012, Emmelkamp, David *et al.* 2014, Forbat, Black *et al.* 2015). As discussed in the next section, more studies are needed to optimize the design of psychological manualized programs.

Theoretical bases for the development of the modules include: positive psychology, mindfulness and self-determination theory (modules 1 & 2; e.g., Kabat-Zinn 1992, Ryan et Deci 2017); neurosciences and cognitive training (modules 3 & 4; e.g., Medalia et Bowie 2016); cognitive biases and theory of mind (modules 5 & 7; e.g., Moritz et Woodward 2007); social cognition and social skills, mentalization, and emotional processing (modules 6 & 8; e.g., Allen et Fonagy 2006, Boisvert et Beaudry 2012, Gross 2014, Roberts, Penn *et al.* 2016). Further, development of the exercises comprised in the M@W program was inspired by the following evidence-based interventions: cognitive remediation therapy (Bowie, Grossman *et al.* 2017); compensatory cognitive training (Twamley, Vella *et al.* 2012); metacognitive training (Moritz, Woodward *et al.* 2016); social cognition and interaction training (Roberts, Penn *et al.* 2016); dialectical behavior therapy (Linehan 2015); mentalization-based therapy (Allen et Fonagy 2006); emotional regulation therapy (Gross 2014); and the MIRRORS intervention (Davis, Lysaker *et al.* 2015), which has adapted the principles of mindfulness-based cognitive therapy (Segal, Williams *et al.* 2013) and mindfulness-based stress reduction therapy (Kabat-Zinn 1992); as well as ‘cognitive-behavioral therapy for SE programs’ (Lecomte, Corbière *et al.* 2014) and ‘cognitive-behavioral therapy for work’ (Kukla, Strasburger *et al.* 2018), both of which were adapted from the Indianapolis Vocational Intervention Program (Mervis, Fiszdon *et al.* 2017).

For all modules, psychoeducation and strategy-based remediation approaches have been used. In accordance with our logic model’s identified mechanisms of action, the sessions are designed to take place in a group setting, be very interactive and filled with discussions and exercises. Further, participants are invited to develop a work-related personal objective at the beginning of the program, which will then be discussed bi-weekly to assess progress and deal with barriers. In line with the ‘cognitive-behavioral therapy’ framework, participants are invited to complete weekly personalized homework (referred to as ‘challenges’ in the program) wherein

they practice the personalized strategies that have been developed during the session. These elements of the program are put in place to maximize participants' motivation and interest. To optimize knowledge transfer opportunities, the vast majority of proposed exercises are directly built from participants' subjective work experiences. Further, it was important to develop interventional material that is both stigma-free and accessible to individuals with different levels of reading and writing skills.

2.4.3.2 Setting

The M@W program is designed for people currently employed and it is ideal for the intervention to be delivered onsite for several reasons. First, it facilitates transportation for participants who would otherwise have to commute from work to where the sessions are taking place. Second, if and when possible, onsite sessions can be delivered during working hours to reduce the possible psychological strain of having to work and additionally attend weekly interventional sessions. Third, if the participants are comfortable disclosing their psychiatric diagnosis, the program is designed to foster collaboration with staff members and participants' immediate supervisors, thus aiming to optimize knowledge transfer and to develop mental health literacy. Hence, it is recommended in the M@W program to involve a staff member (e.g., onsite psychosocial worker, counsellor) to act as group co-facilitator, and to provide immediate supervisors with a presentation of the program's themes and strategies. The objective behind this is to better equip them for the endeavor that they are invited to undertake, namely encouraging and coaching participants to use their strategies at work when they are facing difficulties.

Despite its initial design, the M@W program can be easily adapted for other contexts. For instance, it could be used as a stand-alone intervention or integrated in SE/SE+ initiatives. Therefore, individuals who are not currently working could still benefit from the intervention as a preparation step for a future job. All of the M@W material can be readily used by employment specialists or healthcare workers and include detailed manuals for participants and group facilitators, Microsoft PowerPoint® presentations, exercise sheets, and handouts for participants and immediate supervisors.

2.5 Discussion

The present study's objective was to systematically review the literature on job tenure in people living with a psychotic disorder in order to develop a logic model illustrating the putative links between interventions, processes and outcomes. This subsequently informed the development of a new group psychosocial intervention, called Minds@Work, that specifically aims to improve job tenure in psychosis.

Throughout our literature search, we identified 93 relevant studies from which the findings were qualitatively interpreted and mapped out in our proposed logic model. Two main intervention typologies were identified, namely (1) SE and (2) SE+ augmented with additional interventions addressing cognitive and/or social skills deficits, dysfunctional attitudes and/or beliefs, or a combination of the above. The identified processes included putative mechanisms of action (i.e., connecting, engaging, teaching, transposing) and predictors of job tenure (i.e., related to the individual and to the work environment). This, in turn, is believed to result in desired

outcomes, namely improved job tenure or reduced job termination, which are influenced by contextual moderators (e.g., family issues, positive social support). Our findings allowed us to develop a novel intervention which capitalizes on using putative mechanisms of action to address variables most predictive of improved job tenure in psychosis.

2.5.1 Theoretical implications

First, our proposed logic model provides researchers and clinicians with a more comprehensive understanding of how SE and SE+ programs reach their objectives of improving job maintenance for individuals diagnosed with a severe mental health disorder. Other recent systematic reviews of the literature have already identified factors impacting job tenure (Williams, Fossey *et al.* 2016, Corbière, Charette-Dussault *et al.* 2020) and the present study complements their findings by outlining the putative underlying mechanisms of action.

Another theoretical implication relates to the methodology used in our study, namely, combining literature review and logic model methodologies to inform the development of a psychosocial intervention. When aiming to create a new therapeutic program, researchers in psychosocial fields have few guidelines at their disposal. Prevailing approaches, like the *Medical Research Council Framework* (Bleijenberg, de Man-van Ginkel *et al.* 2018) or *Intervention Mapping* (Bartholomew, Markham *et al.* 2016), mostly come from medical disciplines and can be arduous to implement because they aim to develop very sophisticated interventions involving several stakeholders at different organizational and political levels. Therefore, the present study, along with others (Baxter, Blank *et al.* 2014, Subirana, Long *et al.* 2014,

Winsper, Crawford-Docherty *et al.* 2020), demonstrates how results of systematic reviews can be schematically presented and how smaller-scale psychosocial interventions can be developed and systematically informed by the latest scientific literature.

2.5.2 Clinical implications

One major strength of this study that bears important clinical implication is the development of a readily usable and accessible manualized intervention that psychosocial workers and counsellors can use with their clientele. By involving different organizational stakeholders (e.g., immediate supervisors), by capitalizing on putative mechanisms of action, and by simultaneously addressing several domains predictive of improved job tenure, our intervention aims at overcoming some of the recognized limitations in the field, such as modest knowledge/skills transfer to occupational settings and restricted scope of intervention (Rose, Wykes *et al.* 2008, Keefe, Haig *et al.* 2016, Sauv e, Lepage *et al.* 2019, Bowie, Bell *et al.* 2020).

Other clinical implications of the current work relate to the multidimensional benefits of improving occupational functioning of people diagnosed with a severe mental disorder. Over the years, it has been repeatedly demonstrated that work participation and recovery beneficially impact one another (e.g., Hagler, Hamby *et al.* 2016, Gibbons et Salkever 2019, Thomas, Prasad Muliya *et al.* 2019). More specifically, at a clinical level, studies have shown that having a job significantly improves psychotic and depressive symptoms, cognitive and emotional health, and quality of life (Bejerholm et Eklund 2007, Bio et Gattaz 2011, Martin 2018, Ogden 2018, Davidson 2020). In addition to these individual benefits, more inclusive work

participation of people living with a severe mental disorder can also have positive economic impacts for society by reducing healthcare costs (Dewa, Hoch *et al.* 2019, Sultan-Taïeb, Villotti *et al.* 2019). Therefore, our proposed logic model also has the advantage of informing researchers, clinicians and decision-makers about putative underlying mechanisms of action that could be used to optimize existing programs so as to further mitigate the economic burden of mental illness on public healthcare systems.

2.5.3 Limitations

This study presents several limitations. To begin with, the large scope of our literature review search raises the possibility that not all relevant published studies were identified. Further, our proposed logic model was informed only by the scientific literature and did not include perspectives of multiple sources of stakeholders, as suggested in the guidelines of the W. K. Kellogg Foundation Team (2004). However, these guidelines have been developed specifically for program development, management, and evaluation. Therefore, their recommendations more specifically target local endeavors that are planned to be implemented onsite and so, coherently encourage involving people working at different levels of the organization. Our aim being slightly different (i.e., developing an accessible intervention that could be implemented in different sites and contexts), we followed the guidelines' steps that were most applicable to our objectives. We also recognize that our search strategy did not yield a large number of studies in the fields of industrial and organizational psychology. Future research might benefit from including additional keywords and expanding their search to databases related to human resources management and administration fields.

Another important limitation is that the acceptability, feasibility and efficacy of our proposed intervention has not yet been validated as part of a behavioral therapeutic trial. Nevertheless, its readiness of use and accessibility will facilitate such an endeavor in future studies. The possible drawbacks surrounding the disclosure of one's psychiatric diagnosis should however be carefully considered whenever other stakeholders are involved, as it is suggested in the present program (Corbière, Villotti *et al.* 2014). Also, our proposed logic model does not distinguish between stages of illness (i.e., clinical high-risk, first-episode, multiple episodes; McGorry, Nelson *et al.* 2010, McGorry, Keshavan *et al.* 2014). Because of previous studies showing the efficacy of supported employment programs in first-episode psychosis (Bond, Drake *et al.* 2016, Rosenheck, Mueser *et al.* 2017), we decided not to restrict our search to specific stages of psychosis. It will be interesting in future investigations to verify if our proposed logic model represents an adequate portrayal of how supported employment interventions facilitate job tenure at different stages of illness. Finally, the M@W program's duration has been equally divided for each component, which might not be optimal since it could be argued that more time should be spent on some specific modules. More studies are needed to better understand the specific effects of different treatment components for more effective designs (Chorpita, Daleiden *et al.* 2005). A more refined understanding of the weight of each predictors of job tenure will also inform future endeavors in how best to modularize interventions' components.

2.5.4 Conclusions and future directions

The current study aimed at reviewing the literature on job tenure in psychosis and to map out the findings using logic model methodology, in order to ultimately develop a

scientifically informed intervention to improve duration of employment in people living with psychotic spectrum disorders. Our proposed model notably highlights the putative mechanisms of action that allow existing supported employment interventions to promote occupational functioning in severe mental illness. Important future directions include the enhancement of mental health literacy in employers, immediate supervisors, union representatives, insurers, and other workplace stakeholders to facilitate the hiring and maintenance at work processes of individuals living with severe mental disorders. In the time of COVID-19, it will also be worth investigating how remote work affects the occupational functioning of people already struggling with mental health issues.

