Vocational Rehabilitation and Mental Health

Edited by

Chris Lloyd

School of Population Health
The University of Queensland and the Queensland Centre for Mental Health Research
Australia
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PREFACE

Employment in mental health services

Unemployment is harmful to health and is linked with increased general health problems. Unfortunately, unemployment can lead to social exclusion (Turner et al., 2009). It has been found that employment is beneficial in many aspects of people’s lives, while not working can have detrimental effects on people’s general health and well-being (Rinaldi et al., 2008). Work may be used to reintegrate people with mental illness into the community. As well as income, work provides other important benefits such as social identity and status, social contacts and support, a means of structuring and occupying time, activity and involvement, and a sense of personal achievement (Evans & Repper, 2000).

The emphasis on social inclusion and integration rather than segregation has resulted in attempts to enable people with mental illness to gain and retain open employment through implementation of evidence-based practices in vocational services (Marwaha & Johnson, 2004).

Over the past several years, there has been very little change in the proportion of adults with mental illness participating in the workforce. This is in contrast with the increases of the employment rate in the general population and in those with physical disabilities. More concerning is the finding that the rates of employment for people with schizophrenia has actually decreased over the last decade (Perkins & Rinaldi, 2002). The lack of employment in those with severe mental illness, such as schizophrenia, is costly to society in terms of being in receipt of the disability allowance and not contributing to payment of taxes.

The increasing emphasis on productivity and the dominance of services industries and technology means that much of the nature of work has changed. This poses a problem for people with severe mental illness as they often have a poor work history and have problems with social skills (Tsang, 2001). These problems may be compounded by a lack of dedicated services helping people to obtain and to stay in work. There are also problems concerning being in receipt of disability allowances – the benefit trap – which may deter people from seeking employment. This may be particularly applicable for people considering working part-time. It seems that the main barriers to employment are stigmatisation of the mentally ill, economic disincentives, the attitudes and self-esteem
of those with severe mental illness, and the response mental health services to their needs for support in obtaining and maintaining employment (Marwaha & Johnson, 2004). One of the biggest barriers to them finding and keeping work is that of stigma (Perkins et al., 2008).

It has been found that in most studies, the majority of respondents say they do want to work (McQuilken et al., 2003). However, it has been reported that people have concerns about receiving low pay and of being ashamed of their employment history and fears about their ability to cope with the work. These attitudes and beliefs can affect the likelihood of getting work and keeping it. Mental health professionals may unintentionally collude with barriers that people with mental illness face in gaining work. For example, vocational rehabilitation may not be included in the care plans of people with mental illness (Lehman & Steinwachs, 1998). The low expectations held by mental health professionals have been influenced by the dominance of a model for illness that emphasis symptoms and cure as opposed to a model of recovery. It may well be that mental health professionals may underestimate the skills, experiences and capabilities of their clients. These low expectations can create a cycle of decreasing hope and opportunity that has a direct impact on people with mental illness (Rinaldi et al., 2008).

There is an increasing interest in the subject of work for those with severe mental illness. This has arisen by the appearance of newer service models such as Individual Placement and Support (IPS; Bond et al., 2008). This model aims to assist clients get their chosen job and to provide the support they require to keep it rather than focusing exclusively on pre-vocational training. Potentially, this model has made employment for people with severe mental illness more achievable. It is thought that people with a mental illness are likely to regard meaningful recovery as involving a return to open market employment paid at a full usual rate. Seven core principles are included in this model. These principles include (1) a desire to work, (2) a focus on obtaining competitive employment, (3) an emphasis on rapid job placement, (4) the plan is individualised and based on consumer preference, (5) an integrated approach to service delivery, (6) follow-along supports are based on consumer needs rather than predetermined timeframes and (7) provision of benefits counselling.

This approach focuses on rapidly placing the person in a competitive employment situation, often within weeks after their initial enrolment in the programme (Corbiere & Lecomte, 2007). This is based on the client’s choices and capabilities and does not require extended pre-vocational training. The employment specialist actively facilitates job acquisition. Staff tend to accompany clients on interviews, and they provide ongoing support once the client is employed. Most importantly, the IPS model integrates vocational and treatment teams. The major advantage of supported employment programmes over other vocational services is that the clients actually obtain real-world competitive jobs. This is important in promoting the client’s role in society and facilitating
their integration while working against the stigma of mental illness (Corbiere & Lecomte, 2007). But despite the increase in the number of programmes to assist people with severe mental illness find work, employment outcomes continue to be poor.

