NATIONS FOR MENTAL HEALTH

WHO/MSD/MPS/00.2
Distribution: Limited
English only

Mental health and work:

Impact, issues and good practices

Mental Health Policy and Service Development
Department of Mental Health
and Substance Dependence
Noncommunicable Diseases and Mental Health

World Health Organization

Target Group Unit
InFocus Program on
Knowledge, Skills and Employability

International Labour Organisation

Geneva
2000

Mental health policy and service development team

Objectives and strategies

- To strengthen mental health policies, legislation and plans through: increasing awareness of the burden associated with mental health problems and the commitment of governments to reduce this burden; helping to build up the technical capacity of countries to create, review and develop mental health policies, legislation and plans; and developing and disseminating advocacy and policy resources.

- To improve the planning and development of services for mental health through: strengthening the technical capacity of countries to plan and develop services; supporting demonstration projects for mental health best practices; encouraging operational research related to service delivery; and developing and disseminating resources related to service development and delivery.

Financial support is provided from the Eli Lilly and Company Foundation, the Johnson and Johnson European Philanthropy Committee, the Government of Italy, the Government of Japan, the Government of Norway, the Government of Australia and the Brocher Foundation.

Further information can be obtained by contacting:

Dr Michelle Funk
Mental health policy and service development (MPS)
Department of Mental Health and
Substance Dependence (MSD)
World Health Organization
CH - 1211 Geneva 27, Switzerland
E-mail: funkm@who.int
Telephone: (41) 22 791 3855
Fax: (41) 22 791 41 60

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Gaston Harnois
Phyllis Gabriel

Mental Health Policy and Service Development
Department of Mental Health
and Substance Dependence
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This document is a joint product of
the World Health Organization and the International Labour Organisation.

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Chapter 5
Work as a mechanism for reintegrating persons with serious mental illness

Preface

All of us have the right to decent and productive work in conditions of freedom, equity, security and human dignity. For persons with mental health problems, achieving this right is particularly challenging. The importance of work in enhancing the economic and social integration of people with mental health problems is highlighted in this monograph.

The International Labour Organisation (ILO) has long recognized the importance of documenting the extent of disabilities among the labour force and setting up effective preventive and rehabilitative programmes. The ILO's activities promote the inclusion of individuals with disabilities in mainstream training and employment structures. The importance of addressing specific issues related to the employment of persons with mental health problems has also been recognized.

ILO promotes increased investment in human resource development, particularly the human resource needs of vulnerable groups, including persons with mental health problems. Employees' mental health problems and their impact on an enterprise's productivity and disability/medical costs are critical human resource issues. Increasingly, employers' organizations, trade unions and government policy-makers are realizing that the social and economic costs of mental health problems in the workplace cannot be ignored.

Because of the extent and pervasiveness of mental health problems, the World Health Organization (WHO) recognizes mental health as a top priority.

Using instruments that allow us to see not how people die but rather how they live (*1*), we now know that the problems of mental illness loom large around the world. It accounts for 12% of all disability-adjusted life-years (DALYs), and 23% in high-income countries.

Five of the 10 leading causes of disability worldwide are mental problems (major depression, schizophrenia, bipolar disorders, alcohol use and obsessive-compulsive disorders). These disorders – together with anxiety, depression and stress – have a definitive impact on any working population and should be addressed within that context. They may also develop into long-term disorders with accompanying forms of disability.

Given the fact that numerous affordable interventions exist, the time has come to challenge both the low priority given to mental health and the stigma that those with mental ill-health still endure around the world.

We now know that when essential drugs, if needed, are made available and access is offered to a psychosocial rehabilitation programme (including the access to meaningful and realistic employment) many persons will be able to lead more socially and personally satisfying lives.

WHO has made a renewed commitment to mental health in making it one of its priorities. Mental health will be the theme of World Health Day 2001 and also the *World Health Report 2001*. Given the multifaceted nature of the factors that contribute to good mental health, WHO is ever mindful of the need to highlight activities that foster good practices in mental health. In this monograph the issue of work as it relates to mental health is addressed.

The publication of this document is particularly important because it has brought together two large United Nations agencies involved in rehabilitation, namely WHO and ILO. The document examines the importance of mental health in the workplace in general, and suggests appropriate management for workers with mental health problems. In addition, it takes a practical look at strategies to promote and sustain good mental health while highlighting examples of good practices.

The document was written jointly by Dr Gaston Harnois on behalf of WHO and Phyllis Gabriel on behalf of ILO. Dr Harnois is Director of the Montreal WHO Collaborating Centre at the Douglas Hospital in Montreal, Canada. He is also Associate Professor of Psychiatry at McGill University, and former President of the World Association for Psychosocial Rehabilitation. Phyllis Gabriel MPH, MA is aVocational Rehabilitation Specialist at the ILO headquarters in Geneva. She has worked as a Vocational Rehabilitation Counsellor in US community-based social service agencies as well as in mental health care facilities.

It is hoped that this important document will assist employers and employees in raising awareness of the benefits of good mental health practices and encourage the implementation of strategies to maintain a healthy working environment.

Dr Benedetto Saraceno
Director
Department of Mental Health and
Substance Dependence (MSD)
World Health Organization

Mr Pekka Aro
Director
InFocus Programme on
Knowledge, Skills and Employability
International Labour Organization

Chapter 1
Introduction

1.1. Scope of the problem

There is growing evidence of the global impact of mental illness. Mental health problems are among the most important contributors to the burden of disease and disability worldwide. Five of the 10 leading causes of disability worldwide are mental health problems. They are as relevant in low-income countries as they are in rich ones, cutting across age, gender and social strata. Furthermore, all predictions indicate that the future will see a dramatic increase in mental health problems (*2*).

The burden of mental health disorders on health and productivity has long been underestimated. The United Kingdom Department of Health and the Confederation of British Industry have estimated that 15-30% of workers will experience some form of mental health problem during their working lives. In fact, mental health problems are a leading cause of illness and disability (*3*). The European Mental Health Agenda of the European Union (EU) has recognized the prevalence and impact of mental health disorders in the workplace in EU countries. It has been estimated that 20% of the adult working population has some type of mental health problem at any given time (*4*). In the USA, it is estimated that more than 40 million people have some type of mental health disorder and, of that number, 4-5 million adults are considered seriously mentally ill (*5*). Depressive disorders, for example, represent one of the most common health problems of adults in the United States workforce.

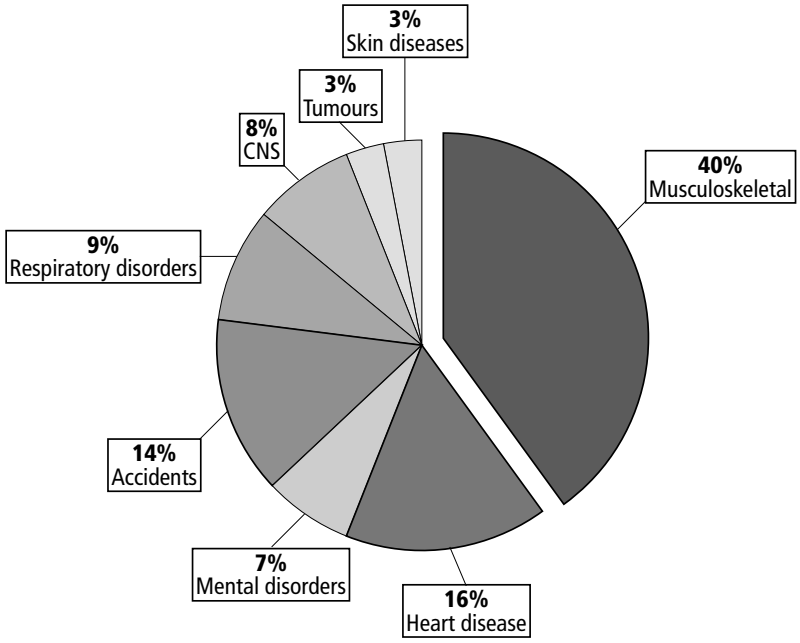
The impact of mental health problems in the workplace has serious consequences not only for the individual but also for the productivity of the enterprise. Employee performance, rates of illness, absenteeism, accidents and staff turnover are all affected by employees' mental health status. In the United Kingdom, for example, 80 million days are lost every year due to mental illnesses, costing employers £1-2 billion each year (*6*). In the United States, estimates for national spending on depression alone are US$ 30-40 billion, with an estimated 200 million days lost from work each year (*7*, *8*).

1.2 Mental health problems cause disability

As illustrated in this monograph, mental health problems affect functional and working capacity in numerous ways. Depending on the age of onset of a mental health disorder, an individual's working capacity may be significantly reduced. Mental disorders are usually one of the three leading causes of disability, together with cardiovascular disease and musculo-skeletal disorders. In the EU, for example, mental health disorders are a major reason for granting disability pensions (*9*).

Disability not only affects individuals but also impacts on the entire community. The cost to society of excluding people with disabilities from taking an active part

Costs of occupational and work-related diseases



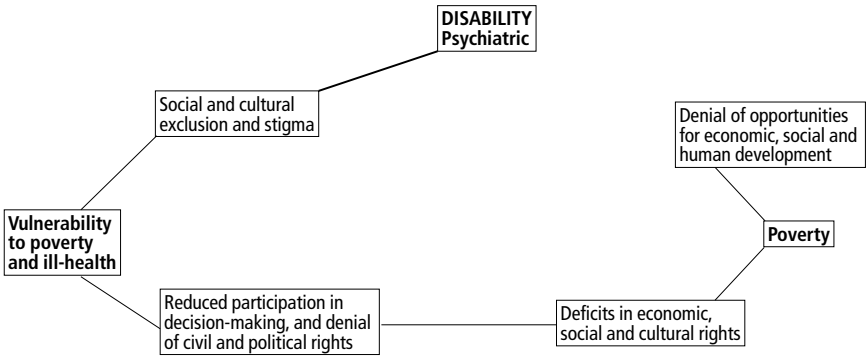
Source: Takala J. (ILO) Indicators of death, disability and disease at work. African Newsletter on Occupational Health and Safety, December 1999, 9(3):60-65.

in community life is high. This exclusion often leads to diminished productivity and losses in human potential. The United Nations estimates that 25% of the world's population is adversely affected in one way or another as a result of disabilities. The cost of disability has three components (*10*):

- the direct cost of welfare services and treatment, including the costs of disability benefits, travel and access, possible medication, etc;
- the indirect cost to those who are not directly affected (carers);
- the opportunity costs of income foregone as a result of incapacity.

For example, analysis of Tanzanian survey data has revealed that households with a member who has a disability have a mean consumption less than 60% of that of the average household. This leads the authors to conclude that disability is a hidden aspect of African poverty (*11*).

People with disabilities, particularly psychiatric disabilities, face numerous barriers in obtaining equal opportunities – environmental, access, legal, institutional and



Source: United Kingdom Department for International Development. Disability, Poverty and Development, February 2000 (modified)

attitudinal barriers which cause social exclusion (*12*). For people with mental illness, social exclusion is often the hardest barrier to overcome and is usually associated with feelings of shame, fear and rejection.

It is clear that mental illness imposes a heavy burden in terms of human suffering, social exclusion, stigmatization of the mentally ill and their families and economic costs. Unfortunately, the burden is likely to grow over time as a result of ageing of the global population and stresses resulting from social problems and unrest, including violence, conflict and natural disasters (*13*).

1.3 Using the workplace to prevent mental health problems and provide solutions for referral and rehabilitation

Globalization and interdependence have opened new opportunities for the growth of the world economy and development. While globalization has been a powerful and dynamic force for growth, work conditions and the labour market have changed dramatically during the last two decades. The key elements in these changes are increased automation and the rapid implementation of information technology. Workers worldwide confront as never before an array of new organizational structures and processes – downsizing, contingent employment and increased workload.

Employers have tended to take the view that work and/or the workplace are not etiological factors in mental health problems. However, whatever the causal factors, the prevalence of mental health problems in employees makes mental health a pressing issue in its own right (*14*). Although, effective mental health services are multidimensional, the workplace is an appropriate environment in which to educate individuals about, and raise their awareness of, mental health problems. For example, the workplace can promote good mental health practices and

provide tools for recognition and early identification of mental health problems, and can establish links with local mental health services for referral, treatment and rehabilitation. Ultimately, these efforts will benefit all by reducing the social and economic costs to society of mental health problems.

For people with mental health problems, finding work in the open labour market or returning to work and retaining a job after treatment is often a challenge. Stigma surrounds those with mental illness and the recovery process is often misunderstood.

This monograph addresses these issues. It provides a practical guide and resource for human resource managers, mental health professionals, rehabilitation workers, policy-makers, trade unionists and other concerned individuals.

The central themes of this monograph are:

- To examine the importance of mental health problems in the workplace.
- To consider the role of the workplace in promoting good mental health practices for employees.
- To examine the importance of work for persons with mental health problems.
- To discuss the different vocational strategies and programmes for persons with mental health problems.
- To provide examples of good practices. These examples illustrate:
  - good mental health promotional practices in the workplace by employers;
  - how to handle an employee who becomes ill with a mental health problem, such as depression;
  - vocational rehabilitation models/programmes for persons with long-term mental health problems.

Chapter 2
The importance of work to an individual's mental health

2.1 The workplace and mental well-being

> Work is at the very core of contemporary life for most people, providing financial security, personal identity, and an opportunity to make a meaningful contribution to community life.
>
> **Source: NAMI (15).**

The workplace is one of the key environments that affect our mental well-being and health. There is an acknowledgement and growing awareness of the role of work in promoting or hindering mental wellness and its corollary – mental illness. Although it is difficult to quantify the impact of work alone on personal identity, self-esteem and social recognition, most mental health professionals agree that the workplace environment can have a significant impact on an individual's mental well-being.

2.2 Categories of psychological experience (16)

Employment provides five categories of psychological experience that promote mental well-being:

- time structure (an absence of time structure can be a major psychological burden);
- social contact;
- collective effort and purpose (employment offers a social context outside the family);
- social identity (employment is an important element in defining oneself);
- regular activity (organizing one's daily life).

Many large companies now realize that their employees' productivity is connected to their health and well-being. However, more emphasis has traditionally been placed on physical health than on mental health and well-being.

Several factors at a workplace can promote employees' psychosocial well-being and mental health. Especially important in this respect is the opportunity to be included in planning and carrying out activities and events in the workplace (e.g. the opportunity to decide and act in one's chosen way and the potential to predict the consequences of one's action). A related feature is the degree to which the environment encourages or inhibits the utilization or development of skills. Physical security, opportunity for interpersonal contact, and equitable pay are also important.