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2.7 Tables and figures

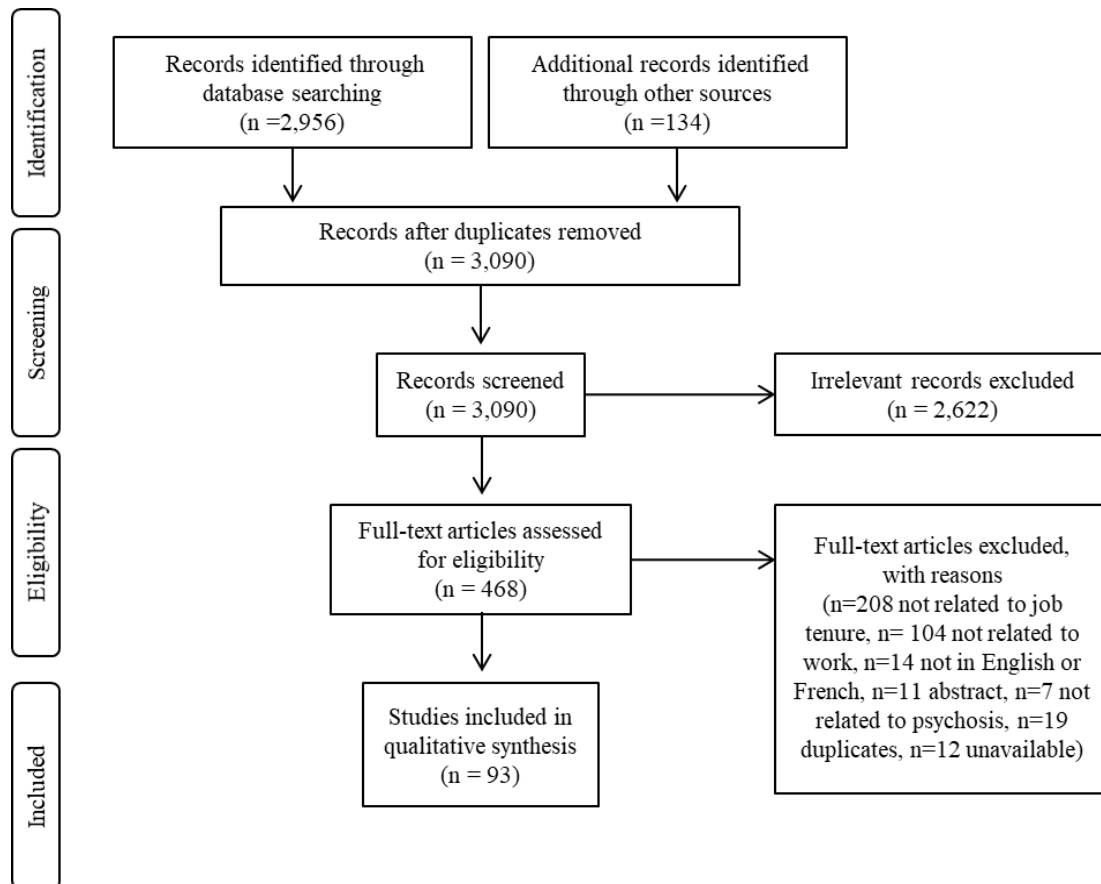


Figure 2.1 PRISMA flow diagram of study selection, inclusion and exclusion. N = number of studies

Table 2.1 Description of included studies

Reference	Country	Sample (total N, age)	Setting	Study design	Intervention	Outcome measures	Main findings on job tenure
(Allott <i>et al.</i> , 2013)	Australia	N=135, 20.3 yo	IPS	RCT	IPS vs TAU	Vocational data (enrollment in education, competitive employment attainment, hours of competitive employment); Cognitive data (WRAT-4, WAIS-III, TMT-A, TMT-B, SDMT, RAVLT, RCFT, COWAT, Animal Fluency Test, PST, FBDST, Hinting Task, Face and Prosody Emotion Recognition)	Visual organization and memory predicted enrolment in education and hours of employment. No relationship between social cognition and vocational outcomes.
(Au <i>et al.</i> , 2015)	China	N=90, 35.4 yo (ISE + CRT), 36.9 yo (ISE)	SE+	RCT	ISE + CRT	Vocational data (employment rate, job tenure)	No evidence that CRT facilitated further improvements beyond ISE alone.
(Bechi <i>et al.</i> , 2017)	Italy	N=37, 37.2 yo	SE	Comparison	CACR + WGT vs CACR + WGT + ToM	Vocational data (WPS); Cognitive data (WAIS-Revised, BACS, ToM); Symptom data (PANSS)	Greater improvements in cognition and ToM in ToM group. Age at onset, cognitive abilities, and degree of ToM improvement predicted work outcome.

(Becker <i>et al.</i> , 2007)	US	N=38, 49.2 yo	IPS	Mixed (qualitative + quantitative)	n/a	Vocational data (employment history, work assistance provided, perceived facilitators of work, perceived barriers to competitive employment, perceived effects of working)	Major barriers to work: psychiatric illness. Major facilitators of work: part-time employment, long-term supports. Perceived influences on work-related behavior: symptom management (including medication adjustment) and coping skills; working fewer hours/days at a time; ongoing IPS support. Reported benefits with work: enhancements to self-esteem, relationships, illness management.
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(Begin et Corbière, 2012)	Canada	N=112, 40.0 yo	SE	Longitudinal	n/a	Vocational data (SDS); Symptom data (BSI)	Increased congruence between perceived competency to perform job and skills required for job were associated with job maintenance.
(Bond et Kukla, 2011)	US	N=142, 39.7 yo	IPS	Observational	n/a	Vocational data (duration of employment)	Ongoing support (> 1 year) predicted longer job tenure. Frequency of contact by IPS specialist correlated with months of work at follow-up.
(Bond <i>et al.</i> , 2012)	US	N=618, 39.5 yo	IPS	Secondary analysis of RCT data	IPS vs VR	Vocational data (employed at any time, total weeks worked, tenure in the longest-held job, total hours worked, average hours per week worked, total wages, days to first job, and working ≥ 20 hours per week during follow-up)	IPS outperformed VR group on all outcome measures.

(Bryce <i>et al.</i> , 2018)	Australia	n/a	n/a	Letter to the Editor	CRT	n/a	Practical considerations for CRT delivery: practice newly acquired skills developed within supportive learning environments; obtain attribution-based feedback and performance-based feedback; encounter and overcome cognitive and functional challenges.
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(Bryson et Bell, 2003)	US	N=96, 42.8 yo	n/r	Prospective	n/a	Vocational data (WBI); Cognitive data (WAIS-Revised, WCST, CPT, WMS-Revised, HVLT, GPT, BLERT); Symptom data (PANSS)	Cognitive performance (but not symptoms) related to rates of improvement in job performance. Rates of improvement associated with measures of attention during first half of work development, and measures of verbal memory during second half.
(Buizza <i>et al.</i> , 2014)	Italy	N=84, 37.6 yo	Vocational integration service	Retrospective	n/r	Vocational data (duration, type and outcome of vocational integration program; number of interventions)	Number of interventions received before job placement associated with employment maintenance.

(Cameron <i>et al.</i> , 2012)	UK	N=14, 42.5 yo	n/r	Qualitative	‘Retain’ project (i.e., supportive counselling, confidence building, problem solving, education on employment law, negotiating return to work, redeployment and/or adjustments)	Vocational data (difficulties at work; supporting self-confidence, communication skills and problem solving; analyzing jobs and identifying changes; help to collaborate with employer; skills and competencies of project workers; impacts and outcomes of job retention intervention)	Obstacles to job retention: feelings of guilt and self-blame. Facilitators of job retention: identification of job accommodations & adjustments; self-confidence (leading to improved dialogue with employer); peer support.
(Campbell <i>et al.</i> , 2011)	US	N=681, 39.5 yo	IPS	Meta-analysis	IPS	Vocational data (job acquisition, total weeks worked, job tenure)	Findings favor IPS across all outcome measures independent of demographic and clinical characteristics.

(Carmona <i>et al.</i> , 2017)	Spain	N=2,364, 37.7 yo	n/a	Meta-analysis	SE vs TAU	Vocational data (number of people in employment, number of hours and weeks worked)	Intervention groups had increased likelihood of obtaining competitive job. Intervention had small effect on job tenure assessed as hours worked in any job.
(Caruana <i>et al.</i> , 2015)	Australia	N=135, 20.4 yo	IPS	Secondary analysis of RCT data	IPS + TAU vs TAU alone	Vocational data (employment duration); Cognitive data (WAIS-III, TMT, Symbol-Digit Modalities Test, RAVLT, RCFT, CO-WAT, Animal Fluency Test)	Better visual organization and memory and greater job complexity predicted longer employment duration.
(Cather, 2005)	USA	N=30, n/r	n/a	RCT pilot data	FCBT vs PE	Functioning data (SFS); Symptom data (PSYRATS, PANSS)	Greater reduction in positive symptoms in FCBT group correlated with increased functioning post-treatment.
(Cella <i>et Wykes</i> , 2019)	UK	N=46, 17-65 yo (range)	n/a	Secondary analysis of RCT data	CRT + TAU	Cognitive data (RCFT, WCST); Functioning data (time spent in structured activities); Symptom data (PAN Psychotic Symptoms Rating Scales SS)	Therapeutic alliance positively associated with improvements in functioning and cognition.

(Choi <i>et al.</i> , 2013)	US	N=123, n/r	Vocational rehabilitation program	Secondary analysis of longitudinal data	NET + WT	Vocational data (work performance, number of hours worked per week); Cognitive data (HVLIT, WCST, Digit Span, Digit Symbol); Motivation (QLS)	Baseline cognition and motivation predicted better work outcomes. Changes from individuals' own baseline motivation linked to better work outcomes.
(Coombes <i>et al.</i> , 2016)	Australia	N=5, 25 yo	IPS	Qualitative	n/a	Consumer perspective of factors impacting success of IPS	Core category of pushing through, a three-step process that involved experiencing discomfort, learning to adapt, and getting into a groove.
(Corbera <i>et al.</i> , 2017)	USA	N=112, 33.0 yo	n/a	RCT	CRT vs CST	Cognitive data (WAIS-III, WAIS-IV); Symptom data (PANSS); Functioning data (UPSA)	Increased benefits of CRT on cognitive outcomes in younger patients with shorter illness durations, but did not extend to functioning.

