Chapter 1

EMPLOYMENT AND PEOPLE WITH MENTAL ILLNESS

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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

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

may impair social skills development. Psychiatric symptoms are potentially disabling and can vary over time, yet are not consistent predictors of vocational outcomes. Tsang et al. (2000) reviewed controlled studies between 1985 and 1997 and found in particular that diagnostic category and psychiatric symptoms were inconsistent predictors. The most consistent predictors of employment outcomes were found to be work history, premorbid functioning and current social skills.

The episodic nature of the disorders

Mental illnesses can be episodic and fluctuating in nature despite optimal pharmacological treatment and good psychological and social support. The first and subsequent episodes can be frightening and traumatic experiences which damage a person's stability and identity, thus weakening their ability to commit to longer term endeavours such as vocational rehabilitation (Rutman, 1994). In addition, during relatively stable periods people can have their assistance needs underestimated by providers of housing, disability, income, family and employment assistance, which can lead to refusal of services or under-provision of support, leading to adverse events causing frustration and hopelessness, further weakening the person's capacity to manage vocational challenges. A way to assess career-related assistance needs is to take account of predictors and correlates of employment outcomes, namely level of employment restrictions, lifelong pattern of illness, premorbid functioning, educational attainment, relevant work history, relevant vocational skills and current social skills (Waghorn et al., 2005a).

Treatment interventions as indirect barriers to employment

Both pharmacological and psychological treatment interventions can produce additional barriers to obtaining and retaining employment. The known side effects of anti-psychotic, antidepressant and mood stabilising medications and the time taken to establish optimal medication type and dosage can cause difficulties for the provision of vocational assistance. In addition, suboptimal treatment can contribute to poor adherence, which in turn can exacerbate symptoms, interfere with planned treatment and undermine vocational interventions.

Treatment and vocational rehabilitation interventions need to be coordinated so that changes to treatment plans (e.g. a new medication trial) do not conflict with planned vocational activities. Sometimes treatment goals need to be balanced by vocational goals. For instance, some residual positive symptoms may be preferred to a symptom-free state with lowered energy levels, insufficient to

sustain preferred hours of employment. Failure to actively coordinate interventions may create a barrier to employment, placing the onus on the person least likely to manage this responsibility.

Low vocational expectations by health professionals

Blankertz and Robinson (1996) believe that health professionals' low vocational expectations of service users is a major problem because it prevents the majority of people from receiving vocational rehabilitation and supported employment services. Mental health professionals often report that people with mental illness have unrealistic work expectations and goals (Becker et al., 1998). In examining programmes with low rates of people with mental illness in competitive employment, it was found that the onus was left on individuals to bring up their interests in employment with the service provider. In addition, service providers tended to emphasise prevocational programmes devoted to job preparation, did not pursue rapid assessment to capitalise on the service users' motivation for work, had limited contact with vocational services, had little direct employer contact and provided minimal support to people once they were in employment (Gowdy et al., 2003).

Community stigma

In general, the public does not understand the impact of mental illness and frequently fears people with these disorders. Members of the community withhold opportunities related to housing, work and community participation (Corrigan, 2003). People with mental illness have fewer opportunities to work than the general population, mostly owing to the many misperceptions and prejudices about their abilities and needs. They are not expected to work, and indeed they are often considered not fit or well enough to work (Evans & Repper, 2000). The lack of work serves to reinforce negative stereotypes and social exclusion associated with mental illness. By not appearing within employment settings, it is mistakenly believed that people with mental illness are too incapacitated to work (Evans & Repper, 2000). An additional issue is that some people with mental illness also endorse stigmatising attitudes about mental illness. This internalised stigma affects the individual's self-perception and has the potential to impact on the success or failure of employment opportunities (Caltruax, 2003).

Community stigma and unfair discrimination are frequently reported by people with mental illness (World Health Organisation, 2001) as adding to the difficulties of obtaining and retaining employment. The extent of past stigma

experiences and reactions to those experiences can influence personal decisions about whether or not vocational goals are adopted. In addition, past stigma experiences may exert a strong influence on disclosure preferences throughout psychiatric vocational rehabilitation (Waghorn & Lewis, 2002). To overcome the adverse effects of prior community stigma, vocational professionals can provide stigma assessment and counselling and develop ongoing stigma countering and disclosure strategies within every individual's vocational rehabilitation plan.

