Employment assistance for people with mental illness

Literature review
This literature review is based on research conducted by URBIS in 2007 for the Department of Education, Employment and Workplace Relations, 2008.
Contents

1 The aim and parameters of the literature review 3

2 Some understandings of mental illness 5

3 Employment 9
   3.1 Definition of employment 9

4 People with mental illness and the world of work 12
   4.1 Participation and recovery 12
   4.2 The benefits of work 13
   4.3 Barriers to employment success 14
      4.3.1 Characteristics pertaining to mental illness and its treatment 14
      4.3.2 Psychosocial stressors 15
      4.3.3 Access to care, service use and treatment 16
      4.3.4 Characteristics of labour markets, work and employer attitudes 17
   4.4 Predictors of occupational outcomes 17
      4.4.1 Level of functioning before the onset of mental illness 18
      4.4.2 Psychiatric symptoms and diagnoses 18
      4.4.3 Assessment of work behaviours 18
      4.4.4 Social skills and social networks 19
      4.4.5 Cognitive functioning 19
      4.4.6 On site support and accommodations 20
      4.4.7 Training in critical vocational skills 20
      4.4.8 Job satisfaction 20

5 Employment assistance for people with mental illness 21
   5.1 Employment assistance within the context of psychiatric rehabilitation 21
   5.2 Vocational services 22
      5.2.1 Vocational assessment and evaluation 22
      5.2.2 Vocational treatment planning and career counselling 23
      5.2.3 Job development 24
5.2.4 On site job support targeted at the individual employee 24
5.2.5 On site organisational interventions 26
5.2.6 Strengthening the informal support provided by family and friends 26
5.2.7 Off site job skills training and education 27
5.2.8 Off site vocational counselling, mentoring and support 28
5.2.9 Job related transportation 28
5.3 A recommended typology of employment assistance models 28
5.4 Identification of best practice principles when competitive employment is the goal 32

6 Evaluation of the effectiveness of employment assistance models 33
6.1 Methods of evaluation 33
6.2 Key findings of some reviewed evaluation studies 36
6.3 Areas requiring further research 40
6.4 Methodological issues in relation to the evaluation of employment assistance for people with mental illness 41
   6.4.1 Research design issues 41
   6.4.2 Implementation issues 42

7 Summary of key issues 44

Appendix A 45
1 The aim and parameters of the literature review

The key aim of the literature review is to locate relevant research that can describe models of employment assistance for people with mental illness and identify good practice and ‘what works’ in relation to assisting people with mental illness into employment. In determining the scope of the literature to be reviewed, it was decided to focus on the following:

- literature that describes service models and approaches to employment assistance for people with mental illness
- research that has sought to identify best (or good) practice principles and practices associated with these models
- research that has evaluated the effectiveness of relevant service models
- literature that discusses methodological issues in relation to the evaluation of employment assistance for people with mental illness.

The review has focused on literature published since January 2000. Several key studies were undertaken in the early 2000s and most of the literature from the last seven years can be accessed electronically.

The review has searched for all relevant material published in Australia and key international literature from the following countries where available in English: New Zealand; United Kingdom; United States of America; Canada; Sweden; Holland; Germany; Hong Kong; and any other country where relevant material is published in international journals.

The literature search methods included the following:

- electronic searches of relevant data bases including:
  - Informit Family and Society (Australian)
  - APAIS (Australian Public Information)
  - EBSCO Host (academic, humanities, international)
  - JSTOR (academic, humanities, international)
  - Expanded Academic (Gale) (international)
  - Web of Science (academic, humanities, international).
- internet searches
- direct contact with relevant federal, state and territory government departments and agencies, key academics and peak bodies to identify ‘grey’ unpublished literature
- annual conferences of peak associations such as ACE National Network and Jobs Australia.
The electronic data searches and internet searches have been completed. In conducting these searches, the following key words were used to locate relevant literature:

Mental health
- mental illness
- mental ill health
- psychiatric disability
- psychiatric rehabilitation
- social inclusion
- depression
- schizophrenia
- bipolar disorder
- anxiety disorder
- obsessive/compulsive
- self harm

Employment assistance
- employment
- employment assistance
- supported employment
- welfare to work
- job support
- work support
- work outcomes
- job capacity
- labour market
- training
- vocational education/rehabilitation
- work ready

A list of the references located is attached at Appendix A.

This review describes definitions of mental illness, and provides an overview of the policy landscape in the Australian context. It then outlines research in relation to people with mental illness and the world of work, and the nature of employment assistance for people with mental illness, before presenting some emerging findings in relation to the effectiveness of employment assistance models.
2 Some understandings of mental illness

In a research paper focusing on the importance of considering mental health in the context of welfare reform, the former Department of Family and Community Services (FaCS, 2004) refers to mental health as a person’s ability to function and undertake productive activities, to develop and maintain meaningful relationships and to adapt to change and cope with adversity. Mental health problems and disorders refer to the negative end of the continuum of mental health, and are characterised by alterations in thinking, mood or behaviour associated with distress or impaired functioning. Each condition is unique in terms of its symptoms and effects, its causal factors and treatments. The paper makes the point that it is important to recognise that mental disorders affect people differently.

The constitution of the World Health Organisation (WHO) mandates the production of international classifications on health so that there is a consensual, meaningful and useful framework which governments, providers and consumers can use as a common language (see www.who.int/classifications/en).

The WHO has developed a framework for measuring health and disability at both individual and population levels. The earlier version of this framework, known as the International Classification of Impairments, Disabilities and Handicaps, went through an extensive period of revision in order to put the notions of ‘health’ and ‘disability’ in a new light.

In 2001, the 191 WHO member states endorsed a new framework, now known as the International Classification of Functioning, Disability and Health (ICF). It acknowledges that every human being can experience a decrement in health and thereby experience some degree of disability. By shifting the ‘focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric—the ruler of health and disability’ (WHO, 2001).

In a review of literature from around the world since the endorsement of the ICF, Bruyere et al (2005) affirm that the ICF is increasingly affecting the practice of particular professions more broadly and they write about the conceptual utility of this classification framework for the fields of rehabilitation, health and other clinical disciplines. They refer to the introduction of the ICF into Australian data dictionaries and its use as a framework to inform and structure questions in the Australian National Disability Survey.

The Australian Institute of Health and Welfare (AIHW) notes that the value of using the ICF in Australia is that it combines the major models of disability, and recognises the role of environmental factors in the creation of disability and the importance of participation as a desired outcome. In addition, it provides a framework within which a wide variety of information relevant to disability and functioning can be developed, assembled and related (AIHW, 2003: 5).

The ICF makes no use of the concept ‘handicap’ and instead provides a classification of:

- body function and impairments of body functions as a significant deviation or loss
body structures and impairments—
i.e. problems in structure as a significant deviation or loss

activities (execution of tasks or actions by an individual) and participation (involvement in a life situation), with associated activity limitations and participation restrictions

environmental factors, which make up the physical, social and attitudinal environment in which people live and conduct their lives.

The phenomena of concern to this literature review, i.e. mental illness and employment, can be found in the ICF in respect of:

- **body function and impairments**—
  global mental functions (b110–b139) and specific mental functions (b140–b179)
- **activity limitations and participation restrictions**—major life areas (sub-category 'work and employment', d840–d859).

The AIHW (AIHW, 2006) notes that disability can be measured along a continuum and that estimates of people with disability vary with the particular definition used. In 2003, there were an estimated 3 946 400 people with disability in Australia, representing about 20 per cent of the total population. In 432 200 people (2.2 per cent of the total population) psychiatric disability is reported as being the main disability (AIHW, 2005: 213). The number of adult Australians (aged between 20 and 64) with a psychiatric disability is approximately one per cent of that age group and exceeds the numbers with intellectual disability or acquired brain injury alone (SANE Australia, 2003: 3).

Mental illness is the leading cause of the non fatal burden of disease and injury in Australia, estimated to have caused about one eighth of the total Australian disease burden in 2003, exceeded only by cancer and cardiovascular disease. An estimated one in five Australians will have mental illness at some time in their lives (AIHW, 2006: xii).

The definition of psychiatric disability provided by the AIHW is the following:

Psychiatric disability is associated with clinically recognisable symptoms and behaviour patterns frequently associated with distress that may impair personal functioning in normal social activity. Impairments of global or specific mental functions may be experienced, with associated activity limitations and participation restrictions in various areas. Support needed may vary in range, and may be required with intermittent intensity during the course of the condition. Changes in level of support tend to be related to changes in the extent of the impairment, or in the environment. Psychiatric disability may be associated with schizophrenia, affective disorders, anxiety disorders, addictive behaviours, personality disorders, stress, psychosis, depression and adjustment disorders. (AIHW, 2006: 5)

Internationally, two major classification systems are in use to describe and diagnose psychiatric conditions/mental illnesses. These are now briefly described.
The World Health Organisation’s International Classification of Diseases (ICD)

The International Classification of Diseases (ICD) is one of the WHO family of international classifications. The ICD is a structured classification of diseases with associated codes, the purpose of which is to allow morbidity and mortality data to be systematically collected from different countries and statistically analysed. It is currently in its tenth revision (hence ICD–10) and was published in a revised second edition in 2005.

The ICD–10 uses as its core a single list of three alphanumeric codes from A00 to Z99, and is structured in 21 chapters. Chapter Five focuses on ‘mental and behavioural disorders’, which are classified with the codes F00 to F99 (access via www.who.int/classification/en).

The DSM-IV of the American Psychiatric Association

The Diagnostic and Statistical Manual of Mental Disorders is published by the American Psychiatric Association and covers all mental health disorders for both children and adults. It is currently in its fourth edition and known as DSM-IV. The DSM uses a multi axial or multi dimensional approach to the diagnosis of psychiatric conditions in the acceptance that other factors in a person’s life have an impact on their mental health. The five dimensions are:

**Axis I**—clinical syndromes, i.e. ‘the diagnosis’ in the currently accepted terminology, such as ‘dementia of the Alzheimer’s type’, ‘obsessive compulsive disorder’ or ‘schizophrenia’

**Axis II**—developmental disorders (such as autism and intellectual disability, typically first evident in childhood) and personality disorders (clinical syndromes which have more long lasting symptoms and encompass the individual’s way of interacting with the world)

**Axis III**—physical conditions which play a role in the development, continuance or exacerbation of Axis I and II disorders

**Axis IV**—severity of psychosocial stressors (events that can impact on the disorders listed in Axis I and II)

**Axis V**—highest level of functioning, where the clinician rates the person’s level of functioning both at the time of assessment and the highest level within the previous year. This helps to understand how the above four axes are affecting the person and what type of change could be expected (for further detail see www.allpsych.com/disorders/dsm.html).

One of the types of psychiatric illness, namely schizophrenia, will be described in brief as an example. The discussion is based on material in the Royal Australian and New Zealand College of Psychiatrists’ treatment guide for consumers and carers (see RANZCP, 2005).