(Corbière <i>et al.</i> , 2014)	Canada	n/a	n/a	Review	n/a	n/a	Requiring work accommodations related to disclosure of mental disorder (when natural supports are unavailable). Tools to support management of plan to disclose personal information: DMDS, BECES, WANSS.
(Corbière, 2008)	Canada	n/a	n/a	Review	n/a	n/a	Individual factors accounted for 1/3 of variance in active labor market presence. Workplace accommodations influenced continued employment.
(Corbière <i>et al.</i> , 2014)	Canada	N=124, 39.7 yo	SE	Longitudinal	n/a	Vocational data (WANSS); Symptom data (BSI)	Supervisor and co-worker supports in workplace facilitated work tenure.

(Cunningham <i>et al.</i> , 2000)	USA	N=17, 20-40 yo (range)	ACT	Qualitative	n/a	Vocational data (number of hours employed, length of time jobs held); Symptom data (BPRS)	Attitude toward illness, awareness of illness, and strategies managing illness associated with increased job tenure.
(DeTore <i>et al.</i> , 2018)	USA	N=41, 24.6 yo	n/a	Secondary analysis of longitudinal data	n/a	Functioning data (SAS); Family burden (QRS); Symptom data (BPRS)	Baseline levels of family burden predicted work status and number of hours working/going to school at 6-months and 1-year.
(Dickinson <i>et al.</i> , 2007)	USA	N=55, 40.2 yo	n/a	Secondary analysis of longitudinal data	n/a	Cognitive data (WAIS-III, WMS-III, WCST, COWA, WRAT); Functioning data (MASC);	MASC scores predicted good vocational functioning independently of cognitive performance.
(Dorio et Marine, 2004)	USA	n/a	SE	State of affairs piece	PASS to success	n/a	Components of proposed model predicting vocational success and job retention: P lacement, A ttitude, S upport, S kills

(Ergül et Üçok, 2015)	Turkey	N=64, 23.0 yo	n/a	Longitudinal	n/a	Cognitive data (RAVLT, Stroop Test, WCST, Digit Span Test, CPT, TMT, N-Back Test); Symptom data (BPRS, SANS, SAPS); Functioning data (GAF, PAS)	Patients working during 24-month follow-up had less motivation-pleasure deficits.
(Evans <i>et al.</i> , 2004)	USA	N=112; 39.0 yo	DPA; SE	Longitudinal	DPA vs SE	Vocational data (WPS, WBI, weeks worked, total hours worked, total wages earned); Cognitive data (CVLT, WCST, WAIS-III, TMT, Digit Symbol Test, Digit Span Test, Symbol Search); Symptom data (PANSS)	Verbal learning & memory, speed of processing, executive functioning, and cognitive disorganization predicted better employment outcomes (more hours, weeks, and wages earned), and these relationships were more prominent in DPA vs SE program. Negative symptoms were related to all vocational outcomes. Hostility symptoms were related to total wages earned.

(Franck, 2014)	Canada	n/a	n/a	Review	SE + CR vs SE	n/a	Significant improvement in employment rates in SE + CR condition.
(Giugiaro <i>et al.</i> , 2012)	Italy	N=253; 40.1 yo	n/a	Cross-sectional	n/a	Cognitive data (Stroop Test, CVLT); Symptom data (PANSS; SUMD)	Employment associated with verbal memory, general psychopathology, and awareness of mental illness (SUMD). Both general psychopathology and awareness of mental illness mediated verbal memory-competitive employment relationship.

(Gold <i>et al.</i> , 2002)	USA	N=150; n/r	IPS	RCT	IPS vs TAU	Vocational data (total hours worked); Cognitive data (WRAT, Woodcock-Johnson Listening Comprehension, WAIS-III, TMT, Stroop Test, CPT, WCST, Verbal Fluency, WAIS-III, Halstead-Reitan Finger Tapping, Purdue Pegboard, WMS-III, RBANS)	Baseline cognitive performance did not differentiate patients who obtained employment from those who remained unemployed. Better baseline cognitive performance was associated with number of hours worked at 12- and 24-month follow-ups.
(Graham <i>et al.</i> , 2010)	Canada	N=72; n/r	n/a	Qualitative	Life-skills training program; Job-skills training program	Skills and characteristics necessary to maintain labor force participation and foster labor market attachment; availability and type of support services required to meet labor market attachment needs	Life skills (i.e., gaining awareness of oneself, developing self-esteem/confidence) vs labor-market skills more associated with success in overcoming personal barriers to securing/maintaining employment.

(Harris <i>et al.</i> , 2017)	Australia	N=86, 42.3 yo (CogRem), 36.8 yo (WebInfo)	SE	RCT	Internet-based CR + SE (CogRem) vs Internet-based information + SE (WebInfo)	Vocational data (hours worked, wages earned); Cognitive data (CPT, Digit Span Test, Word List Recognition, Verbal Interference, Choice Reaction Time, Attention Switching), Motor Tapping, Maze Completion); Symptom data (BASIS-24); Functioning data (WHOQOL-BREF)	CogRem worked more hours and earned more money at 6-month follow-up than WebInfo. No change in cognition observed in either group.
(Huff <i>et al.</i> , 2008)	USA	N=51; n/r	SE	Qualitative	n/a	Reasons for staying or leaving job	Interest/engagement with work, support of supervisor and coworkers, perceived level of competence.
(Ikebuchi <i>et al.</i> , 2017)	Japan	N=47; 34.8 yo	SE	Secondary analysis of RCT data	CRT + SE	Vocational data (competitive employment rates, total days employed, total earnings during follow-up); Cognitive data (BACS)	Improvement in cognition contributed to total days employed and total earnings.

(Iyer <i>et al.</i> , 2015)	Canada	n/a	SE	Perspective	Work Preparation Group (promotes recovery and return to work via acquisition of job-related cognitive and social skills)	n/a	Participants reported having more interviews and jobs post- group (unpublished data).
(Jabben <i>et al.</i> , 2008)	UK	N=708; 38.3 yo	Case Management	Secondary analysis of RCT data	n/a	Vocational data (number of months in employment and independent living); Cognitive data (TMT, NART); Symptom data (CPRS); Functioning data (number of hospital admissions, number of days spent in hospital, WHO-DAS); QoL data (Lehman QoL Interview, CAN)	At baseline, processing speed was associated with social and subjective outcome after controlling for psychopathology, and with objective outcomes of hospital admissions, independent living and employment. Unclear association between cognition and functioning across time.

(Johannesen <i>et al.</i> , 2009)	USA	N=56; 39.6 yo	SE	Longitudinal	n/a	Vocational data (employment activity); Barriers to employment (23-item list of personal factors thought to relate to employability); Rehabilitation outcomes (Lehman's QoL interview; HAPI-A; Hope Scale)	Reductions in illness-related barriers were associated with improvement in subjective QoL and hopefulness. Among participants who attained employment, those reporting reductions in illness-related barriers worked twice as long as those with stable barrier ratings. Reductions in common barriers predicted improvement in clinician-rated independent functioning, but were unassociated with employment outcome.
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(Karambelas <i>et al.</i> , 2019)	Australia	N=134; 20.8 yo	IPS	Secondary analysis of RCT data	IPS vs TAU	Vocational data (total hours employed over 18 months, employment status); Cognitive data (WRAT-4, WAIS-III, TMT, RAVLT, RCFT, Animal Fluency, COWAT, SDMT); Symptom data (SANS)	Poorer verbal learning, more severe negative symptoms, and male gender were predictive of decreased total hours worked over 18 months.
(Kern <i>et al.</i> , 2018)	USA	Veterans Affairs: N=11, 49.6 yo (EL + SE); N=13, 46.1 yo (SE) Community Mental Health Center: N=17, 40.8 yo (EL + SE); N=17, 34.1 yo (SE)	SE+	RCT	EL + SE vs SE alone	Vocational data (job tenure, work behavior, hours worked and wages earned per week, WBI); Cognitive data (MCCB); Symptom data (BPRS)	EL + SE group stayed in jobs longer than SE group. Differential treatment effects favoring E + SE group on targeted work behavior problems (improvement from baseline to follow-up). Social skills better explained variance in job tenure beyond levels of cognition, symptom severity, and past work history.

(Kern <i>et al.</i> , 2009)	USA	N=20, 46.5 yo (EL); N=20, 48.6 yo (conventional instruction)	SE	RCT	EL vs conventional instruction	Vocational data (WBI, number of weeks on the job or total number of hours worked prior to quitting or study end); Personal well-being data (self-esteem, job satisfaction, work stress)	EL performed better on work quality score (WBI), and this was stable across 12-week period. No group differences on self-esteem, job satisfaction, or work stress.
(Kirsh, 2016)	Canada	n/r	SE	Review	n/a	Factors influencing longevity of SE effects; characteristics of people who benefit from SE; barriers to SE implementation	Social skills and cognitive skills training enhanced job tenure by enabling more effective problem-solving and relationship-building at work. Barriers to SE related to negative attitudes regarding work potential of people with mental illness (highlighting need for education and anti-stigma interventions).

(Koren <i>et al.</i> , 2006)	USA, Israel	n/r	n/a	Review + pilot validation study	n/a	Illness insight (SUMD); Competence to consent to treatment (MacCAT-T); Cognitive data (WCST)	Poor insight and decision-making competence were more strongly related to deficits in metacognition than to particular cognitive deficits.
(Kukla <i>et al.</i> , 2018)	USA	N=75; 50.2 yo	SE	RCT	CBTw + CR vs CBTw alone vs vocational support	Vocational data (hours worked, weekly work performance ratings); Cognitive data (MCCB)	CBT + CR group worked more hours, had greater improvements in global work performance, work quality, and cognitive domains (verbal learning and social cognition) compared to both CBT alone and vocational support groups.