Workplace stigma

The attitudes of employers towards people with mental illness may reflect the ignorance and stigma prevalent in the wider community (Waghorn & Lewis, 2002). This then may result in the belief that people with mental illness are unable to work or that it is not possible to accommodate psychiatric disorders within the workplace. Negative employer attitudes have a number of implications, including that an employer will not hire a person with psychiatric disability or advance or retain people with these disorders (Spillane, 1999). When a person with a mental illness is hired, they may be treated differently from other workers. For example, Murphy (1998) reported that people with mental illness faced discrimination and prejudice by employers and co-workers once they knew the person had a disability. This included that the employer began to be afraid of the person, verbal abuse, harassment and belittling the person's ability and judgement.

Career immaturity

Mental illness can create unique individual experiences, which can lead to inappropriate values, attitudes and aspirations regarding work and careers (Rutman, 1994). Impaired work values and impaired perceptions of current work skills can cause unrealistic vocational goals, where perceptions of own work skills may diverge from actual skill levels and experience. These experiences may also represent career immaturity thought to result from the lack of exposure to typical life experiences, responsibilities and roles which help a person form appropriate work perceptions, work confidence, work interests, work values and work ethics. Although the precise psychological processes are unclear, it is likely that career maturity is influenced by the person's life experiences, personality, perceptions of illness experiences, family background, educational attainment, work values, and knowledge of workplaces and employer requirements.

Subjective experiences and personal resources

Internal barriers to achieving vocational goals include unpredictable sleeping patterns, fear of failure, fear of relapse, lack of confidence in vocational abilities, difficulties with concentration and fear of resuming work after years of unemployment (Corrigan, 2003). In addition, Waghorn et al. (2005a) found that a range of varied subjective experiences perceived to impact on work functioning and self-efficacy for specific work-related activities were closely associated with employment status.

Mallick et al. (1998) found that financial resources, employment resources and vocational skills presented the greatest barriers to community integration. Financial resources included money for meeting financial obligations such as rent, food and other daily expenses. Employment resources were employment opportunities and available resources to find a job and maintain employment. Waghorn et al. (2005a) found that self-efficacy for core employment activities includes career planning, job-securing skills, job-retaining work skills (e.g. start work soon after arriving, complete tasks in the time required, identify and correct own mistakes) and job-retaining social skills (e.g. can follow instructions without resistance, can cooperate with co-workers to perform a group task, can check instructions with supervisors).

Vocational interventions and a recovery framework

Recovery is defined as the process of overcoming symptoms, psychiatric disability and social handicap. It can involve a redefinition of the self, the emergence of hope and optimism, empowerment and the establishment of meaningful relationships with others (Resnick et al., 2004). Recovery is oriented towards the reconstruction of meaning and purpose in one's life, the performance of valued social roles, the experience of mental health and well-being and life satisfaction. It means maximising well-being within the constraints imposed by health status. A recovery framework incorporates continuing care with relapse prevention plans and psychosocial rehabilitation (see Chapter 8 for a detailed discussion on the importance of vocation in recovery). The lived experience of the person with the mental illness is also acknowledged and attempts are made to maximise their well-being along with that of their family (Rickwood, 2004).

As an evidence-based form of psychosocial rehabilitation, vocational rehabilitation is ideally suited to a recovery framework. Recovery planning can incorporate a discussion of preferred socially valued roles, and if vocational roles are chosen, vocational activities can become the focus of the recovery plan. A comprehensive recovery plan can also include crisis planning, a list of things that people have done in the past to help themselves to stay well and a list of things they could do to help themselves feel better when things are not going well (Rickwood, 2004).

How employment and education contribute to recovery

Work has an important role in the recovery of people with mental illness and many of the goals of rehabilitation are best served by addressing the person's vocational aspirations (Corrigan, 2003). Employment contributes to the recovery process through being perceived as a means of self-empowerment and by promoting a sense of self-actualisation (Provencher et al., 2002). Meaningful activities can also contribute to the recovery process through active participation in structured social, recreational, volunteer work, arts and education.