Chapter 3
The workplace and mental health

3.1 Promotion of mental health in the workplace

Notions of mental health at work tend to focus on the individual rather than the organization. A comprehensive policy of mental health at work includes, however, an assessment of the mental health of the organization itself. The gain to both individuals and the organization from promoting good mental health at work is reflected in increased presence, well-being and production.

> "We at the CBI are convinced that the mental health of a company's employees can have an important impact on business performance in the same way as do industrial relations climate or inadequate training. That is why the CBI continues to add its voice to the campaign to raise the profile of mental health as a workplace issue."
>
> **Howard Davies, Director General, Confederation of British Industry.**

The constant and unremitting rate of change that affects all businesses today is increasingly motivating employers to address the health of their staff. Moreover, it is taking its toll on employees, some of whom fail to cope with the changes and need support to help them avoid under-performance and absenteeism. The global marketplace is forcing organizations to upgrade their efficiency and this, in turn, is encouraging employers to seek ways of enhancing the performance of employees and to avoid losses associated with health and safety (see example of Marks & Spencer, UK on page 7).

3.2 Job stress – stressful characteristics of work

Job stress can be defined as the harmful physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources or needs of the worker (*18*). Job stress can cause poor health and can increase rates of work-related injuries and accidents. Some potential causes of work-related stress are overwork, lack of clear instructions, unrealistic deadlines, lack of decision-making, job insecurity, isolated working conditions, surveillance, and inadequate child-care arrangements (*19*) (see examples on page 10). Although sexual harassment and discrimination are often excluded from lists of traditional job stressors, they must be included in any comprehensive analysis of the causes of workplace stress. Sexual harassment is a stressor for women in the workplace; and discrimination is a stronger predictor of health outcomes, including mental ill-health, for ethnic minorities than traditional job stressors (*20*). Some of the many effects of stress include numerous physical ailments as well as mental health problems such as depression and increased rates of suicide (*21*).

> The nature of work is changing at whirlwind speed. Perhaps now more than ever before, job stress poses a threat to the health of workers and, in turn, to the health of organizations.
>
> **Source: National Institute for Occupational Safety and Health, 1998.**

Good practice: Workplace activities for mental health, United Kingdom

A large international retailer with 696 stores in many parts of the world including North America, Asia and Europe employs some 56,000 people. Over 52,000 of these are employed in stores. 83% of the workforce is female and 62% of these are part-time.

Their stated policy is to take the mental health of its workforce seriously: "We realize that in ensuring the mental well-being of staff we benefit from an individual and company point of view."

Strategy for health promotion

The strategy for overall health promotion, which includes mental health, is based on the following:

- health education to raise awareness of factors affecting health and well-being;
- screening programmes to detect risk factors or early signs of disease;
- action programmes to do something about them.

The role of the occupational health service

The occupational health service works closely with personnel and line management regarding all aspects of mental and physical health of employees. The occupational health team is available to look at the effects of health on work or of work on health, to discuss with staff any health problems they may have and to promote good health through health education, screening and action programmes. The company believes that an occupational health service can play a major role in helping:

- to identify work problems caused by mental ill-health;
- to take action to improve the health of employees;
- to assist employers in modifying the work and work environment;
- to enable employees to remain at work rather than withdraw.

The organization assists in preventing mental ill-health by giving people a good working environment and a clearly defined job. Following absence, it is often essential to be able to modify working hours during the rehabilitation period and to provide a gradual return to usual working practices through a good sick pay scheme. Financial support at this time allays anxiety and encourages a speedier return to work.

Regular honest appraisals are important and problems in performance should be discussed when they occur, with an opportunity to follow up and review progress. People should feel able to contribute to their development and feel accountable for their jobs.

On-site counselling facilities from personnel or health professionals are available, reducing time away from work (*17*).

There is growing global concern about the impact of job stress, including issues related to gender, ethnicity, sexual harassment, violence and mobbing at work, family, and underemployment (*22*). Job stress is one of the most common work-related health problems in EU countries. The Second European Survey on Working Conditions indicated that 28% of workers reported that their work causes stress. In Japan, the proportion of workers who report serious anxieties or stress in relation to their working life increased from 53% in 1982 to 63% in 1997. In developing countries, there is increasing concern regarding the health impact of job stress. For example, an increased risk of work-related illnesses and accidents has been observed in South-east Asian countries that have experienced rapid industrialization (*23*).

In most countries there is no specific legislation addressing the impact of job stress. Most countries have at least minimum standards for safety and health features of the workplace. These standards tend to focus on the physical aspects of the workplace and do not explicitly include the psychological and/or mental health aspects of working conditions. Notable exceptions include the Netherlands and the Nordic countries (*24)*.

3.3 Consequences of mental health problems in the workplace

The consequences of mental health problems in the workplace can be summarized as follows (*25*):

Absenteeism

- increase in overall sickness absence, particularly frequent short periods of absence;
- poor health (depression, stress, burnout);
- physical conditions (high blood pressure, heart disease, ulcers, sleeping disorders, skin rashes, headache, neck- and backache, low resistance to infections).

Work performance

- reduction in productivity and output;
- increase in error rates;
- increased amount of accidents;
- poor decision-making;
- deterioration in planning and control of work.

Staff attitude and behaviour

- loss of motivation and commitment
- burnout

- staff working increasingly long hours but for diminishing returns
- poor timekeeping
- labour turnover (particularly expensive for companies at top levels of management).

Relationships at work

- tension and conflicts between colleagues;
- poor relationships with clients;
- increase in disciplinary problems.

Workers' health is a separate goal in its own right. Addressing mental health issues in the workplace means incorporating social responsibility in a firm's everyday practices and routines.

3.4 Mental health and unemployment

Re-employment has been shown to be one of the most effective ways of promoting the mental health of the unemployed (*26*).

A review of studies of the mental and physical health effects of unemployment and the mechanisms by which unemployment causes adverse health outcomes reveals a complex relationship. There has been a serious debate about the direction of causality. Does unemployment cause deterioration in health, both mental and physical? Are the sick more likely to become unemployed?

Fact: The National Institute of Mental Health estimates that more than 3 million adults aged 18-69 have a serious mental illness. Estimates of unemployment among this group are 70-90%, a rate higher than for any other group of people with disabilities in the USA. Recent surveys report that approximately 70% of those with psychiatric problems rank employment as an important goal.

Source: NAMI (27).

In a study reported in the *Journal of Community Psychology* (*28*), an analysis of employed respondents revealed that those who became unemployed had over twice the risk of increased depressive symptoms and diagnosis of clinical depression than those who remained employed. Furthermore, the data did not support any relationship between clinical depression and becoming unemployed. In the respondents' community at the time of the study, depression was not a causal factor for the unemployment rate. The incidence and prevalence of depression increased once individuals became unemployed.

Stressful characteristics of work

Work characteristics	Condition defining hazard (demands, control and support)
CONTEXT	
Organizational function and culture	Poor task environment and lack of definition of objective
	Poor problem solving environment
	Poor development environment
	Poor communication
	Non-supportive culture
Role in organization	Role ambiguity
	Role conflict
	High responsibility for people
Career development	Career uncertainty
	Career stagnation
	Poor status or status incongruity
	Poor pay
	Job insecurity and redundancy
	Low social value to work
Decision latitude/control	Low participation in decision-making
	Lack of control over work
	Little decision-making in work
Interpersonal relationships at work	Social or physical isolation
	Poor relationships with supervisors
	Interpersonal conflict and violence
	Lack of social or practical support at home
	Dual career problems
CONTENT	
Task design	Ill-defined work
	High uncertainty in work
	Lack of variety of short work cycles
	Fragmented or meaningless work
	Underutilization of skill
	Continual exposure of client/customer groups
Workload/work pace	Lack of control over pacing
Quantities and quality	Work overload or underload
	High levels of pacing or time pressure
Work schedule	Shift working
	Inflexible work schedule
	Unpredictable working hours
	Long or unsociable working hours

Consensus from literature outlining nine different characteristics of jobs, work environment and organization which are hazardous.

Source: HSE Contract Research Report No. 61/1993. Cox T. *Stress Research and Stress Management: Putting Theory to Work.*

Chapter 4
Mental health: an imperative concern

4.1 Issues facing employers and managers

Although our knowledge of mental health issues has increased over the past few decades, employers and enterprises have lagged behind in their understanding and acceptance of the pervasiveness, treatment and impact of mental health problems on organizational life (*29*). Most human resource management and public administration training programmes do not cover adequately the area of mental health and employment. Recognition of mental illness in the workplace is often difficult for there is often a psychological component to physical symptoms and physical ailments may be present in some mental disorders (*30*). Whatever the original cause, employers and managers are faced with three main issues as they attempt to address the mental health needs of their employees:

Recognition and acceptance of mental health as a legitimate concern of organizations (31)

There is a need among employers to recognize mental health issues as a legitimate workplace concern. As disability costs and absenteeism increase in the workplace due to mental ill-health (whatever the precipitating factors), more and more employers are faced with the challenge of developing policies and guidelines to address these issues.

Effective implementation of a country's anti-discrimination provisions (32)

The last decade has seen a significant increase in anti-discrimination legislation specific to employment for people with disabilities. Although many of these laws and statutes have weak enforcement mechanisms, there is an increasing need for employers and their human resource managers to understand how these laws affect their company's employment policies.

Preventive, treatment, and rehabilitation programmes that address employees mental health needs

The development of appropriate prevention and mental health promotion policies in the workplace is an increasing concern for many employers. Understanding the need for early intervention and treatment, as well as reintegrating an employee into the work environment, is also a critical challenge.

Good practice: Promotion/prevention – a case study in organizational stress, United Kingdom

A Mental Health Trust – organizational stress pilot for employees (33)

A Mental Health Trust employs some 846 people and provides mental health services to a large catchment area in Britain. The trust's data showed that stress-related illness was responsible for 25% of all absence. To address this issue, the trust implemented the Health Education Authority's anti-stress pilot programme designed to reduce the anxiety and tension of employees within the organization. The programme was introduced at a time of major organizational change at the trust. As a result of the programme, absenteeism due to stress-related conditions was reduced. Moreover, a "general sense" of improved morale among the employees was noted.

Key components

- Formation of a Stress Management Group (SMG). The SMG managed the programme. It was usually led by the human resource director with the full support of the chief executive.
- The Listening Group. This was a two-day event for 25-30 people representing all sections of the organization. The Listening Group was led by the consultants to the programme. Its aim was to develop a preliminary analysis of the nature and extent of organizational stress by listening to the views of the staff.
- Post -Listening Group action. Following the Listening Group, the SMG worked with consultants to plan the Organizational Stress Workshop on the basis of the findings of the Listening Group.
- The Organizational Stress Workshop. This was a second two-day event for 30-60 people who had a particular involvement in the findings of the Listening Group. Their role was to draw up action plans.
- The Action Groups. A number of groups were formed, coordinated by the SMG, to see through the action plans over a period of months or even years.

Reasons for stress as expressed by the employees in the Listening Group

- Staff felt uninvolved in the planning and process of change, leading to a loss of control, of choice and ownership and a sense of devaluation and powerlessness.
- Staff did not know what was happening when it happened. Decisions could change from one week to the next.
- Many were struggling to cope with changes in their work environment, such as service relocations and new methods of recording information.

Outcomes/effectiveness

Sickness absence in the Mental Health Trust

1993-4	1994-5	1995-6	1996-7	1997-8
6.17%	5.72%	5.59%	5.6%	4.79%

Proportion of sickness absence due to stress, 1993-1997

1993-4	1994-5	1995-6	1996-7	1997-8
19.9%	20.4%	20.2%	19%	16.8%

Employees' comments after participation

Managers were generally more enthusiastic about the programme than staff. Most participants in workshops or action groups felt they had benefited. Several described the programme as "therapeutic" and constructive.

Communications were better, more information was getting through, the lead up to the move was better. It felt as though there was more support and team effort. "Things are changing in my department - there's more on offer, training, support but don't know if it's the result of this intervention."

A few identified other beneficial changes in attitudes or culture. Before the project it had not been possible to admit to certain feelings, such as being upset about the closure, but now it was.

Some felt more confident that things could be influenced from the bottom up.

4.2 Country examples

4.2.1 United Kingdom – The health of the nation (34)

The Health of the Nation is a national response to WHO's campaign for *Health for all by the year 2000*. It sets goals for health outcomes and selects mental illnesses as a priority area.

The overall mental illness goals are to prevent mental illness, improve health and social functioning of people with mental illness, reduce mortality from mental illness, reduce stigma, deliver effective services, and continue research into causes, care and consequences of mental illness.

The national targets for mental illness are:

- to significantly improve the health and social functioning of mentally ill people;
- to reduce the overall suicide rate by at least 15% by the year 2000 from the 1990 level of 11 per 100,000;
- to reduce the lifetime suicide rate of severely mentally ill people by at least 33% by the year 2000.

The overall strategy to achieve the targets is:

- to improve information and understanding about mental illness;
- to continue developing local comprehensive services;
- to promote good practice in mental health promotion, primary, secondary and tertiary prevention, and prevention of mortality.

The mental illness key area encompasses the National Health Service (NHS) as well as a whole range of organizations and settings such as local authorities, the voluntary sector, the criminal justice system, schools, workplaces, cities and rural areas.

Since the United Kingdom does not have a national occupational health service, many large employers have established their own occupational health services for their employees.

4.2.2 Mental health issues in the Finnish workplace (35)

Measures most commonly taken at the Finnish workplace aim to:

- improve work environment (e.g. enhancing occupational safety and ergonomics, communication, clear goals, independence at work);
- provide further training and learning opportunities (e.g. improving occupational skills and team work or promoting independent studying);
- promote health (e.g. promoting physical activities, healthy lifestyle, offering rehabilitation and preventing substance abuse).

The Finnish Institute of Occupational Health recommends the following means to promote mental health in work organizations (*36*):

- to implement models of good workplace practices and disseminate this information in the community;
- to increase the cooperation of mental health and occupational health professionals in promoting mental health activities at the workplace;
- to train occupational health care professionals in mental health issues and mental health professionals in work-life issues.
- to increase the general knowledge of the whole population regarding the preconditions for and value of good mental health in working life, and develop self-help skills for creating satisfactory working conditions.