(Kukla <i>et al.</i> , 2014)	USA	N=50; 45.9 yo	SE	Secondary analysis of RCT data	CBTw	Cognitive data (WAIS-III; WCST); Symptom data (PANSS); Self-esteem data (RSES)	Poor treatment engagement and engagement in work were associated with lower educational attainment, more severe negative symptoms, and lower WAIS-III scores. Among intervention-engagers, younger age and poorer working memory predicted shorter initial job tenure. More positive symptoms and lower self-esteem during later stages of treatment were associated with worse employment outcomes.
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(Kukla <i>et al.</i> , 2017)	USA	N=19, 57.0 yo	SE	Mixed (quantitative + qualitative)	CBTw	NEII; SWS	<p>Participants reported satisfaction with components of intervention, e.g., advice and knowledge acquired, support and help with work goals, perceived competence of group facilitators. Participants reported improvements in self-efficacy regarding ability to work and be productive, enhanced insight and understanding of themselves as worker, increased motivation to participate in workforce, more positive beliefs that vocational success is attainable, and sense of connection with others and normalization of complex employment challenges.</p>
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(Kukla <i>et al.</i> , 2018)	USA	N=52; 50 yo	SE	Pilot study	CBTw	Vocational data (employment status, total hours worked, total wages earned)	Among participants unemployed at baseline, 50% attained work at follow-up.
(Lanctôt <i>et al.</i> , 2013)	Canada	N=126, 40.0 yo	SE	Mixed (quantitative + qualitative)	n/r	Self-esteem data (SES); Symptom data (BSI); Vocational data (qualitative interview question, i.e., 'What are the reasons why your job ended?')	Majority of participants voluntarily ended their job due to external and uncontrollable factors.
(Lecomte <i>et al.</i> , 2014)	Canada	N=24, 32.0 yo	SE+	Preliminary results of RCT	CBT-SE vs SE	Custom questionnaires on therapists and participants' appreciation, participants' attendance, job status, number of weeks and hours/week worked	Higher job acquisition rate in CBT-SE. Group format represents a facilitator. No significant difference between experimental and control group on job tenure.

(Lexen <i>et al.</i> , 2016)	Sweden	N=39, 38.2 yo	SE	Cross-sectional	n/r	Vocational data (competitive employment, work hours/week, income/month); Cognitive data (TM, D-KEFS, WAIS-III, WMS-III, Tower of London)	Cognition correlated with job tenure (immediate and delayed verbal recall, immediate visual recall, planning, reasoning, problem-solving).
(Lindenmayer <i>et al.</i> , 2018)	USA	N=78, 41.0 yo (patients), 42.7 yo (controls)	n/r	RCT	CRT + Social cognition	Cognitive data (MCCB); Social cognition data (Facial Emotion Identification Task, DSCB, Penn Emotion Recognition Task); Functioning data (UPSA)	No effect of intervention on functioning.
(Llerena <i>et al.</i> , 2018)	USA	N=112, 45.0 yo	SE	Cross-sectional	n/a	Vocational data (number of weeks/hours worked, income); Cognitive data (MCCB)	Experiential negative symptoms (avolition/apathy, asociality/anhedonia) correlated with hours worked.

(Lord <i>et al.</i> , 2014)	USA	n/a	IPS	Review	n/a	n/a	Benefits of technology: enhance direct service and workflow in IPS process, leading to improved fidelity and client outcomes; increase opportunities for collaboration, self-directed care, ongoing support to help clients obtain/maintain meaningful employment.
(Lystad <i>et al.</i> , 2017)	Norway	N=131, n/r	SE	Longitudinal	JUMP (CRT + SE vs CBT + SE)	Vocational data (occupational status, hours/week worked); Cognitive data (MCCB, WAIS)	Intervention improved job tenure in both groups. Working memory predicted job tenure.
(Matthewson <i>et al.</i> , 2015)	Australia	n/r, 18-65 yo (range)	n/a	Review	n/a	n/a	Psychological predictors of return to work: identity, self-management of illness, social cognition, hope, self-esteem, motivation.

(McGuire <i>et al.</i> , 2011)	USA	N=91, n/r	IPS	Longitudinal	n/a	Vocational data (weeks worked in competitive employment); Symptom data (PANSS)	Intensity of IPS services associated with weeks worked. Cognition attenuated relationship between service intensity and weeks worked. Intensity of mental health treatment unrelated to weeks worked.
(McGuire <i>et al.</i> , 2007)	USA	N=52, 39.6 yo	SE	Longitudinal	n/a	Vocational data (WBI, weeks of paid employment, total hours of paid employment, total earnings from employment)	WBI ratings were positively associated with total wages earned, weeks/paid hours worked.
(McGurk <i>et al.</i> , 2018)	USA	N=945, 47.2 yo	IPS	Longitudinal	n/a	Vocational data (average number of hours worked per week on main job); Cognitive data (BACS)	Cognitive functioning (composite score) and verbal learning subscale scores predicted amount of work over 2 years.

(McGurk <i>et al.</i> , 2009)	USA	N=34, 45.5 yo (CRT), 42.4 yo (VR only)	SE	RCT	CRT + VR vs VR only	Vocational data (job type, competitive/non-competitive, hours worked, wages earned); Cognitive data (WAIS-III, TMT, DSST, CVLT, WCST)	CRT + VR group showed greater cognitive improvements over 3 months and better work outcomes at 2-year follow-up.
(McGurk et Mueser, 2006b)	USA	N=25 (Stage 1), N=50 (Stage 2), n/r	SE	Qualitative	n/a	Strategies used to help clients cope with cognitive deficits; efficacy of strategy use	Strategies for dealing with attention problems were rated by employment specialists as more effective than strategies used in other domains (psychomotor speed, memory, problem solving). Number of coping strategies correlated with perceived effectiveness of strategies and proportion of clients who worked.

(McGurk et Mueser, 2006a)	USA	N=30, 39.7 yo	SE	Longitudinal	n/a	Vocational data (number of jobs, hours worked, wages earned); Symptom data (PANSS); Cognitive data (WRAT, Digit Span Test, Letter Number Sequencing Test, TMT, DSST, WCST, CVLT); Symptom data (PANSS); Functioning data (SAS)	Cognitive functioning more predictive of work during follow-up years 3 and 4 (vs years 1 and 2). Symptoms were weak predictors of work. Learning and memory and executive functions correlated with job task complexity during 3-4-year follow-up.
(McGurk et al., 2005)	USA	N=44, 31.4 yo (Site 1) and 43.7 yo (Site 2)	SE	RCT	CT + SE vs SE only	Vocational data (type of job, hours worked, wages earned, job tenure); Cognitive data (WRAT, Digit Span Test, Letter Number Sequencing Test, TMT, DSST, WCST, CVLT); Symptom data (PANSS)	CRT + SE group showed greater improvements in cognitive functioning and had higher rates of competitive work, (number of jobs, hours worked, wages earned).

(McGurk <i>et al.</i> , 2007)	USA	N=44, 37.6 yo	SE	RCT	CT + SE vs SE only	Vocational data (type of job, hours worked, wages earned, job tenure); Cognitive data (WRAT, Digit Span Test, Letter Number Sequencing Test, TMT, DSST, WCST, CVLT); Symptom data (PANSS)	CRT + SE group showed greater improvements in cognitive functioning at 3 months, and were more likely to work, held more jobs, worked more weeks, worked more hours, and earned more wages over 2-3 years.
(McGurk <i>et al.</i> , 2016)	USA	N=54, 39.0 yo (VR-E), 36.4 yo (TSW)	SE	RCT	VR-E vs TSW	Vocational data (nature of work, number of hours worked, wages earned); Cognitive data (Digit Span, Letter Number Sequencing, TMT, DSST, CVLT, WCST), Symptom data (PANSS)	TSW improved more in cognitive functioning (composite measure and executive functioning). No added benefit of adding TSW on job outcomes (although TSW group more likely to engage in work activity).

(Mervis <i>et al.</i> , 2016)	USA	N=54, 38.5 yo	SE	Longitudinal	CBT	Vocational data (WBI, EAS); Functioning data (DAS, PCS, SOFAS, RSES); Symptom data (PANSS, SANS)	Baseline work-specific defeatist beliefs related to baseline self-esteem, employment attitude, work behaviors. Decline in work-specific defeatist beliefs associated with better social functioning, self-esteem, work behaviors. Decline in global defeatist beliefs only associated with improvements in social functioning.
(Milfort <i>et al.</i> , 2015)	USA	N=430, n/r	SE	Qualitative	n/a	Barriers to employment	Most frequently identified barriers to employment: poorly controlled illness symptoms, nonengagement in SE, poorly controlled general medical problems.

(Millner <i>et al.</i> , 2015)	USA	N=76, n/r	n/r	Qualitative	n/a	WOW survey	Perspectives on work clustered under domains representative of primary constructs of social cognitive career theory, i.e., self-efficacy, outcome expectations, personal goals, contextual barriers.
(Mueser <i>et al.</i> , 2005)	USA	N=35, 37.7 yo	SE	RCT	Workplace fundamentals (i.e., skills training program) vs TAU	Vocational data (hours worked, wages earned); Workplace Fundamentals Knowledge Test	Workplace fundamentals group improved more in knowledge of workplace fundamentals. No group differences in number of hours/days worked, salary earned, or receiving additional vocational services.

(Mueser <i>et al.</i> , 2004)	USA	N=204, 41.7 yo (IPS), 41.1 yo (PSR), 40.9 yo (TAU)	SE	RCT	IPS vs PS vs TAU	Vocational data (type/characteristics of job, hours worked, wages earned, tenure); Symptom data (PANSS); Functioning data (GAS, SAS); Social network data (Social Support and Social Network Interview); QoL data (QLS)	IPS group had better employment outcomes than PSR and TAU groups, including more competitive work and any paid work.
(Nuechterlein <i>et al.</i> , 2008)	USA	N=69, 25.2 yo	IPS	n/a	IPS + Workplace Fundamentals Module training program (group skills training approach) vs Brokered Vocational Rehabilitation	IPS	Adaptation involved: individualized evaluation of participants' goals; follow-along support (i.e., work with teachers, aid in study skills/course planning, typical SE activities); work with family members.

(Nygren <i>et al.</i> , 2013)	Sweden	N=65, 19-36 yo (range)	IPS	Longitudinal	IPS	Vocational data (type of work-related activities, total amount of work experience); Symptom data (BPRS); Functioning data (global psychosocial functioning); Clients' perceptions (RSES, MANSA, OSA); Employment support (quantity of support given to each individual)	Only psychiatric symptoms predicted vocational outcomes.
(Pachoud <i>et al.</i> , 2015)	France	n/r, n/r	n/a	Literature review	n/a	Predictive factors of return to work; strategies to optimize vocational services	Individual factors (i.e., clinical state, cognitive skills) optimized by personalized pharmacological treatment and psychosocial interventions (i.e., CR adjusted to clients' specific needs). Environmental factors (i.e., type of vocational support).

(Phillips <i>et al.</i> , 2014)	USA	N=35, n/r	VR	Qualitative	SST	Elements influencing work-related social skills; approaches taken to address social skills deficits	Most salient social skills: non-verbal communication and ability to connect with others. Primary social interventions: informal SST, systems collaboration, creating appropriate job match.
(Prikkens <i>et al.</i> , 2019)	the Netherlands	N=1262, n/r	n/a	Meta-analysis	Computerized cognitive drill and practice training vs control	Cognitive data (MATRICS domains); Symptom data (psychotic, depressive); Functioning data (global, social, vocational)	Patients in computerized cognitive drill and practice training had more improvement on attention, working memory, positive symptoms, depressive symptoms. No effect on functioning.

