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Employability interventions for people with mental health problems

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This paper outlines the importance of employment to the empowerment of people who use mental health services and discusses the evidence on interventions that enable them to achieve their ambitions. Employment is both an important part and a marker of recovery for many people; however, they face significant barriers, most notably stigma and discrimination, which include self-stigma and anticipated discrimination (Thornicroft, 2006; McDaid 2008). There is strong research evidence that the most effective *employability* intervention for people with severe and enduring mental health conditions is the provision of individualized and intensive support to accessing competitive, *paid employment* followed by time-unlimited in-work support for both employer and employee. This approach has become known as individual placement and support (IPS) and has been shown in numerous trials to produce better outcomes than "train and place" methods that focus on employability rather than actual employment and can actually result in people losing confidence and motivation as the period of "preparation" becomes prolonged. Exploring the implications of this, we will argue that one of the most important things mental health services can do to empower people who use services is to make employment for those who want to work a key service outcome and measurement of performance.

Employment not employability

Work can play a vital role in recovery for many people with mental health conditions (Borg & Kristiansen, 2008; Shepherd et al., 2008). Work has been shown to be good for physical and mental health and unemployment very damaging (Waddell & Burton, 2006). Employment also connects people to their communities, gives status, a structure to daily life and the resources to do the things they value (Social Exclusion Unit, 2003). However, despite the fact that work has long been known to be good for people with mental health conditions, competitive paid employment is still often considered to be too stressful. In the past, this view has led to the creation of sheltered work schemes in which people with mental health conditions were segregated from the world of work and the rest of the population of working age (Grove and Membrey, 2005). Where the focus *has* been on real employment, there is often still an assumption that people with mental health conditions need a great deal of help and support before they are "work-ready". in many European countries, this view has resulted in a lengthy system of assessment and vocational training aimed at ensuring people have all the skills and attributes deemed necessary before they encounter an actual employer. The continued use of "train then place" approaches, despite their comparative ineffectiveness and demoralizing characteristics, may be suggestive of a deeper, underlying problem of health professionals' low expectations of people with mental health conditions (Rinaldi et al., 2008; Marwaha et al.,2008).

What service users want and what they get

There is good evidence that the most important predictor of success in achieving and maintaining employment is a strong desire to work. High levels of motivation can override many disadvantages, such as stigmatizing diagnoses, poor social skills when out of work, poor work record, etc. (Grove & Membrey, 2005). There is also good evidence from the United Kingdom and elsewhere that people with mental health conditions consistently say that paid work is very important to them. A recent review of mental health and employment services in the United Kingdom pointed out that people with mental health conditions have the highest "want to work" rate of any disability group (Perkins et al., 2009). Studies in the United Kingdom found that between 70% and 90% of people using secondary services see paid work as an important part of their recovery (Grove, 1999; Secker et al., 2001); a recent study in Australia showed similar results (Waghorn, 2010).

Compare these aspirations with what actually happens. Those who use specialist (secondary) mental health services in the United Kingdom are less likely to be in paid employment than any other disadvantaged group. In 2008, the average employment rate for the working-age population was 74.2% (Labour Force Survey, 2008). By contrast, only 22% of respondents to a national survey of mental health service users (Healthcare Commission, 2008) reported that they either had paid work or were in full-time education. The situation is much the same across Europe (McDaid, 2008) and the United States (Mental Health Commission, 2003). The conclusion of both the Australian researchers (Waghorn, 2010) and the Healthcare Commission is that the problem is one of access. Only half of those surveyed by the Healthcare Commission who wanted help with employment actually received it.

Interventions – what works?

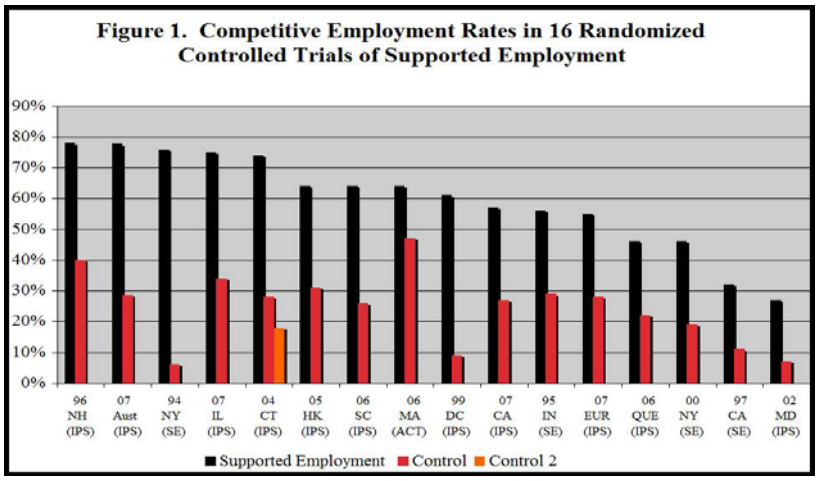
International evidence is available to show that people who use specialist mental health services can be supported in attaining and maintaining competitive employment. The approach, which has been so extensively tested and researched, is known as individual placement and support (IPS). It is a principles-based approach to supported employment that overturns traditional thinking about how to achieve employment goals by integrating with health care, focusing on competitive employment and then supporting someone in a highly individualized way in the context of their work (Box 1).

