Work and employment for people with psychiatric disabilities

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William Faulkner observed that work 'is just about the only thing that you can do for eight hours a day'. Work is something that many of us take for granted, but many people with mental illness are excluded from work and are unlikely to gain or sustain open employment. This is despite the fact that the majority of people with mental illness wish to be engaged in meaningful activity. Being 'in work' has important implications for the personal well-being, social status and civil rights of those with mental illness, as well as for their use of health and social services. Work offers considerable personal and economic benefits for users of mental health services.

EMPLOYMENT, WORK AND LEISURE

Employment, work and leisure are key dimensions of social adjustment. Traditional definitions of work emphasise that it is an activity involving the execution of skills and application of judgement taking place within set limits prescribed by others (Bennett, 1970). Work is therefore essentially something you do for other people. In contrast, in most leisure activities you can 'please yourself'. Employment is, then, work one is paid for. Activities such as childcare, housework and looking after sick relatives are 'work', in the sense that the tasks and outcomes are defined by others, but they do not, at present, usually attract formal payments.

IMPORTANCE OF WORK

Work has a central role in most people's lives, offering rewards beyond that of income. Employment provides not only a monetary recompense but also 'latent' benefits – non-financial gains to the worker which include social identity and status; social contacts and support; a means of structuring and occupying time; activity and involvement; and a sense of personal achievement (Shepherd, 1989). People with mental illness are sensitive to the negative effects of unemployment and the loss of structure, purpose and identity which it brings (Rowland & Perkins, 1988). Work is linked to social inclusion, and gives people with mental illness opportunities to participate in society as active citizens. The barriers to work are linked to stigma, prejudice and discrimination.

Work is important both in maintaining mental health and in promoting the recovery of those who have experienced mental health problems. Enabling people to retain or gain employment has a profound effect on more life domains than almost any other medical or social intervention.

Studies show a clear interest in work and employment activities among users of psychiatric services, with up to 90% of users wishing to go into (or back to) work (Grove, 1999). Assisting people to gain and sustain employment is central to achieving many of the Government's targets for mental health services in the UK.

BARRIERS TO EMPLOYMENT

For people with long-term mental illness, rates of employment are low. Eight per cent of people with long-term disabilities of working age in Great Britain have a mental health difficulty as their main problem, and in this group 18% were in employment in 2000. This figure is significantly lower than that for people with long-term disabilities but no mental health difficulty, of whom 52% were in employment in 2000 (Office for National Statistics, 2000).

Mental health service users have much in common with other disability groups. All experience a process whereby they are excluded from 'normal' social roles and entitlements, which in turn can lead to the internalisation of the sick or 'patient' role as the dominant feature of their lives. Employment can halt or reverse the disabling process. However, users of mental health services face more significant barriers to work than do people with other disabilities: only people with a severe learning disability find more difficulty in obtaining paid work. These barriers are made up of several components. Historically, the employment of people with disabilities has depended on economic growth, the overall rate of employment and times of labour shortage. The welfare system has built-in disincentives to returning to work – known as the 'benefits trap' – and a fine balance exists between supporting people who cannot work and the creation of disincentives to returning to work for those who can.

Those with a history of mental illness face problems in the open employment market, including stigma, a reluctance to employ them and a perceived risk of failure (Manning & White, 1995). There is a tendency for mental health professionals and others to underestimate the capacities and skills of their clients and to overestimate the risk to employers. This may extend to general practitioners and employers who give insufficient attention to helping people return to their jobs. When this is combined with a lack of appreciation by health professionals of the importance of work and employment, accompanied by the dominance of a model of illness that emphasises symptom 'episodes' and 'cure' as opposed to one that focuses on 'disabilities' and the social aspects of management, it is not surprising that work is neglected. The shift in mental health services from large asylums to community-based services has meant that current responsibilities for providing work and employment activities for people with mental health problems are not clearly defined and allocated among various organisations dealing with health and employment issues, such as the National Health Service, local authority social service departments and the Department for Education and Skills. Each government department tends to have its own, different, set of priorities.

WORK SCHEMES IN THE UK

There is widespread ignorance of the existing evidence about services and approaches that are effective in helping people with mental illness to work and keeping them

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in employment. Work schemes for people with mental illness have been traditionally linked to the large mental hospitals in the form of 'sheltered' workshops. However, during the past two decades there has been an expansion of employment initiatives for such people. These fall into three broad categories (O'Flynn & Craig, 2001): sheltered employment, 'open' supported employment and 'social firms' – market-oriented businesses with a social mission to create employment for people with disabilities (Grove & Drurie, 1999). Associated services include pre-vocational training, user employment programmes in which mental health services seek positively to recruit and support service users (Perkins, 1998), and the 'clubhouse model', which has a 'work-ordered' day and organises transitional, paid work-experience placements (Beard *et al*, 1982). Surveys of the provision of such schemes in the UK estimate that there are 135 organisations offering sheltered employment, 77 providing open employment and about 50 social firms (Grove & Drurie, 1999; Crowther *et al*, 2001). These schemes are not evenly distributed across the UK.

Most work on the effectiveness of work interventions comes from the USA and points to the value of supported employment schemes. A systematic review by Crowther *et al* (2001) examined 11 randomised, controlled trials. Supported employment was superior to pre-vocational training in finding competitive employment and there was no evidence that success was due to the selection of the most able or most easily placed people. Such schemes have not been evaluated in the UK, and these and other work-based schemes need evaluating here.

IMPLICATIONS FOR SERVICES

Vocational rehabilitation is poorly developed in the UK. As with other complex psychosocial interventions, there is a need to evaluate a number of different approaches, geared to different levels of disability. There will then be a need to develop a range of effective vocational services that will cover the spectrum of disability. This will inevitably involve a range of partnerships, including primary care, occupational health services, mental health services, social and employment services, and the voluntary sector.

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No one model of service is right for everyone, and each approach may help different people at different times in their recovery and reintegration. Ideally people should have access to a range of work, training and support which is relevant to their changing needs. They should have the opportunity for progression towards paid employment, but they should not be forced to move on to situations of greater stress and responsibility if they do not wish to do so. A local comprehensive mental health work and employment service should contain a spectrum of opportunities, with possibilities for access at any point and the flexibility for people to move or to stay, according to individual needs (Grove, 1999).

Community mental health teams have a central role in assessing need and facilitating access to relevant local opportunities. Specialist vocational workers integrated into these teams can ensure that these needs are met within the existing care-planning approach. Vocational support cannot be simply handed over to specialists, and once people are in work any continuing support should remain the responsibility of the key worker. A satisfactory working life may reduce the need for clinical support, but such support should remain available and be tailored where possible to the constraints of the individual's working life (Secker *et al*, 2002).

There is an urgent need for more research in this area. The consequences of making wrong choices based on insufficient knowledge about 'what works and for whom' might be serious in both personal and financial terms. The Department of Health has already commissioned guidance – due for publication later this year – on how the requirements for work opportunities in the National Service Framework can be implemented in the light of the experience and knowledge now available. This will be a starting point. Turning it into universally available services that are based on evidence and are effective and cost-efficient will be the biggest challenge for the future.

DECLARATION OF INTEREST

J.B. was Chair of the Royal College of Psychiatrists' working group on employment opportunities for people with psychiatric disabilities. B.G., R.P. and G.S. were members of the working group.

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