(Rajji <i>et al.</i> , 2014)	Canada	n/r, n/r	n/a	Review	n/a	n/a	Some studies suggest impact of cognition on functioning depends on severity of baseline cognitive deficits; others suggest it depends on phase of illness.
(Reddy <i>et al.</i> , 2015)	US	N=65, 45.0 yo	IPS	Longitudinal	n/a	Vocational data (employment status, hours worked, weeks worked, dollars earned); Cognitive data (MCCB); Symptom data (BPRS); Motivation (MBEQ, IMI)	Variability in both intrinsic and extrinsic motivation to work. Intrinsic motivation related to valuing and feeling useful in work role was predictive of employment.
(Roder <i>et al.</i> , 2006)	Switzerland	N=73, 33.5 yo	IPT	Column piece	Skills training programs (recreational, vocational, residential programs)	Cognitive data (concentration, attention, memory); Functioning data (GAF, SIS, DAS); Symptom data (BPRS, SANS)	Medium effect sizes were observed for all three programs

(Rollins <i>et al.</i> , 2011)	USA	N=100, 39.3 yo	IPS, DPA	Qualitative	n/a	Vocational data (job tenure, IJSS); Workplace Network Grid	No group differences in workplace network characteristics. Workplace network characteristics correlated with job satisfaction, but not with hourly wages or overall job tenure.
(Salyers <i>et al.</i> , 2008)	USA	N=135, 37.6 yo (least successful), 40.3 yo (most successful)	IPS, DPA	Mixed methods (qualitative and quantitative)	n/a	Factors identified by practitioners as contributing to success or lack of success for consumers in both categories (least successful, most successful); Symptom data (PANSS)	Success viewed by practitioners as job tenure + maintenance. Success attributed to consumer motivation; lack of success attributed to mental health symptoms.
(Sandoval <i>et al.</i> , 2019)		N=16, 24.3 yo	CET	Pilot study	PSI (ORM w/ PSI) vs N-PSI (ORM w/o PSI)	Cognitive data (MCCB, WRAT); ORM performance (assesses alertness, attention, concentration, vigilance, persistence, processing speed)	Patients in PSI group performed better on ORM exercises than N-PSI group.
(Sauvé <i>et al.</i> , 2019)	Canada	N=334, 36.0 yo (SE+), N=322, 37.0 yo (SE)	SE	Meta-analysis	SE+ (SE + CRT) vs SE	Job tenure	Adding CRT to SE does not influence job tenure.

(Sumiyoshi <i>et al.</i> , 2018)	Japan	N=96, 35.8 yo (deteriorated IQ), N=42, 40.9 yo (preserved IQ), N=156, 43.5 yo (controls)	n/a	Longitudinal	n/a	Vocational data (SAS); Cognitive data (WAIS-III, NART); Functioning data (UPSA); Social functioning data (SFS); Symptom data (PANSS, QLS)	Intelligence decline predicted work status. Psychiatric symptoms and social functioning predicted community functioning (including work).
(Tan <i>et al.</i> , 2016)	Singapore	N=371, 41.5 yo	SE	Longitudinal	n/a	Vocational data (mean job tenure, types of jobs, reasons for stopping work)	Prior vocational training predicted longer job tenure; education level and duration of unemployment had no effect on job maintenance.
(Tsang <i>et al.</i> , 2007)	USA, China	N=100, n/r	n/a	Qualitative	n/a	Employers' concerns about hiring people with psychotic disorders	Chinese (compared to USA) employers more likely to view people with mental illness as exhibiting weaker work ethic and less company loyalty. Employers in China more people-oriented vs USA more task-oriented.

(Tsang <i>et al.</i> , 2010a)	China	N=189, 34.1 yo (ISE), 34.1 yo (IPS), 36.5 yo (VR)	SE	RCT	ISE (IPS + SST) vs IPS vs VR	Vocational data (employment rate, job tenure, salary, number of job terminations); 21-item Chinese Job Stress Coping Scale; Personal Well-Being Index; Chinese General Self-Efficacy Scale	ISE obtained higher employment rates, longer job tenure, and fewer interpersonal conflicts at work than IPS and VR groups.
(Tsang <i>et al.</i> , 2010b)	China, USA	n/r, n/r	n/r	Meta-analysis	n/a	Employment outcomes	Significant predictors of employment outcomes: cognitive functioning (most significant), education, negative symptoms, social support and skills, age, work history, rehabilitation services. Non-predictors: positive symptoms, substance abuse, gender, hospitalization history.

(Twamley <i>et al.</i> , 2017)	USA	N=153, 43.7 yo	SE+	RCT	CCT vs ESE	Vocational data (number of weeks worked, job attainment, hours worked, wages earned); Cognitive data (MCCB, TMT, WCST, Letter Fluency, MIST); Functioning and QoL data (UPSA, SSPA, ILLS, QLS); Symptom data (PANSS, HAM-D)	No differences in work attainment, weeks worked, or wages earned between groups. CCT-associated improvements on measures of working memory, depressive symptom severity, QoL (but immediate post-treatment effects not sustained at 2-year follow-up).
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(Villotti <i>et al.</i> , 2018)	Italy	N=139, 41.0 yo	SE	Secondary analysis of longitudinal data	SE	Occupational Self-Efficacy Short-Form Scale; Job Content Questionnaire; Organizational Constraints Scale; Motivation to Keep a Job Scale; Endicott Productivity Scale; Stigma Scale; Symptom data (BSI)	Perceived workplace support positively linked to work outcomes (i.e., motivation to maintain job, improved working/social skills). Occupational self-efficacy positively related to the motivation to keep working. Severity of symptoms did not affect motivation to work. Positive link between motivation to keep working and having perception of improved working/social skills (which then enhanced perceptions of being productive).
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(Waghorn <i>et al.</i> , 2007)	Australia	N=92, 19-56 yo (range)	n/r	Summary report	n/a	Social support (SSQ); Health outcomes (HoNOS, CGI)	Work-related subjective experiences and work-related self-efficacy correlate with current employment, independent of other correlates including measures of disability and illness severity.
(Waynor <i>et al.</i> , 2016)	USA	N=105, 44.0 yo	SE	Longitudinal	SE	Vocational data (employment history, time in SE, employment status); Self-efficacy data (WSS); Symptom data (BSI)	38% of participants achieved competitive employment at 6-month follow-up. Self-efficacy was not a positive predictor of competitive employment.

(Williams <i>et al.</i> , 2016)	Australia, Canada, Israel	n/a, n/a	n/a	Review	n/a	Job tenure (time spent in individual jobs)	Factors contributing to job tenure: worker's experience of performing current job; natural supports in workplace; strategies for integrating working, recovery and wellness.
(Yamaguchi <i>et al.</i> , 2017)	Japan	N=92, 34.8 yo (CR+SE), 34.5 yo (VR)	SE	RCT	CR + SE vs VR	Vocational data (employment rate, job tenure); Cognitive data (BACS); Symptom data (PANSS, HAM-D); Functioning data (GAF)	CR + SE had better vocational and cognitive outcomes than VR.
(Zhang <i>et al.</i> , 2017)	China	N=162, 32.3 yo (ISE), 34.7 yo (IPS), 31.5 yo (VR)	SE	RCT	ISE vs IPS vs VR	Vocational data (Employment Outcome Checklist, Chinese Job Termination Checklist); Symptom data (BPRS); Functioning data (CGSS, GAF, PWI)	Higher employment rate and longer job tenure in ISE vs IPS and VR. Most positive psychological outcomes in ISE group.

Legend: ACT = Assertive Community Treatment; BACS = Brief Assessment of Cognition in Schizophrenia; BASIS-24 = Behavior and Symptom Identification Scale-24; BECES = Barriers to Employment and Coping Efficacy Scale; BLERT = Bell-Lysaker Emotion Recognition Task; BPRS = Brief Psychiatric Rating Scale; BSI = Brief Symptom Inventory; CACR = Computer-Assisted Cognitive Remediation; CAN = Camberwell Assessment of Need; CBTw = CBT for Work Success Program; CCT = Compensatory Cognitive Training; CET = Cognitive Enhancement Therapy; CGI = Clinical Global Impressions; CGSS = Chinese General Self-Efficacy Checklist; COWAT = Controlled Oral Word Association Test; CPRS = Comprehensive Psychopathology Rating Scale; CPT = Continuous Performance Task; CRT = Cognitive Remediation Training; CST = Computer Skills Training; CT = Cognitive Training; CVLT = California Verbal Learning Test; DAS = Dysfunctional Attitude Scale; D-KEFS = Delis-Kaplan Executive Function System; DMDS = Decision-Making About Disclosure Scale; DPA = Diversified Placement Approach; DSCB = Dynamic Social Cognition Battery; DSST = Digit Symbol Substitution Test; EAS = Employment Attitude Survey; EL = Errorless Learning; ESE = Enhanced Supported Employment; FBDST = False Belief and Deception Stories Task; FCBT = Functional Cognitive-Behavioral Therapy; GAF = Global Assessment of Functioning; GAS = Global Assessment Scale; GPT = Gorham's Proverbs Test; HAM-D = Hamilton Depression Rating Scale; HAPI-A = Hoosier Assurance Plan Instrument for Adults; HoNOS = Health of the Nation Outcomes Scale; HVLT = Hopkins Verbal Learning Test; IJSS = Indiana Job Satisfaction Scale; ILLS = Independent Living Skills Survey; IMI = Intrinsic Motivation Inventory; IPS = Individual Placement and Support; IPT = Integrated Psychological Therapy; ISE = Integrated Supported Employment; MacCAT-T = MacArthur Competent Assessment Tool for Treatment; MANSA = Manchester Short Assessment of Quality of Life; MASC = Maryland Assessment of Social Competence; MATRICS = Measurement and Treatment Research to Improve Cognition in Schizophrenia; MBEQ = Motivators and Barriers to Employment Questionnaire; MCCB = MATRICS Consensus Cognitive Battery; MIST = Memory for Intentions Screening Test; n/a = not applicable; NART = National Adult Reading Test; NEII = Narrative Evaluation of Intervention Interview; NET = Neurocognitive Enhancement Therapy; n/r = not reported; ORM = Orientation Remedial Module ©; OSA = Occupational Self-Assessment; PANSS = Positive and Negative Syndrome Scale; PAS = Premorbid Adjustment Scale; PCS = Perceived Competence Scale; PE = Psycho-Educational Program; PSI = Peer Social Interaction; PSR = Psychosocial Rehabilitation Program; PST = Picture Sequencing Task; PSYRATS = Psychotic Symptoms Rating Scale; PWI = Personal Well-Being Index; QLS = Quality of Life Scale; QoL = Quality of Life; QRS = Questionnaire of Resources and Stress for Families with Chronically Ill or Handicapped Members; RAVLT = Rey Auditory Verbal Learning Test; RBANS = Repeatable Battery for the Assessment of Neuropsychological Status; RCFT = Rey-Osterrieth Complex Figure Test; RCT = Randomized Controlled Study; RSES = Rosenberg Self Esteem Scale; SANS = Scale for the Assessment of Negative Symptoms; SAPS = Scale for the Assessment of Positive Symptoms; SAS = Social Adjustment Scale; SDMT = Symbol Digit Modalities Test; SDS = Self-Directed-Search; SE = Supported Employment; SE+ = Augmented Supported Employment; SES = Self-Esteem Rating Scale; SFS = Social Functioning Scale; SIS = Social Interview Schedule; SSPA = Social Skills Performance Assessment; SST = Social Skills Training; SSQ = Social Support Questionnaire; SUMD = Scale to Assess Unawareness of Mental Disorder; SWS = Satisfaction with Services Scale; TAU = Treatment as Usual; TMT = Trail Making Test; ToM = Theory of Mind; TSW = Thinking Skills Work; UPSA = UCSD Performance-Based Skills Assessment; VR = Vocational Rehabilitation; VR-E = Vocational Rehabilitation, Enhanced; WAIS-III = Wechsler Adult Intelligence Scale, Third Edition; WAIS-IV = Wechsler Adult Intelligence Scale, Fourth Edition; WANSS = Work Accommodation and Natural Support Scale; WBI = Work Behavior Inventory; WCST = Wisconsin Card Sorting Test; WGT = Work Group therapy; WHO-DAS = World Health Organization-Disability Assessment Schedule; WHOQOL-BREF = World Health Organization Quality of Life-BREF; WMS-III = Wechsler Memory Scale, Third Edition; WOW = World of Work; WPS = Work Placement Scale; WRAT-4 = Wide Range Achievement Test, Fourth Edition; WSS = Work-Related Self-Efficacy Scale; WT = Work Therapy; yo = years old