4.2.3 Targeted intervention to facilitate return to work

The Association of Canadian insurance companies estimates that 30-50% of disability allowances are paid on account of mental health problems. This is therefore the principal cause of long-term absences from one's job. The experience of many employers is that once an employee is absent for "mental health" reasons for 3 months, the likelihood is very high that the absence will last more than 1 year.

4.3 Action needed

4.3.1 Specific steps an employer can take to help an employee return to work after treatment for a mental health problem such as depression (37)

- Inform the attending physician or appropriate mental health professional of the exact duties of the job before the physician makes a final decision on return to work.
- In consultation with the individual's physician or other mental health professional, encourage an early to return to work. The longer an employee is out of work due to treatment, the more he/she will worry about losing the job. Furthermore, the longer a person is away from the job, the more mentally detached he or she will become.
- Consider gradual return to work. Allowing part-time work for several weeks may help reduce stress, leave time for additional medical counselling and allow the worker to quickly get back into a normal routine. Flexitime, temporarily changed duties that involve less job-related stress or other flexible arrangements may be useful. However, there should be a clear understanding between the employee and the employer as to the details of the return-to-work programme: the expected length of time for which special accommodations will be granted, what day-to-day flexibility is allowed, the exact duties of the employee and who will supervise the work.

Good practice: Total Wellness Programme, Finland

One of the world's leading wireless and wireline telecommunications firms runs a total wellness programme which includes mental health issues for its employees. The programme's purpose is to create an efficient and healthy workplace and health promoting working conditions. This company's human resources and occupational medicine departments are responsible for workplace health promotion and prevention programmes. The Total Wellness Programme was developed in collaboration with the Finnish Institute of Occupational Health.

To plan its health promotion activities, the company uses its own statistics on working days lost due to illness, industrial accidents and occupational diseases, as well as data on staff satisfaction and the health of employees. The occupational medicine department organizes medical examinations and assessments of the need for rehabilitation. As part of the fitness survey, employees are assessed on a scale of one to five on health-related issues such as work, physical condition, and ability to cope with stress, family life, social contacts and hobbies. Receiving the lowest score in any of these sections prompts quick intervention to determine how the situation can be improved. Participation in the programme is evaluated on a regular basis. Work stressors and health and career development are part of the agenda of annual development discussions between employees and their superiors. The company places great emphasis on continuing professional education. It has established its own global learning centre network.

- Other possible stress-reducing accommodations include:
  - altering the pace of work;
  - lowering the noise level of work;
  - providing water, tea or soda and crushed ice to combat a dry mouth caused by some medications;
  - extra encouragement and praise of job performance, but only if warranted and not obviously excessive;
  - while taking steps to reduce stress, avoidance of over-protection of the employee;
  - making sure the employee is treated as a member of the team and not excluded from social events, business meetings or other activities relevant to the job.

4.3.2 Employee assistance programmes

Employee assistance programmes (EAPs) are company-sponsored programmes designed to alleviate and assist in eliminating workplace problems caused by per-

Good practice: the use of group process to facilitate work reintegration of employees with mental health problems in Canada

A 12-week programme was created to bring about a "synergetic partnership" and a dynamic alliance between employee, employer, health professionals, unions and insurance companies.

The programme, offered to no more than 12 individuals at any one time, combines group intervention and an individual action plan; it is action-oriented and centred on the regaining of power for the person.

First, the programme aims at:

- identifying and resolving collective and individual problems;
- reviewing vocational skills and interpersonal relationships;
- consolidating job skills.

Secondly, the employee is accompanied in the negotiation of his/her progressive return to work. A joint supervisory process (involving the employee, the vocational consultant and the employer) takes place on the job scene. This serves to give confidence to the employee while at the same "sensitizing" other workers.

Thirdly, in order to avoid relapses and to consolidate job stability, the individual is followed up for 6 months and as needed thereafter.

Results: After 2 years, 85% of the employees who took the programme have returned to their jobs and are still in them.

Cost: The programme costs Cdn.$ 2600 (US$ 1700) for 12 weeks.

Charbonneau, C.: Accès Cible S.M.T. Dix ans à faire renaître la confiance. November 1998.

sonal problems. These programmes typically provide supportive, diagnostic, referral and counselling treatment services. Many EAPs began as occupational alcoholism programmes and gradually evolved into broader-based efforts as employers recognized that alcoholism was not the only problem that could negatively affect job performance.

Although some EAPs continue to focus only on identifying and assisting workers who are substance abusers, most now offer a wide range of other services to help employees resolve personal and work-related problems. These services may include:

- on-site and telephone counselling;
- referral for psychological symptoms or mental health disorders (e.g. depression, stress, anxiety);
- marital or family-related issues;
- legal and financial problems;
- catastrophic medical problems (e.g. AIDS, cancer);
- pre-retirement planning needs;
- career-related difficulties (*38*).

Many EAPs have been affected by changes in national and regional legislation. As an employer develops programmes to respond to national policies as well as legislation, EAP professionals have had to become knowledgeable about the statutes and how they affect their company's employees and policies (*39*).

4.3.3 Practical suggestions for small businesses (40)

Often the smaller employer (with fewer than 25 employees) cannot afford to have a specific EAP or medical and rehabilitation experts on the staff. However, the model that is often used by many large employers can be adapted to a small setting:

- The personnel or human resource director or other appropriate officer of the company should visit the employee who is on a medical/disability leave as soon as possible to demonstrate concern and to encourage an early return to work.
- Always try to return the worker to his or her old job, even if an accommodation or flexible work time is required. This minimizes complications to the employee, reduces stress which may trigger a reoccurrence of depressive symptoms, and maximizes the company's advantage of having a trained employee.
- Use community resources. Local rehabilitation agencies and support groups may aid in a successful return to work with minimal or no expense to the business.
- Make a special effort to inform the employee's physician or mental health professional regarding the requirements of the job and possible changes and accommodations.

Good practice: Employee assistance programme, USA

A large diversified health care company with more than 54,000 employees.

The following psychiatric disability case illustrates the benefits of an effective workplace programme to manage mental health problems. An office assistant in her early thirties was a divorced single mother with two children. Her manager, having observed her recent problems with concentration and productivity, referred her to the company's EAP.

Due to the severity of the employee's condition, the EAP recommended that she be placed on medical leave. The employee, who had a history of childhood abuse and symptoms of depression, had been under the care of a psychiatrist and therapist. These providers were not responsive to the EAP's request for additional evaluation and more intensive outpatient treatment. Therefore, with the employee's agreement, she was referred to in-network providers, a psychiatrist and psychologist team, who quickly determined that she needed more timely intensive care. Her medications were modified and she began partial hospitalization treatment. The EAP case manager also arranged for the employee to receive financial assistance through a company programme, which helped to reduce her level of stress.

After seven weeks, the woman had stabilized and was returned to work. However, shortly thereafter she had a relationship break-up and quickly slipped back into crisis mode, including suicide ideation. The employee was again placed on medical leave and her providers admitted her to an inpatient programme. After a few days in the hospital, the employee stabilized again, returned to partial hospitalization and began attending a depression support group.

Within six weeks, the employee returned to work for a second time. This time, she was eased back into the work routine, beginning on a part-time basis and slowly increasing her work hours. Within a month, she returned to full-time work. The EAP case manager maintained contact with her after the return to work, and also worked with the employee's manager to ensure a successful transition back to work. The employee has since demonstrated positive progress with a good prognosis.

Over a 10-month period, the EAP had made a total of 163 contacts with the employee, providers and company personnel. This investment in support has enabled an employee who had been a probable candidate for long-term disability to remain productive (*41*).

Chapter 5

Work as a mechanism for reintegrating persons with serious mental illness

5.1 Size and profile of this group

According to WHO, more than 500 million people around the world are afflicted with serious mental illness, alcoholism and/or drug addiction. Expressed differently, 1.5-2% of the population of each country has to face this issue.

According to ILO (*43*), mental illness hits more human lives and gives rise to a greater waste of human resources than all other forms of disability.

> "We have been asking for the means to actively construct the real access to rights for years: not only the right to medical care, but also the right to produce, to have a house, an activity, a relationship, economic means, value."
>
> **Source: Franco Rotelli (42)**

The unemployment rate of this group is around 90% — in contrast to that of persons with physical or sensorial disabilities, which is approximately 50%. Again, expressed differently, only 10% of persons with a serious psychiatric background who wish to work and are judged capable of working are in fact working. Women fare less well than men.

It has long been known that severe mental illness often impairs dramatically one's capacity to work and to earn a living. It can lead to impoverishment, which in turn may worsen the illness. Thus, all efforts to find employment for these persons are essential since they improve quality of life and reduce both impoverishment and the high service and welfare costs engendered by this group (*44*).

5.2 Historical perspective

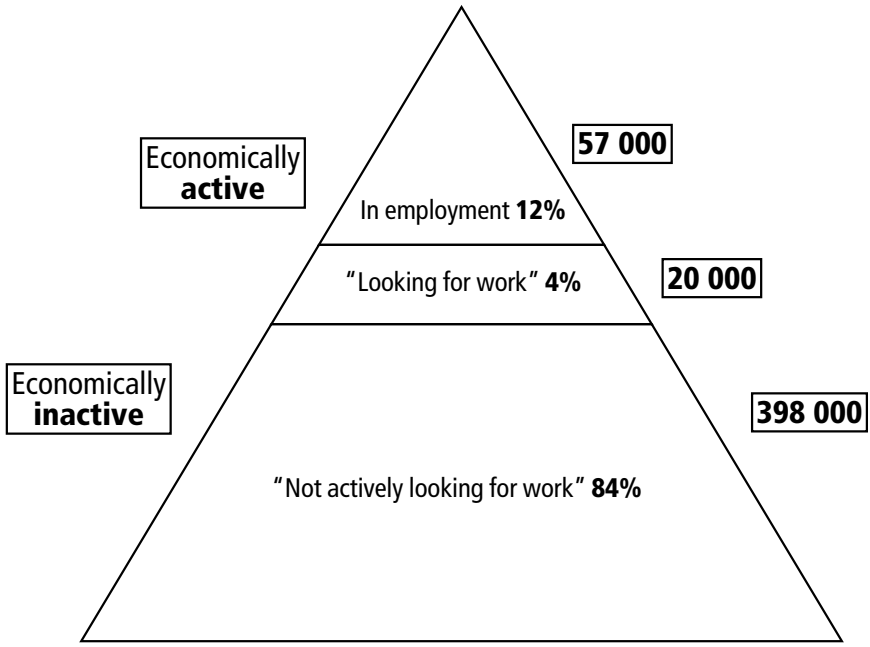
Tremendous changes have taken place in the management of persons with severe mental illness over the past 50 years.

5.2.1 Deinstitutionalization

Until the early 1950s we had to resort to long-term hospitalization, usually in a psychiatric hospital, since few very effective treatments were available. The negative side of prolonged hospitalization was that patients not only had the signs and symptoms of their illness but also had a tendency to lose the social skills which they possessed that are required in order to live in society (such as the ability to

Disabled people with mental health problems and work, United Kingdom

(Total of working age with mental health problems = 475,000)



Source: Labour Force Survey, Spring 1998. United Kingdom Educational and Employment Committee, Opportunities for Disabled People

dress and to feed oneself appropriately, to relate to other persons, to take the bus, or go to the bank, etc.). This phenomenon, referred to as "institutionalization", became more evident when the first neuroleptic drugs ("tranquillizers") were discovered in the 1950s. These had the capacity to control symptoms such as thought disorder, hallucinations, restlessness and agitation. Their discovery had a dramatic impact on the life of many long-term psychiatric patients who could then be discharged much more rapidly and also benefit from other treatments such as psychotherapy. However, a good number of patients whose active symptoms were well looked after with the first and successive generations of neuroleptic medication were still showing other symptoms such as withdrawal, lack of motivation, a certain degree of apathy, and the so-called "negative symptoms" of major psychiatric illness, most notably schizophrenia. It is only since 1985 that we have medications available (so-called atypical neuroleptics) that can significantly impact on negative symptoms.

All the above medications are powerful and they must always be carefully prescribed and monitored. Several can cause secondary effects such as thirst, involuntary movements and problems with vision, although this is less frequent with the newer molecules.

The other categories of illnesses normally included under the term "severe mental illness" are the major depressions, be they unipolar or bipolar ("manic-depressive illness"). Tricyclic antidepressants and MAO inhibitors are used for the former and mood stabilizers (mostly lithium carbonate) for the latter.

5.2.2 Organization of services

In developed countries today, most admissions take place in general hospitals rather than in psychiatric hospitals.

A substantial percentage of persons are able to return to live in society, either with their own families or in different types of living arrangements with more or less need for supervision and support. Many patients can be treated in day or night hospital programmes. By far the majority of patients are treated as outpatients, ideally by a multidisciplinary team that participates in carrying out a plan or project that has been developed jointly with the patient.

Today, the vast majority of persons with mental illness live in the community and not in institutions.

5.2.3 Psychosocial rehabilitation

Coincidental with these changes, we have witnessed a rapid development in the field and practice of psychosocial rehabilitation, a discipline which aims to overcome the difficulties of playing a social role and living in a social environment (*45*). The emphasis is on skills and abilities rather than on symptoms and disabilities, and the focus is on the areas of activities of daily living, socialization and work. The practice of psychosocial rehabilitation can be done by existing professionals such as psychiatrists, psychologists, social workers, occupational therapists and nurses if they have the necessary skills and training, or by persons who have received specific training in psychosocial rehabilitation in university programmes which are growing more numerous nowadays. All groups share a belief that most persons with serious mental health problems can improve if properly evaluated, trained and supported in the community (*46*).

Whereas physicians (mostly psychiatrists) are responsible for hospital admissions and treatment, including the prescription of appropriately monitored medication (which a majority of patients will require, often for long periods of time), most facets of reintegration and life in the community are looked after by professionals who use a psychoeducational approach rather than a medical one.

With appropriate treatment and psychosocial rehabilitation programmes, many people who would formerly have had to spend years in psychiatric institutions are now able to lead fairly interesting lives in the community.

Mental illness should be distinguished from mental retardation. The latter refers to subnormal intellectual functioning which usually begins before adulthood (*47*).

5.2.4 Developing work skills

While our focus is on access to paid employment, we know that a majority of persons with severe mental health problems have been exposed to programmes that focus more on developing work skills than on actual paid work. These programmes are summarized briefly (*48*).

- Hospital-based programmes of training and work integration

These are less used now than in the past; their aim is to increase self-confidence and general functioning and the type of activities that one finds in such programmes include food distribution, gardening, running a small store, etc. While participants tend to have reduced numbers of days of hospitalization, it appears that few obtain successful permanent employment.