Evidence-based vocational interventions

Various vocational interventions suitable for people with mental illness have evolved over time. Although each approach to vocational assistance has its advocates, a positive development in the literature is a new focus on the ingredients of effective vocational rehabilitation specifically designed for people with mental illness. Vocational interventions for people with mental illness have included unpaid voluntary work, the Boston University psychiatric rehabilitation model (Choose-Get-Keep) with extended pre-vocational career exploration, job clubs (Corrigan et al., 1995), the Programme of Assertive Community Treatment, generic supported employment, Clubhouse transitional employment, specialised supported employment (also known as the Individual Placement and Support model of supported employment), generic vocational rehabilitation and specialised vocational rehabilitation (Waghorn & King, 1999).

In addition, there are interventions such as business services (sheltered workshops), work crews, community cooperatives and social firms. These services are usually designed to increase employment opportunities for people with disabilities by providing supportive and low stigma work environments and by producing goods or services in order to pursue employment as a social justice mission. In social firms, the proportion of disadvantaged workers does not exceed 30–50% and every worker is paid an industrial award wage or a productivity-based wage. Both disabled and healthy workers are intended to have equality in terms of opportunities, rights and responsibilities.

Unique principles of transitional employment

Although on-site support is commonly provided in supported employment and vocational rehabilitation, an important and unique principle of Clubhouse transitional employment programmes is the continuous availability of intensive on-site support (Bilby, 1999). This aims to overcome employment barriers in the workplace by demonstrating core work skills and appropriate work

behaviours, using on-site training to teach and reinforce good work attitudes, behaviours and performance. Consequently, the close relationship formed between Clubhouse staff and employers enables a suitable training environment to be created for assisting new members at work and for countering stigma by educating others in the workplace about mental illness and mental health.

Transitional employment is a form of psychiatric vocational rehabilitation developed specifically for people with psychiatric disabilities (Henry et al., 2000). Intensive forms of on-site assistance are routinely provided at each entry-level job held by the Clubhouse. Staff members learn the job in order to perform the duties on days when the member(s) selected to perform the job for a specified period is unwell or unable to attend. The aim is to provide members with real employment experiences (paid-at-award wages) to overcome career immaturity and to help people form and test career goals. Transitional employment placements are typically part-time, linked to prior participation in Clubhouse day programmes (the work-ordered day) and limited to a duration of 4–6 months, to enable other members to share the available opportunities. Clubhouses may also offer housing, social recreation and supported education programmes.

Although not formally identified as contributing to employment outcomes, the Clubhouse member-based organisation provides an appropriate infrastructure for people with mental illness. Like social firms, Clubhouses provide safe low-stigma environments which encourage vocational recovery and support general illness recovery through peer support, sharing of resources and increased social and recreational opportunities to help rebuild personal and social confidence.

Principles of specialised supported employment

Specialised supported employment (Drake et al., 2003) is important for both its evidence base of randomised controlled trials and day-centre conversion projects and for the empirical identification of its underlying theoretical principles. Previously known as the Individual Placement and Support (IPS) approach to supported employment, evidence is accumulating that this form of specialised supported employment is effective for 40–60% of volunteers (Lucca et al., 2004). A consensus is emerging as to the evidence-base for each of the seven principles while research efforts continue to identify programme enhancements. According to Bond (2004), there is consistent evidence for the first four of the following seven principles, while the evidence for the latter three remain relatively weak:

(1) Eligibility based on consumer choice
(2) Integration of vocational rehabilitation with mental health care

(3) A goal of competitive employment
(4) Rapid commencement of job search activities
(5) Services based on consumer preferences
(6) Continuing support to retain employment
(7) Income support and health benefits counselling.

Service eligibility is based on consumer choice (Bond et al., 2001c). No attempt is made to screen out participants on grounds other than individual preferences and motivation. This approach has been found to be more effective when integrated within the mental health treatment team (Mueser et al., 2004). Integration is considered advantageous in four ways: (1) better engagement and retention of clients, (2) better communication between employment specialists and clinicians, (3) education of clinicians about employment issues and (4) incorporation of clinical information into vocational plans (Drake et al., 2003).