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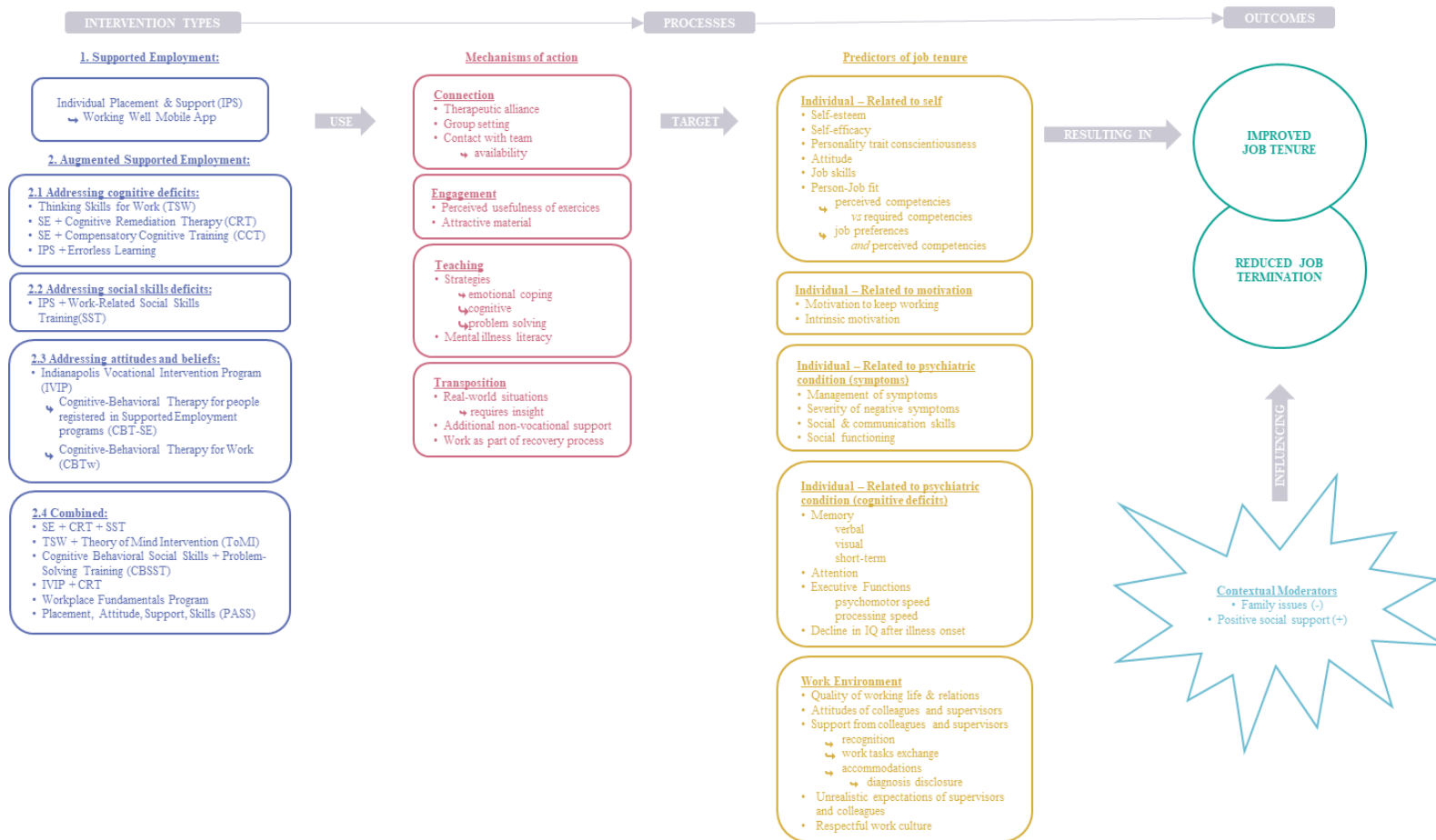


Figure 2.2 Proposed logic model illustrating putative links between intervention typologies, processes and outcomes.

Table 2.2 Description of the ‘Minds@Work’ program modules

Module	Title	Description	Exercises & Homeworks
1	Personal strengths and motivation at work	Participants’ character strengths, motivation at work, and universal psychological needs	<p>Identification of work elements that satisfy/thwart universal psychological needs</p> <p>Development of personal strategies to increase satisfaction and decrease thwarting of universal psychological needs</p>
2	Self-compassion and personal objectives	Mindfulness, self-compassion, S.M.A.R.T. method for fixing personal objectives	<p>Jacobson progressive muscle relaxation session</p> <p>Identification of work situations wherein relaxation techniques could be personally helpful</p> <p>Development of personal strategies to facilitate using relaxation techniques in identified situations</p> <p>Love and kindness meditation session</p> <p>Personalized messages/behaviors to be more self-compassionate</p> <p>Development of personalized S.M.A.R.T. objective.</p>
3	Problem solving	Iterative 6-step method for problem-solving	<p>Testing of the 6-step method in group using personal example</p> <p>Identification of personal problem to solve and</p>

			solutions to be tested
4	Attention and Memory	Definitions and domains of neurocognitive functioning, Strategy toolbox, Neurocognitive training	Development of personal strategies for work tasks requiring attention & memory
5	Cognitive biases	Jumping to conclusions (mind reading & prediction errors), Defeatists beliefs, Personalized strategy teaching; Review of personal S.M.A.R.T. objective	Scripted role-play exercises (4) using work-related example for jumping to conclusions and defeatist beliefs Identification of at-risk work situations for cognitive biases (jumping to conclusions and defeatists beliefs) and development of personal strategies for thought reappraisal
6	Emotions	Emotion recognition, Emotional vocabulary and literacy, Emotional regulation, Personalized strategy teaching	Body scan meditation session Emotional labelling using scripted role-play Development of personal strategies for emotional regulation
7	Understanding others better	Theory of mind (What and Why Others Do, Think and Feel), Personalized strategy teaching, Review of personal S.M.A.R.T. objective	Scripted role-play exercises (3) using work-related examples to identify what and why people behave, think and feel the way they do
8	Communication	Verbal and non-verbal communication, Positive assertiveness, Interpersonal problem solving, Receiving feedback, Personalized strategy teaching	In-team practice of handshaking and feedback In-team practice of positive assertiveness using personal work-related example Scripted group role-play (2)

			for receiving feedback and solving interpersonal problem
9	Learning consolidation and future plans	Review of personal S.M.A.R.T. objective, Review of themes and strategies, Participants feedback on program, Future occupational aspirations, All-strategies cheat sheet	Discussions & quizzes on previous learnings

CHAPITRE III

CONCLUSIONS ET PISTES FUTURES

Le présent projet de recherche avait pour objectif d'effectuer une recension des écrits scientifiques portant sur le maintien en emploi des personnes vivant avec un trouble psychotique et d'en modéliser les résultats selon la méthodologie des modèles logiques afin de développer un nouveau modèle d'intervention.

Tel que décrit préalablement, le degré de fonctionnement au travail des personnes vivant avec un trouble psychotique a des conséquences cliniques, économiques et sociétales importantes. Alors que certaines retombées théoriques et cliniques du présent projet ont été évoquées dans la partie précédente, les prochaines sections mettront en relief les contributions de ce dernier en soulignant notamment les impacts du maintien en emploi durable sur le processus de rétablissement de l'individu et les façons d'impliquer les autres acteurs du monde du travail dans ce processus. Pour finir, les limites de la présente étude et les pistes de recherche futures seront présentées.

3.1 Le travail comme composante du processus de rétablissement

Pendant plusieurs décennies, le concept de rétablissement des individus ayant reçu un diagnostic psychiatrique était limité à la réduction de la sévérité de leurs symptômes.

Plus récemment, des approches axées sur le rétablissement, centrées sur la personne dans son ensemble, ont été développées. Ainsi, le concept de rétablissement est maintenant défini par certains comme un *processus* multidimensionnel, dynamique et subjectif (Davidson et Roe, 2007; Slade *et al.*, 2008).