Various combinations, adaptations and integrations of specific vocational service components are used in order to help people with severe mental illness attain their vocational goals. It is important that practitioners become familiar with the types of approaches that have been developed, which augment vocational services. It is only by doing so that they will be better able to achieve more positive employment outcomes for their clients.

How the book is organised

Chapter 1 explores the impact that mental illness has on employment and looks at the value of work for people with mental illness.

Chapter 2 examines the evidence for supported employment services, in particular the IPS model.

Chapter 3 looks at the challenges of integrating mental health and employment services.

Chapter 4 examines the effect that stigma has on people with mental illness and looks at how supported employment may be used as an integrated employment strategy.

Chapter 5 looks at how motivational interviewing may be used as a means of assisting clients clarify and enhance motivation for change and resolve ambivalence about employment.

Chapter 6 examines the problems related for employment experienced by people with mental illness, in particular personal, environmental and occupational factors are addressed.

Chapter 7 examines the components thought to be important in the therapeutic relationship and in developing a strong therapeutic alliance in vocational rehabilitation contexts.

Chapter 8 suggests that a useful approach for practitioners to use is a recovery framework combining evidence-based employment and education assistance with mental health care provided in parallel with some other specific strategies.

Chapter 9 looks at the importance of planning and conducting employment programmes for young people with early psychosis.

Chapter 10 examines the importance of work-related social skills in job retention and outlines a protocol for integrated supported employment.

Chapter 11 looks at how symptoms of mental illness can interfere with employment outcomes and talks about various strategies to reduce the negative impact of symptoms.
Preface

Chapter 12 looks at the health benefits of education and describes the features and strategies that practitioners can employ to develop supported education programmes.

Chapter 13 talks about developing explicit plans with clients to comprehensively manage their personal information in order to access reasonable job accommodations.

Conclusions

Employment of people with mental illness has become an issue that has caught the attention of policy-makers. Researchers have demonstrated the effectiveness of the IPS approach to supported employment. It is now the time for mental health practitioners to consider the evidence for this approach to employment and look to using this information to better inform their practice. This book offers a variety of approaches and strategies designed to assist practitioners develop a comprehensive approach to assisting their clients find and maintain competitive employment.

References


Chapter 1

EMPLOYMENT AND PEOPLE WITH MENTAL ILLNESS

Geoff Waghorn and Chris Lloyd

Chapter overview

This chapter explores the impact of mental illness on employment. It goes on to talk about the value of employment and how people with a mental illness have both the capacity and the desire to work. There are a number of barriers to employment, ranging from the nature of the disorder, stigma and career immaturity. Today, recovery is an important concept and we talk about how employment and education contribute to recovery. We conclude the chapter by examining evidence-based interventions that will assist people in achieving their goal of competitive employment.

Introduction

There is substantial evidence that the vocational rehabilitation needs of people with mental illness are not being adequately addressed. Labour force non-participation and unemployment levels of 75–90% are found in the USA (Hughes, 1999), 61–73% in the UK, and reach 75–78% among people with psychotic disorders in Australia (Waghorn et al., 2004a). In countries with developed market economies, people with mental illness experience difficulties in achieving the basic right to work (Harnois & Gabriel, 2000). They are also sensitive to the negative effects of unemployment and the loss of purpose, structure, roles, status and sense of identity, which employment provides (Boardman et al., 2003). Employment enables social inclusion in the wider community and represents an important way in which people with mental illness can meaningfully participate in society. People with mental illness need the same opportunities to participate in life activities and their local communities as people with good mental health (Corrigan, 2003). All people in our community have the right to suitable employment in conditions which reflect equity, security, human dignity and respect. Work is important to the mental health and wellbeing of individuals. It is a central aspect of life for most people and provides economic security, valued personal roles, social identity and an opportunity to make a meaningful contribution to the community. Suitable employment enables social and economic participation in society.
This chapter aims to discuss how mental illness can cause barriers to employment and identify the evidence-based ingredients to employment assistance.

The impact of mental illness on employment

Anxiety and depression are prevalent in the community and together are found in approximately 5–10% of the population (Australian Bureau of Statistics, 1998) at any time. Anxiety disorders are associated with increased non-participation in the labour force, deflated employment trajectories and impaired work performance compared to healthy people (Waghorn et al., 2005b).

Depression is known to cause absenteeism from work (Kessler & Frank, 1997) and impair work performance when at work (Kessler et al., 2001). People with depression also have reduced labour force participation, reduced working hours and may earn less than healthy workers (Whooley et al., 2002). People with depression may have impaired motivation, impaired decision-making and a reduced capacity to initiate a particular course of action. Depression can be misunderstood by employers and vocational service providers as poor motivation for work generally or, when employed, as low motivation for working productively.