- Sheltered workshops

This is another traditional approach where subcontract work is used. It is felt that this type of work does not prepare very well for remunerative employment and that the person tends to remain in a patient role. However, 10-15% of participants have been found capable of moving to a more intensive programme.

- Training in community living

These programmes have been developed through the pioneering efforts of Stein, Test & Marx (*49*). They attend to basic needs and feature strong individual management as well as a global approach. While participation in such programmes reduces hospitalization and increases independent living, it has not been found to have a great impact on keeping a permanent job.

- Programmes of assertive community treatment (PACT)

These programmes were also developed by Stein, Test & Marx in response to the growing need for community-based services for persons with severe mental illness. The focus has been on recovery from illness and enhanced quality of life. This training has been implemented in Canada and in several areas of the United States. PACT is an interdisciplinary team approach including a psychiatrist, registered nurses, peer specialists, vocational specialists, an addiction specialist and a programme administrator. Crisis care is available 24 hours a day.

This integrated, community-based model provides "the treatment, rehabilitation, and support services that persons with severe mental illness need to live successfully in the community" (*50*).

The clinical principles of treatment include, in part, an assertive approach to keeping individuals involved; continuous monitoring to maintain current knowledge of their functioning and to facilitate intervention when necessary; and individually tailored treatment and rehabilitation programmes (*51*).

PACT appears to be the model that has resulted in the most candidates being able to obtain increased competitive employment.

Other approaches are described later under 5.10.

5.3 Current context: changes in the nature of work

Obtaining competitively paid employment for a person with a background of serious mental illness remains a challenge at the best of times. It is even more difficult in periods of high unemployment when the availability of nondisabled workers is plentiful.

Globalization, technological development and changes in the organization of work are having an impact worldwide (*52*).

In the manufacturing sector of OECD countries, the employment of unskilled labourers has fallen by 20% (*53*) and there is a definitive trend towards the hiring of highly-skilled workers.

We are forced to acknowledge that important changes have taken place in the very nature and organization of work: the free-market economy which predominates, is often accompanied by downsizing of human resources and increased loss of job security. Moreover, various governments, in order to balance their budgets, have felt the need to reduce their social costs from which persons with serious mental illness traditionally get support: conditions of eligibility have been made stricter and the duration of the support programme often shorter.

With respect to the near future, there seem to be two schools of thought – one pessimistic and the other more optimistic.

The pessimist's viewpoint, as represented by sociologist Jeremy Rifkin (*54*), states that we are nearing the "end of work". The recent technological advances have resulted in a sharp reduction of new jobs in the industrial sector and he predicts that, with the assistance of computer technology, the reduction will be even greater in the services sector.

The optimists, as represented by Charles Goldfinger, are of the opinion that "each time a new technology is developed, it brings not a decrease, but an increase in job opportunities, albeit, not necessarily of the same kind as before". The new economy contains huge pools of new jobs which can more than make up for the inevitable loss of traditional jobs" (*55*). This latter viewpoint seems to be borne out in several countries that have experienced sustained growth in the

last few years: this has "revived the demand for a great variety of workers in many spheres of economic activity" (*56*).

Supporters of both viewpoints seem to agree that the organization of work is becoming more intangible and that regular 8 to 5 jobs may be less common, to be replaced by "flexible schedule, increased part-time work, short-time contracts, often done in the employee's own home…"

There seems to be agreement that the newer jobs will be in the following sectors:

- handling information and knowledge;
- information technology;
- the health sector;
- the leisure economy.

Whenever they have been successful in finding a paid job in the past, persons with a backgound of serious mental illness tended to work either in the traditional industrial sector or in service areas that did not require high technological capacity.

While it is too early to predict what will happen in the 21st century, it is obvious that work programmes for these persons will have to take into account the changes in the nature of work. This will include the need for a better education and the development of professional skills in keeping with the requirements of the new jobs.

5.4 Overcoming obstacles affecting clients' ability to access work (57)

Individuals with mental illness want to work but are often discouraged by many barriers in the current public system. A recent survey in the United States showed that 72% of unemployed people with disabilities, including people with severe mental illness have a strong desire to work. Several recent surveys have found this rate to be as high as 80% for adults with mental illnesses (*58*).

Six principal barriers to the employment of individuals with severe mental illness:

1. Lack of choice in employment services and providers.
2. Inadequate work opportunities.
3. Complexity of the existing work incentive systems.
4. Financial penalties of working.
5. Stigma and discrimination.
6. Loss of health benefits.

Employment is an essential part of recovery for people with mental illnesses and recent advances in treatment services and medications have increased the capacity of people with mental illnesses to join the mainstream and live independently.

5.4.1 Context

Shorter periods of hospitalization when needed and appropriate follow-up in the community prevent people from losing the social skills that are essential to adequate living in the community. The approach is also somewhat less costly to governments. However, we find that, while they are saving millions of dollars by closing psychiatric beds, at least in most developed countries, few governments have promulgated policies and developed community resources necessary to ensure the social integration of these patients. It takes greater political will and skills to put in place the conditions and programmes that will permit the meaningful return to life and society (including work) of persons with serious mental illness than it does to close a psychiatric hospital.

In the past, policies and programmes have tended to lump together the requirements of persons with mental retardation and those of persons with serious mental illness. Whereas they can have several needs in common, it has to be realized that the requirements for both groups are vastly different when it comes to "reasonable accommodation".

It is useful to review how to overcome the main obstacles that impact on the ability of persons with serious mental illness to have access to work.

5.4.2 Overcoming obstacles linked to the illness

A substantial majority of persons with serious mental illness take medication. When appropriately prescribed and monitored, these medications, especially the newer molecules, not only control the positive symptoms of illness (agitation, restlessness, etc.), but also have a significant impact on negative symptoms such as apathy, passivity and social withdrawal, as well as interpersonal relationships. All in all, 60-80% of persons with serious mental illness can be substantially helped with a well monitored medication regime and an appropriate psychosocial management and support programme.

It remains essential for persons with serious mental illness to have access to (and be able to afford) both appropriate medication and a psychosocial programme that will focus on the person's living conditions, his/her ability to relate to others, and his/her willingness and capacity to work. In all instances the person's choices must be sought and taken into account.

There is still a debate as to how much an employer should (or wants to) know concerning an employee's psychiatric background. In all modern legislation, disability cannot be sufficient grounds to refuse employment if otherwise the person can do the job.

The assurance that there will be a quick and easy access to appropriate medical and psychological help has been found to influence very positively the willingness of employers to offer jobs to persons with mental health problems.

In the past, and still today, many persons with psychiatric backgrounds have had to lie to a potential employer about their illness. Some of the most successful programmes are those where a mutual trusting and respectful attitude has been developed so that issues that may arise are easier to address.

5.4.3 Overcoming obstacles linked to lack of educational training and lack of work experience

Mental illness can strike at any age of life: some of the most severe forms begin in the late teens and early twenties and usually prevent the person from completing secondary education, college and/or university. This renders the person ill-equipped to face the requirements of a job, especially in today's world. Other forms of illnesses start in the late twenties and early thirties while the person is already working.

The work milieu is often intolerant of a colleague suffering from mental illness; the first episode may result in a demotion or a change of job, if not an outright firing. The impact on the person's self-esteem is usually very negative. The loss of one's remuneration brings with it economic hardship, notwithstanding the various aid programmes that exist in developed countries.

Research has shown a constant positive relationship between the skills of a client and his/her vocational outcome (*59*) and that persons with severe psychiatric disability can indeed learn new skills (*60*). With the ever-increasing importance of technology, we find that the "low-tech jobs" to which many persons with serious mental illness had access in the past are no longer available, at least in developed countries.

We need to develop training programmes that take into account the needs of persons with mental health problems as well as the requirements of potential employers.

In low-income countries, greater use should be made of the apprenticeship model.

We now believe that it makes eminent sense to encourage someone whose academic career was interrupted by mental illness to go back to school, college or university, in order to complete a qualification and therefore have access to a much wider choice of jobs and opportunities. Whereas government programmes have traditionally supported direct employment, there now exists a number of support programmes that will allow one to return to school.

Good practice: Supported education in Boston – Choose/Get/Keep

As part of its array of rehabilitation services, a University-based Centre for Psychiatric Rehabilitation has developed an extensive programme of "supported education". The centre applied a basic model (*61*) called "Choose/Get/Keep" which was initially developed for persons seeking a return to employment.

Supported education has been defined (*62*) as "the provision of post-secondary education in integrated educational settings for people with psychiatric disabilities whose education has been interrupted, intermittent or has not yet occurred because of a severe psychiatric disability, and who, because of this psychiatric impairment, need ongoing support services in order to be successful in the educational environment." The programme utilizes "supported learning specialists" with a masters degree in psychiatric rehabilitation (practitioners) who assist and accompany the person with a former psychiatric disability throughout the three phases of the programme. The guiding principle is to focus on "participant process" rather than on "practitioner activity."

- In the "Choosing" phase the participant is helped in describing why he/she wishes to go back to school and in making an enlightened choice as to the type of environment which suits his/her needs, as well as in making a choice as to which school might meet expectations. The eliciting of educational goals, the assessment of personal criteria, and the realistic objective evaluation of the student's abilities are paramount in facilitating the decision-making process. Part of this phase also involves the identification and securing of other sources of support for the student, including family and friends.

- In the "Getting" phase a decision is made by the practitioner and the student concerning the assignment of responsibility for getting enrollment in the academic facility chosen, including obtaining the financial support needed. A decision has to be made concerning the amount of information which the student may wish (or may not wish) to disclose concerning the psychiatric disability.

- In the "Keeping" phase efforts are made to continue to support students in enrollment and in academic success. The practitioner needs to provide the teaching of special skills which the student might need to pursue the programme. Coordination also applies to those facets of academic life with which the students might encounter some difficulties. Experience has shown that the need for greater support arises during stressful periods such as examinations.

All in all, the relationship established between the practitioner and the participant (student) is a crucial factor. It has to be egalitarian, continuous and very flexible.

As with other successful rehabilitation programmes, the outcome has an impact on the person's illness. There tend to be fewer rehospitalizations and a need for lower doses of medication (occasionally the need for medication may disappear) for persons involved in the programme.

5.4.4 Overcoming obstacles linked to prejudice and stigma

> "There is a growing awareness that disability is not so much an impairment of the individual as a product of the environment in which he or she lives."
>
> **Source: ILO (63).**

Stigma is basically an attitude that aims at marginalizing and ostracizing someone because that person has a mental health problem. While the stigma can be quite overt, it tends nowadays to be more subtle. For instance, a person may find it very difficult to obtain appropriate lodging or to join a social club. It may include fears of violent behaviour on the part of the person with the mental health problems.

While violence attributable to mental illness exists, it is very low when compared to other forms of violence. The risk of violence is much greater when severe mental illness is associated with alcoholism and drug abuse (*64*) and when there is a past history of violent behaviour.

In its most advanced forms, stigma leads to exclusion of the person from several spheres of social functioning. Stigma may have disastrous consequences when a person with a mental health problem starts believing that he/she deserves to be treated in such a way. Stigma can also manifest itself in the "denial" of the person's competence, ability and potential.

The best way to fight stigma is through appropriate education and information. This may include a public information campaign, courses, conferences, etc. It is important to delineate very precisely what component of "general stigma" one wants to address and to develop a specific plan of action for it.

The mass media often portray persons with mental illness in a most unfavourable light. It has been shown (*65*) that nearly half of health journalists have serious misconceptions concerning mental illness. Codes of ethics should be strengthened and rigorously applied to eradicate the altogether frequent "sensationalism" with which the press treats stories involving persons with "alleged" or "real" mental health problems. Since the media play a crucial role in filtering information that reaches the public, it is obvious that all efforts should be made by mental health professionals to work closely with them and to correct the misconceptions which they may harbour.

Recently, advocates in the mental health/illness field have made progress with the mass media, stirring up interest and controversy at both the international and national levels. In general, there has been more widespread discussion in the press and on television regarding the situation of this traditionally overlooked disability group and more in-depth presentations about some of the political and professional issues in this field.

Today, advocates are more successful at working with the press and on the Internet to bring mental health/illness issues both into the mainstream of the

disability rights movement and to the attention of the public. At the international level, advocates are combining three themes to attract media coverage: redefining the bottom line as a universal human rights issue, subjecting residential institutions to worldwide exposure, and building support for community based services (*66*). Ultimately, this type of advocacy can ameliorate negative myths and stereotypes and, in turn, can impact and influence work opportunities for individuals with mental health problems.

Another important way to fight stigma is to inform the community of "good practices" and of programmes that work.

5.4.5 Myths about mental illness and the workplace

The following are major myths and facts regarding the impact of mental illness on the workplace (*67*):

The facts dispute major myths about mental illness in the workplace.

- Myth 1: Mental illness is the same as mental retardation.

Facts: These are two distinct disorders. A diagnosis of mental retardation is chiefly characterized by limitation in intellectual functioning as well as difficulties with certain daily living skills. In contrast, among persons with psychiatric disabilities, intellectual functioning varies as it does across the general population.

- Myth 2: Recovery from mental illness is not possible.

Facts: Long-term studies have shown that the majority of people with mental illnesses show genuine improvement over time and lead stable, productive lives. For many decades mental illness was thought to be permanent and untreatable. People with mental illness were separated from the rest of society through institutionalization in mental hospitals. As medications were discovered which helped to alleviate the symptoms of mental illness, there was a gradual evolution towards the provision of treatment and rehabilitation services in the community.

- Myth 3: Mentally ill and mentally restored employees (the term denotes when the disorder is effectively treated) tend to be second-rate workers.

Facts: Employers who have hired these individuals report that they are higher than average in attendance and punctuality and as good or better than other employees in motivation, quality of work, and job tenure. Studies reported by US National Institute of Mental Health and National Alliance for the Mentally Ill conclude that there are no differences in productivity when compared to other employees.

- Myth 4: People with psychiatric disabilities cannot tolerate stress on the job.

Facts: This oversimplifies the complex human response to stress. People with a variety of medical conditions, such as cardiovascular disease, multiple sclerosis, and psychiatric disorders, may find their symptoms exacerbated by high levels of stress. However, the source of personal and job-related stress varies substantially

between individuals. Some people find an unstructured schedule to be very stressful while others struggle with a regimented workflow. Some people thrive on public visibility or high levels of social contact, while others require minimal interaction in order to focus and complete tasks. Workers with psychiatric disabilities vary in their response to stressors on the job. In essence, all jobs are stressful to some extent. Productivity is maximized when there is a good match between the employee's needs and working conditions, whether or not the individual has a psychiatric disability.