Parmi les dimensions du rétablissement, on retrouve le fonctionnement au travail, qui inclut la réappropriation de certains rôles (e.g., travailleur, étudiant, bénévole) permettant du même coup la reconstruction de l'identité (Saavedra, 2009) et ce, malgré la présence (ou après un épisode) de difficultés psychologiques. Les conceptions modernes du rétablissement semblent donc encourager la reprise des activités de la personne même si celle-ci présente encore des symptômes psychiatriques résiduels. Pour les individus ayant vécu un ou plusieurs épisodes psychotiques, ceci peut représenter une perspective optimiste puisqu'une grande proportion d'entre eux affichent encore des symptômes négatifs à la suite d'un épisode psychotique (SauvéBrodeur, *et al.*, 2019). Ces symptômes négatifs, comme l'amotivation, l'asocialité et l'anhédonie, ont une forte composante psychologique et font en sorte que ces personnes entretiennent des croyances défaitistes à propos d'eux-mêmes, ont plus de difficultés à se mobiliser, à interagir avec les autres et à prendre plaisir à certaines activités, comme occuper un emploi (Beck *et al.*, 2013). Tel que proposé dans notre modèle logique, la sévérité et la gestion des symptômes négatifs représentent un prédicteur du maintien en emploi chez cette population (Evans *et al.*, 2004). Puisque les traitements actuels pour traiter les symptômes négatifs associés aux troubles psychotiques sont modestement efficaces (Fusar-Poli *et al.*, 2015; Lutgens *et al.*, 2017), il est raisonnable de penser que la réinsertion professionnelle pourrait représenter une voie intéressante à considérer pour l'amélioration voire la disparition de ces symptômes malléables. Ainsi, en plus de promouvoir le maintien en emploi, le programme développé dans le cadre du présent projet propose d'aborder directement ces thématiques en ciblant les attitudes et croyances problématiques et utilisant des techniques de remédiation sous l'angle de la

psychologie positive dans le but de réduire les symptômes négatifs et d'envisager une voie de rétablissement plus soutenue (Campellone *et al.*, 2016).

Des stades et styles de rétablissement ont été proposés par certains auteurs. Dans leur modèle, Andresen *et al.* (2003) identifient 5 stades du processus de rétablissement, nommément les périodes : moratoire, de prise de conscience, de préparation, de reconstruction, et de croissance (traduction libre de : *moratorium, awareness, preparation, rebuilding, growth*). Selon Lemos-Giraldez *et al.* (2015), le *premier* stade est en partie caractérisé par le déni et la confusion; le *deuxième* par l'émergence de l'espoir et du sentiment d'agentivité sur son processus de rétablissement; le *troisième* par l'établissement d'objectifs de vie significatifs pour la personne; le *quatrième* par une poursuite active des buts et la construction d'un sens de soi positif, et finalement; le *cinquième* par une quête d'auto-actualisation et l'adoption d'une perspective positive par rapport au futur. Le processus de (ré)intégration sur le marché du travail et le désir de se maintenir en emploi s'insère ainsi pleinement dans les stades 2 à 5 du rétablissement. Les résultats du présent projet permettront par conséquent de mieux guider les chercheurs et cliniciens dans le développement de leurs traitements centrés sur la personne et orientés vers le rétablissement, ce qui représente d'ailleurs de nouvelles retombées théoriques et cliniques.

De plus, les styles de rétablissement ayant été identifiés inclus : l'intégration et l'isolement (traduction libre de : *sealing over*; Drayton *et al.*, 1998). Selon McGlashan *et al.* (1975), le premier réfère à la capacité de la personne à concevoir son/ses expérience(s) psychotique(s) comme faisant partie d'un continuum de son activité mentale dont elle possède une certaine agentivité et conscience. Le deuxième style représente plutôt la tendance d'une personne à isoler son/ses expérience(s) psychotique(s) et à les comprendre comme des épisodes interrompant sa vie. Le maintien en emploi pourrait donc être vu comme pouvant favoriser ou faisant partie d'un style de rétablissement plus adaptatif (intégration). En se maintenant en emploi

de façon pérenne, les personnes vivant avec un trouble psychotique possèdent peut-être des repères plus stables leur permettant ainsi de mieux s'adapter et se rétablir à la suite d'épisodes psychotiques. De plus, l'adoption d'un style de rétablissement moins adaptatif (isolement) pourrait potentiellement brimer le maintien en emploi puisque le/les épisode(s) psychotiques peuvent être perçus comme une rupture des activités et rôles de l'individu. Il serait donc intéressant d'investiguer la relation entre le style de rétablissement et la durée du maintien en emploi puisque certaines études ont suggéré qu'une majorité d'individus vivant avec un trouble psychotique quittent volontairement leur emploi (Tan *et al.*, 2016). Lors du développement de l'intervention « Cerveaux@Travail », une approche centrée sur la personne a été adoptée (p. ex., en basant les exercices sur les expériences subjectives des participants, en travaillant sur un objectif personnel), ce qui pourrait laisser penser que le matériel thérapeutique promeut un style adaptatif de rétablissement.

D'un point de vue qualitatif, plusieurs études utilisant ce type de devis de recherche ont rapporté que les personnes vivant avec un trouble psychotique trouvent plusieurs bénéfices à occuper un emploi. Parmi ces bienfaits, on retrouve des changements au niveau de la perception de soi et des autres, comme l'augmentation du sentiment d'être utile et de contribuer à la société (Saavedra *et al.*, 2016). En travaillant, certains retrouvent un sentiment d'autonomie et d'indépendance puisqu'ils n'ont plus à compter sur les programmes gouvernementaux pour une assistance sociale et financière (Marwaha et Johnson, 2005). Dans la même étude, d'autres participants ont également rapporté que le travail leur a permis de réduire leur isolement social et de structurer leur temps. Tous ces éléments, qui représentent des effets indirects positifs du maintien en emploi, contribuent sans aucun doute à un processus de rétablissement plus adaptatif. Par conséquent, il n'est pas surprenant de constater que le travail représente souvent l'objectif premier des jeunes adultes vivant avec un trouble psychotique, soulignant l'importance du fonctionnement au travail comme

composante essentielle du rétablissement (de Waal *et al.*, 2018; Iyer, S. N. *et al.*, 2011).

3.2 L'implication des autres acteurs du monde du travail

Selon une perspective réaliste, l'amélioration du maintien en emploi des personnes vivant avec un trouble psychotique ne pourrait pas se faire sans impliquer les autres acteurs du monde du travail. Parmi ceux-ci, on retrouve notamment les employeurs, supérieurs immédiats, les spécialistes en emploi, représentants syndicaux, gestionnaires des ressources humaines et les compagnies d'assurance.

Les données de la littérature scientifique semblent malheureusement rapporter que des individus occupant ces fonctions tiennent parfois certains préjugés face aux personnes ayant reçu un diagnostic de santé mentale. Dans une étude menée par Tsang *et al.* (2007), les auteurs relatent que des inquiétudes quant à la productivité, au risque de rechute et à la potentielle dangerosité des personnes ayant reçu un diagnostic de santé mentale font partie des craintes de certains employeurs. D'autres mythes entretenus chez certains acteurs du monde du travail incluent également qu'il serait trop stressant de travailler pour les personnes ayant reçu un diagnostic psychiatrique, qu'ils ne désireraient pas ou ne pourraient pas occuper un emploi dans le marché du travail régulier, ou qu'ils devraient être rétablis de tous symptômes avant de pouvoir travailler¹ (Hampson *et al.*, 2018). Ces croyances et attitudes

¹ L'auteure tient à accentuer le fait que ces propos représentent des mythes et des croyances entretenues par certaines personnes, et qu'ils ne reflètent donc pas la réalité des individus ayant reçu un diagnostic psychiatrique.

représentent des barrières significatives à l'intégration au marché du travail régulier des personnes vivant avec un trouble psychotique (Corbière, M., Charette-Dussault, *et al.*, 2020). À l'inverse, le modèle logique proposé dans la présente étude suggère que lorsque ces attitudes sont positives et que ces acteurs prodiguent du soutien aux travailleurs vivant avec un trouble psychotique, ces derniers peuvent plus aisément se maintenir en emploi (Corbière, M., Charette-Dussault, *et al.*, 2020; Corbière, Marc *et al.*, 2014; Rollins *et al.*, 2011).

Par conséquent, l'utilisation d'approches éducatives et psychopédagogiques permettant de développer la littératie en matière de santé mentale des acteurs du monde du travail ont été proposées comme stratégies pour surmonter les obstacles liés à la stigmatisation et aux préjugés. Selon une étude qualitative de Can Öz *et al.* (2019), certains employeurs ont rapporté être ouverts à l'idée d'embaucher des personnes vivant avec un trouble psychotique, mais indiquent se sentir peu outillés pour le faire et aimeraient développer leurs connaissances sur ce sujet. En impliquant directement certains membres du personnel des entreprises (p. ex., supérieurs immédiats, intervenants psychosociaux) dans le processus du maintien au travail, le programme d'intervention développé dans le cadre du présent projet offre une voie efficace et précise pour éduquer et outiller les acteurs du monde du travail quant aux enjeux et stratégies à adopter face aux problématiques liées à la maladie mentale en milieu de travail (Corbière, M. Mazaniello-Chézol, *et al.*, 2020). De plus, compte-tenu de l'utilisation de l'approche centrée sur la personne, les informations et connaissances transmises aux membres du personnel des entreprises sont adaptées et personnalisées à leur milieu de travail spécifique. Un avantage apparent de cette approche semble donc être d'offrir de l'information immédiatement utilisable, concrète, qui peut être perçue comme ayant une grande pertinence pour les acteurs du monde du travail.

De tels efforts éducatifs et de sensibilisation pourraient également avoir des impacts positifs sur la culture organisationnelle, qui fait également partie du modèle logique proposé. D'un point de vue psychologique, on peut définir la culture organisationnelle comme étant l'ensemble des pratiques, valeurs et attitudes qui sont promues par une entreprise (Warrick, 2017). Ainsi, en développant les connaissances des acteurs du milieu du travail en matière de santé mentale, il est raisonnable de penser que leurs attitudes, valeurs et pratiques organisationnelles pourraient être modifiées de manière positive. Ceci devrait avoir pour effet, selon notre modèle, de promouvoir le maintien en emploi des personnes vivant avec un trouble psychotique .

