

MAKING EMPLOYMENT WORK

**for people with experience of mental
illness**

**A review of research on the nature of effective
employment support services**

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Executive Summary

Why employment is important for people with experience of mental illness

Levels of unemployment

Across the developed world unemployment is higher for people with experience of a mental illness than for people in the general population. Unemployment is higher internationally for people with experience of a mental illness than for those with other types of disability. Individuals with both a mental and physical disability experience more unemployment than those with one disability. Rates of employment are particularly bad for people with experience of severe mental illness.

People with experience of mental illness want to work

Despite this, most people with experience of mental illness consider employment to be a priority, whether they are from New Zealand, the United Kingdom or America. In New Zealand 80% of people on a sickness or invalid benefit, due to mental illness, are estimated to want to work, and vocational services have been identified by mental health consumers as one of the top unmet needs.

Barriers to employment

There are many barriers to employment for people with experience of mental illness. Barriers include interrupted schooling, lack of qualifications and limited work experience as well as 'internalised stigma' whereby individuals believe that they are not capable of working or that they will not be hired because of their illness, is another barrier.

Other barriers include the negative attitudes of mental health staff and employers in respect of the ability of mental health consumers to cope with work and make good employees. Fear of losing social welfare benefits holds many people back from taking on paid work, as do practical difficulties such as lack of transport and money. Limited employment support services and lack of workplace accommodations (such as flexible hours) also form barriers.

One of the biggest barriers to work, both in New Zealand and overseas, is benefit policy and administration. Consumers fear a reduced income as a result of losing allowances when they enter paid work, or being ineligible for the same benefit if they have to stop work due to illness.

Positive consequences of employment

Employment has been found to have a number of positive consequences. Employment tends to be followed by greater well-being, reduced symptoms of mental illness, more compliance with medication, lower relapse rates, better quality of life, and increased social contact and use of leisure time. Competitive employment in the open labour market is associated with reduced symptoms, greater satisfaction with services, improved leisure and finances, and higher self-esteem when compared with sheltered work and

minimal work. Continuous work by people with experience of mental illness, over a ten year period, has been found to result in a \$700,000 saving in benefit costs in Canada.

In contrast, unemployment is associated with worse mental health, including greater likelihood of anxiety, alcohol and drug abuse, distress, suicidal thoughts and death by suicide. It also tends to result in lower earnings in future jobs and decreased employment chances, especially when it goes on for some months. Risk of crime is also higher for people who are out of work. This research has been carried out with the general population, but it is likely that the same consequences result for people with experience of mental illness.

The success of approaches to improving employment levels

Supported education

More years of education and qualifications are associated with better employability and earnings in the general population. A number of barriers to participation in education exist, including mental health, finances, competing responsibilities and discrimination. Supported education involves helping individuals with mental illness to identify training or education that is congruent with their career goals, applying for courses and financial assistance, and coping with study. It can be on campus or off campus. Rigorous research on outcomes of supported education is lacking. What research there is suggests that supporting people increases participation in post-secondary study, and may improve employment rates. However, more research is needed to be able to conclude that supported education has an impact on rates of competitive employment for people with experience of mental illness.

Vocational training

The traditional approach of providing work experience, social skills and generic work skills training to the point of 'work readiness' before starting job searching has not resulted in high levels of competitive employment according to the most recent and rigorous research. However, there is limited rigorous evidence of training programmes that do improve employment rates. Time-limited training which focuses on work-related skills such as social skills, problem solving and managing work tasks appears more effective than traditional pre-vocational training. In addition, it seems that training which takes place once a person is searching for work or in work, and takes into account their skill needs and the specific job, is both more acceptable to individuals, and more effective.

Supported employment

Supported employment involves actively seeking work opportunities on behalf of people with experience of mental illness, and supporting individuals in the job search process and once they are in work. It does not require prior involvement in training or unpaid work experience, and emphasises consumer choice of work type and conditions. Many reliable and high quality studies show that supported employment is more effective in increasing employment rates than any other approach it has been compared to, including

standard community care, a psychiatric rehabilitation centre, sheltered work and pre-vocational training. Supported employment is also associated with higher work hours and earnings than other approaches, although levels of retention in both services and work are still somewhat problematic.

The aspects of supported employment that appear most important to its success include rapidly moving into the job search phase rather than waiting for 'work readiness' to be achieved, aiming for competitive employment in the open market rather than other types of settings, and integrating clinical services with employment services. Self-help employment centres, run by professional staff and mental health consumers, have also shown some potential for effectiveness, although more research is needed to confirm this.

Sheltered employment

Sheltered work is defined as work alongside largely staff and other people with experience of mental illness, for rates of pay below market rates, in environments outside the competitive work market. The best-known forms of sheltered work include sheltered workshops, the Clubhouse work ordered day, work crews and work enclaves. Social firms do not fall as clearly into the sheltered employment genre as they involve only small numbers of people with psychiatric disabilities, and pay market rates in fairly normal employment conditions. The lack of high quality research on sheltered employment hampers efforts to come to clear conclusions about its effectiveness. But the best of the research suggests that movement from sheltered work to competitive work is very low compared to supported employment. This is the case even for social firms, which are more socially inclusive than traditional sheltered workshops. The lack of empirical evidence is not the only consideration with regard to sheltered work options are less preferable because they exclude people from the mainstream activities of society simply because they have a disability.

What is most effective in helping people find work

There is no doubt from the international research (i.e. research from New Zealand and overseas) that the single most effective approach in increasing rates of competitive employment for people with experience of mental illness is supported employment. No other approach comes close to achieving the same results for employment rates, although rates of retention in services and jobs are still an issue.

What is least effective in helping people find work

The least effective approaches to increasing competitive employment rates are traditional forms of pre-vocational training along with sheltered work in all its forms. There is currently insufficient evidence on supported education, Clubhouses, social firms, work crews and alternative forms of training to make firm conclusions on their efficacy.

Factors that affect employment

Job/marketplace characteristics

There has been little research on wider factors that affect employment rates for people with experience of mental illness, including characteristics of the marketplace. Some studies suggest that work that has more change and variety is associated with higher rates of retention, as is work where less autonomy is required. The benefits system has been found to affect the rate at which mental health consumers are willing to move into open employment and more flexible benefit systems may enhance employment outcomes. Lastly, there does not seem to be sufficient evidence at present to come to any conclusions about the effect of employment rates in the general population on employment rates specifically among people with experience of mental illness.

Service characteristics

The picture is clearer when it comes to the specific characteristics of services which make positive employment outcomes more likely. The freedom to choose both type of work and hours of work is associated with more work satisfaction and longer time in work. Interventions that focus on competitive work only, rather than training or work experience prior to work, appear more effective in placing people into competitive work. Payment for work appears to increase participation rates, and some psychological interventions such as cognitive training, social skills training and family therapy appear to have the potential to aid employment outcomes when used in combination with employment services.

Medication to manage specific symptoms could aid employment outcomes, although research on this is not conclusive. Extended support and greater intensity of support from vocational staff, going beyond the normal one to two year support period, appears linked with better rates of competitive employment. Lastly, integrated teams of clinical and vocational staff are associated with better retention rates in services and employment rates.

Consumer characteristics

Identifying characteristics of people with experience of mental illness that have an impact on employment rates may have potential to help design more effective employment services. However, this is not an argument for excluding particular consumers from employment services which should be open to all both as a matter of principle and because there is evidence that such services are effective irrespective of consumer characteristics.

Greater levels of work experience and better previous work adjustment predict better work outcomes, as do qualifications, especially at the secondary level. Better work-related skills and habits also make good work outcomes more likely. Symptoms of apathy, withdrawal and depression affect employment negatively, as does poor cognitive functioning, including attention difficulties and information processing problems. Chronic and severe experience of mental illness with little experience of recovery is associated with less continuous employment and less current employment than one or

two episodes of illness with good recovery. Consumers with a number of characteristics associated with poorer employment outcomes may need more support or specific types of support to find and stay in work long-term. Employment services which are tailored to meet these needs might improve rates of retention in work.

Improving retention in employment services and jobs

Despite the effectiveness of supported employment, dropout rates from services and jobs remain an issue. Research suggests that retention in employment services could be improved by providing information sessions on what supported employment offers at the start, paying people to take part in supported employment, integrating clinical and employment services to make it easier for people to use them, and moving clients rapidly into the job search process rather than requiring they take part in prior training or work experience. Integration of employment and clinical services also seems to hold potential for improving retention in work through addressing problems with illness symptoms, medication and work tasks that are fairly common reasons for quitting jobs or being fired. The liaison and co-operation of employment and clinical staff on addressing these issues has been indicated as a fruitful strategy.

Accommodations in the workplace have also been reported as improving job retention. Individuals particularly identify flexible work hours as an accommodation which does help them stay in jobs. Matching clients with work and conditions of their preference also holds potential for improving work outcomes. Finally, training at the three to six month period in a job is indicated for those who are experiencing difficulties, particularly those with less prior work experience, who are at greater risk of leaving their jobs. Training appears to be most useful when it addresses the skills that the individual needs to cope with the job and with managing work and illness in general.

General principles of effectiveness

Consumer characteristics

Placement in work is more likely when the following characteristics of consumers are taken into account when providing services. This list is not meant to suggest that people with (or without) these characteristics should (or should not) not be eligible for work placement services, but that some people may require more support, specific types of support, or support at specific times, in order to stay in work and succeed. The main findings are:

- Individuals who have less work experience are less likely to succeed at work, suggesting that aiding people to gain more competitive work experience is a high priority, and that people with less work experience may need more support to succeed in work
- People with experience of mental illness who have more years in education and qualifications (secondary and post-secondary) are more likely to find work and earn more, so informing clients of employment opportunities and benefits, and supporting them in studying is indicated, particularly for those with less education

- Consumers who have better work-related social skills do better at work, suggesting that training in these skills could be beneficial for those who lack them, preferably once they are searching for work or in work and can apply these skills on the job. These skills include interview skills, grooming and presentation, relating to colleagues and supervisors on the job and coping with tasks at work that require social interaction
- Symptoms that impede work, such as withdrawal, lethargy and symptoms of depression are associated with worse work outcomes. Clinical and employment services working together may aid people to stay in work and perform at a higher level. In addition, clients with these symptoms may need more employment support to succeed at work
- Chronicity and severity of illness is associated with poorer work outcomes, suggesting that people may require higher levels of support both to stay in placement services and succeed at work, and attention to clinical issues may be particularly useful in aiding work outcomes for these individuals
- Attention to cognitive functioning issues, such as memory and attention, for people who have difficulties in this area, may aid retention in work and work performance
- Successfully managing the mix of mental illness symptoms, medication, interpersonal relationships at work and work tasks is associated with success at work, suggesting that providing tailored support and training in skills to help manage these tasks may improve work outcomes.

Training services

Based on research on both general training programmes and training specifically with people with experience of mental illness, training is most likely to enhance employment outcomes (i.e. competitive work placement, retention in work, earnings) when it has the following characteristics. The evidence for this is not as strong as the evidence for employment services. To enhance employment outcomes:

- Provide training that is linked to local employers and the skills needed for work in the local marketplace
- Include a high level of work-related content rather than ‘generic’ work training
- Emphasise consumer preference and choice in training and work choice (i.e. do not place an individual in training simply because there are vacancies for people with those skills)
- Train in social skills related to the work-place in particular, including interview skills, grooming and presentation, and skills needed to get on well with others in the job
- Provide training once job searching or employment is underway, rather than prior to job searching
- Make training time-limited whenever it occurs, not to the point of ‘work readiness’ or other open-ended criteria
- Match training to the needs of the individual and the needs of the job, including the tasks and any difficulties that the person has in the workplace

- Use training staff who are committed to placing and keeping people with experience of mental illness in competitive work
- Pay people for their involvement in training
- Use cognitive interventions and teach skills to solve problems, cope with work stress and interact successfully with colleagues and supervisors.

Supported education

There is little rigorous research in this area, and the evidence is the weakest of all areas. This dearth of research makes it difficult to comment on what makes education services investigated through the present review most effective. Based on the Mowbray and Collins 2002 review, the following principles are tentatively suggested:

- Increasing educational involvement and qualifications has the potential to improve employability, work options and earnings
- Students take part in study out of personal preference rather than being coerced to do so
- Choosing courses and qualifications to embark on is done as part of the career planning process
- Students take part in courses that lead to academic or vocational qualifications that are recognised by themselves and employers, preferably in mainstream settings
- Supported education is based on alliances between five key stakeholders: mental health systems, academic institutions, vocational rehabilitation agencies, family members and consumers
- Staff involved in supported education have knowledge of supported education as a type of rehabilitation
- Supported education staff provide services relating to education issues, while mental health treatment is provided by clinical staff
- Staff (clinical, employment and education) have positive attitudes towards the ability of people with experience of mental illness to study and take part in competitive work
- Assessment of students' mental health, educational and rehabilitation needs takes place
- Barriers to education are identified and addressed, including policy, resource and administrative barriers, as well as the challenges of people coping with psychiatric illness
- Support is provided by staff and/or peers, on campus or off campus
- Support includes helping people cope with stress, providing information on courses, finances and assistance, giving practical help (e.g. helping fill out forms, helping people gain social acceptance in educational settings, and liaising with support staff at academic institutions to make sure students get all the services they are entitled to and need).

Employment services

The research evidence in this area is strongest of all, although not all the following points are based on equally strong research. The strongest findings are:

- supported employment services are more effective in placing people into work than other types of service, including sheltered work, training, or Clubhouses
- support from both employment and clinical staff is provided to clients for at least one to two years
- consumers actively participate in employment services and support
- vocational services are integrated with mental health services rather than clinical services brokering clients to separate employment services
- services that accelerate individuals straight into competitive work rather than delaying employment to take part in training or work crews
- services aim to place people in competitive employment as a priority
- improving work experience and adjustment increases employability.

The following points are based on less rigorous research, contradictory research or need more research to become strong points:

- consumers choose the type of work/training/education they want to be involved in, and work the hours they choose
- people receive ongoing, time-unlimited support once they are gain work
- people are matched with jobs that suit their preferences, symptoms and diagnosis
- employment does not make consumers financially worse off as a result of working, due to loss of benefits that are not compensated for by employment
- starting supported employment with two sessions of information about the service can improve retention in services
- providing complementary interventions (e.g. family therapy, cognitive-behaviour therapy) may aid employment outcomes
- assessment of clients is continuous throughout job search and placement
- increased support, at the three to nine month point in placement, can improve retention in work, particularly for people with lower levels of work experience.

Introduction

There is now strong evidence that employment services for people with mental illness can increase the rate at which consumers move into work and the amount they earn. Most effective are specialist employment services which move consumers rapidly into open-market jobs of their choice. These employment services work best when integrated with mental health treatment teams (Crowther, Marshall, Bond & Huxley, 2001, 2003; Schneider, Heyman & Turton, 2002).

The present review highlights some of the issues surrounding employment for people with experience of mental illness, including high levels of unemployment, positive consequences of employment and barriers to employment. The evidence for the effectiveness of different types of employment support services is then explored. This is followed by a consideration of the factors which have an impact on getting work, including characteristics of interventions, jobs/workplaces and individuals. The paper concludes with an analysis of the most important characteristics of services involved with supporting people with experience of mental illness into work.

Research from New Zealand and overseas was reviewed to determine what is most effective in increasing rates of paid employment among people with experience of mental illness. While some aspects of overseas systems (particularly benefit systems) differ from New Zealand, the international research on training, education and employment was carried out with similar client groups and interventions to those in New Zealand, making it broadly relevant to this country. As there is very little New Zealand, or even Australian research available there is unfortunately an unavoidable dependence on overseas research when assessing 'what works'.

One factor that should be taken into account in reading this review is that it is narrative rather than systematic nature. Although a few unpublished studies have been included the focus of the review was on studies that have been published, which may be more likely to show positive results. This may skew the findings somewhat. Moreover, while the search for published articles took in most of the major social science/medical databases, it was not exhaustive.

In addition, analysis of studies located through the search was narrative rather than systematic in style, meaning that individual studies were not analysed and rated in a tabular form with regard to rigour, reliability and replication. This could also skew findings towards a less objective, balanced view of outcomes. Many of the findings were drawn from other narrative reviews, which may have had their own errors or biases. Data on some areas were also very hard to find.

One check on bias was that more emphasis was placed on systematic reviews, meta-analyses, more rigorous studies and replicated findings rather than on narrative reviews and un-replicated or quasi-experimental findings. A further check on bias was provided by the peer reviewing system used. The draft literature review was peer reviewed by two international experts in the area, Dr Justine Schneider from the University of Durham in

the United Kingdom and Dr Gary Bond from Indiana University in the United States. Dr Schneider was lead author of the comprehensive 2002 review “Occupational Outcomes: From Evidence to Implementation” commissioned by the UK Department of Health. Dr Bond is the author and co-author of many studies and articles on employment services for people with experience of mental illness. He was also one of the team of researchers who carried out the systematic review of randomised studies of employment services for the Cochrane Collaboration (Crowther et al, 2003), which is regarded as the definitive review of the area. Other peer reviews were carried out by New Zealand experts from the Ministry of Social Development, Mental Health Commission, Mental Health Foundation and New Zealand employment support services. The comments of reviewers were taken into account in producing the final version of the literature review.

Section One: Background issues

Involvement in employment and motivation to work

Key point summary – involvement in employment and motivation to work

- Internationally, unemployment levels are higher for people with experience of mental illness than for the general population or for people with physical disabilities
- Local data specifically relating to mental illness and employment is difficult to find but that this is similarly the case in New Zealand, particularly by Maori and Pacific peoples
- The problem is greater for those with a serious mental illness
- Unemployment tends to be higher for people with experience of mental illness than for other types of disability
- Having both a mental and physical disability tends to result in higher levels of unemployment than having a single disability
- People with experience of mental illness do succeed in finding and keeping jobs
- People with mental illness want to work, according to surveys and studies in New Zealand and overseas
- Vocational services have been identified as one of the top unmet needs in New Zealand, and 80% of people on a sickness or invalid benefit, due to mental illness, are estimated to want to work
- People with experience of mental illness perceive advantages to working as well as disadvantages

Low involvement of mental health consumers in employment

Effective employment services are greatly needed given the relatively high levels of unemployment for people with mental illness, internationally and in New Zealand. International figures are easier to come by than local figures, and there is a great need for better information in New Zealand (Mental Health Commission, 1999).

New Zealand figures

In New Zealand the figures are not disaggregated by type of disability, so statistics quoted here are for all disabilities rather than mental illness specifically. *Disability Counts 2001*, a 2002 Department of Statistics publication on disability statistics, shows that 40% of people with disabilities were in the labour force compared to 70% of people without any disability. 44% of people with disabilities were either working or looking for work compared to 74% of the non-disabled population. This figure is for all types of

disabilities, with psychiatric disabilities making up the fourth largest group, or 15% of all disabilities (Department of Statistics, 2002a).

Information on receipt of benefits in New Zealand casts some more light on the employment situation of people with experience of mental illness. At the end of June 2002, 26% of invalid beneficiaries had a psychiatric disability as their primary reason for being on a benefit, as did 34% of sickness beneficiaries (Ministry of Social Development, 2003). People with experience of mental illness form the single largest group on invalids and sickness benefits, and the fastest growing.

Figures for Maori

It appears likely from general statistics that Maori with mental illness are more likely to be unemployed than other New Zealanders with mental illness. Two sources indicate that Maori are around three times as likely to be unemployed as Pakeha (Department of Statistics, 2002b, 2003). Rates of unemployment for Maori were around 16.8% in 2001 and 9.7% in 2003, compared to 5.6% and 3.3% for Pakeha.

Rates of some psychiatric illness are also higher for Maori than non-Maori. For example, the rate of admission of Maori to psychiatric wards and hospitals for affective psychosis and schizophrenic is twice that of non-Maori. The rate of Maori admissions to psychiatric institutions has increased while general admissions have decreased. In addition, Maori males have double the rate of in-patient admissions for alcohol and drug related disorders of non-Maori (Ellis & Collings, 1997). Maori have higher rates of disability than others— 34% of Maori aged 45 to 60 years compared to 25% of the total population in that same age group (Department of Statistics, 2002a).

All of this suggests that there will be disproportionate numbers of Maori who are unemployed and on benefits due to psychiatric illness. While disability statistics indicate similar proportions of people with disabilities for Maori and Pakeha, benefit figures show that 28% more Maori with experience of mental illness are on an invalids benefits than one would expect from numbers in the general population (19.7% of all people on invalids benefit vs 14% in the general population) (Department of Statistics, 2002a; Ministry of Social Development, 2003). Sickness benefits show an even greater disproportion, with 40% more Maori on these benefits than one would expect from the general population (23.5% of all people on sickness benefits versus 14% of the general population).

Figures for Pacific people in New Zealand

Unemployment figures show that – like Maori – Pacific people in New Zealand are around two to three times as likely to be unemployed as Pakeha. Unemployment rates for Pacific peoples were 16.2% in 2001 compared to 5.6% for Pakeha, and 6.6% in 2003 compared to 3.3% for Pakeha. But in contrast to Maori, Pacific people living in New Zealand use disproportionately less benefit services than would be expected from numbers in the population. Pacific peoples make up 3.8% of invalid benefits clients, whereas they account for 6% of the population aged over 15 years (New Zealand of Statistics, 2002b). This lower number for Pacific peoples may be due to the requirement

for a person to have lived in New Zealand for ten years before being eligible for the invalids benefit (Ministry of Social Development, 2003). Pacific peoples make up 6.9% of sickness beneficiaries, which is in line with the proportion of Pacific people in the total population. Pacific peoples also have similar levels of disability to the total adult population (Department of Statistics, 2002a).

Australian figures

Australian research finds an unemployment rate of 83.7% for people with schizophrenia, which is 10.6 times higher than the unemployment rate for all Australians in 1997 (Waghorn, Chant & Whiteford, in press, as cited in Waghorn, Chant & Whiteford, 2002). Another Australian study found that unemployment rates for people with a psychiatric disability remain persistently above 80% in Australia (Carr & Halpin, 2002, as cited in SANE, 2003).

UK figures

Rates of unemployment for people with mental illness are also high in the UK. Among people with long-term mental health problems, in the inner London Borough of Wandsworth, unemployment levels were 80% in 1990 and had increased to 92% by 1999. For those with a diagnosis of schizophrenia, unemployment started at 88% in 1990 and grew to 96% in 1999 (Perkins & Rinaldi, 2002). A recent review noted rates of 61 to 73% unemployment reported in the UK (McCreadie, 1992, Meltzer, 1995, as cited in Crowther et al, 2003). Schneider et al (2002) estimated that only 17% of the working age men and women in the UK who report they have a mental health need, are in any kind of employment. Another very low estimate is that only 4 to 12% of people with serious mental ill-health are employed in the UK (Perkins & Rinaldi, 2002; Secker et al, 2001b, as cited in Seeborn, Grove & Secker, 2002). Competitive work (holding a regular paid job in the community) has been estimated at 20% for people with severe mental illnesses (Lehman, 1995, as cited in Bustillo, Lauriello, Horan & Keith, 2001).

US figures

Unemployment rates of 75 to 85%, among individuals with experience of mental illness in America have been reported (Lehman, 1995, Ridgeway, 1998, as cited in Crowther et al, 2001) somewhat contradictory, in contrast other US figures reflect that around 28% to 56% of Americans, with a mental illness, are unemployed (McAlpine & Warner, 2002). A study of a range of health conditions found that mental illnesses had the second greatest negative impact on employment levels after central nervous system trauma (Wilson, 2001).