Schizophrenia is one of a group of mental disorders known as the psychoses. The condition affects around one in 100 people across all countries, social classes and cultures. Symptoms usually begin to show when people are aged between 15 and 25, and men and women are affected equally. Individuals with a parent or sibling with psychosis have more risk of developing schizophrenia.
There are two main types of symptoms in relation to schizophrenia that is, positive symptoms (experiences that happen in addition to normal experience, for example having hallucinations) and negative symptoms (incorporating a loss or decrease in normal functioning, such as feeling apathetic, depressed or suicidal).

There is currently no cure, although many treatments that aid recovery have been developed. Treatment includes the administering of antipsychotic medications (older agents, first generation antipsychotics such as Chlorpromazine, and newer agents, second generation antipsychotics such as Clozapine), and psychosocial treatment (for example, psycho-education, family therapy and cognitive behavioural therapy). The RANZCP notes that ‘the combination of treatments is crucial’ in a comprehensive program of therapy (2005:15).

An important aspect with schizophrenia is what is known as a ‘prodrome’, the period before an acute episode of psychosis, indicating that a psychotic episode may be about to occur. Prodromal symptoms include changes from normal behaviour such as worsening of usual work or school performance, social withdrawal, emerging unusual beliefs and changes in perception such as experiencing brief instances of hearing sounds not heard by others. People with prodromal symptoms are strongly encouraged to be thoroughly assessed and monitored so that, if clear psychotic symptoms emerge, early specific treatment can be made readily available thus avoiding the need for hospitalisation and minimising the impact of a potential psychotic episode (RANZCP, 2005: 7-11).
3 Employment

3.1 Definition of employment

The definition of employment used in the Australian Bureau of Statistics’ Labour Force Survey, the official source for Australian employment and unemployment statistics, aligns closely with international concepts and definitions.

Employed persons are defined as:
‘... all persons 15 years of age and over who, during the reference week:

- worked for one hour or more for pay, profit, commission or payment in kind, in a job or business or on a farm (comprising employees, employers and own account workers) or
- worked for one hour or more without pay in a family business or on a farm (i.e. contributing family workers) or
- were employees who had a job but were not at work and were:
  - away from work for less than four weeks up to the end of the reference week or
  - away from work for more than four weeks up to the end of the reference week and received pay for some or all of the four week period to the end of the reference week or
  - away from work as a standard work or shift arrangement or
  - on strike or locked out or
  - on workers’ compensation and expected to be returning to their job or
- were employers or own-account workers, who had a job, business or farm, but were not at work.’ (Australian Bureau of Statistics, 2006: 3)

Kravetz et al (2003: 279) provide a model of employment which makes use of the construct ‘the work life domain’. This domain refers to ‘a set of socially defined roles and associated obligations concerning activities that an individual has to perform to benefit and be benefited by society’. It contains:

- boundaries that set it apart from other domains
- gates and gatekeepers by means of which persons can enter and leave the work domain
- work paths or careers that can lead to quantitatively and qualitatively different obligations and benefits.

The authors extend the model by describing ‘adult work phases’ as ‘partially ordered components of the developmental process of assimilating the skills, values and roles of the work life domain and adapting to its demands’. The authors describe these phases as:

Entry/re-entry—finding employment for the first time or finding new employment due to dissatisfaction with previous employment or after a period of unemployment or education and training.

Sustention/mastery—adaptation to and maintenance of a new employment position, including learning the roles and regulations of the workplace and making the accommodations with other personal, familial and social domains of life that the employment requires.

Career development/building—horizontal or vertical changes in the work position, usually made to increase the
intrapersonal and interpersonal benefits provided by participation in the work life domain.

The authors point out that engagement in work activities cannot be evaluated solely in terms of the adult work phases. They extend their model by providing a list of levels of person-environment interaction, which they describe as ‘the sets of activities by means of which an individual can take advantage of personal and environmental resources to participate in the different adult work phases’ (Kravetz et al, 2003: 280).

These levels are:

- **Personal resources and deficits**—psychosocial and demographic characteristics, skills, attitudes towards self and others, and coping strategies that could facilitate or hinder an individual’s participation in the various adult work phases.

- **Work situation**—the nature of the work demands and career opportunities of a particular employment position and the situational and interpersonal characteristics of the work setting associated with that position.

- **Support systems**—public and private agencies that are sources of resources and interventions such as legislation, insurance, social skill training and supported employment.

- **Cultural and economic factors**—aspects of the social context such as family and friends and aspects of the economic context such as level of employment, that can be brought to bear or taken into consideration when helping a person sustain and gain mastery over and develop an employment position.

This is a useful model that can provide a framework for better conceptualising the ‘factors that impact upon the participation of persons with a psychiatric disability in the work life domain’ (Kravetz et al, 2003: 280). The report will discuss these issues in greater depth further on.

When considering the concept of employment in the context of people with disability, two main types of employment can be distinguished:

**Supported employment/employment operated by disability business services** is characterised by pay at productivity and/or competency based wages, segregated work settings, jobs reserved exclusively for people with disability and supervision provided by mental health staff or by other staff external to the workplace. The Disability Services Act 1986 uses the term supported employment to refer to group based assistance provided by business services, offering sheltered work in modified, not fully competitive work settings.

**Competitive/open employment** is defined as part time or full time work in the competitive labour market at or above minimum wages with supervision provided by personnel regularly employed by the business. The work is performed alongside people without disability in integrated settings and the job can be filled by people without disability (Bond, 2004: 346; Waghorn & Lloyd, 2005). Leff et al (2005: 1238) include four components as criteria for competitive employment, namely pay at minimum wage or higher, a job located in a mainstream integrated setting, a job that is not set aside for mental health consumers, and a job that is...
held independently, i.e. not controlled by a service agency. It should be pointed out that in the American literature, the term 'supported employment' refers not to sheltered employment as defined above, but to an approach to vocational rehabilitation, which will be described further on.
4 People with mental illness and the world of work

4.1 Participation and recovery

Participation is ‘a widely recognised goal of people with disabilities, an explicit goal of disability programs, and hence a key criterion for judging outcomes for people with disabilities within Australian society’ (AIHW, 2006: 43).

Social relationships and social support are important for good mental health for all people. Social connections include engaging with friends and peers, maintaining employment and economic well being, undertaking education, hobbies and other activities and physical exercise and recreation. People with mental illness are more likely to have smaller social networks, and their network tends to decrease in size as the duration of illness increases (Harvey et al, cited in Merton & Bateman, 2007: 6).

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, Rosenheck & Lehman, cited in Waghorn & Lloyd, 2005: 32).

It was only recently during the 1990s that the concept of recovery gained credibility, largely through the emergence of consistent evidence that showed that people can recover from mental illness and that, following the initial onset of mental illness, further episodes can be prevented. It is in the ‘area of employment that there is the most compelling evidence linking social inclusiveness with improved mental health and recovery from mental illness’ (Merton & Bateman, 2007: 14). ‘Social interaction, having a purpose or a role in society, and the self-sufficiency that comes from gainful employment can all be seen as dimensions of social inclusion’ (Schneider et al, 2002: 15).

‘There is no shortage of evidence that mental health service users want and are able to work or that employment can benefit mental health. Surveys have found that aspirations to work are widespread, even amongst those who have lost touch with the labour market over an extended period’ (Secker & Membrey, 2003: 207).

In 1995, the Copenhagen Declaration and Program of Action acknowledged that people with disability are too often forced into poverty and unemployment. Australia was one of 82 governments that committed to a policy focus upon the creation of adequately remunerated employment and the reduction of unemployment (Bill et al, 2006: 210). The employment status of people with severe mental illness is recognised as an ‘indicator of the quality of our society’ (King et al, 2006: 472).

The Council of Australian Governments (COAG) agreed to a National Action Plan on Mental Health in July 2006. The Plan ‘provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community’ (COAG, 2006: i). One of the five areas for action focuses on
‘Participation in the Community and Employment, including Accommodation’. Commencing in July 2006, one of the implementation plans within this area for action is referred to as ‘Helping people with mental illness enter and remain in employment’.

4.2 The benefits of work

‘There is a strong evidence base showing that work is generally good for physical and mental well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment’ (Waddell & Burton, in Freud, 2007: 5).

Work is commonly viewed by clients as a critical step in the recovery process and because work is broadly considered normative behaviour, employment may have anti stigmatising effects on people with severe mental illness (McGurk & Mueser, 2003: 789).

Employment is not only a necessary condition for truly independent community living but also a platform from which people with chronic mental illness can obtain the rewarding aspects of mainstream living that most people take for granted (Yankowitz, cited in Frost et al, 2002: 5). Research from the United States shows that the majority of adults diagnosed with severe mental illness express the desire to work in competitive jobs and that competitive employment is now widely endorsed as a central goal of the public mental health system (Rogers et al; Bond; Salyers & Mueser, cited in Alverson et al, 2006: 15).

The many other benefits of work, apart from generating income, include providing a time structure for the waking day, regular contact with people outside the immediate family, involvement in shared goals, enforced activity and a sense of identity (Dollard & Winefield, cited in King et al, 2006: 472; Ruesch et al, 2004: 686; Merton & Bateman, 2007: 4). A number of studies attest to the positive impact of employment on a range of non vocational domains of functioning. Some pertinent studies are summarised by Frost et al (2002: 2):

- Lysakar and Bell (1995) found a significant improvement in social skills after 17 weeks of job placement.
- Bell et al (1996) found that employment resulted in significant symptom improvement and fewer hospitalisations.
- In a longitudinal study of people with severe mental illness, Mueser et al (1997) found that participants who were in employment after 18 months tended to have lower symptoms (particularly thought disorder), higher Global Assessment Scores, better self esteem and more satisfaction with their finances and vocational services than those who were unemployed.
- In a review of four models of psychiatric rehabilitation, Baronet and Gerber (1998) concluded that being in employment was associated with an increase in independence, an improved sense of self worth and an improved family atmosphere.

It is important to note that some people who have more severe forms of mental illness, such as schizophrenia, and who attempt employment, may not experience reduced clinical symptoms.

A study by Lysaker et al (cited in Wag horn & Lloyd, 2005: 13–14) found a subgroup of
people with cognitive deficits whose symptoms either increased or remained the same following five months of vocational rehabilitation. The researchers suggested that ‘severe cognitive impairments may interfere with the ability to fully appreciate the purpose of a work activity, thereby rendering work activity unduly stressful for some people’.

A related point was made by Muntaner (cited in Schneider et al, 2003: 13), who noted that ‘unemployment is not necessarily bad, particularly when compared to employment which is demoralising, degrading or ‘noxious’.

4.3 Barriers to employment success
In 2004, Australia reached its highest employment rate in over thirty years at 71.2 per cent and there have been significant falls in the unemployment rate in the last ten years, with the unemployment rate now down to 4.2 per cent. The country faces a challenge of those on ‘incapacity and lone parent benefits, with the proportion of the working age population receiving incapacity benefit now exceeding the percentage receiving unemployment benefit’ (Freud, 2007: 124).

Despite agreement on the benefits of work to people with mental illness, ‘high levels of unemployment and non-participation in the labour force prevail among people with mental illness in Australia and in other countries with developed market economies’ (Waghorn & Lloyd, 2005: 4). Labour force non participation levels of 75 to 90 per cent are found in the United States, 61 to 73 per cent in the UK and around 70 to 78 per cent among people with psychotic disorders in Australia.