Bipolar disorder can fluctuate more than most other mental disorders, and may involve a manic phase where productivity and creativity can be high, time and energy management may be impaired and the person may over-exert themselves until a depression cycle is reached. People with bipolar affective disorders may have relatively little difficulty obtaining employment, but unless new strategies are learned to monitor warning signs (e.g. increasing energy, productivity and creativity at work; or increasing social withdrawal at work and difficulty getting to work) job retention is likely to be the major issue.

The onset of mental illness can permanently disrupt education, employment and career development (Waghorn et al., 2004b). Although of low point prevalence compared to anxiety and depression at approximately 0.47% of the population, mental illness is associated with a lifelong career disruption. Despite evidence of career disruption, long-term outcome studies (Harding et al., 1987) and successful vocational programmes (Bond et al., 1995) support the feasibility of employment for a substantial proportion of persons with mental illness.

Employment restrictions among people with mental illness

At a population level the most commonly reported employment restrictions among people with anxiety disorders are restricted in the type of job (24.0%), need for a support person (23.3%), difficulty in changing jobs (18.6%) and restricted in the number of hours (15.4%). A substantial proportion of people
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with anxiety disorders (23.3%) and 61.3% of people with psychotic disorders (Waghorn & Chant, 2005) report a need for a support person if participating in employment. The psychotic disorders are associated with the greatest proportions of employment restrictions. However, substantial proportions of people with depression and anxiety disorders also report employment restrictions.

The impact of mental illness on education and vocational training

The onset of mental illness can truncate primary, secondary or tertiary educational attainment and vocational training, and disrupt normal career development. For psychotic disorders, this may occur because the typical onset age is from 10 to 30 years, which may coincide with the critical career stages of completing formal education and establishing a career pathway. Through disrupting education, mental illness can indirectly cause long-term unemployment and limit career prospects. Hence, mental illness can displace career paths downwards and limit attainment to less skilled jobs, lowering both work status and income expectations.

Several studies have identified the importance of education to career development. A longitudinal study (Mueser et al., 2001a) and a secondary analysis of data (Mechanic et al., 2002) linked educational attainment to increased employment outcomes and higher employment status in the USA. In Australia, educational attainment is closely associated with employment outcomes. Waghorn et al. (2002) found positive links between educational attainment and both current employment and durable employment among people with psychotic disorders.

The need for specialised treatments to reduce employment restrictions

People with mental disorders can have difficulty obtaining both optimal treatment and suitable vocational assistance. They may be turned away by practitioners who recognise the extensive employment restrictions associated with the severe forms of these disorders. Practitioners may be unwilling or unable to provide specialist psychological and psychiatric treatments as part of a comprehensive vocational rehabilitation plan. However, specialised psychological treatments coordinated by a vocational plan may be particularly effective through leveraging treatment motivation with vocational motivation. Providing timely and effective supplementary treatment is, therefore, likely to reduce employment restrictions and increase the prospect of favourable vocational outcomes. Specialised treatment need not delay vocational plans because these can be provided in parallel with vocational interventions.
Capacity and desire for work

Non-participation in the labour force and high unemployment do not mean that people with mental illness are incapable of working. Studies of the long-term course of illness and health outcomes of people with schizophrenia (Mechanic et al., 2002) have found substantial heterogeneity of course and outcome, with improvement over time in social functioning in 40–70% of people previously classified as having the most severe disabilities. Controlled studies of the effectiveness of supported employment (Bond et al., 2004) demonstrate the feasibility of competitive employment, even when no screening criteria other than the initial interest determine programme entry. Bond et al. (2004) found that 40–60% of consumers receiving evidence-based supported employment assistance obtained competitive employment. Long-term outcome research and controlled studies of supported employment support the feasibility of psychiatric vocational rehabilitation for people with mental illness, including a substantial proportion of persons with the most severe forms of schizophrenia.

Labour force non-participation and high unemployment do not imply that people with mental illness do not want to work. Low labour force participation may represent discouraged job seeking or loss of vocational hope, because a substantial proportion of mental health service consumers with severe mental illness consider employment feasible and a key element to their recovery (Liberman et al., 2002). When specifically prompted, consumers frequently state that they want employment (Davidson & McGlashan, 1997) even when mental health providers rate employment as a low priority (Fischer et al., 2002). Other qualitative studies (Honey, 2000) have found that people with a severe mental illness actively strive to obtain meaningful roles and an appropriate vocational place in the community.