Figures for people with experience of severe mental illness

The problem is greater for those with a serious mental illness. National US surveys highlight that people with schizophrenia, and related conditions, have the highest levels of unemployment, with around 60% to 78% unemployed (McAlpine & Warner, 2002). Similar figures for New Zealand were not located.

Historically, people with severe mental illnesses have shown lower levels of employment, post-discharge from services, than other disabled groups in the US

(Malamud & McCrory, 1988). A review carried out in the 1970's showed that only 10 to 30% of people with severe mental illnesses in the US were employed in the year following discharge (Anthony, Cohen & Vitalo, 1978, as cited in Malamud & McCrory, 1988). This rate was lower than that of people with non-psychiatric disabilities (e.g. physical, intellectual), although rates of employment improved over years in the community.

Mental illness compared to other types of disability

Unemployment rates are worse for mental illness than for other types of disability. Unemployment rates for Australians with a psychiatric disability are the highest of any disability group (Carr & Halpin, 2002, as cited in SANE, 2003). American research shows that people with a mental illness had a 25% higher level of unemployment than people with other kinds of disability. This was even taking into account an 18% growth in employment of mental health consumers in the US over the study period of 1983 to 1994 (Trupin, Sebesta, Yelin & LaPlante, 1997, as cited in McAlpine & Warner, 2002).

Unemployment for people with multiple disabilities

For those with both a mental disorder and a physical disorder, unemployment rates in the US were higher than for those with a physical disorder only. For example, in a 1994/95 survey, 59% of people with a physical disorder were employed, compared to 36% of people who experience both a physical and mental disorder (McAlpine & Warner, 2002). Another American study, using a data set of 14,000 households, found that employment is significantly less likely for people with multiple health conditions. For those with two or more severe conditions, employment levels can be halved (Wilson, 2001).

Positive findings for employment of people with experience of mental illness

Waghorn et al (2002) note that unemployment does not inevitably follow the experience of mental illness. A 32 year longitudinal study found that 40% of people with a diagnosis of DSM-III type schizophrenia and 45% of those with a diagnosis of DSM-I type schizophrenia, who received comprehensive rehabilitation during the 1950's in Vermont and were discharged by the end of the 50's, were in paid employment twenty to twenty-five years later (Harding et al, 1987, 1989, as cited in Cook & Razzano, 2000). Waghorn et al note that for one half to two thirds of participants in this treatment the:

long-term outcome was neither downward nor marginal but an evolution into various degrees of productivity, social involvement, wellness, and competent functioning (Waghorn et al, 2002: 40).

Bond, however, comments that this finding is controversial and not supported by other longitudinal studies (personal communication). Studies reviewed by Cook and Razzano (2000) show a range of employment rates from 7% to 34% for people with experience of schizophrenia. Cook and Razzano (2000) conclude that no clear trends are apparent from these findings.

More recent research confirms the reality that people with experience of mental illness do successfully hold down jobs in the open market. An American survey found a group of

500 people who had held down professional or managerial jobs without formal employment support. Despite experiencing serious illnesses such as bipolar disorder, schizophrenia and major depression this group managed their employment by taking breaks from work, using medications and therapy, seeking support from their social circle, and negotiating flexible working conditions (Ellison & Russinova, 1999). As following sections show, low employment rates are not due to any lack of motivation to work, but more to the many barriers to employment that people with experience of mental illness face.

People with experience of mental illness want to work

New Zealand consumers selected access to vocational services and day time activities as their highest unmet need in a survey of 521 users of mental health services (Kydd, Mahoney & Turbott, 1997, as cited in Warriner, 2003). In New Zealand, the Ministry of Social Development estimates that 80% of people on sickness and invalid benefits, because of mental illness, would like to be able to work, and that 20% already access vocational services. At the end of June 2002, 26% of invalid beneficiaries (16,500 people) and 33% of sickness beneficiaries (12,000 individuals) had a psychiatric disability as their primary reason for being on a benefit, (Lapsley, 2003).

Overseas surveys consistently show that most people with experience of mental illness want to work, even when they have been out of the labour market for many years (Bates, 1996; Rinaldi & Hill, 2000, both as cited in Seebomh et al, 2002). In the UK, two-thirds of people with experience of mental illness, who were surveyed, said they wanted to work, no matter how severe their symptoms and disabilities appeared (Young, 2001, as cited in SANE, 2003). Mental health consumers overseas have identified meaningful occupation as one of the top ten priorities for the development of mental health services (Thornicroft et al, 1992, as cited in Schneider et al, 2002). One study shows that up to 90% of consumers have a long-term goal of paid employment, whether full- or part-time. This is true even of people with a very high need for support (Secker et al, 2001a, as cited in Seebomh et al, 2002).

Also in the UK, Schneider, Heyman and Turton (2002) report that there is a steady demand for work on the part of people with mental health illness. Figures from the UK Labour Force Survey suggest that 26% of people with mental health problems would like to work, but only 5% said that they were actively seeking work (Schneider et al, 2002). Another recent and comprehensive review of the area notes that:

despite high unemployment rates amongst the severely mentally ill, surveys have consistently shown that most want to work (Hatfield, 1992, Lehman, 1995, Shepherd, 1994) (Crowther et al, 2003:2).

Similarly in the US most people with a mental illness reported that they wanted to work (McAlpine & Warner, 2002). American data showed that only 29% of the people with a severe mental illness, who were surveyed, were unable to work (Barker et al, 1992, as

cited in McAlpine & Warner, 2002). A recent study, by a group of mental health consumers and academic researchers, found that of 140 people with severe mental illnesses interviewed, 38% did not want to work (McQuilken, Zahniser, Novak, Starks, Olmos & Bond, 2003). Of the remainder, 26% wanted to work but were not looking, 20% were actively looking for work and 16% were working for pay. Interestingly, 67% of the 'do not want to work' group and 87% of the 'want to work but not looking group' agreed with the statement: "If I knew that I would not lose all my benefits, I would try to get a job or a better job". This suggests that most of the interviewees would want to work if they were assured of not losing their benefits, and that it was systemic barriers, rather than lack of desire, that was holding them back from looking for employment.

Perceived advantages to working

Consumers who are in work point out a number of advantages to being employed. These are (in descending order of importance):

- Improved finances
- Self-fulfilment/empowerment/independence
- Self-confidence/esteem
- Social life/network
- Normalising/integrating
- Reduction in symptoms
- Increased skills/abilities/work experience
- More structure/activity (Rinaldi & Hill, 2001)

Some disadvantages of employment were also mentioned, although by fewer respondents:

- Effects on other areas of life
- Effect on health
- Stress
- Lacking of understanding/recognition of impairment
- Discrimination
- Difficulties fitting in
- Financial
- Routine/structure (Rinaldi & Hill, 2001).

The financial difficulties may refer to changes in benefit entitlements that actually leave consumers worse off financially once they start work, or fear that they may lose their benefit entitlement. Only 10% of respondents said there were no disadvantages to work, suggesting that consumers, employers, employment staff and mental health staff need to develop strategies to address these disadvantages and make sure work has an overall positive impact on well-being (Rinaldi & Hill, 2001). However, the most important implication of this research, is that mental health consumers see more advantages than disadvantages in working.

Conclusion

Internationally, employment levels in paid work in the open labour market are low for people with experience of mental illness. Receipt of sickness and invalids benefits is also high for people with psychiatric illnesses. Unemployment and benefit receipt is particularly high for Maori and Pacific peoples in New Zealand. International research shows that unemployment is higher for those with serious mental illnesses, and for those with both a psychiatric and physical disability. Unemployment tends to be higher for people with experience of mental illness than for those with other types of disabilities. Despite these facts, people with experience of mental illness do succeed in finding and keeping jobs. Both New Zealand and international research shows that many mental health consumers want to work, and vocational support services have been identified as one of the top unmet needs in New Zealand. When asked, people with experience of mental illness identify many advantages to working in the open market, as well as some disadvantages.

Barriers to Employment / Education For People With A Mental Illness

Key point summary – barriers to employment

- While people with experience of mental illness often want to work, there are barriers which make finding and keeping employment harder, and this is the main factor that leads to low employment rates
- Many barriers to employment exist, including lack of support, low staff expectations, discrimination, fear of losing benefits, lack of transport and money, lack of confidence, limited employment service options, lack of workplace accommodations, early onset of illness and severity of symptoms, and discrimination on the basis of age and race
- One of the biggest barriers to employment can be benefits policy
- People with mental illness make up the largest and fastest growing groups of invalids and sickness beneficiaries in New Zealand, particularly for Maori
- One benefit barrier is the fear of reduced overall income as the result of working, either due to low income jobs or reduced allowances while working part-time
- Another benefit barrier is the fear that if a person has to stop work due to illness, delay or difficulties in having a benefit reinstated will be encountered
- Lack of information about benefit rules and entitlements, on the part of benefits staff, employment agencies, mental health staff and clients, is also a barrier to employment
- A number of potential solutions to benefit barriers are possible, including increasing the availability of information and the level of knowledge of relevant staff and clients, and finding innovative ways of protecting income levels and security
- The belief that people with experience of mental illness cannot cope with work forms a particularly strong barrier, whether it comes from mental health staff, employers, or consumers themselves.

People with experience of mental illness have identified a number of barriers to employment and education, including:

- Lack of ongoing mental health support after finding a job
- Low expectations from support staff regarding ability to find and cope with work
- Discrimination by employers
- Discrimination by educational institutions
- The benefits system and risk to income from taking on paid work

- Lack of skills and qualifications
- Practical difficulties, with attending work, due to lack of money or transport
- Lack of confidence and job finding skills
- Being expected to take part in training or unpaid work beforehand
- Not being paid
- Service and funding arrangements that tie people with mental illness to particular types of employment or require them to use particular types of employment agencies and limit their choices
- Mental health treatment and support services that are delivered at times or in places that clash with work hours and places
- Lack of access to employment services
- Non-integrated mental health and employment or education support services, which mean that clients have to access multiple services
- Inadequate treatment for mental health illnesses.

(Bell & Lysaker, 1996; Bond, 1998; Cook & Razzano, 2000; Druss et al, 2000, as cited in McAlpine & Warner, 2002; Hall et al, 2003; McAlpine & Warner, 2002; Mental Health Commission, 2001; Mowbray & Collins 2002; Secker et al, 2001a, as cited in Seebohm et al, 2002; Schneider et al, 2002).

With regard to the last point, Warriner (2003) notes that in the New Zealand setting clinical services often operate on a 9 to 5, Monday to Friday basis, which can cause difficulties for people trying to attend both work and clinical appointments during these hours. This can result in situations like:

[a] client who, after succeeding at a job interview (and receiving complimentary feedback from the employer) was talked out of accepting the position because she would 'miss group on Monday and Tuesdays' (Warriner, 2003: 21).

Another person was required to take time off work to attend 'routine' appointments with his clinician, which interfered with work (Warriner, 2003). Siting vocational and clinical services at separate offices can also cause a barrier, with the burden of liaison and communication with both services being found to fall on clients (Bond, 1998). Separate clinical and vocational services are the norm in New Zealand.

Other barriers to unemployment include illness characteristics, such as onset of mental illness early in life which disrupts educational and early work careers (Kessler, Foster, Saunders & Stang, 1995; Turnbull, George, Landerman, Swartz & Blazer, 1990, both as cited in McAlpine & Warner, 2002). Severity of symptoms may affect levels of functioning and make employment more difficult, especially symptoms like poor concentration, fatigue and problems in relating socially (Cook & Razzano, 2000; McAlpine & Warner, 2002). Australian research has shown that chronic experience of mental illness makes current or continuous employment less likely, and the greater the deterioration as the result of ongoing illness, the worse the outlook for employment is (Waghorn et al, 2002).

Poor education and lack of work experience make it less likely that a person will find work, regardless of experience of mental illness (Caspi, Wright, Moffit & Silva, 1998; Mroz & Savage, 2001; Russell & O'Connell, 2001; Seth-Purdie, 2000; Woodward & Fergusson, 2000). People with experience of mental illness, who have less education and poorer previous work adjustment, are less likely to be in paid work, or to stay in continuous employment (Waghorn et al, 2002). New Zealand statistics of 2001 show that the unemployment rate for people who have no qualifications was 60% higher than for people who have both school and post-school qualifications (8.7% vs 3.5%) (Department of Statistics, 2002c). Other 2001 New Zealand statistics show that 39% of people with disabilities had no qualifications compared to 24% of those without disabilities. 27% of people with disabilities had a post-school qualification compared to 34% of those without disabilities (Department of Statistics, 2002a).

Lack of support is one of the barriers to employment. While people with mental illnesses may want to work, the help necessary to do so may not be available. One survey found that of a group of consumers in the United States, 61% wanted help with getting or keeping a job, while only 29% reported that they were getting that help (Becker, Bebout & Drake, 1998, as cited in McAlpine & Warner, 2002). Lack of support once in work, may also form a barrier to employment or lead to loss of employment for someone experiencing a period of acute illness (McAlpine & Warner).

Barriers for the general population, such as being older or a member of an ethnic minority, appear to have an even more severe impact on employment chances for those with experience of mental illness (Yelin & Cisternas, 1997, as cited in McAlpine & Warner, 2002).

McAlpine and Warner (2002) note that characteristics of workplaces, such as stigma, lack of accommodations (e.g. flexible hours) and lack of support are prime barriers to employment for mental health consumers.

In one study practical difficulties in attending work caused by difficulties with transportation were found to affect 24-29% of people with experience of mental illness (Druss et al, 2000, as cited in McAlpine & Warner, 2002). Receiving support with travel – in the form of employment staff travelling to provide advocacy or services, providing transport for clients, and training in how to use transportation - makes it more likely that clients will take part in work in the future according to one study (Jones, Perkin & Born, 2001).

With regard to practical difficulties caused by lack of money, New Zealand statistics show that 56% of people with disabilities have an income under \$15,000 compared to 40% of those without disabilities. In contrast, only 6% of people with disabilities were earning over \$50,000 compared to 13% of people without disabilities (Department of Statistics, 2002a). This suggests that people with experience of mental illness are going to often struggle to find the money to pay for clothes for work and transport, and these are barriers that employment and other services will need to address.

Sickness and disability benefits – barriers and opportunities

As mentioned above, fear of losing welfare benefits can inhibit consumers from finding or taking paid work (Polak & Warner, 1996, as cited in McAlpine & Warner, 2002). This is one of the main barriers to employment and tends to take two forms:

1. a fear that taking on work, or taking on more hours of work, will result in an income lower than that on a benefit through loss of allowances, or being moved to a benefit with less income and higher abatements (deductions from each dollar earned)
2. in case of a relapse which requires leaving a job, fear of financial hardship due to difficulty getting back on the same level of benefit and income, or delays in reinstating the benefit

A more detailed analysis of barriers posed by benefit rules follows.

People with experience of mental illness on sickness/invalids benefits

People reporting they have a psychiatric disability, as their primary illness, make up the largest group of those receiving an invalids benefit in New Zealand (17,500 or 26%). The next biggest groups are intellectual disability (11,000 or 16%) and musculo-skeletal disorders (8,500 or 13%). To receive an invalids benefit a person must have a disability or condition that is 'permanent and severe, that is, which is expected (by a doctor) to last more than two years and mean that they are unable to work for 15 or more hours per week (Ministry of Social Development, 2003).

Likewise, the largest group of people receiving a sickness benefit is those who report a psychiatric disability as their primary condition (13,500 or 34%). The next largest groups are those with a musculo-skeletal disorder (6,000 or 16%) and those with conditions that have resulted from accidents (5,000 or 13%). To be eligible for a sickness benefit a person must have a condition or disability that limits their capacity to seek or maintain full-time employment (meaning at least 30 hours per week).

The growth in numbers of people with experience of mental illness on benefits

Not only are people with a psychiatric disability over-represented in beneficiary numbers, but there has been a rise in the proportion of sickness and invalids beneficiaries who experience a psychiatric or psychological illness. From September 1996 to February 2003, psychiatric and psychological disorders accounted for 20% of the growth in people, under 60 years of age, on sickness and invalids benefits. This was the largest growth of the nine types of incapacity which accounted for 92% of the growth in invalid and sickness beneficiary numbers. The next two largest groups were stress (19% of growth) and musculo-skeletal disorders (15% of growth) (Ministry of Social Development, 2003).

Ethnicity of people on sickness/invalids benefits

Maori are over-represented in numbers of New Zealanders receiving an invalids benefit. They comprise 19.7% of invalids beneficiaries, compared to around 14% of the total population over 15 years of age (Department of Statistics, 2002b). Pacific peoples make up 3.8% of invalid benefits clients, whereas they account for 6% of the population aged over 15 years (Department of Statistics, 2002b). This lower number for Pacific peoples may be due to the requirement for a person to have lived in New Zealand for ten years before being eligible for the invalids benefit (Ministry of Social Development, 2003). More disproportion is evident in figures for sickness benefits, where Maori make up 23.5% of recipients compared with around 14% of the total population. Pacific peoples make up 6.9% of sickness beneficiaries, which is in line with the proportion of Pacific people in the total population.

Despite these, discrepancy figures show that the proportions of Maori and Pakeha with either a disability (whether single or multiple) are similar (Department of Statistics, 2002a).

The nature of benefit barriers

There are several barriers to employment that have been identified to result from welfare benefit systems, both in New Zealand and overseas. These are:

- A barrier to starting work, caused by the fear that once benefit allowances are lost income will be lower (McQuilken et al, 2003; Turton, 2001)
- A barrier to starting work caused by the fear that if an individual becomes unwell and needs to stop work, whether temporarily or permanently, that difficulties will be encountered in getting the benefit reinstated and having a period without income may be a result (McQuilken et al, 2003; Witton, 2002)
- A barrier to working more hours, caused by the fear that going over the minimum number of hours or income allowable, before abatements come into force, will lead to reduced earnings, such a small increase in earnings that the extra hours are barely compensated OR having to move to a benefit which will decrease overall income (e.g. from invalids to sickness benefit) (McLaren, 2004; Turton, 2001)
- A lack of accurate information on benefit rules and entitlements which exaggerates the barriers listed above (Corden & Sainsbury, 2001; McLaren, 2004; Turton, 2001; Witton, 2002).

Some UK studies have concluded that benefit issues are the most common and main disincentive to taking part in work for mental health consumers (Beyer et al, 1996; Davis & Betteridge, 1997, both as cited in Turton, 2001). A UK study found that 25% of people who went from welfare to work were working for less than they had received on a benefit (Ford & Kempson, 1996, both as cited in Turton, 2001).

Another UK study found that maintaining income security, during the transition from benefits to paid work, was just one of a number of factors which affected the decision to go into paid work. Other factors were health, age, family responsibilities, and the availability of suitable work (Corden & Sainsbury, 2001).

Fear of difficulty in getting back on benefits if there are problems with work: In a US study, 82% and 88% of those mental health consumers who check ‘don’t want to work’ and ‘want to work but not looking’ agreed with the statement “[If] I go to work, get off of benefits and get ill again, I’ll have a hard time getting back on benefits” (McQuilken et al, 2003). This is also regularly mentioned as a barrier to moving into work by clients and staff of supported employment agencies in New Zealand. (McLaren, 2004).

Fear of losing allowances and ending up financially worse off: In an innovative American study, carried out by a team of mental health consumers and academic researchers, it was clear that benefits formed a considerable barrier to employment, in terms of both loss of total income and loss of security (McQuilken et al, 2003). The statement that received the most agreement from the 140 consumers interviewed was “[I] am on benefits and cannot risk losing them right now”. In terms of loss of income, 42% of those who did not want to work and 38% of those who wanted to work but were not looking, agreed with the statement “[I] can make more money just collecting my benefit checks than I can if I went to work while on benefits”. Significantly more of those who did not want to work or who were not looking for work agreed with this statement than the ‘want to work’ and ‘working for pay’ groups, suggesting that fear of decreased income was holding people back from looking for work (McQuilken et al, 2003). Also supporting the fear of loss of income as a barrier to work was the fact that the second most endorsed statement was “[If] I work, I do not think I will be paid well enough” (McQuilken et al, 2003).

It was clear from the response to another item that most, of the 26% who wanted to work but who were not looking and the 38% who did not want to work, were being held back from looking for work have a fear of losing their benefits. With regard to the statement “[If] I knew that I would not lose all my benefits I would try to get a job or a better job” 67% of the ‘do not want to work’ and 87% of the ‘want to work but not looking’ groups agreed (McQuilken et al, 2003). In another American study 22% of unemployed consumers who were interviewed said that their fear of losing disability allowances was a reason for not seeking employment (McAlpine & Warner, 2002).

A UK study found that losing health subsidies and allowances had the potential to wipe out any financial gains from working extra hours as people with severe mental illnesses have such high health costs (Turton, 2001, as cited in Schneider et al, 2002). Information on whether this is an issue in New Zealand is lacking.

Measures such as an extra weekly payment for up to 26 weeks, to encourage beneficiaries to take on work they would otherwise not consider, were viewed with concern by some beneficiaries because of the fear of losing benefits after 26 weeks, fear of how that allowance would interact with other benefits, and overall perceptions of a lack of any significant financial benefit (Corden & Sainsbury 2001).

A lack of accurate information on benefit rules and entitlements: Corden and Sainsbury (2001) found that, in the UK, awareness of incentives for people on incapacity benefits to move to paid employment was low. Part of this was due to the level of knowledge that benefits staff had and part by the influence that performance targets had on advice and guidance provided by benefits staff. Work incentives that were tied to staff performance targets appeared more likely to be recommended than those that were not. Another qualitative study found that mental health service users in the UK identified a need for ‘informed reassurance’ and access to expert advice, in order to navigate the complexities of the benefit system, maximise their income and minimise the risks to their only source of income (Witton, 2002). Service users in this study valued advice from benefits staff, but also from people within mental health or employment settings. However, gaps in knowledge were identified in all sources of advice (Witton, 2002). Intensive practical help when moving into work was also identified as a need in this study, not only with benefit advice but with completing forms and liaising with agencies. Witton reported that an emphasis on getting all the income entitlements that are available can form a disincentive to work because of a fear that the same income cannot be maintained through paid employment. On the other hand, Witton also identified that lack of knowledge about entitlements and benefit rules was actually holding people back from work that would not financially disadvantage them. Interestingly, Witton found that where employment project staff had received training in benefits they were more likely to be asked for advice by clients, and more likely to be pro-active in offering benefits advice as one of their services. Staff who had not received training in benefits advice said that they would feel better equipped for the job if they had. Those who had received such training found it very relevant to their work. One staff member noted that the rules on benefits are changed so often that up-to-date training was very reassuring. Another staff member noted that:

It's very confusing stuff particularly when the names of things change and the goal posts shift
(Witton, 2001: p.35).

