The value of work in the 1980s*

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Mental health professionals seem to have a curiously ambivalent attitude towards work. On the one hand, it is generally accepted that the experience of unemployment is often associated with severe social and psychological distress. On the other, we seem reluctant to strive to provide work for those patients who have the greatest social and psychiatric disabilities and for whom work, in all its forms, may have the greatest benefit. I don't wish to speculate on the psychological roots of this ambivalence, although I suspect that it stems, at least in part, from the way in which we all feel about our own jobs. However, there are other reasons why the concept of work has always sat uneasily within the context of psychiatric services.

Psychiatry deals, after all, with *patients* and patients are "sick". The "sick", it is well known, need rest not activity. The idea that sick people should work in order to regain their health seems illogical and slightly bizarre. Work also brings with it the dangers of exploitation. How can we ask people to work when the financial rewards are patently not commensurate with the effort expended? In any case, surely work is an anachronism as far as the mentally ill are concerned in today's "high-tech", high skills, and high unemployment economy? Psychiatric patients are clearly neither competent nor motivated to compete in the modern labour market and it is obvious that few of them will ever get back to "proper" work, i.e. full-time paid employment. So, what is the point? Wouldn't we be better off training patients to make more use of their leisure time, to develop their hobbies, to widen their social networks, etc.?

The arguments are familiar and they contain a grain of truth, but they also run the risk of further limiting the choices of a group of people whose options are already extremely restricted. Enforced idleness is certainly as damaging as enforced activity, especially if you have chronic schizophrenia. The long-term mentally ill also have the stigma of mental illness to contend with and for them unemployment means not only financial loss, but also social damage. Work meets a complex range of psychological and social needs and if we are moving towards a new "leisure age", then surely the chance to work should be retained for those who need it most? Work, as Freud reminded us, remains our strongest tie to reality; until we have something definite to put in its place, we should be cautious about giving it up.

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In order for the mentally ill to have the chance to benefit from involvement in work projects, statutory services have first to accept that the provision of work opportunities is a legitimate call on their funds and this has long been a bone of contention. For the reasons suggested above, health authorities tend to see work as either inappropriate or irrelevant. Health services are there to cure people, and managers view with some alarm the suggestion that the need to work may not be amenable to treatment. Health authorities may therefore be reluctant to support work ventures because of the long-term commitment involved; they see it as social "support" and therefore Social Services' responsibility. This view is particularly worrying in the context of hospital closures where the failure to reprovide sheltered work in the community may contribute to neglect and a further sense of hopelessness for many "deinstitutionalised" patients. However, Social Service departments may not see it as their business either. They may feel that since work has to do with employment it should be left to the Manpower Services Commission (Training Commission), the Department of Employment, or some kind of specialised voluntary agency. (The voluntary sector are already a very important provider of work for the mentally ill, but their resources are extremely limited). Thus, if the "appalling inadequacy of day care facilities" found by the House of Commons Select Committee (1985) is to be remedied, then statutory services will have to sort out their responsibilities rather more clearly than has been the case up to now.

At this point it might be helpful to clarify our terminology. After Hartley (1980) we may define "work" as any activity which is purposeful, which requires effort and discretion, which has social significance, and which operates within some set of external parameters (judgements, time structure, etc.). Work does not necessarily lead to a financial reward based on the market value of the labour involved. "Employment", on the other hand, is work linked to wages, i.e. it is an economic exchange between employer and employee within the context of a larger economic structure. By this definition, child care, housework and voluntary work are all *work*, although those engaged in them may not actually be *employed*. People may thus choose to work because they value the social and psychological benefits of the activities involved – satisfaction, sense of achievment, avoidance of boredom, social status, etc. – and the mentally

ill will be motivated to engage in sheltered work projects to the extent that they perceive them as offering these benefits, independent of financial reward. If they see work as boring, unsatisfying, and lacking in status, they are unlikely to be interested.

This argument for the value of work in terms of its social and psychological benefits is not new. The mental hospitals were founded on a belief in the importance of work. Based on experience in the York Retreat, the Victorian reformers demanded that the new asylums provided a range of work activities to suit patients of a variety of abilities and "descriptions". They required that the new superintendents subscribed to the belief that, "a state of entire indolence and mental inertness was decidedly prejudicial to the patient" (Jones, 1972). Nor was work simply seen as a means of occupation, it was important because of its direct, therapeutic value: it was *treatment*. This stemmed from the "associationist" theories of mind which suggested that work could be used to channel thoughts and ideas and distract the mind from "painful and injurious associations". Modern theories of mind, based on information processing models, make similar suggestions.

Of course, this emphasis on work, and in particular on a range of activities to suit different interests and abilities, was lost as the asylums became increasingly overcrowded (and underfunded). The importance of work was then rediscovered in the 1920s, notably by Simon in Germany, and reintroduced into English mental hospitals after the war (Bennett, 1983). However, it was not until fairly recently that experimental research has begun to accumulate regarding the benefit of work-related activities for people with long-term psychiatric and social disabilities (Pilling, 1988). Wing & Brown's (1970) classic "Three Hospitals" study showed that the single most important factor determining levels of negative symptoms among long-stay patients in hospital was the amount of time spent doing nothing. Similarly, Linn and her colleagues (1979) found that the most effective kinds of day programmes for the support of schizophrenics in the community contained a predominance of occupational and recreational activities. The least effective offered intensive group or individual psychotherapy (and employed the most psychologists!). Work therefore *is* treatment and for many chronic psychotic patients it may be the most effective treatment we have. It certainly has some of the fewest side effects.