Les entreprises d'économie sociale représentent une démonstration intéressante des impacts positifs d'une culture organisationnelle axée vers le rétablissement et l'inclusion sociale des personnes vivant avec une problématique de santé mentale. Ces entreprises ont une mission organisationnelle à caractère social et réinvestissent leurs profits de façon à améliorer les conditions de travail de leurs employés qui vivent pour la plupart avec des problématiques de santé mentale ou physique (Corbière, M.Villotti, *et al.*, 2019). Au Québec, ces entreprises sont encadrées par la *Loi sur l'économie sociale* et représentées par le *Chantier de l'économie sociale* ainsi que le *Conseil québécois de la coopération et de la mutualité (Loi sur l'économie sociale)*. Des études ont démontré que les travailleurs œuvrant dans ce type d'entreprise se sentent compétents et utiles, et sont même plus productifs, utilisent moins de services de santé et se maintiennent en emploi plus longtemps (Corbière, M.Zaniboni, *et al.*, 2019; Dewa *et al.*, 2019; Sultan-Taïeb *et al.*, 2019; Svanberg *et al.*, 2010). Le modèle logique proposé ainsi que l'intervention développée dans le cadre du présent projet pourraient être d'une grande utilité pour ces entreprises compte-tenu de leur alignement avec leur mission qui est de servir les intérêts de la communauté qu'ils représentent. On peut également penser que cette nouvelle intervention pourrait permettre d'inspirer une mission d'inclusion sociale semblable dans les entreprises du milieu du travail ordinaire, notamment en outillant les

employeurs qui désirent embaucher des personnes vivant avec un trouble psychotique, mais qui se sentent démunis pour le faire.

3.3 Limites

La présente étude comporte plusieurs limites qui doivent être mentionnées. Tout d'abord, il est attendu que même une recension systématique des écrits scientifiques ne puisse identifier tous les articles publiés sur un sujet puisqu'il s'agit d'une des limites inhérentes de cette méthodologie. Malgré l'adhésion aux lignes directrices PRISMA sur les recensions systématiques des écrits et les méta-analyses, une identification exhaustive de toutes les études effectuées sur un sujet demande énormément de ressources (p. ex., publications Cochrane) et il est attendu que certaines données non-publiées ou repérables dans la littérature grise soient plus ardues à identifier (Bertrand *et al.*, 2014; Potvin, 2020).

Ensuite, le modèle logique proposé dans le cadre du présent projet a été développé uniquement en fonction des résultats de la recension systématique des écrits scientifiques et n'a pas inclus de consultations auprès d'acteurs impliqués dans le processus de maintien en emploi des personnes vivant avec un trouble psychotique, tel que suggéré par les lignes directrices pour le développement de modèles logiques (W. K. Kellogg Foundation Team, 2004). Cependant, il est important de noter que ces lignes directrices ont été développées pour la planification et l'évaluation de programmes. Leurs recommandations s'adressent donc plus particulièrement à des personnes désirant développer et implanter un nouveau programme dans un milieu spécifique. Les premières étapes de la planification impliquent une recension des écrits scientifiques, et c'est seulement par la suite qu'il est recommandé de consulter les différents acteurs du milieu. Ainsi, compte-tenu de notre objectif qui est un peu

différent dans le cadre de ce projet, nous avons suivi les recommandations qui correspondaient davantage à notre but soit de proposer une version préliminaire d'un modèle logique.

Une autre limite de la présente étude concerne le faible nombre d'articles provenant du domaine de la psychologie organisationnelle. Dans le futur, il pourrait donc être pertinent d'inclure d'autres bases de données qui ne sont pas directement liées à la psychologie, mais qui pourraient permettre de repérer des articles provenant des domaines de la gestion, de l'administration et de l'organisation des ressources humaines.

L'absence de validation empirique de la faisabilité et de l'efficacité de l'intervention développée dans le cadre du présent projet représente une autre limite importante. Néanmoins, une attention particulière a été portée pour rendre le matériel de l'intervention accessible et facilement utilisable par d'autres équipes de recherche afin de favoriser entre autres sa validation scientifique en dehors du contexte dans lequel l'intervention a été créée. Un excellent exemple de l'efficacité de cette approche de libre accès revient aux créateurs du programme d'entraînement des habiletés métacognitives (Moritz et Woodward, 2007). Ces auteurs ont décidé de rendre accessible en ligne tout le matériel d'intervention et ce, sans frais. Durant les années qui ont suivies, on constate que des dizaines d'études menées par diverses équipes de recherche ont scientifiquement vérifié les effets de leur intervention (Sauvé *et al.*, 2020). Cette approche de libre accès semble donc permettre de produire des connaissances plus riches étant donné qu'elle permet de contourner certains biais, par exemple en lien avec la généralisation des résultats de recherche qui seraient effectuées auprès des mêmes populations provenant des mêmes régions géographiques et évoluant dans des contextes socioéconomiques et culturels similaires.

Finalement, une dernière limite à mentionner est à l'effet que le modèle logique proposé n'offre pas de distinction des différents stades des troubles psychotiques (McGorry *et al.*, 2014) et la présence de troubles psychiatriques comorbides (p.ex., troubles liés à une substance et troubles addictifs). Il est raisonnable de penser que les processus de (ré)insertion sur le marché de l'emploi et de maintien au travail pourraient être différents pour des personnes ayant récemment vécu un premier épisode psychotique comparativement à celles ayant fait l'expérience de multiples épisodes, ainsi que pour celles qui vivent avec plusieurs symptômes psychiatriques de différentes natures. De plus, la notion de fonctionnement au travail implique probablement pour les populations plus jeunes la notion de retour et/ou de maintien aux études (Iyer, S. *et al.*, 2018). Bien que des études suggèrent que les programmes de soutien à l'emploi soient efficaces autant auprès de personnes ayant récemment vécu un premier épisode psychotique que chez celles ayant fait l'expérience de multiples épisodes (Bond *et al.*, 2016; Rosenheck *et al.*, 2017), il pourra être pertinent de vérifier l'applicabilité du modèle proposé pour ces différentes populations.

3.4 Pistes futures

En proposant un modèle théorique et une nouvelle intervention, le projet développé dans le cadre de cet essai doctoral pourrait servir de fondement pour plusieurs études futures. Dans un premier temps, il serait pertinent de valider scientifiquement la faisabilité, l'acceptabilité et l'efficacité de l'intervention proposée dans le cadre du présent projet. Tel que mentionné précédemment, les entreprises d'économie sociale pourraient représenter une population intéressante pour vérifier les effets de l'intervention. De plus, des aspects additionnels pourraient être considérés dans une version future et élargie du modèle théorique et de l'intervention, par exemple : (1) comment peut-on mettre à profit le soutien social/familial des personnes vivant avec

un trouble psychotique dans leurs efforts de maintien en emploi, et (2) quels seraient les ajustements à faire au programme pour prendre en compte la réalité des personnes vivant avec un trouble psychotique qui vivent également avec un trouble comorbide (troubles liés à une substance et troubles addictifs) notamment dans leurs parcours d'emploi (Luciano et Carpenter-Song, 2014).

Par la suite, il pourrait être avantageux de s'inspirer du matériel de l'intervention pour développer une formation qui pourrait être offerte aux différents acteurs du milieu du travail, incluant les spécialistes en emploi. Plusieurs objectifs pourraient être envisagés dans ce contexte, comme améliorer la littératie en matière de santé mentale et assister les entreprises à surmonter les difficultés auxquelles elles peuvent faire face en lien avec le maintien au travail de leurs employés (Therrien *et al.*, 2020). De plus, d'autres types d'intervenants, comme les spécialistes en emploi, conseillers en orientation, psychoéducateurs, travailleurs sociaux et intervenants communautaires, pourraient aussi potentiellement profiter des enseignements prodigués dans le cadre d'une telle formation. En lien avec ce point, il serait également intéressant d'investiguer l'impact des caractéristiques des acteurs du milieu du travail et des spécialistes en emploi sur le maintien au travail des personnes ayant un trouble psychotique.

Dans un avenir plus éloigné, il pourrait être intéressant de vérifier si le modèle logique proposé ici s'applique également aux personnes ayant un trouble mental courant (e.g., trouble anxieux ou dépressif; Danielsson *et al.*, 2019). Dans l'affirmative, il pourrait ensuite s'avérer pertinent d'adapter l'intervention à cette population qui fait souvent face à plusieurs obstacles lors d'un retour au travail suivant un arrêt pour cause de trouble mental (Corbière, M. *et al.*, 2018). Ces obstacles font parfois en sorte que ces individus se retrouvent dans un cycle répétitif d'arrêt et de reprise de travail qui pourrait être similaire à celui vécu par les personnes vivant avec un trouble psychotique .

De manière plus générale, deux événements récents ont inspiré d'autres pistes de recherches futures. Tout d'abord, la pandémie du coronavirus (COVID-19) a forcé de nombreuses entreprises à revoir leurs pratiques organisationnelles en favorisant le télétravail (Raisiene *et al.*, 2020). Il serait donc intéressant d'investiguer les répercussions de ces changements organisationnels sur les personnes vivant avec un trouble psychotique . Deuxièmement, la résurgence récente du mouvement social « *Black Lives Matter* » suivant les circonstances entourant le décès de M. George Floyd aux États-Unis (Agence France-Presse, 2020, 4 juin) a entre autres eu pour effet de sensibiliser la communauté académique aux biais ethnoculturels présents dans le monde de la recherche. C'est dans ce contexte que l'initiative « #ShutDownSTEM² » a pris place sur les réseaux sociaux le 10 juin 2020 (Nature, 2020). Celle-ci avait pour but d'encourager les membres de la communauté scientifique à mettre une pause sur leurs travaux, le temps d'une journée, afin de réfléchir à des solutions pour enrayer le racisme systémique envers certains groupes issus des minorités culturelles. C'est donc dans cet ordre d'idées qu'il pourrait être pertinent d'investiguer les impacts (et les solutions aux impacts négatifs) de l'appartenance culturelle sur le fonctionnement au travail chez les personnes vivant avec un trouble psychotique (Boydell *et al.*, 2013; Cooper *et al.*, 2008; Morgan *et al.*, 2008).

Pour conclure, le présent projet propose un modèle théorique illustrant comment les programmes de soutien à l'emploi utilisent certains mécanismes d'actions pour améliorer le maintien en emploi chez les personnes vivant avec un trouble psychotique . Ce modèle comporte des retombées théoriques et cliniques, et a permis

² Traduction libre : « Interrompons les sciences, technologies, ingénierie et mathématiques »

le développement d'une nouvelle intervention psychosociale intégrative visant spécifiquement l'amélioration du maintien au travail des personnes vivant avec un trouble psychotique . Tel qu'illustré précédemment, des efforts pour optimiser le fonctionnement au travail de ces individus s'inscrit dans une démarche centrée sur la personne et axée vers le rétablissement. L'implication d'autres acteurs du monde du travail, comme les employeurs et les supérieurs immédiats, devrait permettre d'améliorer la qualité de vie au travail des personnes ciblées dans ce projet.

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