Possible solutions to benefit barriers

A number of authors and commentators have suggested ways that benefit systems can reduce barriers to work. These include:

- Increasing the availability of information and advice on welfare rights, benefits and allowances for those seeking work (Corden & Sainsbury, 2001; Turton, 2001). A UK study found that anxieties about paid work are not helped by lack of understanding of benefit and tax systems and complicated administrative procedures (Corden & Sainsbury 2001). It also found that one of the best incentives available – the 52 week linking rule (see below for more information) – was potentially underused because of a lack of awareness of the rule and a fear that it would prove too complex to use. A US study found that a well-designed programme of systematic counselling on benefits led to significantly higher earnings for vocational rehabilitation clients, compared to historical controls

- (Tremblay, Smith, Xie & Drake, as cited in press, in Bond, 2004). Benefits counselling is now included as the seventh principle of supported employment, although Bond (2004) notes that the evidence of its impact is weak, with only one quasi-experimental study (Tremblay et al 2004) available thus far.
- Allowing people to retain their benefits while in work (e.g. a 50/50 arrangement whereby a person retains their benefit and pays 50% tax on their earnings) (Turton, 2001)
 - More widespread access to support into work and while in work (Turton, 2001).
 - Protecting income security in the face of relapsing mental illness by making it easier for people to return to full benefits when unable to work. A 52 week linking rule, which allows beneficiaries to return to an incapacity (or invalids) benefit if they have to leave employment within 12 months of starting a job, has been introduced in the UK (Corden & Sainsbury, 2001). These authors note that this has a positive influence on consumer decisions to take jobs. The downside of this policy was delays experienced in resuming the benefit, which could potentially result in a period without income (Corden & Sainsbury 2001). Witton (2002) suggests extending the 52 week linking rule to five years in recognition of the ‘chronic and fluctuating nature of mental illness’.
 - More knowledgeable and experienced staff administering benefits and providing advice. This had a significant impact on the use of work incentive measures in the UK (Corden & Sainsbury, 2001). The authors note that potentially effective incentives to paid work, such as the 52 week linking rule, were constrained in use by lack of understanding of operational staff.
 - Work trials of 15 days, without losing any benefits, have been viewed positively by those who have experienced them in the UK, (Corden & Sainsbury, 2001). However, it was not clear whether these trials had increased numbers of beneficiaries taking up paid work on a long-term basis.
 - Tax credits have been found to have a positive impact on decisions to move from benefits to paid work, particularly when the weekly entitlement comes to more than fifty pounds (Corden & Sainsbury, 2001)
 - Better liaison and communication between benefits staff and clients, and benefits staff and staff of employment services with clients who have experience of mental illness (Witton, 2002).
 - Training of employment services staff, both WINZ and non-governmental, to keep them up-to-date with benefit rules (Witton, 2002).

Barriers to employment caused by stigmatising attitudes

Low levels of employment of people with experience of mental illness appear due not only to disabilities caused by mental illness, but also to discrimination and stigmatisation (Lehman, 1998, as cited in Crowther, et al, 2003). Attitudes of others to people with mental illness form a significant barrier to employment and education. Interestingly, this applies to vocational and mental health service providers who believe their clients are not able to work or study as well as to employers who discriminate against hiring mental health consumers (Rutman, 1994, as cited in McAlpine & Warner, 2002). For example,

one study found that staff were focusing on providing social skills training rather than the work-related training that consumers actually wanted. On enquiry they found that this was because staff believed that consumers did not really want to leave the sheltered environment for open employment, and that doing so would harm their mental health (Martin, 1996, in Schneider et al, 2002). One reviewer commented that:

staff members at community mental health centres often have low expectations for the employment of consumers with SMI [serious mental illness] so it is not surprising that clients in such programs often receive little encouragement to work (Braitman et al, 1995, as cited in Bond, 1998).

This also applies to supported education. One person reported that:

I remember clearly the day I told my mental health worker I was going back to school. He let out a short laugh, shook his head, and said, "It's doubtful you will ever get a master's degree. If by chance you do, you will never be able to use it" (Shepherd, 1993:8, as cited in Mowbray & Collins, 2002).

As one reviewer noted:

Most consumers are motivated to work, provided they perceive that the professionals helping them also embrace the belief in the importance of work and genuinely believe that they can work (Rogers, Walsh, Masotta & Danley, 1991) (Bond, 1998: 17).

In the New Zealand setting supported employment specialists have experienced psychiatric services as placing a low priority on employment. For example, Warriner (2003) notes that:

Despite the fact that work is a high priority for many mental health consumers, this is not supported as a possibility, let alone a priority for many clinically oriented staff (Harris, 1995). In spite of the benefits that can accrue from work, mental health service systems have traditionally been hesitant to promote work as a valued component of rehabilitation services (Curtis, 1997) (Warriner, 2003:5 page 5).

This literature highlights that staff attitudes to work can either promote or impede movement into competitive work by people with experience of mental illness.

But the most commonly acknowledged negative attitudes occur in the workplace. Some of the best US data available show that just over a third of 3500 mental health consumers aged 18 to 55, have faced discrimination in the workplace at some time in the past five years (McAlpine & Warner, 2002). In one study, employers were more willing to offer an interview to a person with a criminal record (81% interviewed) than to a person identified as an ex psychiatric patient (58% interviewed) (Laird, 1990, as cited in McAlpine & Warner, 2002). At least one consumer has taken advantage of this bias:

On two occasions I lied when I applied for jobs. On both of these occasions I said that my two and a half year absence from employment was due to a term spent in prison. I was accepted for the first and short listed for the second. Whenever I have been truthful about my psychiatric past, I have never been accepted for a job (MIND, 2003, as cited in Peterson, 2003:3).

In the UK 72% of a sample of 56 employers, thought that they would have more difficulties employing a person who had had experience of mental illness than one who had not. The difficulties they envisaged included more need for supervision and greater use of sick leave (Rinaldi & Hill, 2001). In addition to these attitudes, a third of the employers interviewed stated that they would use different selection criteria for disabled people compared to non-disabled, particularly with regard to asking disabled people how well they would cope with the work and stress.

The New Zealand Mental Health Commission discussion paper on employment and mental health includes the experience of:

A personal assistant who was offered employment and then found the offer was retracted when the employer found out that they had a short admission to a psychiatric ward in the past. The employer said the dishonesty would not be tolerated and that an interview wouldn't have taken place if the disclosure had been made (Mental Health Commission, 1999).

Other research suggests that employers may be more open to employing people with physical disabilities than people with mental illness. An American survey of 127 Fortune 500 companies – the top ranked 500 companies in the country in terms of financial performance – found that companies preferred employees with physical disabilities over employees with psychiatric disabilities. Only 13 of the 127 companies which responded had a policy on hiring people with mental illnesses, and only one company had set hiring goals for this group. Companies without policies were concerned that people with experience of mental illness might not perform their jobs up to standard, or might be late for work, compared to employees without a mental illness (Jones, Gallagher, Kelley & Massari, 1991).

In another American study, only 16% of employers said they would be uncomfortable hiring a person with a physical disability compared to 44% who would feel uncomfortable hiring someone in treatment for depression. The levels of discomfort rose for hiring someone with a previous psychiatric hospitalisation (52% felt discomfort), on antipsychotic medication (67% felt discomfort), and someone with a history of substance abuse (69% felt discomfort) (Scheid, 1997, 1998, 1999, Scheid & Suchman, as cited in press, all as cited in McAlpine & Warner, 2002).

Not only is external stigma and discrimination a problem but these negative views can also be internalised by people with mental illnesses so that they under-estimate their own ability to work (Garske & Stewart, 1999, as cited in Schneider et al, 2002).

Another internal barrier to work is that of attachment to the labour market. Attachment refers to either involvement in paid work, or the desire to be involved in work, so a 'weak' attachment indicates either unemployment, or a relatively low desire to be in work and possibly a low level of searching for paid work. One study found (33%) of people with experience of mental illness have a weak attachment to the world of work compared to only 10% of long-term unemployed people (Turton, 2001, as cited in Schneider et al, 2002). This meant that people with experience of mental illness were less motivated to work and possibly less involved in actively searching for work.

There is some evidence that general economic and labour market conditions affect employment of people with experience of mental illness, with rates of employment rising along with general employment rates (McAlpine & Warner, 2002). However, other research showed that over the period 1992 to 1998 general employment rates went up but rates for persons with disabilities declined (Burkhauser, Daly & Houtenville, 2000, as cited in McAlpine & Warner, 2002.)

Conclusion

A number of barriers to employment exist. Low availability of support to find work is one, along with low expectations of some mental health staff that people with severe mental illnesses can find and cope with work. Practical barriers, such as lack of transport and finances are also barriers. The provision of clinical services during work hours makes employment more difficult. Another barrier is the lack of options for types of work placements and employment services. Interruption in education and work experience, due to early onset of illness and hospitalisation, are also problematic, as are age-ism and racism. A big impediment to employment can be benefit policy. The three major benefit barriers are lack of information about benefit rules and entitlements among benefits staff, mental health staff, employment staff and clients; consumer fears of lower income after going into work, and fears of breaks in income or going onto a lower benefit if individuals have to stop work. Potential solutions to benefit barriers are increasing knowledge among all concerned parties about benefit rules and entitlements, and finding innovative ways of ensuring that clients do not end up earning less in work than on a benefit, and do not suffer breaks in income. A further barrier is the stigma and discrimination of employers in respect of employing people with experience of mental illness. Finally, people with experience of mental illness can internalise attitudes which can compound difficulties in finding and coping with competitive work.

Consequences of Employment and Unemployment

Key point summary – consequences of employment and unemployment

- Unemployment has adverse consequences for mental health in the general population, including greater likelihood of anxiety, alcohol and drug abuse, distress, and suicidal thoughts and acts
- Employment tends to have positive effects on well-being, symptoms of mental illness, compliance with medication, relapse rates, quality of life, use of leisure time and social contact for people with experience of mental illness
- Competitive work in the open labour market has been found to improve symptoms, satisfaction with services, leisure and finances, and self-esteem more than sheltered work and minimal work do for people with experience of mental illness
- Unemployment tends to result in lower earnings in future jobs, especially when it goes on for some months in the general population
- Unemployment also results in decreased future employment chances, especially when it goes on for months or years in the general population

Consequences for physical and mental health

General population: Not only are levels of unemployment for people with mental illness high, but both local and overseas research shows that the experience of being out of work increases levels of psychological distress even for those who did not previously suffer from a mental illness (Brenner, 1990; Brenner & Mooney, 1983; Fergusson, Horwood & Lynskey, 1997; Hammarstrom & Janlert, 1997; Warr, Jackson & Banks, 1988). Young people in New Zealand are 1.1 to 2.7 times more likely to abuse drugs and alcohol and feel extremely anxious when unemployed, compared to those who have work. Researchers estimated that making sure all young people had jobs would reduce the rates of anxiety and substance abuse by 8 to 17% in the New Zealand population (Fergusson et al, 1997).

New Zealand research also shows that young people who were unemployed were more likely to think about killing themselves than those who were not (Fergusson et al, 1997). In addition, New Zealand research has found a link between experiencing unemployment and death by suicide. Young men aged 18 to 24 who were unemployed at the time of the 1991 census were two to three times as likely to kill themselves in the next three years as those who were in work (Blakely, Collings & Atkinson, 2003). About half this association was estimated to be due to the confounding effects of mental illness. Part of the reason for higher suicide rates appeared to be lack of social support and contacts, as much as lack of money and status (Blakely et al, 2003). Overseas research also finds an

increased risk of suicide among unemployed people in both the UK and US (Brenner, 2001; Brenner & Mooney, 1983; Lewis & Sloggett, 1998, all as cited in Seebohm et al, 2002). While some impacts of unemployment take up to 15 years to become apparent, suicide rates tend to rise within a year of unemployment occurring in international studies (Brenner, 2001).

A recent meta-analysis examined 104 studies from 1985 to 2002 on the impact of unemployment on mental well-being. They found that being out of work had a definite negative impact on mental health. The researchers noted that:

It is unrealistic for us to claim we can prove a causal relationship between unemployment and mental health as there are limitations to the causal interpretations of each study that has examined this relationship. Yet, we do feel it is appropriate to state that the evidence is strongly supportive of a causal relationship since there is a consistency in results across multiple kinds of studies and hundreds of data points.

(McKee-Ryan, Song, Wanberg & Kinicki, 2004:28).

This meta-analysis found that levels of mental health during periods of unemployment were not significantly related to levels of mental health once re-employed, suggesting that employment status predicted future mental health better than past mental health levels did (McKee-Ryan et al, 2004).

People who move from being employed to being out of work tend to feel worse, while those who go from being unemployed to getting a job tend to feel better (Clark, 1996, Korpi, 1997, Winkelmann & Winkelmann, 1998, as cited in Machin & Manning, 1999; Creed, 1999; Jackson, Stafford, Banks & Warr, 1983, as cited in Warr, Jackson & Banks, 1988; Kessler, Turner & House, 1989). In a recent meta-analysis a moderate weighted effect size of .36 was found for the decline in mental health when people moved from employment to unemployment, and a more substantial weighted effect size of .54 for the improvement in mental health when they moved from unemployment to employment (Murphy & Athanasau, 1999, as cited in McKee-Ryan et al, 2004). A larger, more recent meta-analysis also found in the longitudinal studies they looked at that mental well-being declined when people became unemployed, and improved when they found work again (McKee-Ryan et al, 2004). This is strong evidence that the absence of work degrades mental health, while the presence of work promotes mental well-being. Interestingly, there is some evidence that people get distressed and depressed not only when unemployed, but when in work they do not find satisfying. Males seem to find the sheer absence of work most difficult to cope with, while females find unsatisfying work most difficult (Winefield, Tiggeman & Winefield, 1991).

This research was carried out on the general population. Logic suggests that if experiencing unemployment has an adverse effect on mental health in a person with no pre-existing mental health problems, and finding work has a positive impact, then these effects are likely to be even stronger in mental health consumers who are arguably even more vulnerable to the stresses involved. It seems unlikely that experience of severe

mental illness would confer some kind of protection from the well-documented adverse effects of unemployment on mental health. However, more research is needed to confirm this.

Death from all causes has been found more likely following unemployment in a number of international studies, as has death from cardiovascular disease, cirrhosis of the liver, malignancies, circulatory diseases, accidents, violence, poisonings and suicide (Brenner, 2001; Brenner & Mooney, 1983). This has found to be true not only for unemployed men but for their wives, compared to wives of employed men (Brenner, 2001). The link between unemployment and subsequent downturns in mental and physical health is attributed by Brenner (1990) to reduction in income. He found strong inverse relationships between individual income levels and health status in studies across the US, UK and European countries. When other factors, such as alcohol, cigarette and fat consumption, were controlled the relationship between economic conditions and health status remained, and even strengthened (Brenner, 1990, 2001). In discussing whether unemployment and consequent low income 'causes' health problems, Brenner concluded that this could not be proved. But he ruled out the existence of an external, unspecified third factor that might explain variation in both economic and health factors (Brenner, 1990). Longitudinal studies in a number of countries also clearly show that the direction of effects is from unemployment to worsened health, rather than vice versa (Brenner, 2001). Given these facts, along with the lack of explanatory power of alcohol, cigarette and fat consumption, this supports a conclusion that unemployment and low income increase the probability of subsequent poor mental and physical health, and death.

People with experience of mental illness: Qualitative research in the UK with people with experience of mental illness suggests that those who move into employment experience a reduction in symptoms (Rinaldi & Hill, 2001). Experimental evaluations of employment interventions with people with experience of mental illness also show that work can have a positive impact on mental well-being. A significant improvement in symptoms and mental state has been seen for individuals in paid work competitive employment (Bell, Milstein & Lysaker, 1993; Drake, Becker & Anthony, 1994, as cited in Crowther et al, 2003; Wing & Brown, 1970; McKeown et al, 1992, as cited in Seebohm et al, 2002). Participation in work has also been shown to have a positive effect on symptoms irrespective of whether it was paid or not, although paid work had more impact (Bell, Lysaker & Milstein, 1996). Involvement in the world of work has also been shown to have a positive effect on symptoms, compliance with medication and relapse rates (Anthony et al, 1995; Bell et al, 1993, both as cited in Seebohm, Grove & Secker, 2002). Other positive effects of taking part in work include improved quality of life, more active use of leisure time and more social contact (Hatfield et al, 1992; Hill et al, 1996, both as cited in Seebohm et al, 2002). Levels of hope and motivation have also been shown to rise once individuals become involved in work (Ridgway, 2001, as cited in Seebohm et al, 2002). The change in self-image from a 'sick' role to a more positive view of self once people with experience of mental illness go into work, training or study has been remarked on by clinicians and carers (Torrey, 1988, as cited in Seebohm et al, 2002). One review notes that:

From a clinical standpoint, employment may lead to improvement in the outcome of severe mental illness, through increasing self-esteem, alleviating psychiatric symptoms and reducing dependency and relapse (Lehman, 1995) (Crowther et al, 2003: 2).

Consequences of paid and open-market work

People with experience of mental illness: The assumption in the studies above, both with the general population and people with experience of mental illness, has been that the work in question has been paid and in the open market. But this is a dangerous assumption when talking about mental health consumers, many of whom are encouraged to take part in voluntary work, unpaid training or sheltered work. Thus, studies that investigate the impact of paid versus unpaid work, and open market employment versus sheltered work, are useful for clarifying which has more benefit. In addition, they help address common conceptions that taking part in the open labour market is too stressful for consumers and might lead to worsened symptoms and relapses.

There are some indications in the research that paid employment has more positive consequences than unpaid employment. A study of 150 veterans with experience of schizophrenia randomly assigned people to paid and unpaid work assignments. Some degree of choice of type of work was available. People who were paid for their work (\$3.40 per hour) worked significantly more hours than those who were not paid, and stayed in work longer (60% sustained some work each week through to the fifth month compared to 16% in the paid condition). Level of welfare benefits received did not have a significant impact on hours worked – the most important factor in the variation in hours worked was found to be pay (Bell, Milstein & Lysaker, 1993; Bell, Lysaker et al. 1996). Not only did pay appear to have an impact on level of work participation, but those who were paid also showed fewer symptoms of mental illness than those who were not paid. Paid workers also showed lower rates of psychiatric hospitalisation while they were working.

Other research has found positive effects for work paid at competitive, market rates. A study of 149 unemployed people with severe mental illness found that over an 18 month period those who took part in competitive work in the open market were more satisfied with the vocational services they received, with their finances and with their leisure activities than people in sheltered work, minimal work and no work. They also showed more improvement in self-esteem and psychiatric symptoms than individuals in the other approaches (Bond, Resnick, Drake, Xie, McHugo & Bebout, 2001). Another study found that at 18 months follow-up, people in paid employment in the open market had lower levels of symptoms, better self-esteem and were more satisfied with their finances and the vocational services they were receiving than those who were unemployed at 18 months follow-up (Mueser, Becker, Torrey, Xie, Bond, Drake & Dain, 1997).

Financial consequences of unemployment and employment

General population: Financial consequences include the impact of work, or the lack of it, on individual earnings and on national benefit costs. In terms of earnings, overseas research shows that after a period of unemployment a person is likely to earn an average of 6% to 10% less in their next position (Arulampalam, 2001; Gregory & Jukes, 2001). In one study, a 13 week gap in employment resulted in an average 3.4% reduction in wages, and even up to four years later, there was an average 1% drop in earnings compared to people who had worked continuously (Mroz & Savage, 2001).

The more time people spend in the workforce, particularly in continuous employment, the better their earnings are likely to be.

Decreased future employment chances

General population: The research makes it clear that the more work experience a person has, the more likely they are to find employment in the future. Even when a person has been out of work for a relatively brief period, the amount they are likely to be out of work over the next year increases by 1.5 weeks compared to someone who has not been out of work at all (Mroz & Savage, 2001).

But the worst impact comes from long-term unemployment of a year or more, which makes it harder to find work in the future even when 'desirable' characteristics like qualifications are taken into account (Gregory & Jukes, 2001; Russell & O'Connell, 2001; Savage, 1999). According to Australian longitudinal research longer spells of unemployment, early in a person's work history, are also associated with longer periods of unemployment later in life (Kryger, 1985, as cited in Savage, 1999). Even worse, with each passing month of unemployment, a person's likelihood of finding work decreases further (Miller & Volker, 1987, as cited in Savage, 1999; Russell & O'Connell, 2001).

In contrast, even casual work experience can make it more likely that someone will find full-time work, provided it goes on for long enough. While having been in temporary work in the previous year makes it less likely that a person will end up in full-time work the following year (Ruiz-Quintanilla et al, 1996, as cited in Savage, 1999), when this work experience goes on for some years it does make permanent employment more likely (Gaston & Timcke, 1999). Data from the Australian youth survey suggests that casual employment works as a 'stepping stone' to permanent employment, rather than as a 'dead end', only when it carries on over a five year period (Gaston & Timcke, 1999).

People with experience of mental illness: Having a substantial work history has been found to predict positive employment outcomes for people with experience of mental illness, as has good occupational performance prior to illness (Tsang, Lam, Ng & Leung, 2000). Schneider et al (2002) conclude that there is strong evidence that people with experience of mental illness are more likely to find work if they have worked before. Individuals with more work experience are more likely to move into competitive

employment as a result of a supported employment programme (Drake et al, 1996, as cited in McAlpine & Warner, 2002). An extensive review found prior employment history to be the best demographic predictor of future work performance, particularly in respect of factors such as presence and length of pre-illness work history, prior occupational status and degree of upward job mobility (Anthony & Jansen, 1984, as cited in Warriner, 2003).

Increased risk of involvement in crime

General population: Longitudinal research shows that being unemployed puts young people at risk of getting involved in crime. Those unemployed for six months or more in New Zealand were three to 10 times as likely to be involved in violence, stealing and other property crimes, and to be arrested and convicted in court, as those who were in work. This was even after family, social, school and individual factors, that put young people at risk of crime, were taken into account (Fergusson, Lynskey & Horwood, 1997). Being out of work seemed to add an extra dimension of pressure which made crime more likely.

Qualitative research from Canada suggests that involvement in crime occurs in part as a way of making money to supplement benefits and buy luxuries. Crime also appears to help unemployed individuals to structure their day and provide opportunities for social interaction, both while selling goods and partying with other people involved in crime (Baron, 2001). But having work does not necessarily prevent crime, particularly if the work in question is lowly paid, unskilled and unsatisfying (Freeman, 1996). Those people who expect their current job to last longer seem less likely to get involved in crime than those who think the work will soon end (Crutchfield & Pitchford, 1997).

Conclusion

Not having paid work can have some quite serious consequences for all people. Even short periods of unemployment have the potential to cause down turns in well-being and make suicide, addiction and crime more likely. For people with experience of mental illness, being without work, has the potential to exacerbate symptoms and create stresses which make it even harder to cope with mental health problems. The negative effects of unemployment are likely to be most marked when people are out of work for a year or more.

The converse is that having work increases the likelihood of people earning more in the future, getting more work, feeling happier, calmer and being less likely to abuse substances or be involved in crime. For people with mental illness, in particular, employment is associated with greater well-being, reduced symptoms of mental illness, less chance of relapse and higher quality of life. These positive effects are likely to be most marked when work is satisfying, continuous, permanent, paid and in the open market, and when periods of unemployment are short, infrequent and preferably non-

existent. Finding regular, paid work has great potential to improve the quality of mental health consumers' lives in many ways – both psychologically and materially.

Section Two: Types of employment support services for people with mental illness and their effectiveness

A variety of employment support services are offered to people with mental illnesses internationally. Most reviews make it easier to assess how effective different types of services are by putting them into one of the three following categories:

1. training and supported education –provided either before or during placement into work in order to increase ‘employability’ in terms of skills and qualifications, whether general or related to a specific job
2. supported employment – this involves placing people into ‘real jobs for real pay’, that is employment in the open labour market at standard pay rates
3. sheltered employment –a work-like setting that is in some way sheltered or protected and provides a paid or unpaid occupation, where workers are mainly in contact with other people with mental illnesses and staff (Schneider et al, 2002).

These categories are also used in this review. Using the approach, developed by Schneider et al (2002) in their comprehensive review of the area, training and supported education includes interventions that are oriented primarily towards education of any type, including the category of open-ended ‘prevocational training’ in generic work skills.

Supported employment includes any type of work in open settings for regular levels of pay, excluding the transitional employment aspect of Clubhouses. This is considered along with work-ordered days because of the difficulty of separating research on the two aspects of Clubhouses.

Sheltered work include Clubhouses, social firms (although these businesses often operate in the open economy through sale of goods and services), sheltered workshops, work enclaves and work crews (Schneider et al, 2002).