The WHO and International Labour Organisation estimate a worldwide unemployment rate of 90 per cent for people with a serious psychiatric background (Ruesch et al, 2004: 686). The employed proportion of people with severe mental illness in 1998 ranged from 16.3 per cent among people with schizophrenia to 21.1 per cent among people with mixed psychotic disorders in contrast to the 73.8 per cent of healthy working age Australians who were employed (King et al, 2006: 472).

Research carried out by the former Department of Family and Community Services (FaCS) indicates that more than 30 per cent of income support recipients have a diagnosable mental disorder in any 12 month period (FaCS, 2007). Based on data obtained from FaCS, Bill et al (2006:211) write that in June 2003, 37.6 per cent of employed people with a primary psychiatric disability worked between one and 15 hours per week compared to 12.2 per cent for all workers. At the other end of the hours’ spectrum, 29.7 per cent of employed Australians worked more than 40 hours per week compared to 1.5 per cent of people with a primary psychiatric disability.

Some of the major barriers to employment success are now briefly described, but readers are referred to the work of Geoff Waghorn (see e.g. Waghorn & Lloyd, 2005), who has carried out systematic research into this topic in Australia.

4.3.1 Characteristics pertaining to mental illness and its treatment
There are several characteristics of psychiatric disability that create difficulties in work functioning. Psychiatric disability is
significantly different from other disability or chronic illnesses in that it can fluctuate and is the result of an intermittent and episodic process. The episodic nature of the illnesses may impact on confidence, cognition, mood, motivation, problem solving and social skills, so that employment is understandably disrupted (Penrose-Wall & Bateman, 2007: 19). Exacerbations in symptoms and deterioration in functioning may recur several times over a period of months or years. Researchers and clinicians are unable to predict the course of illness and disability for one individual at any specific point in time (MacDonald-Wilson et al 2001: 224).

The areas of functioning affected by psychiatric disability have been typically understood to be in the social/interpersonal, emotional and cognitive domains. Emotional and interpersonal problems on the job, more than the quality of work, are the main reasons that people with psychiatric disability leave jobs (Becker et al, in MacDonald-Wilson et al, 2001: 224). Much research has focused on cognitive functioning (see McGurk & Mueser, 2003). Measures of cognitive functioning include areas such as vigilance, secondary memory, verbal and visual memory, executive functioning, verbal fluency and visuo-motor functioning. Recent studies have found that measures of secondary memory, immediate memory, vigilance and executive functioning were significantly related to occupational functioning and independent living (Green et al, in MacDonald-Wilson et al, 2001: 225).

Mental illness can create unique individual experiences which can lead to inappropriate values, attitudes and aspirations regarding work and careers. Lack of exposure to typical life experiences, responsibilities and roles can hinder a person from appropriate work perceptions, work confidence, work interests, work values and work ethics (Waghorn & Lloyd, 2005: 25).

Medication side effects include tremors, blurred vision, low blood pressure and loss of coordination, all of which may affect concentration, memory and information processes (Rutman, 1994; SANE Australia, 2003: 16). A study by Bond et al (2004) found no significant difference in vocational success between clients receiving first generation anti psychotics and those receiving second generation anti psychotics, but rather that employment rates increased when vocational services followed evidence based principles relating to medication management. These include the close monitoring of adverse events, prescribing the lowest effective dose, paying attention to consumer preferences and behavioural tailoring, i.e. fitting medication taking into daily routines.

4.3.2 Psychosocial stressors

People with mental health problems are less likely to be employed than any other disability group and research suggests a shortfall of around 31 per cent between the number of people with mental health problems who are working and the number willing to work (Schneider, 2002: 13). One explanation of why some people with mental health problems do not wish to work lies in the intrapersonal experience of mental illness—’stigmatic thinking’ is shaped by people’s perceptions of society’s negative expectations, which may be aggravated by their actual experience.
of failure, leading to inertia or ‘learned helplessness’ (Schneider et al, 2003: 13).

Community stigma is a significant barrier to employment—‘in general, the public does not understand the impact of psychiatric disability and frequently fears people with these disorders…they are not expected to work, and indeed they are often considered not fit or well enough to work’ (Waghorn & Lloyd, 2005: 22).

The onset of mental illness, occurring as it does typically between 10 and 30 years, ‘can truncate primary, secondary or tertiary educational attainment and vocational training, and disrupt normal career development…mental illness can displace career paths downwards and limit attainment to less skilled jobs, lowering both work status and income expectations’ (Waghorn & Lloyd, 2005: 10).

A 2004 qualitative study by Henry & Lucca (cited in Sneed et al, 2006) refers to consumers’ fear of a work induced relapse as creating so significant a barrier to employment that individuals may be reluctant to even attempt to work.

Material difficulties, including lack of transportation and homelessness, create additional barriers. People living with psychiatric disability often have few family supports and very little support from the wider community. Social skills are often eroded and they can suffer from extreme social isolation, with most relationships being with mental health professionals and other service providers. Alcohol or drug dependency and criminal justice system involvement exacerbate these stressful psychosocial situations (Shaheen et al, 2003).

4.3.3 Access to care, service use and treatment

In a paper published in terms of the National Mental Health Strategy, Frost et al (2002: 13-14) write about mental health service barriers to employment in Australia where ‘specialist community based services are few, particularly in rural areas, as a consequence of the failure to effectively provide communities with the means to meet the broad-based needs of people with severe psychiatric disabilities after the downsizing and closure of long-stay hospitals’.

They note that community treatment has become substantially confined to the ‘domain of medication maintenance’ with the responsibility for meeting the needs in regard to issues such as employment ‘largely fallen to the disabled person and non-government organisations, with little or no contribution from mental health services’.

These authors also point to data from the 1999 Disability Services Census, which showed that 11,621 people with an intellectual disability were accessing supported employment services, compared to 1603 people with a primary diagnosis of psychiatric illness, and that between 1997 and 1999, the number of positions occupied by people with a psychiatric disability in services providing only supported employment improved by only 1.2 per cent (Frost et al, 2002: 16–17).

King et al (2006: 472) adopt the consensus in the literature that the three major barriers to employment for people with mental illness are the impact of mental illness on the person, external barriers, such as the nature of the labour market and the availability of suitable employment
assistance, and other systemic barriers to employment, such as community stigma and low expectations of health professionals.

However these authors point out that in addition to these ‘there are structural barriers that are an effect of the Australian service environment’ and they note that the current organisation of Australian services is ‘inconsistent with those characteristics identified as critical to effective vocational services for people with severe mental illnesses’. They list the following structural barriers:

- the current system of service organisation which provides no incentives for linking health care to vocational services
- historical, legal and design constraints which limit the capacity of vocational rehabilitation and mainstream employment support organisations to provide suitably intensive and continuous services
- limits on allocated places in disability employment services irrespective of demand.

Waghorn & Lloyd (2005: 24) point to state-federal funding arrangements and departmental responsibilities that ‘define mutually exclusive roles which form barriers to employment service delivery when health, education and employment services are required across multiple sectors and agencies simultaneously’.

4.3.4 Characteristics of labour markets, work and employer attitudes

‘In a labour market where jobs are scarce, people with psychiatric disability face a range of additional challenges that make it difficult to find work that accommodates their interests, abilities and support needs’ (Bill et al, 2006: 210). These authors point to a ‘complex interaction of factors’ that mean that people with psychiatric disability are more likely to be unemployed, including lack of training, inappropriate job design and negative employer attitudes. The attitudes of employers towards people with mental illness may reflect the ignorance and stigma prevalent in the wider community (Waghorn & Lloyd, 2005: 23; Pratt et al, 2007: 245-249).

McAlpine & Warner (2002: 24) note that ‘the stigma associated with mental illness remains a significant barrier to work and shapes decisions about either hiring or keeping a person with mental illness in the workplace...[and]...the stigma associated with mental disorders may also make workers reluctant to disclose their condition, and disclosure is necessary if employers are to make accommodations in the workplace’. The issue of disclosure is discussed in greater depth further on.

Pratt et al (2007: 245) note that ‘the most insidious form of stigma may exist within a person with mental illness themselves’. Negative beliefs can be internalised and ‘self stigma’ may be the hardest form of stigma to detect and the most difficult to overcome.

4.4 Predictors of occupational outcomes

In the last two decades, several researchers have cited variables that may be able to predict vocational success/occupational outcomes for people dealing with mental health issues, and these are summarised over the page.
4.4.1 Level of functioning before the onset of mental illness

Based on a review of literature, Tsang et al (2000: 21-22) found that the level of functioning before the onset of mental illness (pre morbid functioning) is predictive of positive outcomes in relation to employment, and this is particularly in respect of ‘pre morbid occupational performance’. Citing Anthony & Jansen, Tsang et al (2000: 21) conclude that ‘the best demographic predictor of vocational outcome among persons with psychiatric illnesses is previous employment history’.

Criteria that are encompassed by this include the number of jobs the individual held before the onset of their illness, types of jobs held, salary, and perceived level of prestige. Although pre morbid functioning is shown to be a consistent predictor, studies indicate that it does not account for all variance in outcome, and these researchers recommend that ‘other strong predictors that account for perhaps larger amounts of variance should also be identified’ (Tsang et al, 2000: 21).

4.4.2 Psychiatric symptoms and diagnoses

The literature is equivocal on the influence of diagnostically specific symptoms on occupational outcomes, and, ‘opposing views on the relationship between psychiatric symptoms and work function have existed for quite a long time and are well known among researchers’ (Tsang et al, 2000: 26).

In 1992, Karen Danley (cited in Dorio & Marine, 2004: 33) reported on research findings that included: psychiatric symptoms do not predict vocational rehabilitation outcomes; psychiatric diagnoses do not predict vocational rehabilitation outcomes; and psychiatric symptoms do not correlate with skill level.

A review of the literature by Anthony and Jansen (cited in MacDonald-Wilson et al 2001: 222) concluded that psychiatric symptoms, diagnostic category, and standardised psychometric assessments (for example, intelligence or aptitude tests) are poor predictors of future work performance and that there is little or no correlation between a person’s symptoms and functional skills.

On the other hand, in a study by Goldberg et al (cited in Schneider et al 2002: 24), people with psychosis were more likely to have been unemployed for five or more years than people with a mood disorder. These authors also point out that factors that impost most on occupational success, including prevalence of ‘negative symptoms’ (see discussion above), a history of poor work performance, less adequate social skills and cognitive impairment, may be more common among people with schizophrenia.

Tsang et al (2000: 26) conclude, based on their analysis, that ‘the conflicting results between the more recent studies and earlier studies may be resolved if a clearer definition of psychiatric symptoms, particularly positive vs. negative is used. It is negative symptoms, not positive, that affect work functioning and job interview performance, which in turn predicts employment outcomes’.