The main goal is competitive employment rather than participation in day programmes or sheltered work, which are usually not provided. The evidence suggests that interventions not focusing directly on competitive employment have little or no impact on competitive employment outcomes (Bond, 2004). In addition, competitive employment outcomes are more desirable and recovery oriented than other forms of paid employment. The early use of supported job searching and job placement is considered important to prevent people from losing interest in the necessary elements of job preparation and training in specific job skills.

Other interventions when provided are done so in parallel and not in series with job searching or job placement. Bell et al. (2003) found that cognitive skills training provided concurrently with supported employment was a successful parallel intervention which need not delay either job searching or job placement. Both treatment and vocational interventions are tailored to the type of job searching or work tasks required.

Services provided are based on consumer preferences, strengths, prior work interests and experiences rather than on a pool of available jobs. The evidence shows that the majority of clients have stable and realistic job preferences (Becker et al., 1998) and jobs matched to the initial job preference had a longer job tenure than those not so matched (Mueser et al., 2001b).

Follow-on support is available continuously over time with no closure date, so that on-the-job or behind-the-scenes support is available when needed. Employment specialists stay in regular contact with clients and employers without arbitrary time limits, although the intensity of support may reduce to a maintenance level of regular contact only. McHugo et al. (1998) found supporting evidence at 3.5 years from the commencement of employment, where 71% of those who continued receiving support were still employed, compared to 28% of those who had discontinued support. Support is provided proactively and in partnership with the person with mental illness.

Health and welfare benefits counselling is provided, although the current supporting evidence is relatively weak (Bond, 2004). Consumers are helped to make well-informed decisions about their entitlements to welfare benefits and health insurance coverage to ensure that benefits entitlements do not add unnecessary disincentives to employment.

Emerging candidates for evidence-based components

The use of explicit strategies to counter workplace stigma and structured counselling to optimise disclosure strategies are also expected to enhance outcomes in psychiatric vocational rehabilitation by improving job commencement and job retention. Some people may fail to seek, obtain or retain employment because of past stigma experiences or previous workplace discrimination (Spillane, 1999). Hence, strategies are needed throughout vocational rehabilitation to counter past and present stigma and strategically manage disclosure of personal mental health information in the workplace (Waghorn & Lewis, 2002).

To prevent negative stigma experiences in a particular workplace, a plan for workplace education can be developed along with the vocational rehabilitation plan. Initial education can be provided to increase mental health literacy generally and to counter stigma-based beliefs prevalent at the supervisory and managerial level (Spillane, 1999). Mental illnesses such as anxiety disorders, depression and even schizophrenia can be discussed in the context of occupational health and safety, the work environment, and general mental health and well-being, which are topics of interest in most workplaces. Ongoing support plans for the individual can encompass a plan to increase mental health literacy, and to prevent and counter stigma in the workplace over time. This can be achieved by (1) facilitating co-worker social interaction, (2) teaching specific work-related social skills to the worker with the mental illness, (3) using peer support arrangements, (4) ongoing strategic and ethical disclosure of health information relevant to work performance and (5) planned ongoing education of employers, supervisors, co-workers and third parties throughout the vocational rehabilitation process.

However, some people may report such negative stigma experiences that they are currently unwilling to consider an open employment placement. For these people, stigma-safe environments may be needed to enable rebuilding of work and social confidence. Hence, to meet a broad spectrum of assistance needs, alternatives to open employment approaches, such as transitional employment, business services, social firms and community cooperatives, can contribute by providing low-stigma work environments as a bridging option towards open employment.

Conclusions

This chapter has reviewed the impact of mental illness on employment. Employment has many advantages for people. People with a mental illness have the capacity and the desire for work; however, their employment is impeded by a number of factors. Practitioners becoming aware and adopting the evidence-based vocational interventions is a key step in assisting people to participate in a socially valued role. Vocational interventions need to focus on eligibility based on consumer choice, integration of vocational rehabilitation in mental health employment, a goal of competitive employment and rapid commencement of job search activities.

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