Value of employment

Rowland and Perkins (1988) identified four benefits of work: work as a restorative psychological process, work to improve self-concept, the protective effect of work and the social dimension of work. Positive and meaningful employment experiences have been linked to improved self-concept and self-efficacy (Strong, 1998), higher ratings of subjective well-being (Laird & Krown, 1991), regaining self-esteem (Van Dongen, 1996), improved engagement in work activity with associated symptom reduction (Bell et al., 1996) and increased personal empowerment (Rogers et al., 1997). Work may also improve clinical insight for those with severe mental illness who have less severe cognitive impairments (Lysaker et al., 1995).
Reviews of randomised controlled trials (Bond et al., 2004) reveal that the main benefit of supported employment is on short-term individual employment outcomes. Other benefits associated with work include structuring time and routine, social contact, collective effort and purpose, social identity and status, personal achievement, and regular activity and involvement (Boardman et al., 2003).

However, job retention challenges all forms of employment assistance (Xie et al., 1997), indicating that continuing support to retain employment is critical for people with mental illness. Although there is evidence that sustained employment enhances the non-vocational outcomes of improved self-esteem and symptom control, there is no consistent evidence that employment leads to reduced hospitalisations or improves quality of life (Bond et al., 2001a, b). Despite these evidence gaps, suitable and meaningful employment can be highly valued by individuals. The following account (S.T Scott, personal communication to MIFA, March 2005) illustrates the personal value of employment:

‘I have found that working part-time has definitely given me the positive edge on a more healthy self-esteem. Working has taken away the dread of socialising and meeting new people as to when I am asked in conversation, what I do for a living. Once upon a time I had the embarrassment of saying nothing or else saying that I was on a disability pension. Then there was the fear that they would inquire more deeply and I would be exposed as explaining I had a mental illness. With a large portion of society ignorant about mental illness and still having stigma, this position would further squash an already low self-esteem. Working has given me the opportunity to flee this scenario as well as giving me structure and routine.

If I have days or weeks where I’m starting to get slightly unwell, work is the best therapy for me. It gets my eyes off myself and focussed on to others’ needs. Being employed as a supervisor of an Activity Drop-In centre for people with a mental illness, I find serving others needs and healing is good for the soul. I have discovered that the best way to help yourself is simply by helping someone else. With mental health issues, loneliness and boredom are a good recipe for becoming unwell and work has structured my time, so even if I feel lazy and unmotivated, I have to get into action and attend and perform in my job. For people who are ready to take the next step of some degree of work I encourage the system to give them every opportunity as it is vital to that road to recovery.’

Reducing workplace and community stigma

People with mental illness experience considerable stigma and discrimination (Waghorn & Lewis, 2002) from both employers and the general community. Practitioners can counter the stigma associated with mental illness by strategic disclosure to employers and to other third parties throughout vocational
rehabilitation. They have the opportunity to counter community stigma by enabling people with mental illness to demonstrate their work potential. Personal contact with people experiencing mental illness in the workplace, supported by planned education of managers, supervisors and co-workers, may counter stigma both in the workplace and in the wider community.

How mental illness produces barriers to employment

Employment barriers can result from the positive, negative and disorganised symptoms of psychosis, from side effects of antipsychotic, mood stabilising and antidepressant medications, and from subsequent impairments to social skills, sense of self, personal confidence and self-efficacy (Anthony, 1994). In addition, indirect barriers to employment can result from the negative experiences of stigma and unfair discrimination, and from the timing of illness onset which can disrupt formal education and training, impede school-to-work transitions and damage the formation of work values and core work skills.

Cognitive impairments

Mental illness can produce cognitive, perceptual, affective and interpersonal deficits, each of which may contribute to employment barriers (Rutman, 1994). Of these, the cognitive deficits have a more consistent association with unemployment (Tsang et al., 2000) and poor work performance. Cognitive deficits consistently found in schizophrenia or schizoaffective disorder includes generalised deficits such as lowered full-scale IQ and a reduced capacity for information processing (Lewis, 2004). Specific deficits can include problems with attention, sustained attention, memory and executive functioning (Lewis, 2004). Cognitive symptoms are likely to cause employment restrictions which limit occupational choice through restricting the type of work activities which can be successfully performed. Industry and job choices can be restricted, work hours and work performance may be limited, and the need for ongoing assistance to retain employment may be increased (McGurk et al., 2003). In addition, general cognitive deficits as well as deficits in social cognition are associated with impaired work-related social skills, and may underlie the impaired social competence which can influence vocational outcomes (Tsang et al., 2000).

Other clinical symptoms

Almost all the clinical symptoms associated with mental illness can, at an individual level, directly contribute to employment barriers. Clinical symptoms