4.4.3 Assessment of work behaviours

With regard to predicting vocational success, Hirsch (cited in Dorio & Marine, 2004) wrote in 1989 that the ‘most common positive predictor stated in the
literature is the assessment of work behaviours’. These behaviours include the ability to be dependable (attendance, punctuality, completing work tasks), appearance, accepting supervision and interacting with co-workers. Reliable clinical predictors of future work performance are ratings of a person’s work adjustment skills made in a simulated work environment (Anthony & Jansen, cited in MacDonald-Wilson et al, 2001: 222).

4.4.4 Social skills and social networks
The ability to get along or function socially is a good clinical predictor of future work performance, and this includes the quality of social interactions on the job (Anthony & Jansen, cited in Dorio & Marine, 2004: 33).

Based on their review of literature, Tsang et al (2000: 24) state that ‘the results of this study support previous findings that social skill or social functioning level is a strong and consistent predictor of vocational outcome’, with support for this position coming from 11 research projects with different methodologies. They conceptualise work related social skills as a three tier structure:

- **basic social and social survival skills** including interpersonal communication, receiving, processing and sending of information and grooming and personal appearance
- **core skills** needed to handle general work related situations (for example, interacting with supervisors, colleagues and subordinates) and specific work related situations (that is, those skills vital for coping with situations specific to a particular kind of job)
- **benefits that a person can obtain by possessing these skills.**

Lysaker et al (cited in Kravetz et al, 2003: 283) state that ‘persons with schizophrenia evince low levels of social skills’ and Cook and Razzano (op cit: 282) have summarised on the basis of research literature that ‘having a psychiatric diagnosis, especially a diagnosis of schizophrenia, has been found to lower a person’s chances for positive vocational outcomes’. This discussion reflects again on the uncertainty among experts and suggests the need for specific research.

4.4.5 Cognitive functioning
Tsang et al (2000: 27) find cognitive functioning to be a significant indicator of employment outcome in their review of the literature and that, in a 1995 study by Van Os et al, ‘controlling for cognitive functioning greatly reduced the strength of the association with unemployment’.

One aspect of cognitive functioning that has been explored is the degree of flexibility displayed in problem solving abilities. According to Dorio & Marine (2004: 34-35), people with psychiatric disability often do not have the ego strengths that result in effective coping skills, and symptoms may also ‘prevent an individual from relying on their ability to correctly interpret their reality’, which further exacerbates the amount of stress a person experiences. The authors suggest that understanding how the mind really works is key to emotional health and can create a more positive state of being: ‘when people begin to watch how their minds work they can start to see how thoughts influence emotional states and behaviour. As awareness about this relationship is heightened, individuals can be taught to redirect or replace negative thoughts with more objective or positive
thinking…and begin to realize that they have a choice in every situation’ (Dorio & Marine, 2004: 35).

4.4.6 On site support and accommodations

Uninterrupted vocational support (Cook & Rosenberg, 1994) and job accommodations are cited by Dorio & Marine (2004:33) as evidence based predictors of job retention among people with psychiatric disability. In a review of the literature in the United States, McAlpine & Warner (2002: 22) note that while legislation in that country requires employers to make ‘reasonable accommodations’ in the workplace for qualified people with disability, including psychiatric disability, research suggests that employers are more reluctant to make accommodations for people with mental illness than they are to make accommodations for people with physical disability.

The types of accommodations likely to be successful or acceptable to employers include flexible work hours, unpaid leave days, flexibility in job assignments and accommodations that address the social nature of work (McAlpine & Warner, 2002: 24). The importance of on site support is strengthened by the finding of Anthony & Jansen (cited in MacDonald-Wilson et al, 2001: 222) that a person’s ability to function in one environment is not predictive of their ability to function in a different type of environment.

4.4.7 Training in critical vocational skills

Supported education programs for people with psychiatric disability have been developed in various countries, with a pioneering program developed at the Center for Psychiatric Rehabilitation at Boston University in 1984. Such programs usually include academic and functional assessment, assistance with career choices, skills teaching (such as study skills, stress and time management) and the utilisation of equipment, for example computers (Frost et al, 2002: 19).

In a review of supported education programs, Baronet and Gerber (cited in Frost et al, 2002: 19) concluded that these programs were associated with positive effects on quality of life, educational and occupational status. Danley (cited in Dorio & Marine, 2004: 33) listed training in critical vocational skills as a variable that ‘does improve vocational rehabilitation outcomes’.

4.4.8 Job satisfaction

Job satisfaction has been found by Resnick & Bond (cited in Dorio & Marine, 2004: 33) to contribute to longer job tenure, and in a 1996 study, Becker, Drake, Faragaugh & Bond (cited in Dorio & Marine, 2004: 33) found that ‘improved satisfaction and increased tenure were associated with consumer preferences regarding their job match’.

It is likely that the field of psychiatric vocational assistance would take account of research findings regarding predictors of occupational outcomes and barriers to employment success, and target its services accordingly. A range of vocational services identified in the literature is provided below.
5 Employment assistance for people with mental illness

5.1 Employment assistance within the context of psychiatric rehabilitation

Rehabilitation is the process of helping people with psychiatric disability to make the best use of their residual abilities to function at an optimal level in as normal a context as possible. The goal of psychiatric rehabilitation is to ensure that the person with the psychiatric disability can perform those physical, emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of support necessary from helping professionals and carers. (Liberman, cited in Morris & Lloyd, 2004: 491)

There is a discernable historical trend in employment assistance. Twamley et al (2003: 517) write that the history of work rehabilitation in the United States ‘is interwoven with the history of wartime efforts and labor needs, as well as the history of mental health treatment and the disability rights movement’.

From the 1920s to the 1960s the medical model of disability services prevailed, aiming to cure or protect patients through institutions and sheltered work. Historically, patients living in mental asylums who were deemed capable of working were given jobs at the institution and the types of work considered to be appropriate for those with severe mental illness were limited.

In the 1970s, the disability rights movement promoted the notion that ‘competitive employment, rather than sheltered work, should be the aim of vocational services for persons with disabilities’ and advocates called for a better fit between employment opportunities and clients’ interests and abilities.

From the 1970s to the present, the person centred approach has redefined the goal of vocational services as promoting optimal functioning in the community.

In Australia during the 1980s, the Commonwealth Rehabilitation Service ‘moved away from residential and outpatient institutional settings into community-based delivery, involving a range of allied health practitioners working as case managers in multidisciplinary teams…the 1980s also saw the rise of consumer-led demand for employment access for disabled people to work in competitive employment settings with access to ongoing support’ (King et al, 2006: 473).

The Report of the National Inquiry into the Human Rights of People with Mental Illness published in 1993 ‘found that governments had hitherto neglected vocational rehabilitation for people with mental illness. The Report stated that the needs of this group were varied and proposed that a range of graduated, transitional, vocational and rehabilitation services need to be developed to provide greater access to employment opportunities and more meaningful use of non-working time’ (Frost et al, 2002: 16).

Approaches that have been implemented to assist people with mental illness to gain and keep employment include skills training, vocational counselling, job clubs,
sheltered workshops, work crews, transitional employment and supported employment. These services are provided by organisations such as psychosocial rehabilitation centres, community mental health centres, vocational rehabilitation agencies or employment service agencies (Chalamat et al, 2005: 693-694).

The literature points to two distinct ways of approaching employment assistance (see Crowther et al, 2001: 204-205; Becker & Drake, 2005; Chalamat et al 2005; Waghorn & Lloyd, 2005: 5; Rose & Harris, 2005), and it should be noted that somewhat different terminology is used to describe them, for example in the United States and the UK or Australia:

**Train and place approaches**—these are often categorised as approaches incorporating ‘prevocational training’ which Rose & Harris (2005: 186) define as ‘all activities that are designed to prepare people with a psychiatric disability for the workplace’. This approach assumes that people require a period of preparation before entering competitive employment, that is, a job paid at the market rate, and for which anyone can apply. Pratt et al (2007) identify six approaches to prevocational training, namely job skills and job clubs, hospital based work programs, sheltered workshops or business services, transitional employment (short term usually three to nine months paid placements in open employment), affirmative industries (businesses owned, managed and operated by mental health agencies or consumers) and enclaves or work crews (small teams who work in community employment settings).

**Place and train approaches**—these approaches are described in the United States literature as ‘supported employment’. Clients are placed in competitive jobs without extended preparation and the methodology provides for on the job support from trained ‘job coaches’ or employment specialists. Ongoing assessment is conducted in real work contexts, and lengthy pre-employment assessments and gradual stepwise approaches to vocational rehabilitation are avoided wherever possible. ‘In theory, clients of supported employment services are supported indefinitely’ (Rose & Harris, 2005: 186).

### 5.2 Vocational services

A listing of the range of vocational services that can be identified in the psychiatric vocational rehabilitation literature is now provided. From a research point of view, these can be described as ‘vocational services variables’ (see Leff et al, 2005: 1238-1239; Cook, Lehman, Drake et al, 2005: 1950).

#### 5.2.1 Vocational assessment and evaluation

Assessment forms the foundation on which all psychiatric rehabilitation is built. It involves a full medical and psychiatric diagnosis and a functional assessment of the individual, looking for strengths, weakness and deficits and a resource assessment of the individual’s social environment.

A **functional assessment** identifies impairments, disability and handicaps that affect the individual’s ability to engage in the repertoire of roles, relationships and occupations required in the course of daily life. Assessment is followed by treatment involving a number of treatment domains (biological, psychological and social) which
are determined by the type and stage of the disorder that is present.

**Situational assessment** techniques involve direct observations of a person in a real or simulated work environment and use of behavioural rating scales to assess skill performance over a period of time. These behaviours are known as general work skills or work adjustment skills. For people with psychiatric disability, these skills tend to be in the interpersonal and cognitive domains. A suite of important situational assessment tools are now briefly described, based on a summary provided by MacDonald-Wilson et al (2001: 225-227):

- the Standardized Assessment of Work Behaviour assesses a broad range of behaviours rated on a five point continuum from ‘strength’ to ‘deficit’

- the Work Adjustment and Interpersonal Skills Scales contain two separate scales consisting of 21 work adjustment skills and 14 interpersonal skills. Each item is rated on a behaviourally anchored rating scale based on observation of the person in a preferred work environment

- the Job Performance Evaluation Form is a 25 item checklist of behavioural items in four categories: work readiness, work attitudes, interpersonal relations and work quality and performance

- the Work Behaviour Inventory (WBI) is a 36 item work performance assessment instrument specifically designed for people with severe mental illness. It is intended for use in a real work situation and consists of five subscales: work habits; work quality; personal presentation; cooperativeness and social skills. Items are rated on a five point scale from ‘consistently inferior’ to ‘consistently superior’. The WBI has been shown to predict hours worked and money earned, as well as discriminating between those who worked post-program from those who did not (Bryson et al in MacDonald-Wilson et al 2001: 227).

### 5.2.2 Vocational treatment planning and career counselling

Prevocational interventions have a long history in the field of psychiatric rehabilitation. The Center for Psychiatric Rehabilitation at Boston University was prominent in the development of the Choose-Get-Keep (CGK) model in which ‘practitioners diagnose, plan, and intervene to help individuals with psychiatric disabilities develop the skills and supports required to be successful and satisfied in their chosen roles or environments’ (Rogers et al, 2006: 247).