- Myth 5: Mentally ill and mentally restored individuals are unpredictable, violent, and dangerous.

Facts: The vast majority of these individuals are not dangerous or violent. Upon learning that an applicant has a mental illness, some employers may expect that the individual is likely to become violent. This myth is reinforced by portrayals in the media of people with mental illnesses as frequently and randomly violent. A scholarly review of the research literature by Cornell University indicates that "none of the data give any support to the sensationalized caricature of the mentally disordered served up in the media".

Although stigma and shame are still the dominant attitudes towards mental health and mental illness, there has been a dramatic shift in perception during the last 10 years. Advancement and improvements in the legal system have had a positive impact on attitudes and knowledge relating to all disabilities and to mental illness in particular. This has, in turn, created a greater openness towards all mental health issues. Additional contributing factors include public and professional awareness that prolonged hospital stays can be disabling, advances in pharmacology, and a shift in focus from pathology to strengths and abilities. More importantly, a variety of service models have been developed and implemented over the past decade which are successful in helping people with a depressive illness and other mental illnesses to secure and maintain employment.

5.4.6 Overcoming obstacles linked to government policy

While there exists, in developed countries, a number of programmes to help disabled unemployed persons (unemployment insurance, income support, job training, job search clubs, subsidies to employers, etc.) each programme has its set of fairly complicated rules and it becomes apparent that the philosophy underlying such programmes was not conceived for persons with mental health problems in mind. The programmes are either too short in duration or have requirements of rigid working hours or high output which persons with serious mental illness cannot be expected to fulfil, at least initially.

A cursory look at existing programmes in many countries reveals that, notwithstanding the fact that persons with mental illness may represent a majority of "persons with a disability", only a very small number of structured programmes exist and are adapted to the needs of this group, as compared to programmes for physical or sensorial disabilities.

A paradoxical situation exists in some developed countries. The disability benefits paid to someone officially classified as a "person with a disability" and without any obligation to work may be very close to the minimum wage which the same person would earn if working. To compound the problem, the person may also lose an entitlement to free medication, to transportation subsidies, or other social benefits by accepting the status of employee. This often constitutes a powerful disincentive for a person with a disability to join the labour force.

In the USA, the impact of welfare reform on the employment of people with psychiatric disabilities is an issue worth noting. Many of the problems associated with welfare reform as it concerns people with mental illness are not unique to the USA, particularly as many European countries are trying to decrease their social welfare costs. (Many people receiving welfare benefits have either mental health problems or are at increased risk of them.) In the USA, by focusing on the importance of work and training, the current national trend in welfare reform has the potential to expand employment opportunities for people with psychiatric disabilities. However, many mental health experts express concern about this impact. The reasons cited for concern are:

- increased competition for employment from welfare recipients entering the job market could crowd out people with psychiatric disabilities;
- employment and training programmes designed for the general welfare population are unlikely to address the special needs of people with psychiatric disabilities;
- disincentives to work inherent in many government benefit programmes can make it difficult for persons with psychiatric disabilities to enter and remain in the workforce.

Despite these concerns, many mental health advocates hope that welfare reform will encourage state and local mental health agencies to adopt more innovative and effective strategies to help people with psychiatric disabilities to enter or reenter the workforce. It is hoped that welfare reform will create an environment that encourages state and local agencies to work together in new ways to address the issue of employment and training. In addition, welfare reform offers an opportunity for the mental health system to contribute its considerable expertise and experience to promoting and supporting employment in the effort to assist welfare recipients to enter the world of work (*68*).

5.4.7 Overcoming obstacles linked to the labour market

Previous successful work history has traditionally been mentioned as a key factor in predicting successful return to employment. This obviously puts persons with a background of serious mental illness at a disadvantage.

With a few exceptions (notably the USA), unemployment rates in many countries are around 10%. Changes in the labour structure mean that there are fewer low-tech jobs available. Training may be needed to acquire the competence which newer jobs may demand.

Professionals and workers in the disability field must remember that employers are not social agencies and are traditionally reluctant to hire persons with a background of serious mental illness. Employers are concerned that there will be a loss of productivity and this concern has to be addressed.

5.5 The perspective of international agencies

5.5.1 United Nations

The United Nations, which proclaimed the International Year of Disabled Persons in 1991, adopted the World Programme of Action concerning Disabled Persons in 1992. This emphasized the right of persons with disabilities to "the same opportunities as other citizens and to an equal share in the improvements in living conditions resulting from economic and social development". On the same occasion, it defined "handicap" as a function of the relationship between persons with disabilities and their environment.

In 1994 the United Nations published the "Standard Rules on the Equalization of Opportunities for Persons with Disabilities" (*69*).

The term "equalization of opportunities" means the process through which the various systems of society and the environment such as services, activities, information and documentation are made available to all, particularly persons with disabilities. "Persons with disabilities are members of society which have the right to remain within their local communities. They should receive the support they need within the ordinary structures of education, health, employment and social services."

Article 7 deals specifically with employment; it mentions that "States should recognize the principle that persons with disabilities must be empowered to exercise their human rights particularly in the field of employment. In both rural and urban areas they must have equal opportunities for productive and gainful employment in the labour market."

Sub-article 2 mentions that "States should actively support the integration of persons with disabilities into open employment. This active support could occur through a variety of measures, such as vocational training, incentive-oriented quota schemes, reserve or designated employment, loans or grants for small business, exclusive contracts or priority production rights, tax concessions, contract compliance or other technical financial assistance to enterprises employing workers with disabilities. States should also encourage employers to make reasonable adjustments to accommodate persons with disabilities."

Article 7 also proposes public awareness-raising campaigns and further mentions that the goal should always be for persons with disabilities to obtain employment in the open labour market. However, for those whose needs cannot be met in open employment, "small units of sheltered or supported employment may be an alternative."

5.5.2 World Bank and the Harvard Report

With few exceptions, severe mental illness does not represent an immediate threat to life. Therefore, mortality rates are of little use to measure the true impact of mental illness on an individual, family or society as a whole.

To address this issue, the World Bank has introduced (*70*) the concept of DALYs, or disability-adjusted life-years: "this is a measure that combines healthy life years lost because of both premature mortality and losses resulting from disability."

The sum of DALYs is referred to as the Global Burden of Disease (GBD).

The seminal 1995 Harvard Report (*71*) on *World Mental Health: Problems and Priorities in Low-Income Countries* points out that whereas there have been, over the last 50 years, marked improvements in the physical health of low-income countries (owing among other things to better control of fertility rates, improved perinatal care, and prevention and treatment of several infectious diseases, resulting in reduced mortality rates), on the other hand the mental health of these populations has either remained stagnant or has decreased.

According to *The World Health Report 1999*, neuropsychiatric disorders account for 11.5% of the burden of disease worldwide – as measured by DALYs – which is more than the proportion of the burden imposed by respiratory infections and diseases (10.7%), cardiovascular diseases (10.3%), or malignant neoplasms (5.8%). Even in the low-income and middle-income countries of the world – where it is often assumed that infectious and parasitic diseases are of paramount importance – one finds that neuropsychiatric disorders account for 10.5% of the burden of disease.

Data from the *Global Burden of Disease* provide further evidence. In 1990, among people between the ages of 15 and 44, fully 30% of DALYs were the consequence of mental health problems – about twice the burden imposed by infectious and parasitic diseases, five times that of cardiovascular diseases, and seven and a half times that of malignant neoplasms. For this age group, unipolar major depression accounted for more than 10% of all DALYs and was the single leading cause of disease burden in the world. Put another way, neuropsychiatric conditions were the greatest cause of disability in what is a particularly active and productive age group (*72*).

It has been reported (*73*) that for the USA, the United Kingdom and Australia, 43% of DALYs are traceable to mental disorders and that the latter account for 22% of the GBD. The much higher percentages in developed countries reflect the fact that perinatal death and disability from infectious disease are much lower than in developing countries.

We are aware that criticisms have been leveled against the DALY and GBD concepts (*74*), to the effect that they do not give sufficient importance to social and environmental factors. According to our experience, they remain very useful ways

to describe disabilities in a manner which is clear and likely to be understood by decision-makers who can influence policies.

5.5.3 International Labour Organisation

ILO generally agrees with WHO estimates that more than 500 million people, or 7-10%[1] of the world's population, are disabled. ILO also feels that this number is increasing owing to greater longevity and the physical and psychological ravages of wars.

Today, ILO has a new organizational structure in which the disability programme is part of the Employment Sector which reflects the principle of mainstreaming. The Employment Sector is responsible for developing and promoting employment strategies, job creation programmes, and human resources development policies, and for initiating actions to respond rapidly to economic crisis in conflict countries and to the needs of those devastated by natural disasters. Within the Employment Sector, the disability programme has been integrated into a broader unit (Target Groups Unit of the InFocus Programme on Skills, Knowledge and Employability). The aim behind the establishment of this new unit is to enhance synergy between the ILO's different programmes targeting disadvantaged groups such as youth, older workers, displaced workers and people with disabilities which include mental health disorders. The disability programme works in close cooperation with the ILO's occupational safety and health programmes, especially the InFocus Programme on SafeWorks. The latter focuses on preventive policies and programmes to protect workers in hazardous occupations and sectors.

ILO's focus on persons with disability is outlined in its Constitution's Convention number 159 (*75*) and its recommendation 168 (*76*) (Recommendation concerning vocational rehabilitation and employment – Disabled Persons).

For the purpose of the Convention, the term "disabled person" means an "individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment."

Part II of the Convention urges Member States to "formulate, implement and periodically review a National Policy on vocational rehabilitation and employment of disabled persons," restates the principle of equal opportunity between disabled workers and workers in general, and puts forward the fact that "representative organizations of employers and workers shall be consulted on the implementation of the said policy."

Recommendation 168 is much more explicit and contains 9 sections. After restating that disability can arise "as a result of a duly recognized physical or mental

[1] Dr Gro Harlem Brundtland, Director-General of WHO, Interagency Consultation on Disability, 15-16 June 1999.

impairment" (terms which are not defined), section 2 on vocational rehabilitation and employment opportunities stresses the following:

- Disabled persons should enjoy equality of opportunity and treatment in respect of access to, retention of and advancement in employment which, whenever possible, corresponds to their own choice and takes account of their individual suitability for such employment.
- Measures for disabled persons should conform to employment and salary standards applicable to workers generally.
- Measures which are recommended include:
  - measures to create job opportunities on the open labour market;
  - appropriate government support for the establishment of various types of sheltered employment for disabled persons for whom access to open employment is not practicable;
  - appropriate government support for vocational training and vocational guidance, placement services, etc.;
  - encouragement of the establishment and development of cooperatives by and for disabled persons;
  - elimination by stages if necessary of physical, communication and architectural barriers and obstacles;
  - nondiscrimination and information on successful instances of integration;
  - research on the various types of disability.

The third part of the Recommendation deals with community participation in both urban and rural areas, in particular with that of representatives of employers, workers and disabled persons' organizations.

Other sections deal with vocational rehabilitation in rural areas, the training of staff, the contribution of employers' and workers' organizations to the development of vocational rehabilitation services, the contribution of disabled persons and their organizations to developmental vocational rehabilitation services, vocational rehabilitation under social security schemes and, lastly, coordination, where Article 42 states:

"Measures should be taken to ensure, as far as practicable, that policies and programmes concerning vocational rehabilitation are coordinated with policies and programmes of social and economic development (including scientific research and advanced technology) affecting labour administration, general employment policy and promotion, vocational training, social integration, social security, cooperatives, rural development, small-scale industry and crafts, safety and health at work, adaptation of methods and organization of work to the needs of the individual and the improvement of working conditions."

Both the Convention and its Recommendations cover very extensively the field of disability. Measures described clearly address disability arising from physical and

sensorial problems. Although there is little elaboration of what might be required for persons with disability arising from mental health problems, both the Convention and its Recommendations apply equally to mental health disabilities.

5.5.4 World Health Organization

WHO was founded in 1948 as the main international organization to oversee world health. Its constitution (*77*) gives the organization and member countries the objective of the attainment by all people of the highest possible level of health. It further states that the enjoyment of the highest standard of health is one of the fundamental rights of every human being. In 1977, the World Health Assembly expressed this as *"Health for all by the year 2000"* (*78*).

The 9th General Programme of Work of WHO establishes the global health policy framework for action by the world health community (international organizations of the United Nations system, including WHO, nongovernmental organizations, bilateral and multilateral donor and development agencies, banks and countries themselves).

In 1981, WHO adopted primary health care as the way to achieve the goal of health for all. As a strategy, primary health care seeks reorientation of health systems to enable the whole population to have effective and essential care and to promote individual and community involvement in health, as well as intersectoral collaboration.

Appropriate treatment of common diseases and injuries and mental health care are integral components of primary health care.

Much of the attention of WHO's Department of Mental Health and Substance Abuse is focused on the most effective ways to ensure the highest quality of life for persons with serious mental health problems. Several projects deal specifically with rehabilitation issues, including access to employment.

Throughout the 9th General Programme of Work there is a constant reference to the necessity to improve the quality of life of people and to integrate health and human development in public policies.

The *World Health Report 1998* has the theme "Life in the 21st century: a vision for all" (*79*). The report states that there is increasing life expectancy due mainly to a reduction in premature death and a steady reduction in major infectious diseases. The report identifies as major problems the HIV epidemic and the enormous rise in violent death and injuries from violence.

On the issue of work, the report states that "more working days are lost as a result of mental disorders than physical conditions". It also recognizes that, whereas mental disorders contribute little to mortality, they make a huge contribution to the Global Burden of Disease.

5.5.5 Nongovernmental organizations

There are perhaps thousands of consumer and professional groups for individuals with mental health disabilities and their families in many countries of the world. These groups have had a vital role in raising the awareness of mental health issues, reducing stigma and discrimination, and advocating for appropriate legislation. Jobs and other meaningful activities are important for a person to be included in the social and economic mainstream. Recently, there has been impetus by some NGOs to frame the discussion and advocacy of mental health issues within a "human rights" perspective.

Often NGOs work closely with government agencies, business groups, corporate sponsors and community-based mental health services. They are an important source of expertise and provide opportunities to reach people with mental health problems. They serve as a policy monitor and a catalyst for change.