One of the difficulties in reviewing research under broad categories is that employment support services are not standardised, and can vary widely even when they have the same name (Bond, Campbell, Evans, Gervev, Pascaris, Tice, Del Bene & Revell, 2002; Schneider et al, 2002). The exception is supported employment, where standards have been developed, along with fidelity scales, to measure how closely various services accord with best practice. Despite this, the standard of supported employment services is still variable. A recent study found that only a third of 144 supported employment programmes reviewed were rated as fully implemented according to a fidelity scale based on the research (Bond et al, 2002). Schneider et al (2002) warn that it can be dangerous to assume that interventions which have the same name actually deliver the same services, or that interventions with different names do not. So while interventions are considered through the present review, as broad classes, it should be borne in mind that general conclusions about each area cannot be made with full confidence.

Judging the effectiveness of employment support services

Effectiveness of employment support services is defined in a number of ways in the research. For the purposes of this paper, a three tier classification system has been adopted:

Work outcomes:

1. Placement in competitive employment (defined as a full- or part-time position held by a person in an ordinary work setting, where they receive payment at market rate)
2. Placement in any kind of employment (whether competitive, transitional, sheltered or voluntary)
3. Mean hours per month in competitive employment
4. Time in employment (either continuously or total)
5. Level of earnings (monthly average) and fringe benefits (e.g. superannuation, training)
6. Opportunity to pursue a career rather than 'just a job'

Education outcomes:

1. Participation in any kind of education (including training courses, full or part-time education and vocational education)
2. Finishing courses/training programmes
3. Grades in courses
4. Educational qualifications gained (from certificates to degrees)
5. Functional capacity (i.e. ability to carry out everyday tasks)
6. Work skills and proficiency¹.
7. Finding paid work or competitive work

Other outcomes (including costs):

1. Average monthly programme costs (direct costs of the experimental programme versus direct costs of the control/comparison programme)
2. Average monthly healthcare costs (including costs of all psychiatric/medical care and programme costs, but excluding earnings or transfer costs)
3. Number/rate of relapses and/or returns to hospital
4. Numbers lost to follow up or not participating in the programme
5. Consumer satisfaction with work/living/support/wages
6. Mental health and well-being, including self-esteem and quality of life.

Many of these measures are taken from a comprehensive list developed by Crowther et al (2003) in their review for the Cochrane Library.

¹ The term 'competence' is often used in research to cover the same concept of skills and level of functioning in work.

Of these, the most commonly used in the research are the numbers of people placed in competitive work, time in employment and relapses/return to hospital. There is little research on consumer satisfaction with the outcomes of services, but one study which looks at life satisfaction and social support has been included in the present review in the Clubhouse section (Warner, Huxley & Berg, 1999).

Priority has been given to the most rigorous research, namely randomised controlled trials. In these, individuals with similar characteristics are randomly assigned to either a support or control condition, the control usually being no support or an alternative support. The outcomes of interest (for example, mental health or employment status) are measured before, during and after the delivery of the support under investigation. Differences in outcome can be attributed to particular support conditions given that this is theoretically the only difference between the conditions (random allocation should in theory have ruled out other differences provided the groups were large enough). Meta-analyses and systematic analyses of randomised controlled trials have been given priority as the most rigorous form of evidence for effectiveness. These are studies which analyse single studies and give findings for the group as a whole.

General principles for desirable employment outcomes

Effectiveness of approaches in achieving mainstream employment is the main focus of this literature review, but not the only important consideration in looking at employment outcomes for disadvantaged groups. Principles of social inclusion support involvement in the usual activities of society as a right for disadvantaged groups such as people with experience of mental illness. Underpinning this literature review are concerns not only with what is effective in increasing paid employment in mainstream work settings, but with the rights of people with experience of mental illness to take part in the usual activities of society irrespective of any disability or disadvantage they experience. The general principles for desirable employment outcomes considered in this paper are therefore:

- The right of people with experience of mental illness to choose from the same range of options in respect of work, training and education as people without disabilities.
- Identifying and providing services which are most effective at supporting choice and empowerment of people to take part in the types of work, education and training they choose.

Training and Supported Education

Supported education

Key point summary – supported education

- Supported education aims to provide advice and support to people with experience of mental illness who wish to take part in education.
- It can take a variety of forms, including support to participate in mainstream courses, purpose-run courses in mainstream or sheltered settings, or on-campus support groups.
- Time in school and educational qualifications make employment and greater earning more likely.
- A number of barriers to involvement in education exist for people with experience of mental illness, including impact of mental illness, finances, competing responsibilities and discrimination
- Research on supported education is lacking of a reasonably low level of rigour and tends to be focused only on educational outcomes rather than broader employment outcomes.
- People using supported education services appear to have higher rates of participation in education than those who don't.
- Students using supported education services appear to pass the courses they complete although levels of gaining qualifications appear relatively low to date
- There are some indications that supported education is associated with increased individual work placements, more permanent work, higher earnings and more hours worked, but there are very few studies and these are of relatively low rigour
- Research on supported education services have some positive impacts on self-esteem identified, self-efficacy, quality of life, social adjustment and reduced hospitalisation along with reasonably good levels of consumer satisfaction, although the research is lacking in rigour.

Supported education comes in a variety of forms, depending on the client group and educational institution. In general the aim is to support people with experience of mental illness to participate in some form of secondary or post-secondary education. Education can be at a community college, vocational training institution or other post-secondary institution. Another more 'sheltered' option is that of trained staff running identified 'supported education' courses independently or on host campuses. A further model is to provide an on-campus support group for students with experience of mental illness who are studying at a particular educational institution (Mowbray & Collins, 2002). A recent survey of supported education studies in the US found that the largest number of

supported education services were associated with Clubhouses. There were also programmes located in community colleges and universities, as well as a dozen 'free standing' programmes. A similar exercise does not seem to have been carried out in New Zealand, so the extent and nature of supported education in this country is not clear.

An example of a well-studied supported education programme is that of the Boston University Continuing Education Program programme which helps consumers to draw up a career plan and identify suitable courses or jobs, in addition, a placement specialist supports help students gain social acceptance at their educational or vocational placement (Danley, 1997, as cited in Mowbray & Collins 2002; Ellison et al, 1999; Unger et al, 1991, both as cited in Schneider et al, 2002). A local example is that of the Health and Wellbeing course located on campus at a New Zealand Polytech, which provides a brief course on aspects of health and well-being for people with experience of mental illness. The class involves 9 hours a week over 13 weeks. It is educational rather than therapeutic in focus and results in the crediting of seven New Zealand Qualification Authority units (Clayton & Tse, 2003).

Supported education accords with the principles of the Psychiatric Rehabilitation (PSR) model. These are:

1. *Normalisation* – that for optimal functioning individuals need to feel they are engaged in meaningful activity.
2. *Self-determination* – consumers are involved and empowered, given maximum choice. Students identify and explore their career interests and make choices about the education and training required to achieve their career goals.
3. *Support and relationships* – Support education programmes provide support as well as assisting people to build their own supportive communities and to integrate into the community at large.
4. *Hope and recovery* – each person is treated as a developing individual, capable of growth, positive change and recovery from mental illness.
5. *Systems change* – this emphasises that problems which need to be addressed in order for individuals to achieve their goals do not reside solely within those individuals, but also reside in external environments (Mowbray, 2003).

Supported education services aim to augment rather than replace existing support services at educational institutions. They provide assistance with such things as getting into a school, obtaining financial assistance, becoming prepared for academic demands, planning career and education and setting goals and objectives. These are functions that may not be provided by existing disability support or counselling services on campus, or that students may not know how to access on campus. Supported education staff interface with on-campus support services, making sure that students and families are aware of the support available and their options, and helping ensure that services can be accessed. This is particularly relevant to remaining with education pursuits when a student hits a roadblock such as financial problems, a relapse or academic difficulties, and may find it hard to access services without support (Mowbray, 2003).

Why supported education is relevant to employment outcomes

In the general population, having qualifications makes employment more likely and unemployment less likely (Caspi, et al 1998; Seth-Purdie, 2000; Woodward & Fergusson, 2000). Qualifications also make it more likely that a person will get work again once they are unemployed (Russell & O'Connell, 2001). Evidence from interventions that increase school participation and qualifications show that the end result is more employment, less benefit dependence and higher earnings (Currie, 2001; as cited in Promising Practices Network, 2003). These findings for the general population hold true for people with experience of psychosis. A study of 980 Australians experiencing psychosis found that those who left school with a secondary school qualification were almost twice as likely to be in work as those who left with no qualifications. The higher the qualification the higher the likelihood of current and ongoing work (Waghorn et al 2002).

Earnings are also greater for people who have spent longer in education (Angrist & Krueger, 1990; Blakemore & Low, 1994; Dearden, 1998, both as cited in Coles, Hutton, Bradshaw, Craig, Godfrey & Johnson 2002; Russell & O'Connell, 2001). This seems to relate purely to time in education rather than qualifications gained. One study found that young people, who participated in education for one year longer than others, had 5.5% higher earnings for males and 9.3% higher earnings for females compared to those who had not (Dearden, 1998, as cited in Coles et al, 2002). While ability makes a difference of about 10% to earnings, more education has been shown to result in a 20% to 40% higher rate of earnings than would otherwise have been expected, even once ability has been taken into account (Card, 1999). While these studies were carried out with the general population, there is no reason to suppose the findings would differ for people with experience of mental illness.

However, the benefits of education are less available to people with mental illnesses than the general population (Clayton & Tse, 2003). There is evidence that people with experience of mental illness are less able to access post-secondary education (Ciardiello & Bell, 1991; McPherson, Dore, Loan & Romans, 1992, Mowbray, Collins & Bybee, 1999; Mowbray, Leff, Warren, McCrohan & Bybee, 1997, as cited in Clayton & Tse, 2003). An American study, using nationally representative data, estimated that approximately 4.3 million individuals would have completed post-secondary education had they not experienced a serious mental illness (Kessler, Foster, Saunders & Stang, 1995, as cited in Mowbray & Megivern, 1999).

The barriers to education for people with experience of mental illness include:

- Discrimination, such as mandatory psychiatric withdrawal policies that require students with mental illness to leave campus until they seek treatment or demonstrate competence in employment or education at another institution or both (*Note: this is an American, not a New Zealand, example of discrimination*)
- lack of support from family and/or mental health staff
- financial problems

- competing family responsibilities
- lack of confidence
- worries about possible relapse
- illness symptoms, and
- side effects of medication

(Clayton & Tse, 2003; Mowbray & Megivern, 1999).

In a study of barriers to education, the most common barriers to participating in post-secondary education were (in descending order from most to least):

- mental health complications, in the form of troubling symptoms or relapses (42.6% of respondents)
- lack of income and financial assistance (23.8% of respondents)
- competing responsibilities such as work or children (17.7%)
- academic problems such as flunking, low grades or heavy workload (13.4%)
- physical health problems (8.5%), and
- interpersonal issues, such as family problems (7.9%) (Mowbray & Megivern, 1999).

Onset of mental illness often disrupts educational and work pursuits, leading to a lack of qualifications and work skills (Kessler, Foster, Saunders & Stang, 1995; Turnbull, George, Landerman, Swartz & Blazer, 1990, both as cited in McAlpine & Warner, 2002). Supported education is intended to aid people with experience of mental illness to improve their qualifications so that they can find work that is more satisfying and better paid, where they will have a career path and potentially want to stay long-term (Schneider et al, 2002). Given the relatively high number of people with experience of mental illness who lack formal education, and the evidence of the importance of education to work and earnings, this is an approach with some potential for improving work outcomes (Schneider et al, 2002).

Who supported education is used with

Mowbray and Collins (2002) report that supported education is appropriate for use with a wide variety of people with experience of mental illness. Eligibility criteria for supported education usually specify that participants:

- Are adults
- Have experience of severe and persistent mental illness/psychiatric disability
- Personally wish to pursue postsecondary education or training
- Need ongoing support in order to succeed in education
- Have some basic academic proficiencies, demonstrated by a high school qualification or equivalent
- Have ongoing access to mental health services in addition to educational support.

Within this broad range of criteria specific groups of consumers are often targeted, such as young adults in inpatient treatment, or clients of specific rehabilitation agencies. (Mowbray & Collins, 2002).

Participation rates

In general, participation and completion rates of supported education are similar to those of most transitional or supported employment programmes, and close to the overall student dropout rate for community colleges (Dougherty et al, 1992, as cited in Mowbray & Collins, 2002).

Employment and education outcomes

Research on supported education has considered a range of outcomes, including educational achievement, employment, self-perceptions and client satisfaction with the services (Mowbray & Collins, 2002). However, Schneider et al (2002) highlight that many studies do not report employment outcomes but look only at educational achievements. Only one study, reported through the Mowbray and Collins review in 2002, had used an experimental design – the others varied in rigour, using a range of descriptive techniques, comparison groups and pre/post test designs. Three of the studies reported by Mowbray and Collins, 2002 followed up student outcomes beyond the end of the education course, and these ranged in length from one year to eight years after the programme ended.

Educational outcomes: In the sole New Zealand study located, five of the nine students of a Polytechnic supported education course on Health and Wellbeing went on to enrol in other tertiary courses (Clayton & Tse, 2003). The design of the study makes it impossible to judge whether this was due to participation in the course. Unger et al (1991) found significant increases from 19% to 42% in educational and employment attainment after supported education was introduced (as cited in Mowbray & Collins, 2002). A breakdown of how many achieved each type of outcome was not given.

In a quasi-experimental design, Hoffmann and Mastrianni (1993), as cited in Mowbray & Collins, 2002) found that in-patient participants in supported education were significantly more likely to return to post-secondary education (community college) than in-patient comparison group members who did not participate in supported education (69% versus 47%). The supported education group were also more likely to study fulltime – 70% versus 50% of the comparison group.

In a pre/post designed investigation, the number of individuals involved in college or vocational education more than doubled from the start to the end of the supported education programme. At one year follow-up 24% of the supported education group were enrolled in college or vocational education compared to 9% at baseline (Collins et al, 1998, Mowbray, Collins & Bybee, 1998, both as cited in Mowbray & Collins, 2002).

Conclusion: Overall, the best of the research to date suggests that supported education increases participation in education by people with experience of mental illness. However, the quality of the research is not high and more randomised, controlled trials are needed with longer follow-ups. In particular, more evidence is needed that supported education increases levels of qualifications, as these have the most impact on employment and earnings.

Employment outcomes: Unger et al (1991, as cited in Mowbray & Collins, 2002) found significant increases in competitive employment as a result of involvement in supported education. These were maintained at a five to eight year follow-up (Danley et al, as cited in Mowbray & Collins, 2002).

Follow-up of the Community Scholars programme found that 78% of the 125 students had held at least one job between intake and follow-up, and 47% were employed three years after the intervention (Cook & Solomon, 1993, as cited in Schneider et al, 2002). While a comparison group was not used, the on-course rate is a reasonably good level of employment compared to that for people with experience of mental illness in the US generally (15 to 72% employed) although the three year follow-up rate is fairly average. These outcomes also compare fairly well to rates of placement as a result of supported employment, which range from 32% to 78% (Bond et al, 1997, as cited in McAlpine & Warner, 2002). However, it is not clear whether the results refer to competitive employment or any employment. Lack of a comparison or control group means employment levels cannot be attributed to participation in the intervention. The Community Scholars programme was also associated with increases in hours worked from 17.7 to 21.4 per week in group placements (Cook & Soloman, 1993, as cited in Schneider et al, 2002) an increase in average wage from \$4.35 to \$4.76 per hour.

An increase in productive activity (higher education, vocational training or work), from 27% at the beginning of the programme to 41% at the end, was also found for the Michigan Supported Education Program (Mowbray et al, in press, as cited in Mowbray & Collins, 2002).

Conclusion: there are very few studies which look at the employment outcomes of supported education, and those that exist are not of a high level of experimental rigour. There is a suggestion that attending supported education programmes is associated with positive employment outcomes, in terms of work placements, permanent work, higher earnings and more hours worked. Schneider et al, 2002) conclude that:

Cohorts undertaking college or vocational school-based supported education seem to obtain higher rates of labour force participation than would be predicted for people with severe mental health problems in general (2002: 47).

However, it is difficult to make any firm conclusion about the effectiveness of supported education until more research is carried out, not only in respect of outcomes participation but also attainment of qualifications and employment over the longer term.

Other outcomes: Significant increases in self-esteem have been found to be associated with supported education programmes (Cook & Solomon, 1993; Danley, 1997; Unger et al, 1991, all as cited in Mowbray & Collins, 2002). Participants in the active conditions (classroom and group) of the Michigan supported education programme had higher scores on measures of school self-efficacy and empowerment than those in the control condition (Collins et al, 1998, as cited in Mowbray & Collins). At 12 month follow-up

programme participants in the active conditions also had significantly higher scores for quality of life and self-esteem, and lower scores on social adjustment problems than control group participants (Mowbray et al, in press, as cited in Mowbray & Collins, 2002).

Only one study looked at changes in hospitalisations, and this found a significant decrease in stays in hospital over the first year of the programme and through the five to eight year follow-up period (Danley, 1997; Unger et al, 1991, both as cited in Mowbray & Collins, 2002).

Consumer satisfaction with supported education has generally been found to be reasonably high. Cook and Solomon (1993) found that 49% of participants were very satisfied and 42% mostly satisfied, with 53% rating the programme as excellent and 42% rating it as good. Fifty-nine percent of participants said they would definitely recommend it to a friend and 34% thought they would, as cited in Mowbray & Collins, 2002). Qualitative research with participants also reports positive perceptions of supportive education. Participants frequently mentioned the value of group support and encouragement and said that one of the benefits of supported education was improved self-concept, in terms of self-efficacy and self-confidence. Gaining skills and a feeling of hope for the future were also mentioned as benefits (Bellamy & Mowbray, 1998, as cited in Mowbray & Collins, 2002).

Conclusion on supported education

Increasing education and qualifications has the potential to improve employability and earnings. However, a lack of research, and the low rigour of existing research, makes it difficult to come to any firm conclusions about the impact of supported education on employment. The available research suggests that supported education improves participation in education, although it is not clear whether it has any impact on gaining qualifications. There is also tentative evidence that it improves rates of individual work placements, permanent work placements, earnings, hours worked and non-work outcomes such as self-esteem and quality of life. Consumer satisfaction with supported education services appears reasonable to date. More research, of a higher quality, with longer follow-up periods after intervention, and investigation of employment outcomes and academic qualifications gained, is desperately needed.

Vocational training

Key point summary – vocational training

- Definitions of vocational training differ and there is no standard programme
- The research on vocational training is generally low in rigour, with outcomes broadly defined, and not focused on the impact of training on paid employment rates
- Two bodies of research exist – one on what is effective with the general population, and one on what is effective for people with experience of mental illness
- The characteristics of vocation training that are more likely to result in increased employment and earnings for the general population include: longer duration, more actual training content, leading into formal education, using effective teaching methods, a focus on basic and remedial education, training in specific occupations, a focus on skills in demand in the local market, close contact with local employers, tailored to the needs and strengths of individuals rather than ‘one size fits all’, and either learning at work or combining periods of training with periods of work
- Generic ‘training for the sake of training’ has been found to be relatively ineffective with the general population – less effective than no training at all
- It is not clear how applicable these findings are to people with experience of mental illness
- Rigorous studies of the impact of pre-vocational training on employment of people with experience of mental illness show that it is less likely to lead to competitively paid employment than supported employment and is no more effective than standard community care
- Some less rigorous studies suggest positive impacts of training on non-work outcomes such as skills, functioning, motivation, life satisfaction, mental health and hospitalisation, but more rigorous studies find no significant impact on hospital admissions or discharges for vocational training
- Pre-vocational training, as it is usually conducted, does not appear effective in increasing participation in paid work
- Training for people with experience of mental illness appears more likely to be effective when it occurs in work settings, uses cognitive interventions, teaches skills to solve problems, cope with work stress and interact successfully with colleagues and supervisors, and takes place for a limited time.

‘Pre-vocational training’ refers to training that takes place prior to searching for, or taking part, in paid employment. It is usually focused on generic work skills rather than skills needed for a specific job and often open-ended until the point of ‘work readiness’. Many of the interventions are described in the research as ‘pre-vocational training’, but Schneider et al (2002) note that there is no standard form of pre-vocational training (PVT) with a manual. So, one pre-vocational training programme can differ dramatically

from another. There appear to be more studies of vocational training programmes than of supported education (Schneider et al, 2002). But as with supported education, studies of vocational training interventions suffer from a very broad definition of 'outcomes', and a relatively low level of rigour.

What is effective for the general population

In the general population training programmes aimed at getting young people into work have not proven very successful (Bowers et al, 1999; Lerman, 2000; Ryan, 2001b, all as cited in Higgins, 2003). This is in part because they have been poorly implemented and poorly evaluated (Grubb, 1999, as cited in Higgins, 2003). The training programmes that have worked in supporting young people into employment have some common characteristics. They tend to have more actual training content and be longer in duration (Fougere et al, 2000; Ryan, 2001b, both as cited in Higgins, 2003). They also integrate training with formal pathways into education, particularly for those who left school early or failed at secondary school. This might mean that participants transfer from remedial courses to regular tertiary courses, or that training results in a qualification recognised by both employers and job seekers (Fay, 1996, Grubb, 1999, both as cited in Higgins, 2003).

Effective training programmes, with the general youth population, also use effective teaching methods, focus on both basic and remedial education, training in specific occupations, and work-based learning (that is, learning while on the job) (Grubb, 1999, as cited in Higgins, 2003). They are most likely to be successful in increasing employment when they focus on building skills that are needed in the local market, and maintain close links with local employers. In this way they keep track of what employment opportunities are available locally and ensure that they train in skills that are actually relevant to the local market (Grubb, 1999, Lerman, 2000, O'Connell & McGinnity, 1997, all as cited in Higgins, 2003).

Programmes to move unemployed young people into work are also more effective when they tailor services and interventions to the needs and strengths of the individual, rather than using a 'one size fits all' approach (Fay, 1996; Jackson, 1994, Woodfield et al, 2000, all as cited in Higgins, 2003). Combining training with periods in regular employment also has a greater impact than delivering training in isolation from the work setting (Nicaise, 1999, as cited in Higgins, 2003).

In addition, training programmes have more success when they include a wide range of supports, such as transport, counselling, childcare and job placement services (Grubb, 1999, Lerman, 2000, Nicaise, 1999, all cited in Higgins, 2003). A randomised controlled trial found that cognitive-behavioural therapy was associated not only with improved mental health among job seekers but also with greater success in finding work. While the job seekers did not have previous experience of mental illness, many scored high enough on the general health questionnaire (at the start of the therapy) to qualify for 'psychiatric caseness' (Proudfoot, Guest, Carson, Dunn & Gray, 1997).

Job search assistance, career guidance, and support services have also been found useful, the latter extending after training for six months to a year in some cases (NYEC, 1999, as

cited in Higgins, 2003). There is also some suggestion that services, which are culturally relevant to the participant, such as trainers from the same culture who speak the same language, may be more effective (Higgins, 2003).

Generic ‘training for the sake of training’ has been found to be the least effective approach to improving job placement and earnings for young people in the general population, even less effective than no training at all (O’Connell & McGinnity, 1997, as cited in Higgins, 2003).

It is questionable how applicable these findings are to people with experience of mental illness, given Bond’s (1998) finding that some strategies that work well for the general population (for instance, job clubs) do not work as well for people with experience of mental illness. In the end, while it is useful to consider strategies that are effective with the general population, the more important body of evidence concerns what works with people with experience of mental illness.