The CGK process model is not setting specific, and is not tied to a particular staffing pattern nor to a particular integration of services. Instead, the CGK model ‘focuses on facilitating a specific practitioner and client process to guide the client to choose, get and keep a rehabilitation goal. The CGK model specifies those ingredients that are most apt to facilitate the CGK process…in essence, diagnosing, planning and intervening is what practitioners do to facilitate rehabilitation…[and]…choosing, getting and keeping is what service recipients do to attain their goals’ (Rogers et al, 2006: 250).

Transitional employment programs, which aim to overcome employment barriers in the workplace by demonstrating core work
skills and appropriate work behaviours, often use on site training to teach and reinforce good work attitudes, behaviours and performance. According to Waghorn & Lloyd (2005: 28), ‘transitional employment is a form of psychiatric vocational rehabilitation developed specifically for people with psychiatric disabilities’. One example is Clubhouse programs which ‘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’ (Waghorn & Lloyd, 2005: 28).

5.2.3 Job development

Leff et al (2005: 1238) make use of the term ‘job development’ to describe that aspect of vocational service that involves ‘direct or indirect contact with potential employers or networking with individuals or organizations that had job information’. In Australia, there is an emphasis on employer demand strategies which promote the business benefits of employing people with disability and providing support and incentives to employers to increase demand for such employees. Promotion of the JobAccess web site occurs within this strategy (see www.jobaccess.gov.au). In Canada, job development is described as activities undertaken by employment support workers that include:

- becoming more aware of local labour market trends, the types of jobs available and the employment opportunities within each sector
- gaining an increased understanding of employers’ current attitudes towards people with mental illness and what their past experiences have been with respect to employing consumers in their workplace
- being able to educate employers and business associations about mental illness and about the types of workplace accommodations that are effective
- being able to directly create employment opportunities for consumers.

(See Canadian Mental Health Association, 2007)

In a long term (24 months) study in which data was collected on 1340 participants, Leff et al (2005: 1241) found that ‘the relative probability of obtaining competitive employment was significantly greater for participants who received job development. This finding was consistent within and between sites, and the overall effect across sites was also significant… individuals who received job development were almost five times more likely to obtain competitive employment than individuals who did not receive job development’.

5.2.4 On site job support targeted at the individual employee

The individualised support that occurs on site (i.e. at the place of work) incorporates counselling, problem solving, job coaching and other support measures and accommodations (Leff et al, 2005: 1239). Besides taking on the form of individual (case based) support, this kind of support can also be offered in small group format. In the long term study also referred to above Leff et al (2005: 1243) found that, on average, ‘receipt of job support was positively correlated with the number of months and hours worked in the first competitive job. However, the analyses
that took the time of intervention into account did not rule out the possibility of reverse causality', i.e. that job retention allowed people to receive job support rather than vice versa.

Intervention focusing upon on site job support needs to take into account the issue of disclosure. As discussed, on site support and accommodations have been shown to predict positive vocational outcomes, but such intervention can only take place in a situation of minimum knowledge of the individual’s mental health conditions and needs—in short, there needs to be disclosure.

In the vocational rehabilitation field the term ‘disclosure refers generally to the deliberate informing of someone in the workplace about one’s disability’ (Ellison et al, 2003: 3). Disclosing experience of mental illness in the workplace is a highly complex and contentious area, with arguments both for and against it.

Duncan & Peterson (2007: 28) summarise the reasons for disclosure as:

- **legal**—where the law places obligations on people to disclose
- **ethical**—where people feel that disclosure is the right thing to do
- **practical**—where people must disclose in order to access services and resources.

Consequent upon experiencing symptoms, if people start experiencing symptoms in the workplace, they often have no choice except to disclose, or leave.

Disclosure is beneficial because it can:

- help people with mental illness to organise accommodations and enable access to subsidies and services
- aid employees’ and employers’ understanding of, and dealing with, the onset of symptoms, thus leading to the strengthening of workplace relationships and trust
- ensure people with mental illness are not assessed as having poor work performance rather than experiencing symptoms, which can have adverse consequences for their employment records.

The primary reasons not to disclose relate to the risks of potential and actual discrimination during the hiring process and at work. Research suggests that people have fears of being more closely supervised than previously, isolated from co-workers, not promoted, or have a need to work harder than co-workers simply to prove their competence. Many are afraid that information about their history of mental illness would be misused and that all their subsequent behaviour would be defined in terms of mental illness. Overall, research indicates that the benefits of disclosure outweigh non disclosure (Duncan & Peterson, 2007; Ellison et al 2003).

Vocational services have a clear role in assisting their clients to deal with disclosure and Waghorn & Lloyd (2005: 31) note that strategies to dealing with stigma and disclosure are a core aspect of good practice. Issues to focus on include:

- careful consideration of the purposes, benefits and pitfalls of disclosure
- helping the person decide at what stage of the employment process (on an application form, during the job interview, after being hired) to disclose, if at all
planning a strategy for disclosing, based upon a careful consideration of the work environment and the culture. (See Duncan & Peterson, 2007: 25-35).

### 5.2.5 On site organisational interventions

Secker & Membrey (2003) refer to the promotion of 'natural supports at work' as an important factor that helps consumers to keep their jobs. On the basis of research, they recommend the following as the organisational initiatives that could constitute on site organisational interventions for mental health service users starting or returning to work (Secker & Membrey, 2003: 214-215):

- ensuring that a formal period of induction of sufficient length is routine practice for all new employees
- embedding attention to employees' ongoing development in routine workplace practice through formal supervision and appraisal procedures
- team building aimed at creating a welcoming workplace where difference is accepted and employees' strengths are valued
- training and other learning opportunities, for example learning sets for managers covering mental health and safety at work.

### 5.2.6 Strengthening the informal support provided by family and friends

Janki Shankar and Fran Collyer have been prominent in Australia in undertaking and describing research that focuses on the role of the social network in the psychiatric vocational rehabilitation process. Based on long term follow up of participants of vocational programs who had commenced open employment, Shankar writes that 'many of the ongoing support needs of workers with psychiatric disability may arise from the home/work interface' (Shankar, 2005: 9).

The kinds of issues that employment support workers would need to consider in working with family members include:

- the need to involve family members as partners, including providing education about their relative's capacity to work, support to alleviate their anxieties about relapse and periodic respite from the burden of care
- acknowledging that families are not always completely effective in providing support and that there are issues of stress, carer burden and lack of resources to provide certain kinds of support
- acknowledging issues of overprotection and critical and intrusive behaviours by network members
- providing advice on what to say to employers when their relative is sick, recognising signs of stress and relapse and contacting the professional early to prevent job loss. (Shankar & Collyer, 2003: 11-12)

Shankar and Collyer (2002: 26) summarise their concern: 'Job training and placement support activities which currently comprise the major part of vocational rehabilitation programs for the recovered mentally ill must be complemented by the cultivation of a supportive environment at different levels that can sustain their skills and accommodate their disabilities. Since the family forms the largest part of the network and has several resources to offer, the first level for professional intervention should
be directed towards supporting and involving this network’.

5.2.7 Off site job skills training and education

Much of the available literature describes this aspect of vocational service as ‘supported education’ or ‘specialised supported education’. Supported education has been shown to improve the work status, educational status and quality of life of program participants, also facilitating the ‘normalizing experience of post-secondary education’ (Bellamy & Mowbray, 1998; Collins et al, 1998; Unger et al, 1991, cited in Hutchinson et al, 2007: 190; Waghorn et al, 2004).

Waghorn et al (2004: 444) write that ‘over the past two decades, research on employment outcomes of people with severe mental illness in the United States has consistently concluded that educational attainment is not associated with employment outcome…[but]…in Australia, the evidence suggests that educational attainment is closely associated with employment outcomes’. Two examples of such programs are now briefly described.

Waghorn et al (2004: 452) describe, as an example of an innovative Australian program, the Early Psychosis Intervention Program at Liverpool in South West Sydney. The program utilised a self contained classroom model, which supplemented the limited mobile support options already in place through a TAFE consultant employed to support the educational needs of people experiencing mental health problems wanting to enrol in or currently attending TAFE.

A program that has been evaluated for its outcomes on participants is the Training for the Future (TFTF) program at Boston University’s Centre for Psychiatric Rehabilitation (Hutchinson et al, 2007). The first goal of the TFTF program is to teach people with psychiatric disability computer skills and recovery coping strategies in a supported education environment. The second goal is to provide supported employment services so that students could secure and sustain employment in work with career potential.

Besides needing to demonstrate an expressed willingness to participate in a classroom environment and to have an employment or educational goal, participants are only admitted if they have ‘a person outside of the program who could provide support for the individual’s attendance and completion of the program’ (Hutchinson et al, 2007: 190). Using a pre test-post test design with repeated measures over time, participants were interviewed quarterly using standardised assessments and paid for their participation in the assessments.

Results were positive: 89 per cent of participants successfully completed the 10 month training and two month internship. They experienced a positive change in work status and a significant positive trend in hours worked over time was noted. A significant positive trend in income over time was noted and participants experienced progress in non vocational areas such as decrease in mental health and rehabilitation service use, progress in housing status, positive gains in self esteem and improvement in total Empowerment Scale scores.
5.2.8 Off site vocational counselling, mentoring and support

The role of vocational service workers with regard to off site job related support is likely to take the form of vocational counselling in connection with the job currently held, ongoing information provision and referral. A potentially important source of mentoring and support is also available through the self help movement, which is recognised as a complement or even alternative to the formal service system, having flourished in many countries, including Australia.

These groups ‘give people a sense of belonging, the power to control and make informed choices about their lives and understanding that can only come through someone else …and consumers who are presently working can share their success stories with the group. It can be both encouraging and motivational to hear from someone who has faced similar obstacles and has succeeded in achieving his/her goals’ (Canadian Mental Health Association, 2007: 3).

Another example of peer support described in the Canadian situation is peer mentoring, whereby a consumer who has succeeded in finding and keeping meaningful employment acts as a role model for another consumer who is still working towards this goal. An example of this kind of support movement in Australia is GROW, which began in 1957, and is described as a ‘12 step recovery-focused program for mental health’. It makes use of a group method that includes personal testimonies of recovery or outstanding growth, problem solving, reports on progress and adult education for mental health; it has a ‘vigorous caring and sharing community’ and a ‘legal and organisational structure’ (see GROW web site at www.grow.net.au/Works.htm).

5.2.9 Job related transportation

In a study in the United States carried out in 2000 (cited in McAlpine & Warner, 2002: 20), Druss and colleagues found that lack of transportation was reported by approximately 29 per cent of people with mental disability as a significant barrier to obtaining employment. Material support that addresses this key issue can form part of the package of vocational assistance.

5.3 A recommended typology of employment assistance models

It must be noted that the literature makes use of a variety of terms and concepts to describe and evaluate models of employment assistance, and that it may be difficult to agree on definitions. Factors such as the ultimate objective of assistance, the method or combination of methods used to achieve goals and the level of professional involvement all play a role in determining how a ‘model’ can be described.