Box 1. The key principles of individual placement and support (IPS)

1. Competitive employment is the primary goal.
2. Everyone who wants it is eligible for employment support.
3. Job search is consistent with individual preferences.
4. Job search is rapid: beginning within one month.
5. Employment specialists and clinical teams work and are located together.
6. Support is time-unlimited and individualized to both the employer and the employee.
7. Counselling on welfare benefits supports the person through the transition from benefits to work.

Adapted from Bond et al., 2008.

Sixteen randomized controlled trials conducted in Australia, Canada, China, Hong Kong Special Administrative Region, Europe and the United States demonstrate that this approach is more effective than other forms of employment support and, in Europe, even more effective than the best available vocational rehabilitation services. The bar graph in Fig. 1 highlights the differences between IPS and the control in each study.



Source: Waghorn, 2010

Across the trials, the sites that followed the IPS approach most closely achieved the greatest success with an average of 61% of participants gaining competitive employment compared to 23% in sites that followed other approaches (Bond, Drake & Becker, 2008). IPS has been demonstrated to be more effective than other forms of vocational support across different countries and labour markets and in adverse economic conditions. An analysis of all the available data on the costs of IPS also indicates that the approach is cost-effective and would be affordable within the United Kingdom through the reinvestment of current expenditure on outdated or less cost-effective services (Sainsbury Centre, 2009).

Policy implications

Richard Warner (2009) has shown that in the developed world recovery rates for people with severe mental illness often lag behind those in the developing world due, in part at least, to family and social networks, which assume participation in employment whenever possible. However, it is increasingly accepted, at least in theory, that in the developed world the state should take some responsibility for intervening to provide access to employment support for people faced with the greatest barriers to entering the labour market. Unfortunately for people with severe mental health conditions, this is mostly some way down the list of political priorities. Although evidence on the health, well-being and economic benefits that can accrue from people being in employment has been steadily emerging over the last 15 years, governments, policy-makers and mental health services in the developed world have been slow to accept it and even slower to act upon it (Sainsbury Centre, 2009).

This failure to act, however, is not only a failure to invest appropriately to bring about economic and health benefits. It is increasingly, and rightly, being cast as a denial of what is a fundamental human right (Perkins et al., 2009; Waghorn, 2010). It is becoming increasingly untenable to ignore both the stated wishes of people who use services and the growing evidence that their wishes are realizable (Rinaldi et al., 2008).

Prioritizing employment as a service outcome will require a broader approach to multidisciplinary working. Integrated health and employment support is one of the defining features of IPS. The approach challenges the clinical team to view the person in the context of their day-to-day living arrangements and aspirations for life, making every effort to support the person in achieving their employment goal. It will also challenge the conventional view that a person must be symptom free before starting work (Perkins et al., 2009). The IPS approach also encourages the active involvement of family and friends if desired by the person receiving the service (Swanson et al., 2008). Supporting the person's transition to work with the employment specialist is often the first invitation that families receive to be involved in the care of their family member.

Conclusions

IPS has been described as "relatively inexpensive and highly cost-effective relative to other forms of vocational services" (Drake & Bond, 2008). Evidence shows that the much better outcomes associated with IPS can be achieved at much the same levels of cost per capita as more traditional day/vocational services and, in the longer term, some reduction in the overall costs of services for those who work regularly (Sainsbury Centre, 2009). It is vital that service provision takes account of the emerging evidence base and does not simply repeat failed models.

However, to be effective, employment interventions need to be embedded within the mainstream mental health system. Policy-makers, purchasers and commissioners of services must develop coherent funding structures to ensure that people who need to access employment support are able to receive it. Employment outcome data should be required from services. As yet, mental health services are not typically target driven in the way that disability employment services frequently are but this is the direction of travel and, in the case of employment support, performance management frameworks should incentivize these agencies to work together. It is also essential that programmes, which promote mental health in the workplace and work to reduce stigma, discrimination and bullying, continue and expand in order to create the conditions in which people can fulfil their potential.

Improved employment outcomes bring benefits across the life course in all areas of a person's life:

"In following people for 30 years and then following patients who are in dozens and dozens of research studies that are sent around, it's totally clear to me at this point that there's nothing about medications or psychotherapies or rehabilitation programs or case management programs or any of the other things that we study that helps people to recover in the same way that supported employment does." (Drake, 2008)

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