Work also plays a central role in terms of social functioning. At the level of social support, work and family are the two major sources of friendship and close personal relationships. Being deprived of it can therefore have serious effects on one's ability to create and sustain meaningful networks of social support. In most societies the question, "Am I fit for work?" is fundamental and those who are not able to work, and cannot find a socially acceptable alternative, are likely to suffer significant psychological distress. For those with severe and long-term mental illnesses, work may thus provide one of the few escapes from a chronic "patient role". Work therefore addresses *handicaps*, as well as *disabilities*, and the reduction of handicap provided by access to work opportunities may be a part of the reason why schizophrenia apparently has a superior outcome in the "non-industrialised" as opposed to the "industrialised world" (Warner, 1985).

With all this evidence in favour of the importance of work, we then have to ask again why it is still so unpopular among mental health professionals? Perhaps the simplest explanation is that they know so little about it. Of course, this is not to suggest that mental health professionals don't work hard themselves, but their business is "treatment" and they tend not to know very much about the working lives of most of their clients. The gulf between the world of work and the world of the caring professional is considerable and this is clearly illustrated in a recent study by Courtenay Harding and his colleagues (1987). They surveyed a range of work facilities in New Haven, Connecticut and describe vividly the clash of views between clinicians (doctors, psychologists, etc.) and rehabilitation workers (counsellors, workshop staff, etc.). The clinicians saw themselves as providing "treatment" and generally viewed the contribution of other staff as distinctly peripheral. However, "they failed to appreciate that work or vocational rehabilitation might have an impact on symptom relief or on the course of disorder" (p. 323, *op cit*). On the other hand, the rehabilitation workers resented their "second class" status; they felt isolated and frustrated by the clinicians' emphasis on pathology at the expense of functioning. They also perceived the clinicians as being largely ignorant of the demands of a realistic work setting. Both groups tended to dismiss families, seeing them not as a resource, but as obstacles to effective rehabilitation. Families didn't understand about mental illness and, whether implicitly or explicitly, they were often blamed for the patients' problems. The authors conclude that what is needed is training in an integrated model of rehabilitation practice which brings together biological, psychological and social factors and enables staff, clients, and their families to participate more effectively in the process of rehabilitation. This raises questions about how effectively clinical staff liaise and follow up patients who are placed in various work projects. It also underlines the tendency to exclude workshop staff from important clinical and planning decisions. If work is to be taken seriously in psychiatry, then some of these traditional barriers will have to be broken down.

Work is not a panacea. It does not suit everyone and some individuals are able to find routines, social

contacts, and satisfying activities without the structure of work. Such individuals cope relatively well with the experience of unemployment (Warr & Jackson, 1985); however they tend not to be disabled, long-term patients. Those who need work most are the ones who have the greatest difficulty in finding an alternative. The aim is therefore not to force everybody to work in some kind of "neo-Calvanist" fervour, it is to ensure that all those who wish to work have an opportunity to do so. It should be noted that this includes women who, because of traditional biases in the nature of work undertaken, tend to be significantly underrepresented in work projects.

All this implies the need for a range of work opportunities to meet a range of individual needs. In our own service, we have tried to provide such a range from simple manual tasks, through to complex, high quality sheltered work in the community (funded through a voluntary body – the Richmond Fellowship). Like many services we most lack opportunities for training in computing and modern office skills, but we do try to give the more able patients a chance to get back to paid employment through work experience and supported placement schemes. We believe that our most consistent fault is to underestimate peoples' abilities. A range of services tailored to individual needs obviously requires coordination and we have followed the model suggested by Harding *et al* (1987) of a sheltered work 'consortium' where staff from the various projects can meet to swap ideas and discuss where each individual's needs are best met within the system.

Of course, as with all interventions, there are dangers with work. Introducing someone to a new work setting can represent a major life event and a significant increase in levels of stimulation. There are thus risks of provoking a relapse in sensitive individuals. However, if the demands are increased gradually and symptoms and medication are carefully monitored, then there should not be particular problems. Indeed, some schizophrenic patients spontaneously report coping with increases in symptoms by increasing activity levels (Tarrier, 1987). (Since others report the opposite, there is clearly a need for an individual approach.) The introduction of new work settings also implies that we provide continuity of support and try to help the person develop whatever new skills they might need. Just as we would not expect a patient leaving hospital to suddenly be able to cope without further help, so we cannot expect someone taking on the challenge of a new work setting not to need ongoing and continuous support.

For the future then, we may hope to see work regain its central position in the provision of psychiatric services. To achieve this requires not only the will on the part of funding agencies, but also the conviction that work *is* important. Part of this conviction has always stemmed from a commonsense belief that being occupied is better than being idle and that having the status of a "worker" – albeit not an employee – is preferable to having the status of a chronic, unemployed, patient. However, we can also point to some good, empirical evidence that work is not simply occupation. It has unique restorative and integrative properties. What we need now is more evaluative research. Professor Peter Warr (1987) has recently proposed a "typology" of environments in which he attempts to specify those factors likely to lead to positive mental health. If this framework proves valid, then we might use it to compare working and non-working settings and examine which factors are most beneficial say, in the long-term support of people with schizophrenia. Being able to ask much more specific questions in this way about the value of different kinds of day support for different kinds of people would be an important step in our understanding of how to provide effective care in the community. For the moment, perhaps we have to rely on commonsense: after all, if work *isn't* of value in the 1980s, what is?

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