5.5.6 Overseeing training and employment of persons with disabilities

In a recent worldwide survey undertaken by ILO (*80*), it was found that the "organization" of vocational rehabilitation is very diverse and occasionally quite diffused in many countries. There is often an obvious lack of communication between the different agencies responsible for policies and programming.

In more economically developed countries, the increase in vocational rehabilitation programmes parallels the increasing strength of the "disability organizations" and their lobby. This has led to continuous surveillance of national policies and programmes by people with disabilities.

For obvious reasons, the lobby representing physical and sensorial disability has traditionally been much stronger and more vocal than that representing mental health problems. For its part, the mental retardation lobby has become strong and vocal owing to the fact that, by and large, families now view the condition as having a physical origin about which one should not be ashamed.

Over the last two decades, the "users" (or "survivors") movement in mental health has grown very significantly and has become an increasingly powerful lobby group, especially in more economically advanced countries. It is making good use of the ever-increasing knowledge that we have of the biological and genetic components of most major mental illnesses to challenge the stigma that is still too often associated with these illnesses.

Good practice: vocational rehabilitation for individuals with a psychiatric disability – the Australia experience

The National Employment and Psychological Services (NEPS) centre was founded in 1992. The centre operates in both Victoria and Queensland. NEPS has employment services, a work crew and two commercial businesses. Most of their clients (85%) have a psychiatric disability. The centre also has a secondary focus on people from non-English speaking background.

The following example illustrates "good practices" that have been effective in assisting people with mental illness obtain and maintain employment. The main features are that this programme is consumer-driven and fully integrated into the community.

According to Leonie Exel from the NEPS centre: "Our staff and clients have been through many an exponential learning curve in the last six years, particularly as we are among the first wave of specialist providers in Australia. Nowadays, we can define some of the service features which are likely to assist our clients to find and maintain relevant jobs. Our knowledge has come from a combination of research, hard work and sometimes painful trial and error. Our experience has taught us that many or most successful factors in our agency can be attributed to plain and simple, garden variety common sense."

The primary factors which ensure that NEPS clients obtain and maintain relevant employment are:

- high levels of client (consumer) participation;
- client-driven processes, goal-setting and methodology;
- an empowerment focus;
- flexibility in service delivery schedules and service re-entry processes;
- strong policies of nondisclosure and confidentiality;
- staff personalization of service delivery.

Implementing these factors involves the following strategies:

- clients (consumers) are highly involved in the design, management and implementation of vocational services;
- clients do what they choose to do ("we don't do things" for people and "we don't chose their goals);
- clients choose the manner in which they are assisted (in group work, one-to-one, or via peer consultancy services);
- clients fail, succeed, try again, and test the jobs, vocations, careers and periods of unemployment until they decide what they would like to do;
- clients can keep their personal lives private from other people if they want to.

Service delivery phases are as follows:

- substantial time is spent working with the client on pre-vocational factors such as medication and illness management in the workplace;
- substantial time is spent on vocational counselling and developing community, social and service provider networks for vocational support;

- substantial time is spent talking with other service providers trying largely to increase their optimism about the client's chance of finding and keeping work in the hope that they will be supportive throughout what can be a difficult process for the job-seeker;
- an emphasis is placed on the staff's own mental health in the workplace with a very strong sense of community and mutual support and emphasis on training and further education for staff.

Source: Exel L. *Vocational rehabilitation of people who have a psychiatric disability: the Australian experience.* Proceedings of the Asia and the Pacific Regional Conference Campaign'98 for Asia and Pacific Decade of Disabled Persons 1993-2000, Hong Kong, 23-28 August 1998.

5.6 Rights of persons with serious mental health problems with respect to access to work

While access to paid work for persons with serious mental health problems can be influenced by a number of contingencies such as low level of development, traditions, culture, and high level of unemployment, we fully share the viewpoint expressed in the ILO Convention and in many countries' legislation that disability, including mental health disabilities, cannot be used as an excuse to refuse access to employment to someone who wishes to work and is capable of working.

We therefore believe that:

- work represents a most important value in society;
- work represents for a person a privileged way to exercise a role in society;
- persons with serious mental health problems have the right to exercise the same social roles as other citizens;
- work is a right for these persons to the extent that they desire to exercise this right;
- services must be developed to answer the work needs of these persons.

5.7 International variations pertaining to culture, social structure and economics that may exist in developing countries

Chronic mental illness is ubiquitous. In developing countries with understaffed mental health services, a paucity of structured programmes and case managers, and very high rates of unemployment, it becomes much more difficult to find a paid job for someone with serious mental illness.

5.7.1 Countries in transition

Effective action to promote the availability of employment for people with mental health problems has been hindered by the difficult conditions in the labour market. The transformation of the economic system has included a massive effort to create new jobs for society and has required individuals to acquire new voca-

tional skills. There have been insufficient resources available to assist individuals with psychiatric disabilities in vocational rehabilitation efforts so they may compete and succeed in the job market.

In rural areas, for economic and pragmatic reasons, there are strong pressures to involve the mentally ill individual in the "field". If community leaders have been sensitized and the individual receives adequate medication and support, this may lead to quite productive employment.

In Viet Nam, we have seen a few examples of women being involved in cultivating rice after discharge from the psychiatric hospital. This was not systematically used, but was always more successful when the "People's Committees" representatives were involved in the process (*82*).

In some countries of Africa (Kenya, Nigeria), there exist so-called "psychiatric villages" where many former patients live with members of their families. In these enclaves, which are quite well accepted by the community at large, the former patients can be reintegrated to a useful role and involved in the production of goods which are then purchased by the community at large. In Abeokuta, Nigeria, we have seen former patients making and selling candles for a reasonable profit from which they derive much of their subsistence.

In large, fast-moving urban areas, with crowded living space and no alternative accommodations available, the situation is often quite difficult.

Success stories, nevertheless, exist.

Good practice: a cotton factory in Beijing, China

In China's urban areas, until recently, the trend was for someone to join a factory and to stay in the same employment more or less for life. The employer was responsible not only for providing a salary as well as living accommodation, but also for the rehabilitation of employees back to their job in cases of serious physical or mental illness.

In Beijing, one of the country's largest cotton factories also has several hundred apartments for its employees as well as a 140-bed hospital and two schools. On a recent visit we talked at length with a 29-year-old woman who had been diagnosed as suffering from schizophrenia and had been hospitalized for a year. On leaving the hospital (where she had been visited regularly by factory workers and managers), she returned to her apartment and to her former job on the "cotton chain" with full pay. After one month, she could not keep the pace of her co-workers in the assembly line and had to be transferred to an office job.

There is little doubt that without a legal obligation on the part of the employer to take her back, she would be unemployed.

We are informed that in recent years, with changing economic conditions, the law is applied much less strictly than in the past.

Harnois, G.: La Chine… Incoutournable! Editorial, WAPR Bulletin, Vol. 7, No. 4, October 1995.

Programmes must be culture-relevant and culture-sensitive. While a sharp division often exists between rural and urban settings, the family remains at the core of provision of services and the main link towards involvement in natural community support.

Currently, in Poland there are occupational therapy workshops and centres for work activities for people with moderate and severe mental health disorders. The primary aim of therapy workshops is to promote the social skills necessary for independent living, including work. There are approximately 300 occupational therapy workshops in Poland which ensure temporary employment for people with mental illness who have lost their jobs. They receive a small stipend for their work. There is one experimental Centre for Work Activities, in which the staff consists of people with severe mental illness. This centre is supported financially by the State Fund for Rehabilitation of the Disabled (*81*).

5.8 Promoting the employment of persons with mental health problems

5.8.1 Political will and legislation

Most countries have legislation which postulates that disability shall not be a barrier to a meaningful life. With respect to access to work, these laws (as is the case with the American Disability Act) dictate that reasonable accommodations should be made by an employer and describe what is meant by this concept.

Because it is in many ways a model legislation, some of the features of the American Disability Act are mentioned here in some detail.

The American Disability Act (*83*) was passed in 1990 after many years of experimentation. Its "Title I" describes the standards of accessibility for persons with physical or mental disabilities in employment and further defines that "reasonable accommodation standards" will also apply to the private sector.

The majority of reasonable accommodation standards pertain to physical disability and include making facilities used by employees readily accessible, the acquisition or modification of equipment or devices, the provision of readers or interpreters, etc. The provisions that apply most often to persons with mental health problems have to be developed individually and have to do mostly with part-time or modified work schedules, job restructuring to eliminate or exchange auxiliary job functions that increase pressure for the worker, and time off for therapy.

Whereas the accommodations necessitated for physical disability are very often technical or a one-time affair, those required for psychiatric disabilities tend often to be quite simple but will last in time and require an attitudinal change on the part of the employer and, quite often, co-workers.

The law also foresees that the cost of bringing about "reasonable accommodations" should not be "unreasonable or unbearable" for the employer.

Good practice: towards "Reasonable Accommodation" for persons with mental health problems

We reproduce here a list of accommodations proposed by Mancuso (*84*):

Changes in interpersonal communication

- Arranging for all work requests to be put in writing for a library assistant who becomes anxious and confused when given verbal instructions.
- Training a supervisor to provide positive feedback along with criticisms of performance for an employee re-entering the workforce who needs reassurance of his/her abilities after a long psychiatric hospitalization.
- Allowing a worker who personalizes negative comments about his/her work performance to provide a self-appraisal before receiving feedback from a supervisor.
- Scheduling daily planning sessions with a co-worker at the start of each day to develop hourly goals for someone who functions best with added time structure.

Modifications to the physical environment

- Purchasing room dividers for a data entry operator who has difficulty maintaining concentration (and thus accuracy) in an open work area.
- Arranging for an entry-level worker to have an enclosed office to reduce noise and interruptions that provoke disabling anxiety.

Job modifications

- Arranging for someone who cannot drive or use public transportation to work at home.
- Restructuring a receptionist job by eliminating lunchtime switchboard duty normally handled by someone in this position.
- Exchanging problematic secondary tasks for part of another employee's job description.

Schedule modification

- Allowing a worker with poor physical stamina to extend his/her schedule to allow for additional breaks or rest periods during the day.
- Allowing a worker to shift his/her schedule by 1? hours twice per month to attend psychotherapy appointments.

In the United States until recently recipients of social security lost cash and medical benefits if they earned US$ 500 per month. This has now been raised to US$ 700 per month in order to create an incentive for social security recipients to go back to work.

5.8.2 Quota system

The quota system that is used, for instance, in 10 European countries is an obligation requiring employers to hire a certain percentage of disabled persons as part of their workforce. If they fail to do so, a fine or "levy" is assessed which is then pooled in a fund to promote the employment of disabled persons. The quota usually applies to all of the public sector and to several components of the private sector, under certain conditions.

In Germany (*85*), the quota is usually (it may be increased or decreased) 6% and applies to all employers with at least 16 employees. A compensation tax of DM 200 per month must be paid for unfulfilled "compulsory places" thus constituting a pool which, in 1992, amounted to DM 960 million.

5.8.3 Support

One needs to emphasize once again the necessity of providing continuing support to both the individual and, most often, to the employer, in order to establish a "working relationship" based on known expectations, cooperation and partnership.

Trial periods on the job site have been found to be very successful and predictive of the employer's capacity to "integrate" the job.

5.8.4 Coordinated action

To help employers and to facilitate access to work for our clientele, it has been found very useful to regroup potential employers. For instance, in the United Kingdom, the Employers Forum on Disability acts as the authoritative employers' voice on disability as it affects employers and service providers. "The Forum is funded and managed by over 350 members who employ nearly 20% of the United Kingdom workforce."

"The Employers Forum on Disability Employment agenda provides the framework for employers committed to developing best practice in the employment of disabled people" (*86*).

For planning purposes, it has been found very useful to have formal input from representatives of employers and from labour unions who can facilitate the required openness to create jobs for persons with a background of serious mental illness.

While they will benefit immensely from initiatives stemming from the private sector, the most successful programmes will require government support.

It is not always easy to decide where the primary responsibility rests among the departments or ministries of a government. Effective intersectoral collaboration will involve the departments of health, labour, employment, education, income support, regional development, social services, etc. A specific formal mechanism which allows for this intersectoral collaboration is a highly effective tool.

5.9 Research findings

5.9.1 Potential predictors of successful participation

Given the size of the mental health population that can and would like to work, there are very few effective vocational programmes available. It would therefore be extremely useful to develop criteria that will identify the likelihood of successful outcomes.

Using a research sample of 279 participants, matched as far as possible with an equivalent number of nonparticipants, project WINS in the USA (*87*) identified three major principles: 1) toward zero exclusion; 2) choose/get/keep; 3) consumers determination.

The variables that were found to be relevant were:

- work expectation (those who expected to be working within a year were 4.5 times as likely to be enrolled in the programme);
- attitudes about work as a source of pride and accomplishment (each increment on the scale resulted in double participation);
- work history (individuals with fewer than 5 paid jobs since age 15 were only 0.4 times as likely to receive services as those with more extensive work experience);
- age was negatively related (with each additional 5 years of age, corresponding to 0.8 times the odds of participation);
- education was positively related (each increase in educational level yielded an increase of 1.48 times the odds of participation).

5.9.2 Developing work skills

In another recently completed (*88*) vast inquiry in the Province of Quebec, Canada, 70% of 115 programmes filled out a lengthy questionnaire which was later followed by 26 thematic group discussions involving 235 persons (127 participant users, 48 nonparticipant users, 60 employers).

The findings revealed two broad categories of programmes:

Group 1: Developing employability

These are much more frequent than programmes offering paid employment. The vast majority (85%) are managed by nonprofit organizations and take place in the community (93%); they evaluate capacities and interest (85%); offer individual follow-up (83%) and programme support; help the acquisition and maintenance of basic work skills (75%); evaluate work competence (72%); and offer training in social skills (60%).

Most programmes have admission criteria that tend:

- to be motivated;
- to have capacities and aptitudes for work;
- to have a good level of overall functioning.

With respect to remuneration (pay):

- a majority receive an increase in social welfare payments;
- receive a "work allowance";
- receive a salary;
- receive nothing.

The majority of programmes rely on government grants while one-third utilize revenues from the production of goods and services.

The most important obstacles identified by programme directors included self-deprecating attitudes, emotional instability, stigma, programmes not well adapted to the person's needs, and lack of recognition of the individual's potential.

Among the most favourable conditions to achieve the programme objectives were positive attitudes of users, openness of the environment, matching the needs of the user, individual follow-up, and sufficient financial resources.

In the thematic groups, support from relatives and families and from programme staff scored very high.