The approach used here is to place the models into categories based on a consideration of all these factors and to select a title to describe the approach based on a reading of the literature, while recognising that this may not be the same title used across all readings. This point has also been made by Schneider et al (2002: 18): ‘a vast array of program labels abound in the literature, with some programs having different labels for essentially the same approach. A more common occurrence is two programs with the same label providing a very different set of program activities’.
A—Employment through disability business services

**Goal:** sheltered employment with no specific aim for competitive employment.

**Characteristics:** high level of involvement by mental health professionals, with a focus on mental health maintenance; contact by consumers is mainly with other people with mental health problems and with staff members.

**Methods:** traditional vocational services, clubhouses, supported education and affirmative industries (businesses owned, managed and operated by mental health agencies or consumers).

**Example literature:** Schneider, 2002: 18; Twamley et al, 2003; Waghorn et al, 2004; Rose & Harris, 2005.

---

B—Prevocational training and transitional employment

**Goal:** preparation for competitive employment via training and/or a transitional placement.

**Characteristics:** vocational rehabilitation models that assume that stress will be reduced if a person is job ready for a role prior to placement in a job. There is a high level of involvement by vocational rehabilitation specialists and mental health professionals and an emphasis on throughput versus permanence.

**Methods:** train and place methods are the norm. They include support groups that provide resources and training in job search and employment, on site employment experiences for inpatients of mental health services, transitional employment which is either in companies owned by mental health agencies or consumers or short term (three to nine months) paid placements in open employment, and enclaves or work crews, these being small teams who work in community employment settings. Collectively also described as programs using psychosocial rehabilitation methods.

**Example literature:** Schneider et al, 2002: 19; Rose & Harris, 2005; Waghorn et al, 2004; Twamley et al, 2003.
C—Supported open/competitive employment

**Goal:** competitive employment.

**Characteristics:** there is a clear disincentive to use extensive pre-employment experiences, such as assessment, skills training, counselling, sheltered work experiences and work trials prior to placement in a competitive job in the belief that ‘individuals tend to become stalled in these prevocational experiences and never make the transition to competitive employment’ (Mueser et al, 2003: 398).

**Methods:** Individual Placement and Support (IPS); the person re-enters employment after mental illness or relearns on the job rather than first attending programs of prolonged training; place and train methods; support is either on site coaching or on site by appointment, off site by appointment or by telephone.


D—Enhanced supported/open employment

**Goal:** competitive employment.

**Characteristics:** complementary interventions, not necessarily targeted at vocational functioning, are used to improve instrumental functioning. This, in turn, might be expected to impact on vocational functioning.

**Methods:** evidence based forms of psychosocial interventions, especially cognitive/behavioural and family therapy interventions are explicitly added to vocational training programs. Family psycho-education is one example, and incorporates at least six months of work with families providing information to them about the psychiatric illness and its management, striving to decrease tension and stress in the family, give social support and empathy, focus on improving the future rather than exploring the past, improve functioning in all family members and seek to form a collaborative relationship between the treatment team and family (Mueser et al, 2003: 396-397).

Another approach is termed ‘illness management and recovery’ which is used as a broad description for methods aimed at helping consumers acquire the information and skills needed to collaborate effectively with professionals and significant others in their lives and to be able to pursue personally meaningful goals, social skills training for improving interpersonal competence, and cognitive therapy, which involves helping consumers evaluate the evidence supporting their delusional beliefs to test out their beliefs in behavioural experiments and to formulate alternative, more viable explanations when faced with evidence that is inconsistent with their convictions (Mueser et al 2003: 399-401).

**Example literature:** Schneider et al, 2002: 26; Mueser et al 2003; Mueser et al, 2004; Penrose-Wall & Bateman, 2007.
E—Integrated supported/open employment

**Goal:** competitive employment.

**Characteristics:** there is a systemic integration of employment, mental health and vocational rehabilitation services resulting in the co-location of clinical rehabilitation with the employment program.

**Methods:** the integration of mental health care and vocational assistance can take the form of full integration, involving structural links and co-location, or the establishment of formal communication structures to enable collaboration and sustained communication supported by formal protocols and regular cross-training (King et al, 2006: 475).

Methods of integrated supported employment include collaborative psychopharmacology, including the adoption of a standard approach to documenting and monitoring symptoms and side effects, guidelines for systematically making decisions about medications, and engaging consumers in shared decision making about medication related decisions whenever possible (Mueser et al, 2003); and Assertive Community Treatment (ACT model), an example of which is the Program of Assertive Community Treatment vocational model in Massachusetts, which offers a team based approach integrating vocational and mental health services, delivered in clients’ natural environments using a shared caseload, with a team vocational specialist assessing, placing, training and supporting service recipients in community based jobs (Cook et al, 2005: 507).

**Example literature:** Morris & Lloyd, 2004; Cook, Lehman, Drake et al, 2005; Cook, Leff, Blyler et al 2005; King et al, 2006.

---

F—Independent employment

**Goals:** competitive employment; self employment, expression of creativity/talents.

**Characteristics:** independently accessed employment in competitive roles or self employment; minimum provision of on site vocational support or explicit involvement by vocational service providers.

**Methods:** service provision is more likely to be delivered by mental health agencies and professionals, but there could be referral to a vocational service such as the New Enterprise Incentive Scheme (see www.jobaccess.gov.au); focus on skills and knowledge related to micro business performance and survival as part of broad strategy of skills transfer in respect of independent living, including assistance in calculating a ‘threshold of performance’ (level of performance desired in order to stay in business) and development of business plans. There may be informal and ad hoc contact to monitor progress and to intervene if there are problems during transitions to new roles.

**Example literature:** Kelly et al, 2002; McGurk & Mueser, 2003; Penrose-Wall & Bateman, 2007.
5.4 Identification of best practice principles when competitive employment is the goal

A crucial influence on the conceptualisation of principles for supported employment for individuals with mental illness has been the work of Robert Drake and Deborah Becker in the development of the Individual Placement and Support (IPS) model. Among the key principles are the following (Bond, 2004: 346):

1. **Services focused on competitive employment.** As described above, competitive employment refers to community jobs that any person can apply for, in regular places of business, paying at least minimum wage, with mostly co-workers without disability.

2. **Eligibility based on consumer choice.** No one is excluded who wants to participate and consumers are not, for example, excluded on the basis of assessment of a lack of ‘work readiness’.

3. **Rapid job search.** Consumers are helped to obtain jobs directly rather than providing lengthy pre-employment assessment, training and counselling.

4. **Integration of rehabilitation and mental health.** The supported employment program is closely integrated with the mental health treatment program.

5. **Attention to consumer preferences.** Services are based on consumer preferences and choices, rather than providers’ judgments.

6. **Time-unlimited and individualised support.** Follow up supports are individualised and continued indefinitely.

Waghorn & Lloyd (2005: 27-31) add the following principles when considering vocational rehabilitation in the Australian context:

7. **Income support and health benefits counselling.** This implies that 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.

8. **Intensive on site support.** Although similar to principle 6, Waghorn & Lloyd (2005: 27) describe the principle that ‘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’.

9. **Multidisciplinary team approach.** The multidisciplinary team provides a form of coordinated mental health care and vocational services through team members being typically experienced in mental health treatment, and through close liaison with the client’s treatment professional.

10. **Emphasis on the rehabilitation alliance.** This is based on a shared understanding of both the staff member’s and the consumer’s roles in rehabilitation. Vocational staff undertake to provide timely and proactive assistance according to mutually agreed needs for assistance which are constantly reviewed. This usually involves active outreach, where meetings can take place in the consumer’s local environment, and follow up action is initiated immediately problems occur.

11. **Stigma and disclosure strategies.** The use of explicit strategies to counter workplace stigma, and structured counselling to optimise disclosure strategies.
6 Evaluation of the effectiveness of employment assistance models

The field of psychiatric vocational rehabilitation has enjoyed noteworthy research interest and there is an extensive body of literature that has aimed to evaluate the effectiveness of assistance models. In the early stages of evaluation (pre 2000) there has tended to be a focus on comparing supported/open employment models, especially the IPS model, with traditional approaches to vocational rehabilitation. In recent years, there have been attempts to look for differences in outcomes also between various combinations of supported employment programs and also to trace long term effects.

This literature is now discussed by describing methods of evaluation that have been used, noting some of the major results of these evaluation studies, and considering what the literature suggests to be areas requiring further research.

6.1 Methods of evaluation

Retrospective studies

As reported on by Lucca et al (2004), one approach to evaluating supported employment programs has been the use of an independent, retrospective evaluation of a specific program. Evaluators established an observation period and selected only those participants who were, in addition to being part of an IPS program, also receiving case management services and clinical services, allowing access to individual diagnostic and functioning information not routinely available from the employment program records alone. The authors note that ‘retrospective studies …tend to suffer from a lack of specificity in the data or from missing data’ (Lucca et al 2004: 256).

Conversion studies

Bond (2004: 347-348) discusses an evaluation methodology that involves the examination of the effectiveness of converting from day treatment services to supported employment. The range of methodologies include comparing a day treatment program conversion to a centre that did not initially convert its services, but later did; comparing a portion of a program that converted to a group of day treatment clients not involved in the conversion; comparing two centres undergoing conversions to one that did not; and a follow up study of consumers enrolled in a day treatment program after its closing.

Randomised controlled and quasi-experimental research designs

Riccio and Bloom (2002) make reference to the following types of randomised social experiments to evaluate ‘welfare to work’ and employment initiatives:

- **Basic randomised designs** that test programs in their entirety—eligible individuals are randomly assigned to either a program group, which is offered the service, or a control group, which is not. The procedure ensures that the two groups are equivalent on all pre-random assignment characteristics.

- **Multiple program groups** that compare alternative program strategies and components—a three way random assignment design enables direct experimental comparisons of alternative
job preparation strategies and alternative ways to structure program caseloads. These research designs are ‘limited by the fact that most social programs are made up of a variety of components, features or strategies whereas, in most cases, it is feasible to implement only large sample randomised social experiments with a small number of program groups’ (Riccio & Bloom, 2002: 19).

- Pooling experimental data in a

  comparison of sites analysis—using the natural variation in true effects across sites, estimated by an experiment for each, and the natural variation in their programs to estimate the influence of each factor on program effects, controlling for the others. The viability of this approach depends on the number of experimental sites for which comparable data have been obtained, the variability of true effects across sites (the dependent variable for the analysis), the size of the experimental sample at each site and the quality and consistency of measures used to characterise programs, sample members and site environments (the independent variables for the analysis). There is the potential for the problem of selection bias due to incomplete model specification that is inherent in any non-experimental research, and the authors suggest that the best way to reduce the potential for such problems is to ‘ground the statistical model to be used as fully as possible in the theory and practice of the program studies, to develop and test carefully the validity and reliability of all measures used and to obtain a sample of sites and individuals that is as large and varied as possible’ (Riccio & Bloom, 2002: 21).

- Using instrumental variables with randomised experiments to explore causal pathways—this approach provides for a clear specification of the causal pathways by which effects are expected to occur and a method of analysis that can test for the existence and strength of the intervening steps in these pathways. This also allows for a focus on ‘the underlying theories of the programs that they are designed to test’ (Riccio & Bloom, 2002: 22).