What is effective for people with experience of mental illness – work outcomes

There is significant rigorous evidence, from the US, that traditional pre-vocational training is not as successful in leading to competitive employment as supported employment, which supports individuals straight into work without prior training (Crowther et al, 2001, 2003). This is based on five randomised controlled trials (RCTs), Pre-vocational training (PVT) was also found to be no more effective than standard community care in supporting people in competitive employment at 18 and 24 months. (Crowther et al, 2003). Adding treatment at a mental health centre to pre-vocational training resulted in a positive trend of increased effectiveness for finding competitive employment. This trend did not reach significance although the intervention did make a significant difference to numbers in any kind of employment (Blankertz & Robinson, 1996, as cited in Crowther et al, 2003) or any kind of employment, training or education (Kline & Hoisington, 1981, as cited in Crowther et al, 2003).

One randomised controlled trial identified positive outcomes for the majority of clients who participated in basic job skills training (34 out of 61). However, the definition of ‘positive outcome’ was very wide. It included moving into competitive employment (six people), state vocational rehabilitation work training programmes (eight people), other work training programmes (four people), further education (four people) and volunteer work (one person); or being in the process of entering the state work training programme or attending interviews (eleven people) (Jacobs et al, 1992, as cited in Schneider et al, 2002). This cannot be taken as evidence of effectiveness in increasing paid, open market employment.

A further randomised controlled trial, of a job search training programme, found that at twelve months only 16% of the programme participants were unemployed compared to 26% of the control group, a statistically significant result. At the six month follow-up the difference was not significant, suggesting that longer follow-ups are needed to tell the true impact of an intervention (Kaufman, 1995, as cited in Schneider et al, 2002). A less rigorously evaluated programme succeeded in getting 32 clients involved in open

employment for at least 60 days, but as there was no comparison group this figure has little meaning (Ahrens et al, 1999, as cited in Schneider et al, 2002).

One RCT showed that significantly more clients in the prevocational training (PVT) programme found any type of work (including but not limited to competitive employment) than in the standard hospital care condition (Becker, 1967, as cited in Crowther et al, 2003). Another RCT found that people in pre-vocational training earned more per month than those in standard hospital care (Kuldau & Dirks, 1977, as cited in Crowther et al, 2003). It should be noted that these two last studies are quite old.

Overall, the randomised controlled trials do not show a high level of evidence for the effectiveness of vocational training prior to job searching or employment in increasing rates of open employment for people with experience of mental illness. There is also some evidence that people on training programmes, who fail to find competitive work, can experience a decline in mental health (Spaulding et al, 1996, as cited in Schneider et al, 2002). Drop out rates from training courses also tend to be high (e.g. Unger 1991, as cited in Schneider et al, 2002). They are often over 40% and little is known about the reasons for this high rate (Bond et al, 1997, as cited in McAlpine & Warner, 2002).

It should be borne in mind that not every vocational training programme is the same in design, quality and effectiveness, so it is premature to lump them all together as 'ineffective'. Clearly, the traditional form of prevocational training, where generic job skills training is provided to the point of 'work readiness' as judged by training staff, and where clients often become "stuck" for long periods of time, is not as effective as supported employment in leading to competitive work. However, some other forms of vocational training may prove helpful. A later section explores the ways that vocational training programmes could be made more effective, based on research with both general populations and people with experience of mental illness, and also looks at why this may be worthwhile doing.

What is effective for people with experience of mental illness – non-work outcomes?

A randomised controlled trial (RCT) of pre-vocational training versus standard hospital care found that there was no difference in rates of discharge from hospital for the two approaches (Kuldau & Dirks, 1977, as cited in Crowther et al, 2003). However it should be noted that this is quite an old study and it is not clear how much it applies to current circumstances. Three other studies showed no differences in rates of admission to hospital for those receiving pre-vocational training versus community care once client differences had been taken into account (Beard, Malamud & Rossman, 1978, Dincin & Witheridge, 1982, Wolkon, Karmen & Tanaka, 1971, all as cited in Crowther et al, 2003).

Participants in a psychosocial education programme showed significant improvements in life satisfaction, functioning, vocational skills and mental health, and a trend towards greater recovery (Bullock et al, 2000, as cited in Schneider et al, 2002). One programme, which added treatment at a mental health centre to the pre-vocational training, did not

find any better clinical outcomes (e.g. reduction in symptoms, admission to hospital) (Kline & Hoisington, 1981, Blankertz & Robinson, 1996, both as cited in Crowther et al, 2003).

Overall, findings are mixed regarding the impact of vocational training programmes on non-work outcomes. The most rigorous studies appear to indicate that pre-vocational training has not more impact than standard hospital or community care.

How vocational skills training could be made more effective in supporting people into competitive employment and increasing earnings

Reasons for continuing to provide vocational training: The consensus of expert opinion is that pre-vocational training is not as effective as immediately supporting people into competitive employment (Crowther et al, 2001, 2003; Schneider et al, 2002). Given that supported employment is so effective in improving work outcomes, there would need to be good reason for continuing to provide vocational training programmes.

One reason is that reviews of training with the general population show that some types of vocational training are more effective in increasing work placement and earnings. (Higgins, 2003). This kind of training should not be confused with traditional prevocational training that is time-unlimited and does not link training to actual vacancies in local markets. However, it is not clear that these effects would generalise to people with experience of mental illness, as this research has not been conducted.

Vocational training which is linked to local market needs, has the specific aim of supporting people into local jobs as soon as they are up-skilled, and which has a high level of specific work-related training content rather than 'generic' training content is effective with the general population (Higgins, 2003). It could be the case that training with this design could also benefit people with experience of mental illness. The emphasis on consumer preference and choice would need to be retained in order to avoid the trap of training people for jobs simply because they are available locally.

Some research on supported employment indicates a tendency for people to leave their jobs after a relatively short period, as little as 9.4 to 13 weeks. Some move to other work, but more either quit or are fired (McAlpine & Warner, 2002). There are a few training programmes that attempt to address this by improving work skills, either before placing people into work or once they are in work. One study showed promising results after providing training in 'workplace fundamentals' for people with experience of mental illness who were in work. The small group of employed people, who received training in identifying work preferences, using problem solving to cope with work stress, manage symptoms and medications, and learning how to interact with peers and supervisors to improve both work performance and socialise, stayed in work for the three months of training and six months to follow-up. The small group of unemployed people who learned the same skills did not show marked levels of job finding six months after training ended (Wallace, Tauber & Wilde, 1999). This suggests that work skills training

was more useful to people who were actually in work and could apply the skills on the job, and more relevant in respect of job rather than job finding. While staying in work for the entire nine months of the study period is a marked improvement over the 9.4 to 13 weeks found in some evaluations of supported employment services (Bond et al, 1997, Becker et al 1998, both as cited in McAlpine & Warner, 2002) the small numbers of people in the group and lack of long-term follow-up or replication makes it impossible to draw firm conclusions about the impact of this approach on job retention.

Training in work-appropriate social skills might aid employment chances (Chadsey & Beyer, 2001, as cited in Schneider et al, 2002). One small study found that time-limited training in social skills related to the workplace, prior to finding paid work, followed by support for an unspecified period, was associated with greater success in obtaining employment when compared with those who were randomly assigned to training only or a control group (Tsang, 2001). This particular training focused on basic social skills (e.g. communication), basic job survival skills, general skills required to find and cope with any job (e.g. making a good impression in an interview, maintaining a good relationship with a work supervisor), problem solving skills, assertiveness and conflict resolution. While the design was rigorous the number of participants (97 spread across three conditions) was relatively low, and the follow-up period was only three months. Statistical significance of results was not provided. The key elements of this type of approach are that it is time-limited, teaching very specific skills which are relevant to the open market workplace, and with the expectation that participants will be seeking competitive work. One caveat concerning the Tsang et al (2001) study is that only 20% of the potential participants referred to training agreed to take part. This is in line with findings that many clients drop out of training, which is required prior to job search, because they find it boring and unnecessary (Drake, Becker, Bond & Mueser, 2003).

Timing of vocational training: Timing of training does seem to be a factor affecting its impact on employment outcomes. Recent research suggests that providing training before placement in work is not the most effective option (Becker, Drake, Bond, Xie Dain & Harrison 1998; Bond, 1998; Crowther et al, 2001, 2003). When two types of supportive employment were compared, one with early placement in employment followed by training and the other with prior training followed by employment, the early placement in employment model resulted in better outcomes for competitive employment (Drake, McHugo, Bebout, Becker, Harris, Bond & Quimby, 1999, as cited in Bustillo, Lauriello, Horan & Keith, 2001). However, it was not clear whether this was due to early placement, or the integration of services in the early placement model. One article that reviewed six rigorous studies concluded that both were important to good work outcomes (Bond, Drake, Mueser & Becker, 1997). Becker, Drake, Bond et al (1998) investigated why people with experience of mental illness left their jobs, and what might make a difference to retention. They found that pre-employment skills training did not reduce the risk of people being fired or quitting, although training was mentioned by some clients as an accommodation that would have helped them stay in work.

A recent review by Drake et al (2003) found that even when training sessions:

Were competently run by an experienced trainer some clients found them irrelevant or unnecessary and dropped out of the program before beginning a job search (page 53).

Work experience and assessment prior to job search were also associated with higher drop out rates. However, even when job search was rapid there were still high drop out rates, suggesting that they may have been related to a failure to engage with clients as much as delaying job finding (Drake, et al, 2003).

Other issues mentioned by individuals who were fired or quit support employment placements include interpersonal difficulties, quality of work, and juggling the competing demands of managing symptoms, medications, work relationships and tasks (Becker, Drake, Bond et al, 1998). The authors concluded that clients need help not just at the beginning of a job but over time, and that interventions need to be specifically tailored to address the skills and supports for a specific job. Warriner (2003) has identified the three to nine month period of work involvement as the crucial period for problems to occur and recommends that employment staff need to prepare to address these as they arise. This suggests that any training that takes place should be purpose-designed for that person, rather than generic, and delivered alongside work involvement, possibly in a coaching rather than traditional training style.

Setting of vocational training: Work training that occurs in integrated work settings, alongside non-disabled colleagues, has been found to offer more positive role modelling than training that takes place in sheltered settings or volunteer work (Cook & Razzano, 1992, as cited in Cook & Razzano, 2000). In addition, training that takes place in the work setting, where the skills are to be applied prevent difficulties transferring the learning from the training to the work environment (Cook & Hoffschmidt, 1993, as cited in Cook & Razzano, 2000). Recent studies, examining the effect of providing training while people are in work report success in improving work performance using cognitive interventions, which personalise the training to the actual job situation (Bell, Lysaker & Bryson, 2003, as cited in Bond, 2004).

What appears to make vocational training more effective: Based on this review, the following strategies are recommended to for making vocational training most effective:

- Provide training that is linked to local employers and the skills they need in the local marketplace
- Include a high level of work-related content rather than ‘generic’ work training
- Emphasise consumer preference and choice in training and work choice (i.e. do not engage an individual in training simply because there are vacancies for people with those skills)
- Train in social skills related to the work-place in particular
- Provide training once job searching or employment is underway, rather than prior to job searching

- Make training time-limited whenever it occurs, not open-ended to the point of 'work readiness'
- Match training to the needs of the individual and the needs of the job
- Use training staff who are committed to supporting people with experience of mental illness in competitive work
- Focus on training for work-relevant qualifications or skills that the individual both wants and needs in order to remain in the job or progress in their career.

Conclusion on rehabilitation/vocational skills training

Vocational skills training does not appear to be nearly as effective in moving people into employment as supported employment. This conclusion is tempered by the facts that not all training programmes are the same, and some may potentially be more effective than others. Certainly the traditional model of pre-vocational training does not appear to be effective. The primary problems with training programmes appear to be a lack of work-related content, a lack of focus on placement into competitive employment, and possibly the fact that they largely take place before people are in a work situation where they can apply what they learn. Schneider et al, (2002) conclude that for training approaches to have an impact on employment outcomes they must have a focus on work skills rather than social skills. They also identify that further evidence is needed, which will involve testing a variety of models of pre-vocational training using scientifically rigorous research designs. A number of studies of innovative approaches are under way in Europe and the US, and the results of these may cast more light on just how effective vocational training is, and what type of training is most effective.

Supported Employment

Key point summary – supported employment

- Supported employment involves support in finding open market employment without prior training or unpaid work, and ongoing support once in the workplace
- Rigorous, randomised and replicated studies of supported employment have found it to be consistently superior to other interventions (including sheltered work, pre-vocational training, standard community care and a psychiatric rehabilitation centre) in supporting people into competitive employment
- A number of studies has found that supported employment also results in more hours of work and greater earnings.
- New Zealand research is lacking but one study suggests positive outcomes for supported employment in this country, although it is low in rigour
- Individual Placement and Support (IPS), a standardised approach to supported employment, has been found to be effective supported employment but has not been shown to be any more effective than other supported employment approaches
- Research on the six principles of IPS suggests that those of aiming for competitive employment, using rapid job search, and integration of employment and clinical services are supported and those of consumer choice, continuous assessment and time unlimited support need more research to be definitely supported
- Research indicates that both rapid placement into work without prior training, and integration of employment with mental health services, are important factors associated with the positive impact of supported employment
- Supported employment does not appear to improve rates of retention in work, and dropout rates from supported employment services appear reasonably high, particularly where employment and clinical services are not integrated
- In terms of non-work outcomes many studies show no significant differences between supported employment and other approaches, although the competitive work that supported employment results in appears to have a more positive impact on non-work outcomes than sheltered work and minimal work, including self-esteem, psychological symptoms, and quality of life
- Reservations about supported employment include placement into entry level jobs, and problems with retention in services and work, although there is little evidence that other approaches do any better
- Well-designed research shows that self-help employment centres, run by people with experience of mental illness and professionals, hold promise for moving people into competitive employment at higher rates than other services, and almost as effectively as supported employment.

A new approach to vocational rehabilitation, known as supported employment, was developed in the mid-1980's known as supported employment (Crowther et al, 2003). With this approach, consumers move into competitive employment in the open job market at regular wage rates without extended prior training and preparation. They are supported in seeking and coping with work by a job coach or other employment specialist. The work may be full- or part-time – the important thing is that it is permanent, and a job that is open to any member of the community to apply for, not just people with experience of mental illness (Crowther et al, 2003; as cited in National Institute for Mental Health in England (NIMHE, 2003).

Impact of supported employment on work outcomes

Overviews of studies: Randomised controlled studies have consistently shown that supported employment, with rapid entry to the workforce, is successful in supporting consumers into competitive employment (Bond, 2004; Bond et al, 1997; Bustillo et al, 2001; Crowther et al, 2001; 2003; Schneider et al, 2002; Twamley, Jeste & Lehman, 2003).

Bond et al (1997) reviewed six randomised controlled trials and concluded that in every case, rapid entry supported employment was more effective than prevocational training followed by work placement. The exception to this finding was a very successful supported employment programme with young people aged 15 to 24, which was preceded by a month of prevocational training (Gerverey & Bedell, 1994). However, as training plus employment services was not compared to employment services without training it is impossible to say whether the training actually made a positive difference, or whether it was the employment support services that were the crucial factor.

Bustillo et al (2001) identified three randomised controlled trials for supported employment. Those trials demonstrated considerable advantages of supported employment over the control interventions (which largely took the form of pre-employment training). In the supported employment programmes an average of 65% of consumers found competitive employment compared with an average of 26% for the control conditions (Bond, Dietzen, McGrew & Miller, 1995; Drake, McHugo, Bebout, Becker, Harris, Bond & Quimby, 1999; Drake, McHugo, Becker, Anthony & Clark, 1996, all as cited in Bustillo et al, 2001). This was despite both supported employment and control interventions providing about the same amount of support overall. Rates of rehospitalisation were equivalent for both experimental supported employment and control conditions (Bustillo et al, 2001). Individuals in supported employment also appear to earn more and work more hours than those involved with other types of employment support services (Crowther et al, 2001). The positive results associated with supported employment reported through the earlier studies have been replicated in urban settings and with people from different cultures. This suggests that the early results were not due to chance but to reliable effects of the approach (Bustillo et al, 2001).

In 2001 a Cochrane Library review carried out by Crowther et al showed that supported employment was more effective than prevocational training at 4, 6, 9, 12, 15 and 18 months and more effective than standard care at 21 and 36 months. In an update, Crowther et al (2003) concluded, on the basis of five randomised trials of reasonable quality, that supported employment was more effective than pre-vocational training in getting people into open-market employment. They reported that in one case 34% of the people in supported employment were employed eighteen months after the intervention was implemented, compared to 12% of those in pre-vocational training, a statistically significant result. Individual Placement and Support was found to be an effective form of supported employment, but there were not enough data to say whether it was more effective than other less specific forms of supported employment (Crowther et al, 2003).

In addition, it was found that consumers in supported employment earned more and worked more hours than those in pre-vocational training (Crowther et al, 2003). An individual study by Lehman et al, (2001) found that individuals who found work through either supported employment or vocational rehabilitation showed no significant difference in hours worked or wages (as cited in Schneider et al, 2002).

A recent meta-analysis of vocational rehabilitation approaches found that supported employment was more effective in supporting people into competitive work than the control conditions. Through the five studies reviewed an average 51% of people doing supported employment were in work at any time during the studies, compared to 18% of those with other types of services. Comparison conditions included unpaid pre-vocational training, unpaid work and standard community care. The effect size of all the supported employment studies was .79, which is large. Overall, people who took part in supported employment were around four times as likely to obtain paid work in the open market as those in the comparison interventions (Twamley et al, 2003).

The quality of the research is high and the findings are consistent. Despite being relatively new, and compared in many cases to well-established vocational services, supported employment services consistently show better results in moving people with experience of mental illness into paid work than other types of approach (Bond, 2004).

New Zealand research

Crowther et al (2001, 2003) have commented that while supported employment results appear generalisable, applying fairly equally across diagnoses, genders and ethnicities, it cannot be assumed that the same positive results will be obtained in countries with different economic and benefit systems. For this reason it is important to examine local data in New Zealand to investigate whether supported employment works as well in this country.

Unfortunately, there is not a lot of New Zealand research on supported employment to date. The Ministry of Social Development is one year through a two-year implementation of supported employment pilots, including two with people with experience of mental illness, but no data is yet available on the outcome of these trials. Through the present review, one piece of literature was found on a supported

employment service in Auckland (Warriner, 2003). This was a report on outcomes for clients of the service only, and did not use a control or comparison group. During the 2001-2002 period, 59% of clients were in employment and 41% not. This compares favourably with rates of placement through supported employment services internationally, which have been found to range from 32% to 78% (Bond et al, 1997, as cited in McAlpine & Warner, 2002). The range of clients using the service in 2001-2002 included 90 with a diagnosis of schizophrenia, 40 with a diagnosis of bipolar disorder, 32 with a diagnosis of major depression, 5 or less with a diagnosis anxiety disorder or borderline personality disorder, and 50 people with other diagnoses (Warriner, 2003). Judging by the two Cochrane Library reviews this makes it fairly similar to overseas client groups, making results comparable in a very broad sense (Crowther et al, 2001, 2003).

The most frequent occupational category was Hospitality/Personal/Service with 21% in this occupation (Warriner (2003) notes that the next most frequent occupational groups were less stereotypical, with 14% in Professional/Trade occupations, 11% in Retail/Sales, and 10% in Factory/Warehouse positions. In 2001-2002 it took an average employment of 80.77 days for clients to be supported into work. For those who found employment in 2003, the average number of weeks in work was 16.1, whereas the previous year it was 39.9. While this is not a study of a level of rigour that make it's findings highly reliable, it does give a preliminary indication that supported employment is effective in placing people with experience of mental illness into competitive work in New Zealand, including people with experience of more severe mental illnesses.

Impact of Individual Placement and Support on work outcomes

Individual Placement and Support (IPS) is a form of supported employment. IPS is not seen as a distinct employment model, but is intended to standardise and clearly describe the principles of supported employment (Bond, Becker et al, 2001, as cited in Schneider et al, 2003). IPS aims to rapidly support consumers into regular jobs at regular pay rates. The employment service provider is part of the community mental health team, rather than being part of a separate team and/or organization (NIMHE, 2003). In IPS an employment specialist has daily contact with the mental health team, attending team meetings and participating in decision-making. Another characteristic of IPS is that support is continued indefinitely rather than being time-limited (Schneider et al, 2002). Seven key principles for IPS have been developed from the literature:

1. The goal is competitive employment in work settings integrated into a community's economy
2. Clients are expected to go straight into work, rather than taking part in lengthy pre-employment training ('rapid job search')
3. Employment is considered a part of overall treatment, and employment services are integrated into mental health treatment services rather than being a separate service
4. Services are based on clients' preferences and choices
5. Assessment is continuous and based on real work experiences,

6. Follow-along support is continued indefinitely (Bond, 1998b, as cited in Crowther et al, 2003)
7. Benefits counselling is provided to address the barrier formed by fear of losing benefit income (Bond, 2004).

Principle 1 *The goal is competitive employment in work settings integrated into a community's economy*

In reviews of research relating to these six principles, Bond (1998, 2004) found good evidence for half of them, and less evidence for the others. In terms of Principle 1, he found that when the goal of interventions was supporting people into competitive employment, more people moved into work. However, when the goal was improving work readiness through ameliorating symptoms or other means, competitive employment was less likely. Also, when other types of work options were offered (such as sheltered work or agency-run businesses) people became less likely to end up in competitive work (Bond, 2004). The best predictor of employment outcomes from the Supported Employment Fidelity Scale is the item assessing whether employment specialists spend most of their direct contact time in activities outside the office, (Becker et al, 2001) as cited in Bond, 2004). There is some evidence that the most effective way of supporting people into work is direct assistance in finding work, and that self-directed job search strategies, such as job clubs, do not work as well with many people with experience of severe mental illness (Bond, 1998). There is little evidence that approaches which do not include direct support with finding employment, such as medication or case management, improve employment outcomes when used in isolation. Rather, some (such as family therapy or social skills training) may enhance the impact of vocational services but be relatively ineffective on their own (Bond, 2004). Research by Wehman and associates have found better employment outcomes for individuals with experience of severe disability including those with experience of mental illness, when they were assisted to find jobs in the community at or above minimum wage in settings with non-disabled people (i.e. mainstream employment) (Wehman & Moon, 1988; Kregel et al, 1989, both as cited in Cook & Razzano, 2000). Non-work outcomes have also been found to be better for people who spend time in competitive employment in the open market (Bond, Resnick et al, 2001, as cited in Bond, 2004). A number of surveys of people with experience of mental illness have shown that work at minimum wages or above is preferred to other options, and offers economic advantages (Cook & Hoffschmidt, 1993, as cited in Cook & Razzano, 2000).

Principle 2 *Clients are expected to go straight into work, rather than taking part in lengthy pre-employment training ('rapid job search')*

Interventions which support individuals straight into work, regardless of their level of work 'readiness', generally lead to more people in jobs than those which provide vocational or rehabilitation services in an attempt to increase work readiness (Dincin & Witheridge, 1982, as cited in Bond, 1998; Bond & Dincin, 1986, as cited in Cook & Razzano, 2000). Work satisfaction has also been found to be higher with rapidly moving into work (Bond, Dietzen, McGrew & Miller, 1995, as cited in Cook & Razzano, 2000). Often feelings of demoralisation can be experienced with prevocational training that is aimed at 'work readiness' and has no clear end in sight (Schultheis & Bond, 1993, as

cited in Cook & Razzano, 2000). Even when supported employment services are provided, asking clients to take part in group skills training before searching for work results in worse employment outcomes than for client groups that move straight into job searching (Drake, McHugo, Becker, Anthony & Clark, 1996, as cited in Bond, 1998). A study of clients with experience of severe mental illness found that those who had previously worked in sheltered workshops were significantly less likely to achieve competitive employment, even after controlling for factors such as education, severity of illness, level of functional impairment, length of time in services and the nature of employment service received (Cook & Razzano, 1995, as cited in Cook Razzano, 2000). Bond (1998) concludes that:

The evidence is strong that prevocational activities do not improve employment chances, but rather do the opposite, that is, decrease the probability of later employment (page 15).