The majority of employers highlighted the importance of being well informed with respect to the illness, developing financial incentives, establishing partnerships, and adapting the work environment.

Group 2

Group 2 consists of the 19% of the programmes which offered what could be called a salary, although in most instances it was not extremely competitive. These programmes tended to function more or less as social firms, which are described later.

Myth re: low productivity

Recent Australian research (*89*) aimed to challenge the idea that disabled employees are less productive than nondisabled persons. With a sample of 196 usable cases, the research revealed that:

- with respect to length of service, workers with a disability served longer;
- there was no difference in absenteeism between disabled and nondisabled workers;
- log-on ratio (subjects' total hours of work) showed no significant difference;

- with respect to contact efficiency, there were no significant differences;
- with respect to upgrades and sales effectiveness, there was no significant difference.

Support in the workplace

Findings of a large inter-state study in the USA (featuring 243 individuals in 10 programmes across 8 states, and utilizing an 85-item questionnaire about individuals, disability information, employment features, employers and community connections) included:

- staff support to a "disabled" employee on the job has a negative effect on work rate, work quality, co-worker relations and typical employment conditions (this is especially true when symptoms are present at work);
- staff support to workplace personnel has a positive effect on work rate, work quality, co-worker relationships, typical employment conditions, and employee satisfaction;

In trying to explain these findings, the authors propose that direct support can possibly be stigmatizing and that believing that the supported employee needs an expert to provide support for his/her symptoms may actually hinder successful outcomes (*90*).

Mental health at work – why is this field so under-researched?

In the United Kingdom, Jenkins has pointed out (*91*) that 14% of the certified absences and of NHS and patient's costs are due to mental illness, which also accounts for 23% of NHS pharmaceutical costs.

Depression alone is estimated to cost approximately £2 billion a year in Britain and, on top of absenteeism, has an impact on reduced productivity, labour turnover, poor timekeeping and accidents.

The author points out that, even if employers take the view that work does not constitute an etiological factor for mental illness, the fact that there are 30 working days lost to depression and anxiety for every single day lost to industrial disputes makes the issue a paramount one. This viewpoint is now apparently shared by employers, employees and trade unions.

The author feels that the main issues for research in this field are:

- more accurate prevalence studies of a wide range of different work settings;
- elucidation of risk factors;
- evaluation of techniques for primary prevention;
- evaluation of techniques for secondary prevention;
- evaluation of occupational mental health services, provisions and policies;
- more accurate estimation of the impact of minor psychiatric morbidity on sickness absence, work performance, relationships with colleagues, accidents and labour turnover.

5.9.3 Costs

There are few complete evaluations of the costs of programmes and services, including subsidies and parity in mental health insurance, as well as the savings accrued to governments from not having to pay social benefits to this clientele.

In the United States, the cost of equal health insurance coverage for mental and physical health services has been one of the most hotly debated issues at national and state levels. Despite vehement opposition by special interests who claimed that parity would be too costly for businesses, the Federal Mental Health Parity Act was passed in 1996, requiring the level of insurance coverage for mental illness to be similar to that for physical illness. Multiple studies show that the cost impact is minimal and that many employers (those with over 50 employees) are instigating policies to provide parity for their workers. The introduction of parity in combination with managed care results in, at worst, very modest cost increases. In fact, lowered costs and lowered health insurance premiums were reported within the first year of the Mental Health Parity Act[2] (*92*).

A recent Canadian study (*93*) found that, over a period of 10 years, 240 persons with serious mental health problems have been able to keep a job, largely owing to the work reintegration programme. Using conservative figures, these persons earned $5 million (all figures in Canadian dollars), paid $1.3 million mostly in income tax, and saved the government an estimated $700,000 in social costs which they would have received had they been unemployed. The net result is therefore an increase in "collective wealth" of the order of $2 million.

5.9.4 Useful research tools

Given the explosion of data in the complex and developing field of disability and mental health, the Internet has become an invaluable tool for obtaining and accessing information on research, policies, legislation, promotion and preventive programmes, rehabilitation and medical treatment. There are numerous databases and websites on disability, mental health, mental illness, psychiatric disabilities and employment issues. Fortunately, with the spread of information technology, most regions of the world now have access to the most up-to-date information on these topics.

In response to this growth, the Global Applied Disability Research and Information Network on Employment and Training (GLADNET) was created a few years ago. This network brings together universities, research centres, employers, worker's organizations, government agencies, and organizations of persons with disabilities.

[2] A recent survey by the US General Accounting Office found that 14% of employers in 26 states were not complying with the federal standards. Most of those companies had lifetime limites on mental health benefits of $100.00 or less but set higher ceilings for medical and surgical benefits. (Many employers found to violate law requiring parity for mental health coverage. *New York Times*, 18 May 2000.)

GLADNET is a nonprofit organization, affiliated with the ILO's Target Groups Unit in the InFocus Programme on Skills, Knowledge and Employability. While it does not deal specifically with disability related to mental health problems, it contains several elements that are related and remains a very useful tool for persons to keep abreast of developments in the field. It can be found at the following Internet address: http://www.gladnet.org.

5.10 Successful work programmes at the international level

5.10.1 Utilization of supported employment programmes

While the obtaining of permanent competitive employment remains a major goal, many persons with severe mental health problems will not be able to achieve this. Many are involved in so-called "supported employment" (SE) programmes.

The American Rehabilitation Act defines supported employment as follows:

"Competitive employment in an integrated setting with ongoing-support services for individuals with the most severe disabilities:

- for whom competitive employment has not traditionally occurred or for whom competitive employment has been interrupted or intermittent as a result of a severe disability;
- who, because of the nature and severity of their disabilities, need intensive supported employment services from the designated state unit (Division of Vocational Rehabilitation) and extended services after transition in order to perform this work; or,
- transitional employment for individuals with the most severe disabilities due to mental illness."

Therefore, most SE programmes will help the individual find a job and may offer assistance before the individual starts working, and usually throughout the employment period. Quite often the jobs found are at the lower end of the salary scale, near the minimum wage. They may include clerks, shippers, helpers, etc.

Substantially more persons who have participated in SE programmes get and maintain a job than comparison groups. While participants report overall improvements in quality of life and job satisfaction, only a minority are able to earn enough so as to be able to do away with the various existing government support programmes.

5.10.2 Finding a job on the regular market (the work integration contract)

In order to foster the progressive reintegration of persons in the job market, individual "work integration contracts" may be used. The employers tend to be small to medium-sized businesses or community agencies.

The contracts, which vary in duration (many do not have any time limits), all receive government support in a decreasing proportion. For instance, in Quebec,

Canada, the government will give the employer a grant of up to 85% of the person's salary for the first year and of up to 75% in subsequent years. The grant will also pay for "special needs" such as access to worksite, accompaniment, evaluation of capacities, and medical treatment, in a proportion ranging from 50% to 100%.

In one such programme, (*94*) 300 of the 3000 persons with work integration contracts have a background of serious mental health problems and the state contributes (after several years) 40% of their salary.

5.10.3 Developing social firms (enterprises)

Social firms are small to medium-sized firms which have been developed with the primary purpose of providing employment for persons with a disability in a context which is more or less the same as that of a regular firm, while at the same time offering the required support to workers who need it.

In social firms, persons with disabilities work side by side with nondisabled individuals. All are paid regular wages and work on the basis of a regular work contract. They all have the same rights and obligations (*95*).

"The balance between commerce and care is the single most critical issue which faces social firms, and this balance is achieved differently according to the origins of the firm and the orientation of its founders." (*96*)

Social firms have developed mostly in the last 20 years in order to deal realistically with increasing unemployment ratios and major changes in the nature of work itself, characterized by downsizing, increasing requirement for specialized training, and an ongoing demand for higher productivity. These are all factors that tend to exclude many persons who have experienced severe mental illness.

Mention should be made of the exemplary support offered by the EU for the development and evaluation of social firms, mostly through its Azimuth and Horizon I and II projects. The projects have fostered transnational cooperation which has allowed participating countries to exchange views, experiences, problems and solutions.

The concurrent existence of the Confederation of European Firms, Employment Initiatives and Cooperatives for People with Psychosocial Handicaps (CEFEC) has been extremely useful. CEFEC has acted as a leader and a broker on many transnational issues regarding the employment of persons with disabilities. Recently CEFEC has extended its membership to other countries, and specifically to North America.

CEFEC's charter, principles and guidelines (*97*) provide very useful orientation for the development of social firms.

Using a broad definition of social firms, and including Italian cooperatives, there are said to be in excess of 2000 social firms at this point in time in Europe offering employment to persons with psychiatric disabilities.

"There are some key differences between social firms and regular businesses:

- First of all it is the mission of a social firm to create jobs for people with disabilities and disadvantaged people. Social firms have a social and a commercial mission.
- One of the most important characteristics of a workplace in a social firm is the 'empowering atmosphere' for their employees with disabilities. While in a regular business people with disabilities might be considered as a disturbing factor, social firms do actively recruit from this target group and provide the necessary reasonable accommodations.
- The emphasis is on the potential and abilities of the worker rather than on potential problems and barriers. With this flexible approach work tasks can be arranged and adjusted to accommodate worker needs. This often results in the job being accomplished as quickly and to as high a standard as in any other workplace" (*98*).

All social firms initially receive support from the state. In the most advanced firms, a full market analysis and business plan must be developed prior to receiving the go-ahead.

Several firms, once established, reach 85% self-financing. All firms employ, side-by-side, handicapped and non-handicapped workers. All are paid the regular rate for the sector of employment in which they work.

While the majority of workers are permanent employees, approximately 25% may use the firm as transitional work while 10-15% receive "qualifying training". A good majority of workers are trained on site and all of them receive ongoing support as necessary.

The firms are involved either in the provision of services (office work, recycling, restaurant, catering, landscaping, etc.) or in manufacturing (textiles, computer hardware, furniture, etc.).

Country list of social firms in Europe (1999)

Country	Social firms	Employees	Disabled employees
Germany (1998)	Approx. 300	Approx. 6000	50%
Italy (1997) (type B social cooperatives)	Approx. 1,600	Approx. 40,000	40%
Spain (Andalusia)	8	340	50%
United Kingdom	72*	370	36%
Austria (Carinthia & Styria, 1999)	8	200	50-60%
Total	**Approx. 2000**	**Approx. 47,000**	**40-50%**

* Includes 50 "emerging social firms"

Source: Schwartz G, Higgins G. *"Marienthal": a social firm's network.* Netherne Printing Services – Social Firms, United Kingdom, 1999:4.

Because of the differing contexts and variations of each individual's disabilities, and because of the lack of evaluative studies with comparative groups, it is difficult to judge the social firm's efficacy solely in terms of economic independence of its members (*99*). "The performance of an integration company (social firm) may not be judged merely in economic terms, it must also be seen in terms of integration" (*100*).

5.10.4 Utilizing the cooperative movement

There exist various models of cooperatives around the world, but perhaps the best known examples are in Italy where more than 700 cooperatives exist.

Italy is well known for its *avant garde* mental health legislation. Law 180, passed in 1978, stopped admissions to psychiatric hospitals, prescribed treatment and follow-up in "community mental health centres", and allowed hospitalization only in general hospitals of fewer than 15 beds. Regions, departments and municipalities (the mayors themselves) play a key role in the operationalization of the law whose philosophy is based on equality of rights, community integration, and full citizenship, including the right of access to work.

Although they function independently from the mental health services, social cooperatives maintain a close working liaison with them. Many cooperatives share the social firms' philosophy of the need to find a place in the labour market. At the same time they provide a protected workplace for persons with disabilities (*101*).

The importance of social cooperatives was acknowledged in 1991 by Law 381 which describes two types of social cooperatives:

- type A which aim to provide social and health assistance (here the workers are involved in the management of care centres; many provide rehabilitation packages and professional education and programmes);
- type B which aim to promote job opportunities for people with disabilities.

Both types of social cooperative must employ a minimum of 30% of persons with disabilities in order to receive government grants.

Given the fact that several younger persons are no longer satisfied with the type of work which traditional cooperatives have been offering them, there has been considerable effort in the last few years to find new types of work which would be more suitable to a younger people who often have more education than in the past (*102*).

5.10.5 Other international examples

Several examples show the great variety of possibilities which exist in the development of social firms and other types of programmes that promote the employment of persons with serious mental illness.

More recently, a number of initiatives have involved the provision of white collar jobs for persons with serious mental health problems, as opposed to jobs which are close to the minimum wage.

In the United States, Project Employ (part of the President's Committee on Employment of People with Disabilities) has identified programmes which offer white collar office occupations (*105*). The common features of most of these new programmes involve the following: many were initiated by large corporations themselves and corporate contacts were systematically used; individualization of job development is the rule rather than the exception, even though it is more costly; several initiatives came from local governments.

Good practice: an American bank

A large US credit card lender provides a variety of jobs for people with cognitive disabilities. This includes positions in clerical support, the mail centre, the copy centre, the fitness centre, environmental services, fleet services, and landscaping. In 1990, a parent advocate approached the company to discuss jobs for people with cognitive disabilities. The chairman made the initial corporate commitment. An in-house staff member assists the managers and co-workers who are mentors to the individuals with disabilities with techniques to give meaningful instructions, encouragement and needed support.

Of the 36 jobs at the company, 20 are nontraditional. Salaries are between US$ 13,000 and US$ 20,000 annually, plus up to US$ 2000 in individual and company performance incentives. All personnel are evaluated after six months and are eligible for merit increases. People receive full company benefits, including health care, life and disability insurance, pension and retirement plans.

Thirty-five employees with disabilities work 40 hours per week, and one works 20 hours per week.

Source: *Supported Employment InfoLines* (*106*).

Good practice: A complete furniture factory, Spain

A major Spanish NGO has created 12 service centres employing more than 800 handicapped persons who fill 183 service contracts (*104*).

In Cabra, Andalusia, they run a commercial furniture factory employing 212 persons, the vast majority having had long stays in psychiatric hospitals. The factory is very modern and has several separate assembly chains where the needs of individual workers are taken into account. There is also a large showroom and the products are sent throughout Europe and even to America.

Most workers live where the NGO is located and they are very well accepted owing, among other things, to the constant cooperation between the city council and the workshop leaders. Seventy workers live in an Andalusian type of residence with a swimming pool next to the factory.

The NGO also has a research centre affiliated to the University of Cordoba where the emphasis is placed on scientific and technical research in rehabilitation with emphasis on computer technologies.

All workshop workers receive salaries equivalent to those of workers in regular industries. The workshop is 90% self-financing.