- Combining ‘cluster’ random assignment with interrupted time series analysis—this approach is useful for testing ‘place-based’ initiatives, combining experimental and quasi-experimental methods. The design represents an extension of before-after analysis with multiple observations on outcomes before an intervention is launched (during its baseline period) and multiple observations after it has been launched (during its follow up period). ‘In its simplest form, interrupted time series analysis estimates program effects for a given follow up period as its deviation from the base line pattern for an outcome of interest’ (Riccio & Bloom, 2002: 26).

Ethnographic studies

Alverson et al report on an ethnographic approach that employs intensive participant observation methods. This form of research is designed ‘to explore in some depth and over time the factors associated with success or failure of interventions to help clients secure and sustain employment’ (Alverson et al, 2006: 16).

In one study conducted in Hartford, Connecticut, participants for the ethnographic sub study within a larger
randomised controlled trial were selected on a stratified random basis and the field workers who conducted the participant observation and data collection were matched with participants from three identified populations (Hispanic American, African American and European American). The principal techniques for establishing or assuring reliability and validity of findings were consistency of observations across intensive event sampling, triangulation (convergent information about actions or events from multiple sources and points of view), constantly comparing clients’ testimonies with personal observations, and working side by side with other field workers and comparing notes.

**Constant comparative methods combined with content analysis**

Gowdy et al (2004) report on a study which uses a comparative methodology comparing programs demonstrating high rates of consumers in competitive employment with those showing much lower rates. Site visits and in depth interviews with key informants from the selected programs served as the primary data collection method. Interview guides for all subjects were based on a framework for best practice derived from the work of Bond and colleagues (Bond, Drake, Mueser & Becker, 1997). Analysis of interview data was conducted using a combination of constant comparative methods and qualitative summary via content analysis. To ensure consistency and reliability in results, team members worked in pairs, cross checking each other’s results as each area was examined.

**Long term follow up studies**

Salyers et al (2004) describe an approach to evaluation which made use of a follow up study with participants in a supported employment program interviewed ten years after program completion about their employment history, facilitators to their employment and their perceptions of how working affected areas of their lives.

**Assessment of cost effectiveness**

Chalamat et al (2005) describe an Australian study which evaluates the cost effectiveness of a number of interventions in mental health based on standardised methods. A comprehensive evaluation protocol was specifically written for the Assessing Cost-Effectiveness in Mental Health (ACE-MH) study. In the UK context, Schneider writes that ‘the costs of occupational interventions can be assessed from the perspective of the individual service users, taxpayers or society at large’ and that ‘the interplay between state-funded welfare benefits and individual earnings is clearly a determining factor in estimating the cost effectiveness of occupational interventions at the level of the individual’ (Schneider, 2003: 4). A cost benefit ratio can be derived by dividing net benefits (gross benefits minus gross costs) by gross benefits plus gross costs, yielding a ratio between -1 and +1.

This author’s review points to large scale surveys with the assessment of cost effectiveness in focus, especially some conducted in the United States, as well as studies focusing upon specific interventions (Schneider, 2003: 5-9).
6.2 Key findings of some reviewed evaluation studies

A retrospective study reported on by Lucca et al (2004) indicated that many of the employment program participants achieved and sustained competitive employment. The authors conclude that ‘these findings are consistent with research indicating that programs following a clearly articulated service model, such as IPS, are more likely to achieve positive outcomes’ (Lucca et al, 2004: 257). The ethnographic study reported on by Alverson et al (2006) makes the following points that have relevance for research in the field:

- actual motivation to seek and hold jobs might be assessed by means other than brief questionnaires or self reports. It helps when, using the terminology of Miller and Rollnick, motivation is ‘construed as a behavioural concept’ (in Alverson et al, 2006: 21)
- the search for work by participants who are living in relatively stable kinship networks or households is inherently a family process and ‘vocational counselors might consider the household, the family, or significant others in social networks as part of the field for rehabilitative or vocational interventions’ (Alverson et al, 2006: 21)
- socially constructed ‘racial’, class, educational, and national background are important factors affecting employment experiences and employment prospects and ‘employment counsellors must deal with these experience-based perceptions just as directly as they address severe mental illness’ (Alverson et al, 2006: 21).

A literature review and meta analysis of randomised controlled trials (Twamley et al, 2003: 521-522) draws the conclusion that supported employment (SE) programs in general and IPS specifically have produced consistently better outcomes than traditional vocational rehabilitation in terms of both competitive employment and employment of any type. The mean effect size of studies comparing IPS/SE to conventional vocational rehabilitation is 0.79, which is considered a ‘large’ effect size. The authors go on to write that although IPS/SE appears to be the most effective type of work rehabilitation, nearly half (49 per cent) of the IPS/SE participants did not obtain competitive work at any time during the study, so that while it appears that IPS/SE is ‘on the right track’, further improvements should be made.

A multi site randomised controlled trial carried out in terms of the Employment Intervention Demonstration Program in the United States is an example of implementation effectiveness trial examining the impact of highly integrated psychiatric and vocational rehabilitation services on the likelihood of successful work outcomes (Cook, Lehman, Drake et al, 2005; Cook, Leff, Blyler et al, 2005). The study used the multi site common protocol of a set of assessments administered at intake and every six months in a follow up 24 month period. The study tested two hypotheses:

- participants in supported employment programs with highly integrated psychiatric and vocational service delivery will achieve superior vocational outcomes compared to those in programs with low levels of integration
The amount of vocational services received will be positively associated with better employment outcomes after control for the amount of psychiatric services received as well as participant demographic and clinical characteristics.

Eight study sites were selected in various states. All of the study subjects met diagnosis, duration and disability criteria for severe and persistent mental illness. At all sites, the subjects were recruited from clinical populations by provider referral, self referral, family referral or word of mouth. Each site received approval from its local internal review board for the protection of human subjects and obtained written informed consent from all participants.

The eligible pool of study participants numbered 10,653, of whom 1,648 consented to participation and were subsequently randomly assigned to an employment support program. The sites tested different models of supported employment and compared them to a variety of conditions. At each site the experimental condition was a form of enhanced best practice supported employment compared to either ‘services as usual’ or an un-enhanced version of the experimental model. None of the sites used a ‘no treatment’ comparison condition. There was a strict set of criteria for operationalising the construct ‘service-delivery integration’, namely that psychiatric and vocational staff interacted on a face to face basis at least three times a week or more; that psychiatric and vocational services were delivered by staff operating at the same location; that both types of services were provided by the same agency; and that a single case record was used.

The two vocational outcome measures were selected to represent fundamentally different conceptualisations of employment success, namely a subject’s ability to vie with workers without disability for a job in the competitive labour market and work for 40 or more hours in a single month. Control variables included:

- age (measured in 10 year intervals)
- self rating of level of functioning in non-work related domains such as independent living and social relationships
- prior work history was reported by the subjects and coded as one or more jobs in the past five years versus none
- receipt of public disability income was reported
- diagnosis—the Structured Clinical Interview for DSM-IV was administered at some sites, while case record diagnoses made by treating psychiatrists were extracted from clinical files at the remaining sites. After calculation and inspection of frequency distributions and zero-order relationships, outcomes were inspected visually for each of the 24 months of study participation. Random effects logistic regression modelling was used to address the two hypotheses at the multivariate level. This method was chosen to address issues commonly found in longitudinal multi site data, including serial correlation, individual heterogeneity, missing observations and fixed versus time varying covariates.

A major finding of this study was that, compared with services as usual or unenhanced comparison programs, the experimental programs had a significant
and positive effect on three employment outcomes namely competitive employment, working for 40 or more hours in a single month, and the economic return (monthly earnings from paid employment) to the individual from his or her labour force participation. The advantage of experimental over comparison group participants increased during the 24 month study period. The authors suggest that ‘the findings of this study confirm the superiority of SE for individuals with psychiatric disability over other approaches such as standard vocation rehabilitation services as usual’ (Cook, Leff, Blyler et al, 2005: 511).

In a study comparing five programs with the highest competitive employment rates compared to the four lowest performing programs, using the constant comparison method described above, Gowdy et al (2004: 152) locate the performance differentials between the two groups of programs in ‘the organizational context in which these programs were imbedded’. They name these factors as:

The active involvement of more than just the supported employment team. Three elements were identified that distinguished high performers from comparison sites, namely supported employment workers meeting frequently with case managers as a team, with a high amount of collaboration between staff; case managers participating in helping clients find work; and therapists involved in supporting consumer employment goals.

A study conducted by the Manpower Demonstration Research Corporation (MDRC), a social policy research firm based in New York, used the comparison of sites approach referred to above and produced the following key findings:

1. quick entry to jobs is a powerful medium for stimulating clients to find jobs
2. emphasis by staff members on personalised attention to clients markedly increases the success of a program
3. large case loads reduce the effectiveness of programs
4. increased reliance on basic education reduces the effects of programs, at least in the short term
5. high unemployment rates reduce the effects of programs.

(Riccio & Bloom 2002: 21)

Bond (2004) provides a meta analysis of a dozen studies using two types of rigorous research designs, namely randomised controlled trial methodology and day treatment conversion studies. The author states that all the recent reviews of supported employment programs that make use of the principles developed by the IPS model (described above), conclude...
that it should be considered to be an evidence based practice. The impact of supported employment is specific to employment outcomes, with no systematic impact on non-vocational outcomes, either on undesirable outcomes, such as hospitalisation, or on valued outcomes, such as improved quality of life. He calls for continued experimentation on enhancing the evidence based practice and additional focused research evaluating specific program components.

Bond’s confidence in the empirical foundation of supported employment is echoed by Morris & Lloyd (2004: 493) who write that there has been an accumulation of a substantial amount of evidence over the past ten years that demonstrates the effectiveness of supported employment for vocational rehabilitation. The authors summarise the following characteristics of supported employment programs as providing successful vocational outcomes:

1. commitment to a competitive employment goal
2. rapid job search and placement
3. jobs selected on the basis of individual preference and the skills and experience of the person
4. follow up employment consultant support and indefinitely maintained case management
5. close integration of supported employment programs with mental health teams.

These are by and large equivalent to the principles that have been identified for supported employment using the IPS model (see above).

In the long-term follow up study reported on by Salyers et al (2004) almost all the consumers reported that they were employed at some point during the follow up period; the majority of the jobs were competitive; many of the jobs they held were long term, with an average tenure of almost three years; and almost all the consumers continued to receive Social Security benefits. The authors point out that their ‘findings also raise questions about whether self-sufficiency is a realistic goal for most mental health consumers... most consumers appear to focus on goals, such as increasing income, self worth, and community integration, rather than on self-sufficiency’ (Salyers et al, 2004: 307).