Principle 3 *Employment is considered a part of overall treatment, and employment services are integrated into mental health treatment services rather than being a separate service* Bond (1998) notes that integration of services has been found to be more difficult with multiple providers. One random controlled trial showed that, where employment services were co-located with mental health services, clients were significantly more likely to find work, work more hours and weeks, earn more, and stay longer in the job (Mueser, Clark, Haines, Drake, McHugo, Bond, Essock, Becker, Wolfe & Swain 2004). Better employment outcomes have also been found for services that integrate employment and other services compared to brokered models. Clinical service providers, brokering to vocational services, have been found to place the burden of integration on clients and lead to conflicting plans, miscommunication and dropouts (Bond, 1998). In contrast, where clinical and employment services are integrated, clients have been found to be less likely to drop out of services before finding competitive work, and employment plans have been more informed by clinical expertise (Drake et al, 2003). Given the link between managing symptoms and medication and early job termination, this input also has the potential to improve retention in work (Becker, Drake et al, 1998).

Principle 4 *Services are based on clients' preferences and choices*

Principle 4 concerns clients' preferences and choices. Contrary to what is sometimes assumed, consumer preferences for work have been found to be realistic, as well as being stable over time (Becker, Drake, Farabaugh & Bond, 1996; Becker, Bebout & Drake, 1998). Consumers also prefer rapid entry into work and paid employment. Studies reviewed by Bond (1998, 2004) found that consumers who were matched with jobs of their choice were generally more likely to be satisfied with work and stay longer on the job. A later replication by Becker, Bebout & Drake (1998) did not find significant differences in job satisfaction or tenure when clients were matched with jobs of their preference. However, very few people (six out of 152) did not work in a job of their preference, reducing the statistical power of analyses. Results were also confounded by use of different instruments in the second study to those used in the first study. Other research has found that individuals who are able to choose how many hours they work are likely to experience fewer mental illness symptoms than those who had to work a set

number of hours, whether a low number (10) or high number (20) (Bell & Lysaker, 1996). Also relevant is the finding that flexible hours was the most commonly requested accommodation at work for people who were having trouble staying in work (Becker et al, 1998). Overall, the evidence for Principle 4 seems less convincing than for Principles 1 to 3 but this is very likely due to a lack of research on consumer preferences and their impacts.

Principle 5 *Assessment is continuous and based on real work experiences*

Principle 5 is that of continuous and comprehensive assessment throughout placement and employment, rather than only occurring prior to employment. The quality of pen and paper and work sample tests traditionally used is questionable, with their ability to predict work outcomes not established. There is some evidence that assessment of people with experience of mental illness may be complicated by medication side effects, symptoms and cognitive impairments that are part of some illnesses (Cook & Pickett, 1995, as cited in Cook & Razzano, 2000). People with experience of psychiatric disorders have also been found to perform differently in different environments (Schultheis & Bond, 1993, as cited in Cook & Razzano, 2000). One study reported by Cook & Razzano (2000) found that situational assessment of work behaviours of 275 clients significantly predicted employment status six months later, even taking into account their symptoms, diagnosis, race, living arrangements and lifetime hospitalisation (Rogers, Anthony, Cohen & Davies, 1997, as cited in Cook & Razzano, 2000). Other studies have also found that situational assessment predicts later employment as well as hourly wage, total weeks worked and total earnings (Black, 1986; Bond & Friedmeyer, 1987; Cook, 1991; all as cited in Cook & Razzano, 2000). While Bond (1998) provides evidence that traditional assessment techniques are lacking in efficacy, there is still not a large body of research to conclude that the methods of assessment used in IPS are more effective.

Principle 6 *Follow-along support is continued indefinitely*

There is some research showing that time-limited support is associated with drop-offs in employment rates, and longer support is associated with maintenance of competitive employment (Bond, 1998). However, contradictory results have appeared, such as that of McHugo, Drake & Becker (1998) who found that even when 40% of vocational service clients stopped receiving support after one and a half years, overall competitive employment rates did not go down significantly in the next two years. However, clients in the IPS condition who continued to receive services over the next two years had twice the levels of competitive employment as those who did not continue to receive support. Clients in the other condition (Group Skills Training) did not show the same response to receiving continued support (McHugo et al, 1998). This suggests that time-unlimited support might be particularly important for people in Individual Placement and Support Services.

Cook and Rosenberg (1994) found in a study of 550 outpatients, who took part in vocational rehabilitation that ongoing support significantly predicted employment six months afterwards, even after controlling for age, education, work history, functional impairment, hospitalisation history, time in treatment and other types of job support received (as cited in Cook & Razzano, 2000).

Principle 7 *Benefits counselling is provided*

The inclusion of benefits counselling as a principle is based largely on the evidence that fear of losing welfare benefits forms one of the largest barriers to employment for people with experience of mental illness (MacDonald-Wilson, Rogers, Ellison & Lyass, 2003, as cited in Bond, 2004; McQuilken et al, 2003). The evidence to date benefits counselling in respect of improving employment outcomes, is more anecdotal than rigorous. Tremblay et al (in press) found that benefits counselling results in higher earnings from employment for people using vocational rehabilitation services compared to historical controls (as cited in Bond, 2004), but this is the only experimental study located.

Overall, some of the principles of IPS have considerable evidential support, while others need more research to be fully supported.

Bond et al (1997) concluded that IPS was more effective in supporting people into work than vocational rehabilitation, standard state-federal provided day treatment, or sheltered workshops. More recent reviews and studies of employment services for people with mental illness support these findings (Bond et al, 2001, Crowther et al, 2001, Lehman, Goldberg, Dixon, McNary et al, 2004). Crowther et al (2001) reviewed 18 random controlled trials of vocational rehabilitation and concluded that the IPS model of supported employment was more effective than prevocational training.

Impact of supported employment on non-work outcomes

There is strong evidence that supported employment is more effective in supporting clients into competitive employment than pre-employment training and sheltered work. It also has an impact on a number of other outcomes, such as earnings, although these are less often investigated.

Retention in work: A recent study found that while supported employment was more effective than psychosocial rehabilitation (the type of approach delivered through Clubhouses) in supporting people into competitive work once in work clients from both programmes showed no differences in how long they stayed in each job (Lehman, Goldberg, Dixon, McNary et al, 2002). Both groups had trouble with maintaining employment. This suggests that while supported employment is very effective in getting people into work, there are still difficulties with supporting clients to stay in work.

Another study found that people were more likely to stay in a job attained through supported employment when they were satisfied with it, but after three months this effect became weaker, so that job satisfaction was not quite as important a predictor of job retention (Resnick & Bond, 2001). Other studies have found that matching people with their preferred type of work increases the likelihood that a person will work longer hours. (Becker et al, 1996, Mueser et al, 2001, both cited in Schneider et al, 2002) and stay longer in their jobs (Xie et al, 1997, as cited in Schneider et al, 2002).

A New Zealand study noted that retention in work usually dips at the three to nine month mark, when the 'honeymoon' of first finding work is over and the reality of going to work each day sets in (Warriner, 2003). Problems experienced at this time are less

associated with tasks of the job, which have usually been mastered, and more with relationships with colleagues, and coping with the social environment and culture of the workplace. For this reason planning and targeting supports for this phase are recommended. By implementing this type of support, this particular service managed to increase the numbers of people staying more than 12 months in a job from 20% over all the years of the operation to 35% in the 2001-2002 period. An even more noticeable increase occurred for the six to 12 month retention rate, from 10% to almost 25%. Clients staying only up to three months in a job dropped from 25% to just over 15%. These figures may be skewed somewhat by inclusion of clients who had been with the service for less than a year, and statistical significance was not tested (Warriner, 2003). This appears to be a better rate than many recorded for overseas interventions, such as an average in two studies of 9.4 and 13 weeks respectively, although the two sets of figures are not directly comparable (Bond et al, 1997, Becker et al 1998, both as cited in McAlpine & Warner, 2002).

Retention in supported employment services: Bustillo et al (2001) also noted that up to 40% of individuals, who started on supported employment dropped out of the service before finding work. So while outcomes are good for those who stay involved, there may be some clients who find the approach not to their liking and would be better suited by a different approach. However, it is not clear whether dropout rates for supported employment were any higher than for other approaches. In one supported employment study the dropout rate was lower than for a sheltered workshop (Gervey & Bedell, 1994).

Quality of life and mental well-being: A rigorous review of eleven trials of supported employment found inconclusive data on differences in clinical and social functioning (participation, hospital admission etc) between supported employment and pre-vocational training (Crowther et al, 2001). The most recent review found no better outcomes for participation, overall functioning, self-esteem, mental state, quality of life or psychiatric symptoms for supported employment than for pre-vocational training (Crowther et al, 2003). The two IPS programmes reviewed also had no more impact on participation, self-esteem, mental state, overall functioning or quality of life than pre-vocational training (Crowther et al, 2003). In terms of costs, one study found no differences, one found differences that were difficult to interpret due to the confounding effects of treatment, and another found overall lower health care costs for supported employment despite higher programme costs. The IPS programmes did not differ significantly in cost from pre-vocational training (Crowther et al, 2003). A recent random controlled trial found few significant differences between supported employment, psychosocial rehabilitation (the Clubhouse model) and standard services for non-vocational outcomes (Mueser et al, 2004).

Supported employment does not appear to have positive impacts on quality of life and mental well-being compared to other approaches. However, competitive work – however people get there – appears to have more positive consequences for individuals than sheltered work or minimal work. People in open employment have been found to have greater satisfaction with vocational services, finances and leisure activities compared to people in minimal work and no work over an 18 month period. They also showed more

improvement in self-esteem and psychiatric symptoms than individuals in the other approaches, who showed no improvement (Bond, Resnick, Drake et al 2001).

Employer involvement: There is a suggestion that outcomes for supported employment programmes may be more positive when employers collaborate with treatment teams in developing work supports (Rhodes, Sandow, Taliaferro & Mank, 1993, as cited in Wehman & Bricout, 1999). Positive, sustained relationships between supported employment staff and employers also seem to be associated with good employment outcomes, although this evidence is not strong (Cook, Razzano, Straiton & Ross, 1994, as cited in Wehman & Bricout, 1999).

Family involvement: Parents of people with experience of mental illness have successfully been involved in managing an supported employment service and providing vocational services at community-based programmes (Killiam, Petranek & Harding, 1996; Kutty, 1993, both as cited in Wehman & Bricout, 1999). The impact of parental involvement on outcomes appears to be mixed, with some research showing more positive results, and others showing less positive outcomes (Kelly & Lambert, 1992; Mowbray et al 1995; Siegel & Gaylord-Ross, 1991, all as cited in Wehman & Bricout, 1999). In two rigorously evaluated studies, families were involved in family therapy at the same time as supported employment in one, and in the other families assisted with the vocational process (Gervey & Bedell, 1994; McFarlane et al, 1995, both as cited in Bond et al, 1997). While results for both programmes were positive, it was not clear what impact the involvement of family had on this.

Reservations regarding supported employment outcomes

It is clear from the research reviewed that supported employment results in more people in 'real jobs for real wages' than any other current approach. But rates of employment vary across services, from 32% to 78% (Bond et al, 1997, as cited in McAlpine & Warner, 2002). Concerns have been expressed by reviewers that people are often supported into 'entry-level jobs' (Schneider et al, 2002) with lower earnings, less satisfaction and less of a career path. In addition, job retention is an issue (McAlpine & Warner, 2002). Two studies found that individuals tended to stay in work for an average of 9.4 and 13 weeks respectively (Bond et al, 1997; Becker et al, 1998). In an 18 month follow-up period, 75% of the people who had found work through supported employment experienced the termination of at least one job. Some people left to go to other jobs (13%), but others quit their job (37%) or were fired (16%). Reasons for leaving included interpersonal and psychological problems, dissatisfaction with work and problems with work quality (Becker et al, 1998). However, another study suggested that low retention in work is not a problem only for supported employment, but also for transitional employment in the Clubhouse context (Lehman et al, 2002). This does not change the fact that low retention rates in work are an issue that needs to be addressed in supported employment..

There is also little evidence that supported employment has a positive effect on symptoms, quality of life or social functioning. However, this is also true of pre-

vocational training, with some exceptions. This is a curious finding given the research reviewed earlier which indicates that gaining employment normally has a positive effect on mental well-being. There are some methodological reasons for this apparent lack of impact. Low sample numbers make it difficult to detect clinical changes (Crowther et al, 2003). Where high participation rates have been attained, significant improvements in symptoms are identified as associated outcomes (Bell, Milstein & Lysaker, 1993).

A further reservation is that a substantial amount of effort may be needed to support a person into work in the first place. In one study, around 1,255 job leads followed up led to 188 interviews and 27 job offers (Gervey & Kowal, 1995, as cited in McAlpine & Warner, 2002). It may be that this is not a cost-effective procedure, although supported employment interventions do not appear to be significantly higher in cost than prevocational training (Crowther et al, 2003). Bustillo et al (2001) also noted that up to 40% of individuals who started on supported employment dropped out of the service before finding work. Relative to other types of support employment services this drop out rate is not extreme. For example, drop out rates from training courses are often over 40% and little is known about the reasons for this high rate (Bond et al, 1997, as cited in McAlpine & Warner, 2002). One study from Northern Ireland found a drop out rate from sheltered workshops of over 50% (Whittington, 1997, as cited in Schneider et al, 2002). Prior training, assessment and work experience are associated with higher dropout rates in supported employment, but even where there is rapid job searching, retention rates have still been a problem (Drake et al, 2003). Drake et al (2003) found that retention in supported employment services could be improved by integrating employment services with clinical services. Payment for involvement may also aid retention in supported employment services (Bell & Lysaker, 1996).

Conclusion for supported employment

Supported employment shows better outcomes in respect of competitive employment attainment, than agency-run businesses, sheltered workshops, general mental health services, prevocational services, and gradual entry into work. Supported employment also results in more hours of work and greater earnings in a number of studies. Competitive work appears to have a more positive impact on non-work outcomes such as self-esteem, psychological symptoms and quality of life than sheltered work and minimal work, although many studies show no significant differences between supported employment and other approaches in terms of non-work outcomes. However, non-work outcomes are often not addressed through supported employment studies which makes it harder to draw conclusions, and design issues mean that positive impacts may not be coming to attention fully. The impact of supported employment on rates of hospitalisation is equivalent to that of prevocational employment services according to research to date. Supported employment does not appear to improve rates of retention in work, and dropout rates from services are reasonably high, particularly where clinical and employment services are not integrated, although possibly no higher than other types of service.

Individual Placement and Support, a standardised version of supported employment, is effective in achieving competitive work placements at a higher rate than non-supported employment interventions, but has not been shown to be more effective than other types of supported employment (largely because little research has been carried out comparing them). Research indicates that some principles of IPS – namely a focus on support into competitive work, rapid entry into job search and integration of clinical and employment staff – are supported by empirical data. The remaining three principles of consumer choice, continuous assessment and time unlimited support have not yet been researched sufficiently to draw firm conclusions in terms of impact on employment outcomes.

Overall, research indicates that supported employment is the most effective approach of those currently in existence people with experience of mental illness to find paid work in the open market, although work is needed to increase retention in work and services.

Work placement

In work placement, consumers work in regular jobs without pay or employment rights, in order to gain work experience and skills. Work placement is sometimes used while a person is being assessed for benefits (NIMHE, 2003). While literature suggests that work placements are used fairly regularly, no research was found on the effectiveness of this approach.

Consumer-run employment services

Mutual peer support and self-help in a consumer-professional “Self-Help Center” for employment was found to improve the vocational rehabilitation of a group of people with experience of serious psychiatric disabilities (Kaufmann, 1995). This model involves collaboration between consumers and staff in a five stage process with consumers spending less time with professional staff and more time with peers as they move through the stages. Stage one involves seeing a vocational counsellor and taking part in activities at the centre. In stage two consumers participate in groups, facilitated by professional staff, who teach skills necessary to finding and keeping a job. At stage three consumers start to form self-help groups, and in stage four settle into paid work. At this stage, members learn skills for coping with job stress and dealing with the problems of long-term work. At stage five, members are encouraged to meet after work with peer support groups run solely by consumers, as well as to engage in other social activities at the centre. These supports are intended to be long-term.

The standard of the study is high, with randomised allocation to control or experimental groups and well-matched groups on education, employment, demographics and severity of mental illness. More people in the self-help group condition were working at six and 12 months after starting the programme than those within the control group. There were significant differences between the two conditions in attitudes and behaviour with regard to readiness to work. These were indicated by an evolution from not looking to work to looking for work, then being in unpaid employment or training, then being in paid

employment, then working longer hours. At 12 months, significantly more of the self-help group were either employed or in volunteer work than people in the control group.

With a placement rate of 44%, self-help employment centres appear as effective in supporting people into competitive work as supported employment services at the lower end of the range of placement rates (32% to 78%) (Bond et al, 1997, as cited in McAlpine & Warner, 2002). This indicates that involving people with experience of mental illness in delivering employment services is valuable in supporting individuals with work. More research would be useful to explore how involvement with the delivery of all types of employment support services could positively impact on outcomes.

In the New Zealand context, a supported employment service run completely by mental health consumers appears as successful as similar services run by people who do not necessarily have personal experience of mental illness (McLaren, 2004). However, there is no rigorous research to confirm this. Clients and staff at the service identified benefits to working with people who had had similar experiences, in terms of having role models for success and staff with a greater sense of empathy for clients' situations. However, clients at supported employment services which were not run solely by mental health consumers also expressed a high level of satisfaction with staff and services (McLaren, 2004).

Conclusion on consumer run employment services: The lack of research on consumer-run services makes it difficult to draw conclusions. The one rigorous study located suggests that while self-help employment centres are not as effective in supporting people into paid work as the most successful supported employment services, they could form a valuable part of a comprehensive employment service. It also seems that peer-run supported employment services can be as effective as standard supported employment services, and may in fact have some added benefits. This is an area in which further research of a higher standard would be of great benefit.

Sheltered Employment

Key point summary –sheltered employment

- High quality research on the Clubhouse approach is lacking, making it difficult to draw firm conclusions on its effectiveness
- The Clubhouse approach, while showing reasonably positive work outcomes, does not appear as successful in supporting people into competitive employment as supported employment
- In respect of the Clubhouse approach some positive impacts on non-work outcomes are apparent, but the low rigour of the research means that these differences may be the result of experimental design
- Rates of competitive employment after transitional employment are relatively low compared to supported employment although there are few rigorous studies available
- More time in transition employment appears linked with higher rates of competitive employment
- Social firms are not much researched but appear to be reasonably low in effectiveness in supporting people into competitive employment compared to supported employment
- Some social firms can be seen to support work outcomes in their own right given that they pay market rates or above, provide normal employment conditions and employ largely non-disabled workers
- Sheltered workshops appear to have a low impact on competitive employment, although research is sparse and generally of low rigour
- There are mixed results regarding the impact of sheltered workshops on non-work outcomes, with the most rigorous study showing no improvement in symptoms, life satisfaction or self-esteem
- Research on work stations, crews, enclaves and temporary sheltered work is sparse and of low rigour
- In general, competitive employment rates, as a result of sheltered employment approaches, do not appear high but more research is needed to conclusively state this
- Work stations, work crews, enclaves and temporary sheltered work are all less socially inclusive options than supportive employment.

Sheltered work situations are those in which people with experience of disabilities and/or disadvantages are employed alongside mainly or predominantly other people with experience of disabilities/disadvantages (NIMHE, 2003). They include: the Clubhouse work-ordered day, sheltered workshops, work crews, enclaves/work stations and social firms (although these do not involve sheltered work in the traditional sense of the term).

Not a lot of research is available on any of these options, and what research exists is not of a high level of rigour, making it difficult to draw as many firm conclusions as in earlier sections. One possible reason for this dearth of research is that early studies, indicating that sheltered workshops were ineffective, have put later researchers off studying them (Schneider et al, 2002).

The Clubhouse model

The Clubhouse approach started up in the 1950's in reaction to sheltered employment and the lack of emphasis on work within mental health services. It was thought that better employment outcomes could be achieved by encouraging consumer autonomy and choices in a setting outside the traditional mental health system. The Clubhouse is a venue run by staff and consumers, where people with experience of mental illness meet for social activity, mutual support and a variety of work experience. The aim is to prepare members for competitive employment through two processes. The first is attending the Clubhouse on a daily basis and experiencing a structured routine working alongside staff to manage and maintain the Clubhouse, generally known as the 'work-ordered day'. This is designed to help move people into the second process, called Transitional Employment (TE) (Crowther et al, 2003; NIMHE, 2003).

In transitional employment people can experience jobs which are 'owned' and controlled by the Clubhouse, for periods of their choosing, in order to develop the skills and confidence needed to move into competitive employment. There is free movement between work crews and transitional employment, and consumers are encouraged to succeed in transitional work before seeking competitive employment (Crowther et al, 2003; NIMHE, 2003). In this review, both the work ordered day and transitional employment are considered within the overall category of sheltered work although it can be argued that transitional employment is a type of supported employment (Schneider et al, 2002). The work-ordered day definitely fits the definition of sheltered work as:

work in which participants are brought into contact mainly with other people with mental health problems and staff members (NIMHE, 2003: 3),

although Crowther et al (2003) define it as a form of pre-vocational training. However, transitional employment involves 'real work for real pay' which are characteristics of supported employment. However it also takes the form of temporary jobs that are 'owned' by the Clubhouse, as compared with employment which is permanent and owned by the individual. The reason both the work-ordered day and transitional employment are dealt with together in this paper is simply that, in much of the research on Clubhouses, it is difficult to distinguish outcomes in respect of the separate components of the overall approach. Clubhouses are not common in New Zealand, and only two local clubhouses are referred to in the international directory.

Impact of the Clubhouse on employment outcomes

The work-ordered day has been found by one study to be no more effective than standard community care in supporting people into competitive employment at 24 months, or any kind of employment at three, six and 12 months (Beard, Malamud & Rossman, 1978, as cited in Crowther et al, 2003). Reviewers have concluded that there is insufficient evidence to judge whether the Clubhouse approach is more effective than other approaches to pre-vocational training (Crowther et al, 2003).

Two random assignment controlled studies have been done comparing supported employment to psychosocial rehabilitation (PSR), the type of approach generally used by Clubhouses. The first found that supported employment had significantly better rates of competitive employment than the psychosocial rehabilitation approach, with 30-40% of IPS clients working each month compared to below 10% for PSR (Mueser, et al, 2004). Another random controlled study also showed that supported employment was more effective in supporting people into work than psychosocial rehabilitation but that once in work both groups had difficulty maintaining employment (Lehman, Goldberg, Dixon, McNary, Postrado, Hackman, & McDonnell, 2002). The authors thought this could be because the Clubhouse did not reach out assertively to involve members in vocational services. Once in work, there was no difference between the two groups for how many jobs were held or for how long people stayed in their jobs. Both groups experienced difficulties with job retention (Lehman et al, 2002).