Like all European programmes mentioned here, this NGO receives material help within the framework of the Horizon and Helios 1 and 2 programmes put together by the EU.

Good practice: Service Cooperative, Italy

This cooperative was founded in 1981 as an "integrated cooperative" because its members both worked together and supported each other.

The cooperative has grown from 9 members to more than 500.

The cooperative offers:

- cleaning services (interior and exterior cleaning in schools, public offices, private homes, industrial buildings and district health offices);
- social services (assistance to elderly and handicapped persons, programmes for children, and work training programmes;
- upkeep of parks and gardens, and reclamation of run-down green areas, using specially trained staff (defence of the environment in cooperation with private individuals, firms, and public entities);
- general maintenance activities (plumbing, electrical work, house painting) (*103*).

Good practice: Gardening project in Milan, Italy

A few years ago, 12 patients were discharged from a psychiatric hospital in Milan, Italy, to be followed up as outpatients. They all found living accommodation either with their families or in apartments with some supervision close to the hospital. They tended to be somewhat passive until a formal work training programme was offered to them in gardening by a cooperative that had been recently created and subsidized by the regional government.

After an apprenticeship of a few months, the cooperative obtained a formal, year-round contract from three suburbs of Milan. This included seeding, planting, looking after flower arrangements and grass, and general maintenance of public gardens.

Within 4 months of initiating their work, all ex-patients had moved to the areas where they were working.

The project includes two monitors who are professional gardeners. All employees are paid the regular rate corresponding to their job.

Harnois, G.: The Role of Work in Psychosocial Rehabilitation – European Union Symposium on Training and Employment for People with Psychosocial Disabilities, Sweden, October 14-16, 1994.

Good practice: An olympic task, Montreal, Canada

An adapted work centre with a yearly budget of $5 million Canadian dollars, of which 25% comes from the Quebec Office of Handicapped Persons (OPHQ). This centre has a staff of 203 persons, of whom 55% have had serious mental health problems.

A small factory at the head location makes carton products for offices. The larger portion of the enterprise has a 5-year contract for cleaning of the Olympic sites and village.

There are 11 teams of 12-16 persons deployed around the clock. In order to ensure full availability, 20 persons are on a standby list. Most of the workers are unionized and are paid union wages.

The employees are very proud to wear their company uniforms. There are very few dropouts.

In order to lessen the stigma problems associated with mental illness, a special educational programme is offered to the non-handicapped employees.

Taking the OPHQ subsidy into account, the company is 75% self-financing.

The majority of handicapped employees freely admit that they would be unemployed but for the existence of the programme.

The board of directors comprises 10 persons, of which 5 are from the private sector, mostly banking. The board also includes one user.

Good practice: A mental health NGO in Northern Ireland

"Through work to health" is the motto of this NGO which operates in Northern Ireland to promote employment opportunities for people who are recovering from mental ill-health. It is one of the largest regional voluntary sector organizations in the United Kingdom providing vocational rehabilitation and personal development training programmes with employment placement and support. Over 1000 adults participate in a range of programmes each year and about a quarter of them move to either full or part-time employment or other training organizations.

A quality provision

This success is due to a number of factors. One clearly relates to the encouragement and training provided to the trainees. The organization's efforts have obtained regional and national recognition in the United Kingdom National Training Awards competition in 1997 and 1999. The other has to do with the strong links which have been established with over 300 of the largest employers in Northern Ireland. Indeed, since its earliest days the work of the organization has been led by businessmen helped by health professionals.

Partnership working

Great importance is attached to maintaining ongoing links with employers and this is promoted on two levels. One had been secured as the result of the organization being successful in attracting subcontract work – based on quality, price and time delivery – from a range of companies. The other is due to the personal links established with human resources departments by the employment service officers. This has helped to overcome the stigma which is still attached to mental illness and, more importantly, has ensured that ongoing help is available to both the employer and the trainee once a job placement has been secured. A range of organizations from many parts of Europe has studied the methods employed by this NGO.

Good mental health makes good business sense

The organization has also recently adopted a more proactive approach by encouraging employers to promote positive "mental health in the workplace" policies. This makes good business sense, as there is clear evidence about the loss of production allied to the litigation which can arise if employees seek compensation payments as the result of work-related stress. To that end, a consultancy and training service to industry has just been launched with the full support of employer organizations, including the Institute of Directors.

There is no health without mental health

This NGO is also proactive in promoting a positive understanding about mental health and has launched a "Design for Life" competition aimed at the student population. Information packs about this innovative competition were circulated to all post-primary schools and youth groups across Northern Ireland. The response was encouraging.

Further information can be obtained from: Cecil Graham, Chief Executive, Action Mental Health, 19 Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8BH, Northern Ireland.

Chapter 6
Discussion

The issue of work and mental health has been explored from two different perspectives. The first emphasized mental health problems that may arise in employees who have an employment history. The second addressed the issue of making employment accessible to persons who never had a job, or have lost it due to serious mental illness.

The magnitude of mental health problems in the general population and in the working population tends to be highly underestimated. The percentages of the population that admitted having had any psychiatric disorder during their life were: Brazil (36.3%), Canada (37.5%), Netherlands (40.9%), USA (48.6%), Mexico (22.2%) and Turkey (12.2%) (*107*). It was also found that the highest prevalence rates occurred amongst the youngest age group with the lowest socioeconomic status. Further, most individuals with mental health problems do not receive professional help.

With respect to the impact of mental health problems at work, a major study (*108*) suggested a prevalence of 18.2% for any mental health problems. Work impairment is always higher in workers with comorbid psychiatric disorders (more than one disease at the same time). "The average number of psychiatric work days loss was 6 days per month per 100 workers, and the average number of psychiatric work cutback days was 31 days per month per 100 workers."

Clinical depression is a major workplace health issue. Employers are beginning to recognize its implications for productivity and, fortunately, there are effective treatments which lead to positive long-term results.

Loss of productivity is often substantial, especially since absenteeism caused by mental health problems can be prolonged, the more so if it is not officially recognized and adequately addressed as part of the health coverage benefits available to the employee. There will be instances in which mental health problems appear to be mostly related to difficult working conditions. In other cases, the illness may appear regardless of the nature of the work environment. Whatever the etiology, the issues must be addressed adequately.

Employers of all sizes are beginning to recognize that depressive disorders often constitute their single highest mental health (medical) and disability cost. Employers experience expensive consequences of depression through absenteeism, lower productivity, disability, accidents and the inappropriate use of medical services (*109*). A large percentage of employers understand the relationship between health and productivity and are improving their management strategies by developing and implementing programmes supportive of work/family/life issues, such as flexitime, part-time schedules, child care benefits, personal leave, wellness health programmes, and family counselling. Innovative employers have developed prac-

tices in conjunction with their health and human resource systems for managing both the direct and indirect cost consequences of mental illness in general and depressive disorders in particular. To recap briefly, these employers are encouraging early recognition, appropriate and cost-effective care management, accommodations, and timely return to work. This is especially evident with the larger employer (over 1000 employees) who is more apt to have the resources in terms of time, staff and capital expenditure. It is important to note, though, that smaller enterprises (under 50 employees) can partially implement aspects of these programmes without incurring financial costs.

Access to sustained employment for individuals with serious mental health problems is a more difficult issue to address.

Serious mental illness affects approximately 2% of the world's population. It results in persons having much difficulty in fulfilling the role which they may have set for themselves in life. Those individuals no longer live in institutions for long periods of time; the vast majority are in the community where they often receive inadequate follow-up.

Even though more than 70% of these people would like to work, only 10-12% do in fact work, all too often in jobs that do not correspond to their liking and capacities. In contrast, the employment rate of other forms of disability is in the vicinity of 50%.

Most countries have legislation which basically states that disability does not constitute valid grounds to deny someone the right of access to equal opportunities, including that of competitive employment.

Within the realm of disability, persons with serious mental illness are particularly vulnerable. We have reviewed how one can overcome obstacles related to ignorance, prejudice and stigma. The concept of rights to equal opportunity fully justifies taking all measures to facilitate access to paid work for those who wish it and are capable of it. Globalization, privatization and downsizing are not valid excuses for social and economic exclusion of individuals with mental health problems.

The "users" themselves now increasingly utilize "empowerment strategies" to demand proactive policies and coordinated action.

Perhaps the single most important myth that has been dispelled is that nothing much can be done for the clientele with serious mental health problems.

Perhaps the single most important myth that has been dispelled is that nothing much can be done for the clientele with serious mental health problems. There is now a very important body of scientific knowledge attesting to the contrary. The skills and tools exist to treat and to facilitate meaningful life in the community and they have been proven successful. Numerous examples of "good practices" have been mentioned. Very often, the most successful stories involve cooperation between the private and public sectors.

The ongoing creation of social firms (enterprises) testifies to the fact that it is possible to function in an entrepreneurial manner and to be competitive, while at the same time not sacrificing the social needs of persons with serious mental illness on the altar of unrestricted profitability. Data now prove that successful employment programmes not only exist but that they can be very cost-effective.

Given the magnitude of the problem, it is expected that government-supported initiatives will remain the rule rather than the exception. We have noticed with approval the active involvement of the EU in support of the development of "model programmes" in 11 countries. Many of these programmes now function in a largely autonomous manner.

Once an employer recognizes that mental health problems are probably the single most important factor responsible for the disability of employees, it makes sense to recognize mental health as a legitimate concern of the organization.

We now know that there are effective preventive and promotion programmes as well as those for treatment and rehabilitation.

The promotion and prevention programmes will attempt to create a climate that fosters motivation and commitment, reduces obvious stressful agents and promotes harmony among co-workers. The good practices in this monograph illustrate the importance of health education in order to increase awareness of factors affecting mental health and well-being; screening programmes to detect risk factors or early signs of stress-related illness; and communication, clear work goals and participation of employees in this process. In addition, occupational health services and employee assistance programmes are instrumental in implementing promotion and prevention activities.

Treatment programmes should include the capacity for correct diagnosis, remembering that often mental illness "hides behind physical signs and symptoms". Quick access to and intervention by competent medical and professional staff will be called for. Integral to quick access and early intervention of appropriate medical treatment for individuals is reducing the stigma and shame associated with mental health problems. As discussed, often an individual will not seek treatment or will delay seeking it because of the stigma associated with mental illness. Furthermore, there is a need for more easily accessible mental health treatment programmes.

Rehabilitation programmes will emphasize the requirements for a prompt return to work by focusing on necessary accommodations to the work situation, as well as required support to the individual. The good rehabilitation practices highlighted in the monograph encourage high levels of client participation in all aspects of the rehabilitation process. This also includes the participation of an individual's support system such as family members, a mental health professional, case manager, vocational counsellor and work supervisor. A successful timely return to work and the identification of necessary accommodations needs to involve the client as well as his/her support system.

Breaking the cycle of discouragement and eliminating the numerous societal barriers that effect employment are key to enhancing the economic and social integration of people with mental health problems.

Breaking the cycle of discouragement and eliminating the numerous societal barriers that affect employment are key to enhancing the economic and social integration of people with mental health problems (*110*). We must consider the mental health system and its influence on challenging negative stereotypes as well as encouraging employers to implement good practices. It is important to recognize that in many parts of the world the mental health delivery system often discourages an individual from entering the workforce or returning to work after a diagnosis of mental ill-health, despite stabilization of symptoms. Although there is an increasing emphasis on employment and re-employment, there is still a tendency by mental health and rehabilitation professionals to minimize the importance of work for many individuals, particularly for strengthening and maintaining recovery. Furthermore, the system of financial supports for individuals with mental health disability is a disincentive for employment. Financial concerns are often cited as a major contributing factor to discouraging a person with a mental illness from seeking employment, education and training opportunities (*111*). It is important that these issues be fully understood as they impact employment prospects.

This monograph has illustrated that steps can be taken to help reduce barriers to employment and the systematic cycle of discouragement. For example, early and timely intervention, networking and client participation in identifying and setting goals are all elements of effective programmes sponsored by some employers and vocational rehabilitation agencies. Engaging all individuals in early discussions about work and recognizing that the purpose of early discussions may ultimately help an individual identify realistic goals and strategies for achieving these goals. Early intervention, for example, in recognizing and ameliorating the impact of workplace stress has shown to be effective in reducing stress-related absenteeism. Accessing resources and referral information to become more knowledgeable in assisting individuals in exploring vocational supports and services are important components of networking. Furthermore, using community resources such as state or local rehabilitation agencies and support groups may aid in the successful return to work of an employee. For the mental health and rehabilitation professional, in particular, learning about all of the options available within the surrounding community – including details about types of employment programmes, eligibility criteria and key contact personnel – is a good practice in assisting the individual to find employment or re-employment (*112*). Lastly, it is important to recognize the impact of family and/or significant others on an individual's choice to engage in education, training or employment activities. A person recovering from mental illness may be reluctant to pursue work-related goals that may reflect the concerns of the family who fears that stressors may occur that could trigger a relapse. Within this context, the family and significant others are often relying on the mental health professional for information regarding resources in their communities for rehabilitation and support.

Chapter 7
Conclusion

The central themes of this monograph were: to address the importance of work for people with mental health problems; to discuss the different vocational strategies and programmes for people with a mental health disorder; and to consider the role of the workplace in promoting good mental health practices for employees. Integral to these themes is the identification of good practices by employers as well as vocational rehabilitation agencies and professionals.

It is clear that there are many factors involved in addressing the importance of work for people with mental health problems, as well as identifying effective practices that encourage employment, re-employment and retention. Social support systems, mental health professionals and employers all have a significant role in helping individuals define options, make choices, learn to manage potentially disabling conditions, and avoid long-term hospitalization. The ultimate goal is for individuals to obtain and/or return to gainful, worthwhile activity, such as meaningful work (*113*).

Access to satisfying work remains one of the most sought-after goals of the adult population of most countries. Employers, employees and unions are starting to realize that, for this population, mental health problems are the single most important cause of disability responsible for a global burden of disease larger than that due to infections, AIDS, cancer and physical accidents. The impact of mental health problems on absenteeism, productivity and job satisfaction is only starting to be realized.

Given the importance of work, and due to advances made in the prevention, treatment and rehabilitation of persons with mental health problems, it makes eminent sense to address all aspects of the mental well-being of employees.

For the same reasons, the disability associated with severe mental health problems can no longer serve as an excuse to deny those who so wish reasonable access to competitive employment. It is a precondition to full citizenship.

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Videos

Nations for Mental Health video: Sriyawathie – Rehabilitation of chronic psychiatric patients in Sri Lanka.

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