A large study commissioned by the Department of Health in the UK (Schneider et al, 2002) concludes that ‘supported employment has the potential to meet the occupational needs of a large proportion of mental health service users, provided it is implemented along clearly-defined lines. For people who, at any point in time, do not require open employment, a range of more or less inclusive alternatives exist’. The key findings of this study are:

1. service users are more likely to get jobs and keep them if they are not impeded by poor social skills and negative symptomatology, but also if they: have worked before; have positive attitudes towards work; are placed as soon as possible in a job of their choice; receive preparation targeted at work rather than general training; receive ongoing support in their job; actively participate in an occupational intervention; and are not worse off as a result of working vocational services seem to be more effective at getting people into work
when integrated with mental health teams

3. the IPS model of supported employment has strong evidence in its favour, but it may not suit everyone at all times.

In her summary of the evidence regarding cost effectiveness of vocational assistance programs, Schneider (2003: 10-13) states that ‘individuals benefit to a greater degree than the state or society, at least in the short term’ and that ‘at the global (state or national) program level, Supported Employment tends to be more favourably evaluated than sheltered work or training, and this is because of its superior employment outcomes, which generate greater tax revenue’.

She concludes: ‘Since most other mental health interventions...are unlikely to make the service user economically better off, much less the taxpayer, the evidence for supported employment over alternative interventions is strong, but still not conclusive. The uncertainty arises from the variability in costs of implementing such support. It is likely that the ultimate criterion of cost effectiveness will be the value that decision makers place on the greater social inclusion promoted by some models of supported employment’.

6.3 Areas requiring further research

Twamley et al (2003: 521-522) make the following recommendations for further research:

- further investigation of modifiable versus non modifiable predictors of success will be needed to better target interventions toward people who are likely to benefit from them. These include factors relating to demographic factors, clinical factors and prior work history. The authors point specifically to the need to focus on vocational rehabilitation in the context of ‘the growing population of middle-aged and older patients with schizophrenia and related psychoses...[which]...presents a significant challenge to the mental healthcare system
  - establishing which consumers benefit from work rehabilitation and which ones do not, possibly leading to the identification of subgroups that will allow for a better matching of the rehabilitation strategy to the individual consumer
  - the costs associated with various types of work rehabilitation
  - given that the ultimate goal of rehabilitative treatment is to increase quality of life in the community, outcome measures are needed that not only indicate whether a participant obtained a job, but also the duration of employment, the wages earned, the participant’s level of job satisfaction, measures of community functioning and quality of life, and longitudinal measures of cognitive functioning.

Drake et al (2006) write that many studies establish the effectiveness of the IPS model and that, in just over 15 years, evidence based supported employment has become the standard of care within psychiatric rehabilitation. The authors suggest that there is nevertheless considerable variance across and within programs and conclude that ‘these differences appear to be related to clinical skills; some employment specialists simply are more proficient or competent at the relevant tasks’ (Drake et al, 2006: 316).
They describe the necessary clinical skills within two broad groupings: those that fit within a matrix of specific interactions, namely transactions with clients, with other staff and with employers; and those required for each of the areas/stages of supported employment, namely engagement, assessment, finding a job that matches talents and interests, insuring success by addressing skills and supports, leaving a job appropriately, and finding another job. They recommend that ‘further work is clearly needed to clarify the critical skills of employment specialists, to develop ways to assess these skills, and to improve the skills through training and supervision’ (Drake et al, 2006: 317).

Based on their wide ranging study in the United Kingdom, Schneider et al (2002: 9) suggest a range of areas for further research ‘on which the experts agree’. In those areas that are not particular to the UK, research is called for:

- about the 30 per cent of people who choose not to work, their motivation, and how socially inclusive provision can be extended to them
- about IPS, in what combination it works best, for whom and at what cost, by using robust study designs, about the longer term (five years plus) costs and outcomes, including the career pathways of service users; and about the acceptability of IPS in different forms to various stakeholders
- about whether changes to the rules for permitted earnings have a positive impact on people with mental health problems
- about the intangible outcomes of paid work, for example, social inclusion, mastery, self efficacy and independence in activities of daily living
- about voluntary (unpaid) working and its impact on vocational and non vocational outcomes
- about whether cognitive behaviour therapy and family therapy can enhance occupational outcomes, alone or in combination with specific programs.

### 6.4 Methodological issues in relation to the evaluation of employment assistance for people with mental illness

#### 6.4.1 Research design issues

A useful summary of issues in evaluating vocational rehabilitation programs for substance users is provided by Staines et al (2003) and it is assumed that similar issues would pertain to studies focusing on psychiatric vocational rehabilitation. These authors list the research design issues as the following:

**Small effect sizes**

The problem of small effect size of the outcomes of interventions is central and ‘may result either from poor outcomes of a vocational program as compared with a no-treatment control group, or from modest differences in effectiveness between experimental and comparison programs’ (Lipsey, cited in Staines et al, 2003: 62).

**Low statistical power**

The ability to discern program effects in vocational studies may be hampered by designs lacking sufficient statistical power, i.e. the ability to detect an intervention effect that actually exists. One cause of low statistical power is sample size limitations for which two general strategies are available, namely implementing a multi site design that replicates the same
intervention and data collection tools at two or more sites, each with a modest sample size; or to enhance sample size by lengthening the projects’ duration so that more participants can enter the project and be serviced.

**Inclusion in the outcome variance of non-program factors**

Another reason that true program effects cannot be determined, according to Lipsey (cited in Staines et al, 2003: 64-65) is ‘inclusion in the outcome variance of two types of non-program factors, patient characteristics and counsellor characteristics’. The authors recommend that using a statistical technique that controls for the variance attributable to factors related to patient characteristics, such as analysis of covariance, can increase statistical power.

All methodologists ‘agree that ignoring the counsellor factor in comparative treatment studies is unacceptable’ (p. 64). Approaches which explicitly take into account the counsellor factor include mixed model ANOVA and multilevel models (Raudenbush & Bryk, cited in Staines et al, 2003: 64). Comparative studies of counselling methods have two basic design options: each counsellor can deliver just one of the counselling methods, such that counsellors are nested under the methods; or each counsellor can deliver all of the counselling methods, such that counsellors are crossed with the counselling methods. It may be advantageous to select counsellors to deliver a particular method based on the counsellor’s past training, experience and motivation with that method—such selection would not be possible in the crossed design. The authors also note that ‘exercising control over counsellor effects through these strategies will come at a price of reduced generalisability with respect to any findings’ (p. 65).

**6.4.2 Implementation issues**

Since research projects are situated in separate service organisations, there are organisational hurdles that have an impact upon implementation, which Staines et al (2003) summarise as follows.

**Conflicting goals**

On a day to day basis researchers are driven by scientific rigor whereas program staff are focused on immediate client needs. Many clinical staff have had little exposure to research and do not understand its goals or methods (Monett et al, cited in Staines et al, 2003: 65).

**The requirement for a high level of cooperation with service providers at all levels**

The authors note that they have found it helpful to engage the staff in the research process using techniques such as providing reciprocal benefits, for example, through expenditures that enhanced staff members’ jobs or work environment but were not fundable by service budgets, invitations to staff to attend and participate in project team discussions, to contribute to the study’s research conference presentations and to co-author published papers and conference presentations.

**Lines of supervision**

Whenever a research project is superimposed on existing services, researchers need to institute their own clinical supervision of the intervention to avoid problems relating to ‘program contamination’ and ‘convergence’. 
The authors have found that delegation of some clinical responsibilities to researchers is easier when the existing service is considered marginal, if a relationship of trust has already been established with the researchers and by ‘frequent and frank communication within good working relationships developed in part through inclusion of the clinic’s vocational director in professional research activities’ (Staines et al, 2003: 67).

This section is ended with a methodological guideline from the literature:

Researchers often have immediate goals that differ from those of clinicians and a need to override traditional lines of supervision to get project activities properly executed. At a minimum, developing cooperative working relationships with clinical staff requires tact, reciprocity, trust, respect and generosity. Investigators must work just as diligently on developing such alliances as they do on devising sound research designs...evaluators must work closely with clinicians to develop innovative models that can transcend design and implementation barriers, and can be used to train other clinicians so that positive outcomes can be achieved throughout the field. (Staines et al, 2003: 67)
Summary of key issues

Some of the emerging themes from this analysis of the literature are as follows:

- there are large numbers of people in Australia with mental health issues, and psychiatric illness is a significant health issue in this country

- currently in Australia, more people are in receipt of disability support payments than unemployment benefits

- there are many people with mental health issues who would like to work and who are not currently in employment; employment is a major contributor to positive mental health outcomes

- success factors for people with a mental illness in employment do not necessarily relate to their skill levels or their type of mental illness but their work history and experience, their motivation to work, their social skills and the quality and duration of the employment and mental health supports they receive

- there is broad support for, and an international trend towards, improving employment outcomes for people with mental illness—large scale studies have been carried out in the UK and the United States to explore what works and what does not. Many of these have produced findings that provide strong indications of successful models, approaches and practices. These lessons need to be tested and applied in the Australian context

- studies reviewed here utilised a range of evaluation methodologies, including multi site approaches

- there is clearly a growing body of research and evaluation on mental illness and employment, and some highly relevant recent studies have been undertaken overseas that will be of considerable value to an Australian evaluation.
Appendix A

A.1 References


Australian Institute of Health and Welfare. 2003. ICF Australian user guide. AIHW, Canberra


Australian Institute of Health and Welfare. 2006b. Australia’s Health 2006: the tenth biennial health report of the AIHW. AIHW, Canberra


Canadian Mental Health Association. 2007. *Making it work – guide to ‘return-to-work’ strategies* located at www.cmha.ca/bins/content


Drake, R.E. Bond, G.R. & Rapp, C. 2006. Explaining the variance within supported employment programs: comment of ‘what predicts supported employment outcomes?’ Community Mental Health Journal, 42 (3): 315-318


King’s College Institute of Psychiatry. 2007. Supported Work and Needs (SWAN) – an innovative employment program for patients with sever mental illness. King’s College, London, located at [www.iop.kcl.ac.uk/departments](http://www.iop.kcl.ac.uk/departments)


Merton, R. & Bateman, J. 2007. **Social Inclusion: its importance to mental health.** Mental Health Coordinating Council, Sydney


Munk, E. & Mackenzie, D. 2007. **Department of Human Services Job Capacity Assessment Information.** Unpublished presentation, on behalf of Department of Human Services, Canberra


Penrose-Wall, J. & Bateman, J. 2007. **Working on Strengths…the evidence so far: models of assistance by mental health community organisations and evidence for their effectiveness.** Mental Health Coordinating Council of New South Wales, Sydney


Shaheen, G. Williams, F. & Dennis, D. eds. 2003. *Work as a Priority: A Resource for Employing People who have a Serious Mental Illness and who are Homeless*. USA Department of Health and Human Services, Rockville MD


[www.who.int/classifications/en](http://www.who.int/classifications/en)

[www.allpsych.com/disorder/dsm.html](http://www.allpsych.com/disorder/dsm.html)

[www.psychnet-uk.com/dsm_iv/misc/complete_tables.htm](http://www.psychnet-uk.com/dsm_iv/misc/complete_tables.htm)
www.grow.net.au

www.iop.kcl.ac.uk/departments Supported Work and Needs (SWAN) – an innovative employment program for patients with severe mental illness

www.jobaccess.gov.au


www.michigan.gov Transitional Employment Program

www.workplace.gov.au