A single study compared the work-ordered day, a key component of the Clubhouse, to PACT, an intensive mobile treatment team providing a full range of clinical and rehabilitation services in the community, including supported employment (Macias, 2001). Both interventions worked with people aged over 18 who had experience of severe mental illness and were not necessarily looking for work. Retention of participants was higher in PACT – 81% of clients were still receiving services at the end of two years compared to 60% of Clubhouse members. For all people who were involved with the services, competitive employment rates were 57% for PACT and 48.3% for the Clubhouse. Competitive employment rates for people who stated that they wanted work from the outset (70% of the intake) were somewhat higher for PACT – 64% at the end of two years compared to 59% for the Clubhouse. The author notes that the 12 month follow-up employment rates for PACT and the Clubhouse of 56% and 48% respectively, for people who were interested in work compare favourably with annual job placement rates for supported employment of 58% and 34%, Macias (2001) does not report whether any differences identified were statistically significant (Bond et al, 1997, Crowther, Marshall, Bond & Huxley, 2001, both as cited in Macias, 2001).

Clubhouse members also worked more hours in competitive employment for significantly higher hourly wages in this study. They were also more likely to be in jobs of white-collar status judged to be of a significantly higher average quality. One possible reason for the success of Clubhouse members is the links between the Clubhouses' transitional employment (TE) programme and local employers (Macias, 2001). On the basis of this study it appears that the Clubhouse approach has a reasonable impact on competitive employment rates, and a good impact on hours of work and pay. But the lack of a high

standard replication of this study makes it hard to draw definite conclusions. The lower retention of people in Clubhouse services is also a concern. These may be due in part to the time taken to move into transitional employment, which another study of a Clubhouse found averaged 356 days (Henry, Barreira, Banks, Brown & McKaye, 2001, as cited in Bond, 2004). Given the evidence that consumers tend to drop out of services when there are delays in looking for paid work in the open market, this kind of wait could lead to major retention problems (Bond, 1998).

There is some evidence that the more time people spend in transitional employment (TE) the more likely they are to attain competitive employment. The rate of competitive employment in one study was 35% six months after involvement in transitional employment, with 19% in full-time and 16% in part-time positions (Rutman & Armstrong, 1985, as cited in Malamud & McCrory, 1988). This is at the low end of the scale when compared with supported employment placement rates, which range from 32% to 78% (Bond et al, 1997, as cited in McAlpine & Warner, 2002).

Malamud evaluated transitional employment in the context of the Fountain House Clubhouse using structured observation of consumers over time (1985, as cited in Malamud & McCrory, 1988). While the evaluation was retrospective, the use of an observational tool to assess changes makes it more rigorous than many other retrospective studies. As with the Rutman and Armstrong study (1985, as cited in Malamud & McCrory, 1988), Malamud found that as people spent more time in TE, their chances of independent employment increased. Only a third of the Clubhouse members were employed in transitional employment, and after 42 months 36% were employed independently (Malamud & McCrory). As most rigorously evaluated supported employment programmes are achieving competitive employment rates ranging from 32% to 78% (Bond et al, 1997, as cited in McAlpine & Warner, 2002) the Clubhouse success rate of 36% independent employment just falls within the range of 'successful' outcomes. However, there is some possibility that this apparently higher than normal success rate is due to the less disabled members being involved in transitional employment, rather than the effectiveness of transitional employment itself. Combining independent employment and Transitional Employment, and taking account of losses from the follow-up, there was an overall 50% employment rate among this group at 42 months, which is reasonably reasonable (Malamud, 1985, as cited in Malamud & McCrory, 1988).

A study that carried out an evaluation with a matched control group who received standard services found positive outcomes for the Clubhouse approach, for both employment and other life outcomes over a two year period (Warner, Huxley & Berg, 1999). Even though the control group were less transient in their accommodation, more often employed full-time, more socially connected and less hospitalised in the earlier stages of the study, the Clubhouse group did better in the long-term. While the number of people looked at (38 in each condition, a total of 76) is relatively low, the use of a control group and two-year follow-up period make this a fairly significant result.

The overall results included: more of the Clubhouse members in work (not statistically significant), fewer Clubhouse members in full-time work; and similar hourly rates of pay for both groups (Warner et al, 1999). However, these results are for all the services that the Clubhouse provides including work-ordered days. In addition, the study by Warner et al (1999) is not as rigorous as a randomised controlled study, and rates of competitive employment are lower than for supported employment.

Gradual entry transitional employment has also been compared with an accelerated entry approach. This occurred through a psychosocial rehabilitation agency which, while it had some features of the clubhouse model, was not in fact a clubhouse (Bond & Dincin, 1986, as cited in Crowther et al, 2003). Results for competitive employment at thresholds fell just short of significance, while there was no difference in rates of any type of employment for accelerated versus gradual entry into transitional employment.

Overall, there is not as much high quality research available on Clubhouses as there is on supported employment. What research there is provides a reasonably positive picture of employment outcomes, although not as positive as for supported employment. However, more research of a more reliable nature, is needed in order to draw definitive conclusions about the effectiveness of the Clubhouse approach.

Impact on non-employment outcomes

Beard et al reported significantly fewer admissions to hospital for participants involved with the Clubhouse approach compared with standard community care. However, this trend disappeared once client differences had been taken into account (Beard, Malamud & Rossman, 1978, as cited in Crowther et al, 2003).

Length of hospitalisation has been found to be decreased after involvement with transitional employment. However, because a control group was not used, the possibility of regression to the mean cannot be ruled out (Malamud & McCrory, 1988). In another study Clubhouse members had significantly higher scores than a control group for finances, legal/safety issues and global well-being after intervention. They also had significantly better social relationships in the form of close friendships (92% compared to 62%) and more had someone to rely on when they needed help (100% versus 63%). A further positive result was a decline in use of services, particularly hospitalisation and out-patient group treatment for the Clubhouse group (Warner, et al, 1999). However, this was for the full Clubhouse range of services so cannot necessarily be taken as evidence for transitional employment alone. In addition, participants were not randomly assigned to the two conditions so individual differences might undermine or reverse the findings if they were fully taken into account.

Over the course of the study the overall costs of services for the Clubhouse members decreased, whereas service costs for the people involved with usual services increased. The usual services group went from an average of US\$550 per person to an average of US\$1500 per person over two years. In contrast, the Clubhouse group went from US\$1500 per six month period to an average of US\$750 per six month period over two years. Unit costs for services were similar, and there were no individuals who received

unusually expensive services that might have skewed results. At the end of the period, employed Clubhouse members were costing least for services, followed by employed people in the usual services, then unemployed Clubhouse members. Highest costs were for unemployed people in usual services (Warner, et al, 1999).

In a comparison of accelerated entry into transitional employment versus the normal gradual entry no difference was found in clinical outcomes (e.g. symptoms, hospitalisations) (Bond & Dincin, 1986 (as cited in Crowther et al, 2003).

Conclusion on the effectiveness of the Clubhouse model

It is difficult to come to any firm conclusions about the impact of Clubhouse work-ordered days, on either work or non-work outcomes, because of the lack of rigorous research. Overall, it appears that the Clubhouse approach can support people into work at reasonable rates. However, it does not appear as effective as supported employment approaches. Once in work, people involved with Clubhouse programmes are just as likely to stay in a job as people involved with supported employment interventions. Clubhouses appear to be particularly successful in facilitating the establishment of natural supports which reduce the need for long-term formal support. There also appear to be positive mental health, social support, life satisfaction and cost reduction outcomes associated with the Clubhouse model, although the research on this is lacking in rigour. More research is required to further explore the impact of Clubhouses.

Social firm, community business or cooperatives

In a social firm consumers work for a business created specifically to employ people who are disadvantaged in the labour market, working alongside employees who are not disadvantaged. Schneider et al (2002) state that in order to be considered a social firm at least 30% of the staff should qualify as disadvantaged in the work place. This is a relatively common form of employment option overseas, and is also used in New Zealand. Social firms include community businesses, where the company is run by directors but profits are invested in employees, and co-operatives, where the company is owned and managed by the employees. Social firms pay market rate wages and employees have the normal rights and obligations associated with employment (Schneider et al, 2002).

Schneider et al (2002) classify social firms as sheltered work, that is, as:

work in which participants are brought into contact mainly with other people with mental health problems and staff members (NIMHE, 2003: 3).

However this classification could be disputed given that people in social firms would in theory be mixing mainly with workmates who do not have experience of mental illness, even if they have some other experience of disability. The average social firm in the UK has around seven employees, two of whom would usually have experience of some kind

of disability (mental and/or otherwise), as well as nine unpaid workers (www.ermis.co.uk, 2002, as cited in Schneider et al, 2002).

A recent comprehensive review of research concluded that social firms have the potential to facilitate social inclusion and a route into employment for ‘even the most disabled service users’ (NIMHE, 2003). However, they have not been studied much to date and preliminary evidence does not indicate high levels of movement into open employment. Further research is needed to explore:

- the potential of social firms to facilitate socially inclusive job opportunities for people with high levels of needs
- levels and types of impairment of people with experience of mental health problems currently with social firms.

The most rigorous research identified was a cohort study comparing workshop outcomes with those for work therapy and social firms. It found a rate of 12% attainment of competitive employment for social firms, compared to 5% for sheltered workshops and 23% for work therapy (Reker & Eikelmann, 1997, as cited in Schneider et al, 2002). This is in comparison to rates for supported employment services which range from 32% to 78% (Bond et al, 1997, as cited in McAlpine & Warner, 2002). So, while doing better than sheltered workshops, the employment rate for social firms is still less than even the lowest point on the range for supported employment interventions. However, pre-existing differences in client groups might account for differences in outcomes given that the sheltered workshop group had been out of the labour market for longer than the other groups, and also had more co-morbid conditions, which make it more difficult to find work (Schneider et al, 2002).

A UK report into six social firms found that only six out of 160 clients moved to open employment over a three year period, a placement rate of around 3.75%. This is markedly lower than pre-vocational training and supported employment (Pannell, 2000, as cited in Schneider et al, 2002).

A randomised, controlled trial with young adults assigned either to an agency run business or supported employment found that, although both groups averaged a similar number of work days, the agency business group tended to stay in that condition and not move into competitive employment (Gervy & Bedell, 1994). Bond (2004) suggests that providing employment options in this way could be considered as substituting for competitive employment rather than supporting open work through the general labour market.

The results of a survey of American mental health agencies running businesses for disabled workers showed that 62% of the disabled workers had psychiatric disabilities, many of them long-term (Granger & Baron, 1996). Agencies reported that consumers worked for an average of 19 hours per week, with hours ranging from 3 to 40 per week. Wages were just above minimum wage on average, with some more than three times as high. Limited benefits were offered by some agencies in the form of paid sick leave, paid

holidays, health benefits and pension, although less than half the agencies paid any of these. Most of the agencies aimed to provide transitional, short-term work experience rather than permanent employment. Consumers worked in these businesses for between 6 and 24 months on the whole, and only 16% were in the job with the agency longer than 2 years. Agency staff who responded to the survey expected that the majority of the consumers in the businesses would go on to competitive employment, or to transitional or supported employment placements (Granger & Baron). In contrast to this expectation, agencies did not report substantial numbers of consumers moving on to private sector employment. One of the most frequently expressed reasons that consumers stayed in these agency jobs was the fear that by moving into competitive work they would lose employment and health benefits.

This is not a rigorous piece of research because of the survey format. The sample could well be biased by the tendency of only certain agencies replying, possibly the ones providing a better service. In addition, it does not track actual employment outcomes from agency-run businesses. However, it does provide some indications that agency owned businesses are not leading to high levels of competitive employment.

Conclusion on social firms

It is difficult to draw firm conclusions on social firms because of the lack of rigorous research. Social firms do not appear promising in terms of movement into competitive employment, but do seem to have potential to provide 'real jobs at real pay' within a partially sheltered setting.

Sheltered workshops

Sheltered workshops involve people working with other consumers, outside regular work situations and normally at less than market or minimum rates of wages (NIMHE, 2003).

The impact of sheltered workshops on work outcomes

Schneider et al (2002) reviewed three studies of workshops, two of which did not report competitive work outcomes. One that did was a 'modernised', non-traditional sheltered workshop which had an orientation towards recovery from mental illness (i.e. living a full life with or without mental illness symptoms), was not segregated and provided support for transitioning to competitive employment. The study had a very short follow-up time and small sample. Three of the 13 workshop users left the workshop intending to find competitive work, although their actual success in doing so was not recorded (Young, 2001, as cited in Schneider et al, 2002).

A cohort study comparing workshop outcomes with those for work therapy and social firms found a rate of only 5% attainment of competitive employment for workshop employees, compared to 12% for social firms and 23% for work therapy (Reker & Eikelmann, 1997, as cited in Schneider et al, 2002). This is markedly less than the lowest point on the range (38%) for supported employment interventions (Bond et al, 1997, as

cited in Schneider et al, 2002). However, pre-existing differences in client groups might account for differences in outcomes given that the sheltered workshop group had been out of the labour market for longer than the other groups, and also had more co-morbid conditions, which make it more difficult to find work (Schneider et al, 2002).

The impact of sheltered workshops on non-work outcomes

One of the two studies that reported non-vocational outcomes found significantly higher levels of subjective quality of life, and physical, psychological and social functioning for sheltered workshop users (Holzner et al, 1998, as cited in Schneider et al, 2002). The review does not note the nature of the comparison group. The second study reported an atypical arrangement of home employment as an alternative for workshop users. This intervention also includes a sheltered work group that home workers could progress to, a monthly lunch for all participants and a monthly newsletter. The intervention was found to result in significant improvements in the medium term in self-esteem and desire to engage in productive activity (Kates et al, 1997, as cited in Schneider et al, 2002).

Bond et al (2001) found that the model of sheltered employment they looked at did not result in any improvements in symptoms, life satisfaction or self-esteem (as cited in Schneider et al, 2002). A Chinese study of sheltered work therapy stations found that they were no more effective than a 'guardianship network' of supportive neighbours in improving social functioning and reducing symptoms and hospitalisation (Zhang, 1994, as cited in Schneider et al, 2002). In Germany, workshops were found to lead to lower work satisfaction than either social firms or work therapy (Reker & Eikermann, 1997, as cited in Schneider et al, 2002).

One study from Northern Ireland found a high drop out rate from sheltered workshops of over 50%. Reasons for this included increased illness, not wanting to talk to other people, feeling that up to date skills were not taught and the work tasks were insufficiently challenging, lack of therapy and failure to check on worker satisfaction (Whittington, 1997, as cited in Schneider et al, 2002). Disappointment with the lack of relevance of the training to 'real jobs' was also reported by workshop attendees, who wanted to increase their job prospects rather than learn general social skills (Martin, 1996, as cited in Schneider et al, 2002). Martin (1996) found that staff continued to teach social skills because they believed that attendees would not cope well with work and did not really want to leave the workshop (as cited in Schneider et al, 2002).

Conclusion on the impact of sheltered workshops

Rates of competitive employment attained through sheltered workshops appear low compared to other interventions. However, lack of research and low rigour of experimental design make it difficult to come to any definite conclusions. Possible reasons for apparently poor work outcomes include lack of relevant and up to date vocational training, lack of staff commitment to open employment, lack of challenge and lack of mental health interventions (Martin, 1996, Whittington, 1997, both cited in Schneider et al, 2002).

In terms of non-work outcomes results are mixed. The majority of studies reported here, including the more rigorous ones, suggest that non-work outcomes are no better for sheltered work than other employment support approaches, and often worse. To some extent this is likely to depend on the nature and quality of the particular workshop, and once again the lack of rigorous research makes firm conclusions difficult.

Work crews / enclaves / work stations in industry / temporary sheltered work

In work crews small groups of consumers carry out a variety of work, such as building, decorating or furniture removals (NIMHE, 2003). These seem to be called 'work cooperatives' in the New Zealand setting (Mental Health Commission, 1999).

Temporary sheltered work

Another intervention involved temporary work for no more than six months, classified as 'sheltered work' because it did not equate to 'real work for real pay' although it was situated in an open employment environment (Schneider et al, 2002). This consisted of working in varying jobs, under varying employment conditions, in a hospital. Sixty-three percent of the 67 participants went on to further work activity, 15% of these in competitive employment (Bell, Milstein & Lysaker, 1993). This is not a high level of competitive employment when compared with supported employment intervention outcomes.

In terms of non-work outcomes, fewer mental illness symptoms were experienced by those people who chose the number of hours they worked. Furthermore, people who were paid for their work also showed improvements in symptoms and lower levels of hospitalisation (Bell & Lysaker, 1996).

Enclaves/ Work stations

Enclaves and work stations involve groups of consumers taking over the function of a particular aspect of a workplace, for example, the mail room (Malamud & McCrory, 1988). Malamud and McCrory (1998) reported that while the research on work enclaves/stations was sparse, researchers had concluded that they were more effective than sheltered workshops in increasing self-esteem, competence and vocational skills (Conte, 1983; Rapp, 1979, both as cited in Malamud & McCrory, 1988).

Work crews

Work crews are found more in the US than in the UK (Schneider et al, 2002). An American study of a sheltered work crew found that involvement in it did not appear to affect Job Performance Ratings or make it more likely that an individual would 'graduate' to a community-based work crew (Schultheis & Bond, 1993, as cited in Schneider et al, 2002). A Hong Kong study of a mobile work crew found that 'many' work crew members moved on to simulated businesses or supported employment, but as numbers and time frames are not given it is difficult to know what this actually involved.

In terms of non-work outcomes the mobile work crew appeared to have a positive effect on quality of life of higher functioning individuals in the short-term, and on lower functioning individuals in the longer term (Chan, 2000, as cited in Schneider et al, 2002).

Conclusion for enclaves/work stations/ temporary sheltered work/work crews

Once again the dearth of research makes it difficult to draw any firm conclusions. Overall rates of placement in competitive employment as a result of these interventions do not appear high. Irrespective of empirical findings, an important point to consider is whether work in sheltered or semi-sheltered environments is an acceptable aim for people with experience of mental illness. A case can be made for preferring options which support mental health consumers into mainstream work environments not only because this is more effective, but because inclusion in wider society is a right of all citizens.

Work placement and voluntary work

Work placement and voluntary work is unpaid work without employment rights in real workplaces. It can be used to increase work experience and skills, building confidence or while an individual's benefit is being assessed (NIMHE, 2003). While a number of personal stories mention both options as a precursor to paid employment, no studies or reviews of the area were found (Anaya, Eggleton, Grant & Shaw, 2000).

Key findings of research on interventions

1. Supported employment is the most effective approach in supporting people with experience of mental illness into competitive work in the open market (Bond, 2004; Crowther et al, 2001; 2003; McAlpine & Warner, 2002; Mowbray & Collins, 2002; Schneider et al, 2002; Twamley et al, 2003)
2. Sheltered work, work-ordered days, pre-vocational training, work in agency-owned businesses and social firms, and supported education do not appear to lead to competitive employment at the high rates that supported employment does although definitive research is lacking on all but pre-vocational training (Crowther et al, 2001; 2003; Chandler et al, 1996, 1997; Gervey & Bedell, 1994, all as cited in Bond et al, 1997; Granger & Baron, 1996; McAlpine & Warner, 2002; Mowbray & Collins, 2002; Schneider et al, 2002)
3. Competitive employment appears to have a more positive impact on earnings and hours worked than other types of work, although transitional employment and social firms also offer market rates (Crowther et al, 2003)
4. While supported employment leads to better employment rates, length of time spent in each job is still relatively low and rates of dropping out of the service appear relatively high (Becker et al, 1998; Bond et al, 1997; both as cited in McAlpine & Warner, 2002; Bustillo et al, 2001)
5. There is no indication that supported employment has a more positive impact on non-work outcomes than other interventions, although this may be due to experimental design factors (Lehman et al, 2002; Crowther et al, 2001)
6. Competitive work results in more positive non-work outcomes (self-esteem, quality of life and symptoms) than sheltered work or minimal hours in work (Bond et al, 2001)
7. Longer periods of ongoing support from supported employment services appear to lead to better outcomes (Bond, 1998; McHugo et al, 1998; Schneider et al, 2002)
8. Early placement followed by training (“place then train”) results in better employment and psychosocial outcomes than training followed by placement (Bond, 1998; Bond et al, Drake, Mueser & Becker, 1997; Drake, McHugo, Bebout, Becker, Harris, Bond & Quimby, 1999, as cited in Bustillo et al, 2001; Drake et al, 2003)
9. Integration of services is important to good outcomes, that is, including mental health treatment staff and vocational staff in one team who work in cooperation (Bond et al, 1997; Bond, 1998; Drake et al, 2003)
10. The Individualised Placement and Support model of supported employment is effective for supporting people into competitive employment but there is no evidence that it is any more effective than other types of supported employment (Crowther et al, 2003)
11. Recent studies indicate that supported employment does not have any greater impact on hospitalisation rates than any other intervention (Crowther et al, 2001, 2003)
12. It is not clear what impact family involvement has on employment support services (Bond et al, 1997).

13. Interventions provided by people with experience of mental illness appear to hold potential for supporting people into competitive employment but more research on this is needed (Kaufmann, 1995)
14. Supported education appears to have the potential to help consumers improve educational involvement, which may lead to greater employment options and earning capability, although more research on this is needed (Mowbray & Collins, 2002)
15. More research of a higher level of rigour is needed to explore the impact of both supported education and work training on qualifications, placement, retention in services and work, work type, career trajectory and earnings.

Section Three: Factors That Have An Impact On Employment Outcomes

There are a number of factors which impact on work involvement for people with experience of mental illness. While the predominant focus of most research is the nature of effective interventions, characteristics of the workplace/labour market and characteristics of the individuals involved also influence employment outcomes. The following section examines all three types of factor – workplace, clients and services. The rationale for examining predictors and promoters of work is that awareness of such makes it possible to design interventions, and make policy recommendations, based on the full range of pertinent information. This will serve to maximise the potential effectiveness of employment support services for people with experience of mental illness.

Characteristics of jobs and the workplace

Key point summary – job/workplace characteristics

- It appears possible that some form of work may be associated with better retention rates, particularly for people with certain types of experience but there is too little research to make definite conclusions
- Benefit systems that are flexible enough to allow some work, without financially disadvantaging individuals may enhance involvement in work
- The relationship between employment rates generally and employment rates for people with experience of mental illness appears complex, contradictory and difficult to map, although there are some indications that improvements in general employment rates are not necessarily reflected in employment rates for people with experience of mental illness.

Nature of employment

Work that has higher levels of change and variety has been associated with individuals staying longer in the job. Remaining in a job has also been found to be more likely with work which involves low levels of autonomy, where individuals have little opportunity to make decisions themselves (Xie et al, 1997, as cited in Schneider et al, 2002). Schneider et al note that this may be more related to stagnation than to staying longer due to job satisfaction, or to a tendency for people with schizophrenia to do better in work that is less demanding (Muntaner et al, 1993, as cited in Schneider et al, 2002). Being paid for work has been found to increase the rate at which people both take up employment, and result in working increased numbers of hours (Bell, Milstein & Lysaker, 1993). Bond notes that although this is an important area research on what aspects of employment are

most associated with finding and retaining work is at present rudimentary (personal communication).

Benefits system

Quite a number of consumers in the UK and US have acknowledged that fear of losing benefits forms a barrier to work (Polak & Warner, 1996, as cited in McAlpine & Warner, 2002; McQuilken et al, 2003; Schneider et al, 2002). In one study 22% of unemployed consumers, who were interviewed, said that their fear of losing disability allowances was a reason for not seeking employment (McAlpine & Warner, 2002). For this reason, removing disincentives to working from the benefits system might increase the movement of people with experience of mental illness into paid work (Schneider et al, 2002). In New Zealand the Ministry of Social Development (which manages income support services) has stated a commitment to developing strategies to encourage people with experience of mental illness into work, including employment assistance, employment incentives, changes in Work and Income practices, and reducing numbers of people on benefits (Lapsley, 2003). The Ministry has also introduced a policy to 'make work pay' by easing difficulties of transitions into work, and looking at the relationship between wages/benefits, childcare subsidies, tax care exemptions and so forth (Lapsley, 2003). Recent changes in policy also make it easier for beneficiaries to retain an invalids' benefit while working more than 15 hours a week for up to six months, and to return to an invalid's benefit in cases where they cannot continue working.

Unemployment rates

There is some evidence that general economic and labour market conditions affect employment of people with experience of mental illness, with rates of employment for this group rising along with general employment rates (McAlpine & Warner, 2002). However, other research reflects that although over the period 1992 to 1998 general employment rates went up, over the period 1992 to 1998, employment rates for persons with disabilities actually declined during this time (Burkhauser, Daly & Houtenville, 2000, as cited in McAlpine & Warner 2002).

A retrospective analysis of labour statistics and employment rates in areas trialling supported employment found no association between demand for labour and rates of unemployment (Catalano et al, 1999, as cited in Schneider et al, 2002). Another study found that unemployment rates for people with experience of schizophrenia went up in the 1990's despite a drop in general unemployment rates (Perkins & Rinaldi, 2000). The indication here is that there may not be a direct relationship between general employment rates and rates of employment for people with experience of mental illness. However, this limited sample of studies cannot provide a full indication of the true relationship.

The Impact of Employment and Mental Health Service Characteristics on Outcomes

Key point summary – service characteristics

- The freedom to exercise personal choice, of work and conditions has the potential to improve work outcomes, although lack of research makes firm conclusions difficult
- Interventions that focus on competitive work only appear more effective in supporting people into competitive work than interventions that are focused on other things, such as mental health or family functioning
- Some non-employment interventions appear to enhance employment outcomes when used in combination with employment services, including family therapy/education, social skills training and cognitive training
- The experience of severe symptoms are associated with poorer employment outcomes
- Greater intensity of support from employment staff while in work, and longer periods of support, are associated with greater participation in employment but more research is needed to confirm this trend
- Going straight into searching for competitive work in the open market leads to better outcomes than being required to take part in training or unpaid work experience beforehand
- Integrated teams of clinical and vocational staff are associated with better retention rates in services and attainment of competitive work, as well as better psychosocial outcomes for clients

Personal choice

There is some evidence that people who are able to decide how many hours they will work each week will work longer (in weeks) and show decreased symptoms compared to people who have no choice over how many hours they work (Bell & Lysaker, 1996). This was found to be the case whether the compulsory hours were low (10 hours) or high (20 hours per week). Contrary to what is sometimes assumed, consumer preferences for work have been found to be realistic, as well as being stable over time (Becker et al, 1996; Becker et al, 1998). Studies reviewed by Bond found that consumers who were matched with jobs of their choice were more likely to be satisfied with work and stay longer on the job. Later research by Becker et al (1998) found trends in this direction, but methodological difficulties (with sample size etc) meant that earlier results were not replicated. Also relevant is the finding that working flexible hours was the most commonly requested accommodation at work for people who were having trouble staying in work (Becker et al, 1998). Overall, it seems that the freedom to exercise personal

choice in terms of work and conditions has the potential to improve work outcomes, although the lack of research on consumer preferences and their impact makes firm conclusions difficult.

Focus on competitive work

Bond (1998, 2004) found that when the goal of interventions was supporting people into competitive employment, more people moved into work. Competitive employment was less likely when services were not specifically focussed on that as the goal (e.g. services aimed at improving work readiness through ameliorating symptoms). In addition, when other types of work options were offered (such as sheltered work or agency-run businesses) people became less likely to end up in competitive work. There is some evidence that the most effective way of supporting people into competitive work is through direct assistance with finding work, and that self-directed job search strategies such as job clubs do not work as well with many people with experience of severe mental illness (Bond, 1998).

Complementary interventions

Psychological interventions that have been found to improve work outcomes include family therapy (McFarlane et al, 1991, as cited in Schneider et al, 2002; Xiong, Phillips, Xiong, Wang, Dai, Kleinman & Kleinman, 1994) and cognitive-behaviour training in job finding (Proudfoot Guest, Carson, Gunn & Gray, 1997). Family-aided assertive community treatment along with a vocational specialist was found to be more effective than an enhanced version of conventional vocational rehabilitation in aiding people to work at all and work competitively. The effect size for working at all was .43 .60 for working competitively both (McFarlane, Dushay, Deakin, Stastny, Lukens, Toran & Link, 2000, as cited in Twamley et al, 2003). When not combined with a targeted vocational programme its impact on employment outcomes has been modest, suggesting that it works best in conjunction with vocational services (Mueser, Salyers et al, 2001, as cited in Bond, 2004). Family therapy involving monthly 45-minute counselling sessions focused on the management of social and work problems, managing medication, family education about the illness, family group meetings and crisis intervention has been found to result in longer duration of employment as well as less and shorter rehospitalisation for people with schizophrenia (Xiong et al, 1994). The significantly better results for treatment compared to a randomly assigned control group who received standard care could not be explained by drug compliance, and held at six, 12 and 18 month follow-ups. Social skills training prior to finding work has also been found to improve work outcomes when combined with employment support, with an effect size of .51, (Tsang & Pearson, 2001, as cited in Twamley et al, 2003).

Given that Becker et al (1998) have found that difficulties in managing problems relating to mental illness and medications is related to being fired or quitting work, interventions that could help with these issues may well aid retention in work. Another family therapy approach, with people experiencing schizophrenia, found that reducing family and client stress by educating the family about the illness and training them in behavioural methods

of problem solving resulted in significantly less worsening of symptoms or relapses nine months later. The control group was randomly assigned to individual in the community (Falloon, Boyd, McGill, Razani, Moss & Gilderman, 1982). Although employment outcomes were not measured. This intervention which was effective in reducing symptoms, particularly negative symptoms, and reducing relapse rates, could be a useful complement to supported employment. Cognitive training, aimed at improving performance on the job and delivered after a person has found work, has also shown promise in improving work outcomes (Bell, Lysaker & Bryson, 2003, as cited in Bond, 2004).

Medication

It has been noted earlier that symptoms of depression and 'negative' symptoms of schizophrenia, including apathy and withdrawal, are associated with poorer employment outcomes (Tsang et al 2000). Medications which have an impact on these symptoms may well assist with performance and retention in work. Reviews of atypical anti-psychotic medications have concluded that they reduce symptoms but that it is not possible at this stage to make firm conclusions about their impact on employment (Bond & Meyer, 1999, Meyer et al, 2002, both as cited in Schneider et al, 2002).

Length and intensity of vocational support

It appears that receiving significantly more input from vocational staff, particularly in the form of travel, training and advocacy unrelated to the job, is associated with finding work. This type of support is named 'active logistical support', as opposed to other types of support such as job-related advocacy. However, this is an association so it is not clear whether people are in work because they got more support, or got more support because they are in work, and whether there is in fact any causal relationship between the two factors (Jones et al, 2001, as cited in Schneider et al, 2002). A further study showed that receiving support services was associated with a higher chance of working for supported employment participants over a three and a half year period, but not for group skills training participants (McHugo, Drake & Becker, 1998). Furthermore, individuals in the supported employment condition, who received Individual Placement and Support (IPS)-type services in the last two years of the trial were more than twice as likely to work as those in the supported employment condition who did not receive this level of support. Interestingly, when individuals in both conditions (supported employment and group skills training) were given the choice of which type of support they wanted in the last two years of the trial, the majority chose IPS-type support, irrespective of which type they had been assigned to during the experimental phase (McHugo et al, 1998).

Cook and Razzano (1995, as cited in Schneider et al, 2002) found a link between the amount of time spent in employment and the amount of time spent with support staff. They conclude from this that longer-term support from staff may help clients both build on strengths and solve problems, presumably making it easier for them to stay at work as a result. An American audit of vocational outcomes for 865,000 clients of vocational rehabilitation provides support for this conclusion. This research showed a reduction in

competitive employment occurred two years after cases were closed (GAO, 1993), as cited in Schneider et al, 2002). This finding is interpreted by Bond (1998, as cited in Schneider et al, 2002) to mean the employment outcomes for people with experience of mental illness are not maintained without ongoing support, one of the key characteristics of Individual Placement and Support.

Accelerated entry into competitive work

Recent research suggests that providing training before supporting employment attainment is not the most effective option for increasing placement in competitive work (Becker et al, 1998; Bond, 1998, 2004; Crowther et al, 2001, 2003). Interventions which move individuals straight into work, regardless of perceived level of work 'readiness', generally lead to more people in jobs than those which provide vocational or rehabilitation services in an attempt to increase work readiness (Bond, 1998, 2004).

When two types of supported employment were compared, one with early employment then training and the other with prior training then employment, the early employment model resulted in better outcomes (Drake, McHugo, Bebout, Becker, Harris, Bond & Quimby, 1999, as cited in Bustillo et al, 2001). However, it was not clear whether this was due to the early employment focus or the integration of services in the early employment model. One article that reviewed six rigorous studies concluded that both were important to good work outcomes (Bond et al, 1997). Becker et al (1998) investigated why people with experience of mental illness left their jobs, and what might make a difference to retention. They found that pre-employment skills training did not reduce the risk of people being fired or quitting.

A recent review by Drake et al (2003) found that even when training sessions were run by a competent and experienced trainer some clients dropped out of supported employment services before even beginning the job search because they found the training irrelevant or boring. Work experience and assessment prior to job search were also associated with higher drop out rates, even when most of the clients had not worked for some years. However, when job search was rapid there were still high drop out rates, suggesting that they may have been related to a failure to engage with clients as much as delaying job finding (Drake et al, 2003).

Overall, it appears that delaying the search for competitive employment whether for assessment, training or work experience does not improve rates of employment attained. In addition, it has the potential to result in attrition from supported employment services. Rapid entry to job search services therefore seems preferable than gradual or 'stepwise' entry.

Integration of vocational staff into mental health treatment teams

Integrating employment services with mental health services, by including employment specialists in the mental health treatment team, is one of the principles of Individual Placement and Support (Bond et al, 2002; Chandler et al, 1997; Drake et al, 1996). Bond et al in their 2002 survey of supported employment programmes noted that comparatively few of the 144 services they surveyed were actually doing this, but that this principle was well supported by empirical evidence.

Bond (1998) notes that integration of services has been found to be far more difficult with multiple providers (Bond, 1998; Drake et al, 2003). Better employment outcomes have also been found for services that integrate employment and other services compared to brokered models. Clinical service providers brokering to vocational services has placed the burden of integration on clients and resulted in conflicting plans, miscommunication and dropouts (Bond, 1998). In contrast, where clinical and employment services are integrated, clients have been found to be less likely to drop out of services before finding competitive work, and employment plans have been more informed by clinical expertise (Drake et al, 2003). Given the link between managing symptoms and medication and early job termination, integration of services also has the potential to improve retention in work (Becker et al, 1998).

When two types of supported employment were compared, one with early placement then training and the other with prior training then placement, the early placement model resulted in better outcomes for competitive employment (Drake, McHugo, Bebout, Becker, Harris, Bond & Quimby, 1999, as cited in Bustillo et al). However, it was not clear whether this was due to early placement, or the integration of services in the early placement model. One article that reviewed six rigorous studies concluded that both were important to good work outcomes (Bond, Drake, Mueser & Becker, 1997).

On the basis of this research, integration of clinical and employment services appears supported in order to improve retention in employment services and rates of competitive employment attainment.

Characteristics of Consumers That Affect Employment Outcomes

Key point summary – consumer characteristics

- Identifying characteristics that affect work outcomes helps service providers to design interventions that are more effective, but should not be used to exclude *any* consumers from competitive employment or employment support services.
- Having more work experience and better previous work adjustment and habits predict better work outcomes for people with experience of mental illness, suggesting that people with less work experience may need more support and that assistance with work habits and adjustment may be useful
- More qualifications (particularly at the secondary level) predict a higher likelihood of finding work for people with experience of mental illness
- It is not clear what impact ethnicity has on work outcomes or whether people from particular ethnic groups do better with specific types of support, but overseas research has found that supported employment services work equally well with clients of different ethnicities
- Better work-related social skills predict better work outcomes suggesting that support with these skills may be useful.
- Symptoms of apathy, withdrawal, flattened emotions, attention difficulties and depression make good work outcomes slightly less likely, suggesting that support to address these may enhance work success
- Chronic and severe experience of mental illness, as compared with experience that is more episodic and mild in nature, is associated with worse work outcomes
- Poor cognitive functioning (attention difficulties, information processing problems etc) is associated with worse employment outcomes so support to improve cognitive functioning may be useful, although there is a suggestion that individuals can compensate for it on the job
- Consumers with characteristics associated with poorer employment outcomes may need more support or specific types of support to find work and stay in work long-term.

The sections above looked in some detail at the characteristics of employment and services that make finding work more likely. But services are only one part of the equation – another equally important part is consumers who use employment services, and the characteristics they bring with them. Consumer characteristics can have an impact on how likely people are to find and stay in work, and how much formal support they need to do so. Awareness of the impact of client characteristics can help both employment and mental health staff to know what kind of support might be most useful to clients with particular types of symptoms or work histories. For example, people with

limited work experience might benefit from more support, particularly in the difficult three to nine month period after starting work.

This is a complex area and different researchers have reached different conclusions. Seebohm et al (2002) concluded that in general the model of employment service is more likely to make a difference to finding work and staying in it than the type of mental illness the person has experienced, their symptoms or history of hospitalisation. They also note that:

few strong associations have been found between individual, demographic, clinical or social characteristics and success in employment, whether this is defined in terms of job attainment, job retention (length of time employed) or number of hours worked (Arns & Linney, 1993; Anthony, 1994; Regenold et al 1999) (Seebohm et al, 2002: 4).

But other researchers have found that some characteristics of people with experience of mental illness do make involvement in work more likely, (McAlpine & Warner, 2002; Schneider et al, 2002; Tsang, Lam, Ng & Leung, 2000). This section briefly reviews these characteristics.

The aim of this section is to identify factors which could make long-term success in work more likely for *all* individuals with experience of mental illness if they were addressed, not to identify some individuals who should be excluded from employment support services because the research shows they find it harder than others to find and retain work. As Warriner (2003) notes:

The challenge is for supported employment services to shape and adapt services to meet the needs of all its clients, rather than assuming an easier option of narrowly defining for itself the clients it will accept using notions of “readiness” (page 12).

Previous work experience and adjustment

Schneider et al (2002) conclude that there is strong evidence that people with experience of mental illness are more likely to find work if they have worked before. Having a substantial work history has been found to predict positive employment outcomes for a person with experience of mental illness, as has good occupational performance prior to illness (Tsang, Lam, Ng & Leung, 2000). Australian research on people with experience of psychosis found that work adjustment before experiencing any mental illness was a significant predictor of whether people were employed continuously, but not whether they were employed at the time of the study (Waghorn, et al, 2002). Individuals with a history of good adjustment to work had just over twice the rate of ongoing employment as those with poor prior adjustment to work (Farrington, 2000). While researchers have found occupational functioning to be important, it accounted for only 43% of the variance in employment outcomes, over an eighteen month period for people with experience of schizophrenia, suggesting that other factors also come into play (Breier et al, 1992, as cited in Tsang et al, 2000).

Prior work history is also identified as important in studies of supported employment (as opposed to studies of employment found through other routes). Individuals with more work experience are more likely to move into competitive employment as a result of a supported employment programme (Drake et al, 1996, as cited in McAlpine & Warner, 2002). An extensive review found prior employment history to be the best demographic predictor of future work performance, particularly aspects such as presence and length of pre-illness work history, prior occupational status and degree of upward job mobility (Anthony & Jansen, 1984, as cited in Warriner, 2003). In addition, the distinguishing characteristics of individuals who stay in work, despite the high rate of termination within the first 18 months (up to 75%), is more previous work experience, rather than demographic characteristics, clinical symptoms, amount of prevocational training or initial job satisfaction (Becker et al, 1998, as cited in McAlpine & Warner, 2002). A recent study found that supported employment clients, with a history of one year or more of continuous work in the open market, worked more hours and earned more wages over the 18 months of the study (McGurk, Mueser, Harvey, LaPuglia & Marder, 2003). Interestingly, this did not only apply to competitive work. The more hours a person had spent in sheltered work prior to the study, the more hours they were likely to work in the open market and the more they were likely to earn (McGurk et al, 2003).

In the general population, previous work experience is a strong predictor of future employment (Leventhal & Brooks-Gunn, 2000; Mroz & Savage, 2001; Savage, 1999). This applies to part-time and temporary work as well as permanent and full-time work, although temporary work has an impact only when it lasts for five years or more (Gaston & Timcke, 1999, as cited in Savage, 1999; Rothstein, 2001). More previous work experience also increases the likelihood of finding work after a previous period of unemployment. This is true even in countries where education is a strong predictor of finding work, such as the UK (Russell & O'Connell, 2001).

Work habits also appear important in predicting who will take part in work, how many hours they will work and how much they will be paid. This is not in respect of paid work but also for volunteer work. Work habits such as coming to work on time, following job rules and standards, taking initiative, and taking only the appropriate number of breaks are predictive of hours worked. Individuals with experience of severe mental illness, who scored high on these work habits on the Work Behaviour Inventory, tended to work more hours in the following six months than those who scored lower (Bryson, Greig, Bell & Kaplan, 1999).

Educational achievement

Having more qualifications has been found to be associated with better work outcomes for people with experience of mental illness (Cook & Razzano, 2000). This finding is not universal. One comprehensive review identified from the three relevant studies they reviewed that level of education was not a significant predictor of employment for people with experience of mental illness (Tsang et al, 2000). However, a study of 980 Australians experiencing psychosis found that people who left school with a secondary

school qualification were almost twice as likely to be in work currently as those who left with no qualifications, and were significantly more likely to be in ongoing work (Waghorn et al, 2002). Furthermore, individuals who gained a vocational qualification were more likely to be in current and ongoing work than those with secondary qualifications, and those with bachelors degrees or higher even more likely than those with vocational qualifications, but these differences were not significant (Waghorn et al, 2002).

There is also a substantial body of evidence showing that higher qualifications or more years in education increases the likelihood that a person will find employment, whether or not they have experienced of mental illness. Both early school leaving and a lack of any qualifications are associated with higher risk of unemployment in the general New Zealand population (Caspi, Wright, Moffit & Silva, 1998; Seth-Purdie, 2000; Woodward & Fergusson, 2000).

Moving from unemployment back into employment is positively affected by more education in some countries, including the UK (Russell & O'Connell, 2001). Furthermore, the higher the level of education (from none through to vocational education through to higher academic education) the lower the risk that an individual, who has previously experienced unemployment as a young person, will experience unemployment later in life (Gregg, 2001). These last two studies are particularly relevant to people with experience of mental illness, who may well have had periods out of work as young people when they first experienced illness.

The implication from these findings is that improving participation in education will support employment prospects, and that this is a legitimate goal of employment support services. However, the research to date does not strongly support pre-vocational training as it has traditionally been practised with people with experience of mental illness (Crowther et al, 2001, 2003; Schneider et al, 2002). Rather, research points to the importance of supporting people to attain formal academic or vocational qualifications acquired in mainstream settings. Hence education needs to be reflected as a valid goal for people with experience of mental illness. To do otherwise is to risk condemning people with experience of mental illness to entry-level and low paid jobs, rather than supporting them to fulfil their potential for a satisfying career.

Ethnicity

In a follow-up of 600 clients of vocational rehabilitation services, (Cook & Razzano 1995), as cited in Schneider et al, 2002) found that belonging to an ethnic minority was associated with a lower likelihood of employment. Being a member of an ethnic minority appears to have an even more severe impact on employment chances for those with a mental illness than for those without (Yelin & Cisternas, 1997, as cited in McAlpine & Warner, 2002).

It appears, from general statistics, that Maori with mental illness are more likely to be unemployed than other New Zealanders with mental illness (Department of Statistics,

2002b, 2003). Rates of unemployment for Maori were around 16.8% in 2001 and 9.7% in 2003, compared to 5.6% and 3.3% for Pakeha.

Maori have twice the rate, of admission to psychiatric wards and hospitals for affective psychosis and schizophrenic disorders, of non-Maori (Ellis & Collings, 1997). This suggests that Maori are more likely to need support from employment services than Pakeha, but it is not clear whether more intensive support or particular types of support would result in better employment outcomes for Maori. This is an area which is a high priority for further research.

Rigorous reviews by Crowther et al (2001, 2003) find that supported employment is effective, in terms of employment outcomes, irrespective of ethnicity. It is not clear from these reviews whether any more support was provided to clients from non-mainstream ethnic groups than mainstream ethnic groups. The one New Zealand study that was located did not comment on the ethnicity of clients or whether any specific approaches worked better with particular cultures (Warriner, 2003).

Social skills

Tsang, et al (2000) reviewed 11 studies which identified social skills to be a significant predictor of employment for people with experience of mental illness (Tsang et al, 2000). One of the reviewed studies found that 64% of the variance in predicting employment of people with experience of schizophrenia was accounted for by adjustment and the ability to communicate in an interview (Charisiou et al, 1989, as cited in Tsang et al, 2000). A two-year follow-up study of people with experience of schizophrenia found significantly poorer work outcomes for those with poorer social skills (Johnstone, Macmillan, Frith, Benn & Crow, 1990, as cited in Cook & Razzano, 2000). Social skills scores on the Work Behaviour Inventory also predicted levels of earnings during the next six months for people with experience of severe mental illnesses, with those who had greater social skills earning more (Bryson, Greig, Bell & Kaplan, 1999).

This finding is undermined by experimental evaluations of interventions aimed at improving social functioning, which found that they rarely supported movement into employment (Mueser et al, 2001, as cited in Schneider et al, 2002). But Tsang found that social skills training not only led to improved social skills but also had a positive impact on finding work in a randomly assigned study (Tsang, 2001). The training conceptualised social skills in a model of three tiers, where each tier leads to the next. Tier one consists of basic social/survival skills, such as grooming, politeness and personal appearance. Tier two involves two clusters of skills. The first is general work-related skills needed in any job, such as job-securing social skills and job-retaining social skills. The second cluster is skills for dealing with a specific job, such as responding to enquiries in a reception job, sales skills in a sales assistant position and so forth. The third tier encompasses the rewards of mastering the first two tiers, including gaining and maintaining employment. The weakness of this approach was that only 20% of those who met the criteria for inclusion actually agreed to take part because of the requirement to undertake unpaid training before finding paid work (Tsang, 2001).

Other research suggests that the lack of employment results from social skills training may be due to a failure of the training to be social skills specific to the workplace (Chadsey & Beyer, 2001, as cited in Schneider et al, 2002). This suggestion is supported by a participant observation study which found that staff providing vocational training at a sheltered workshop were focused on providing social skills training to improve the everyday lives of consumers, rather than skills directly related to finding a job (Martin, 1996, as cited in Schneider et al, 2002). Bond (1998) reviews research which suggests that social skills training is best done on the basis of assessment of both the individual's skill needs and the needs of the job, once a person is in work, not before.

Symptoms, diagnoses and course of illness

While some researchers argue there is not a strong relationship between symptoms and diagnosis and work outcomes (e.g. Anthony & Jansen, 1984, as cited in McAlpine & Warner, 2002), others point out that the available data may understate their importance (Lehman, 1995, as cited in McAlpine & Warner, 2002). Tsang et al (2000) note that some of the disagreement in findings may be due to a lack of consistent diagnostic criteria and processes.

In the New Zealand context, Warriner (2003) notes that 'assumptions that psychiatric symptomology predicts capacity to work' have formed a barrier to employment of people with experience of mental illness. Both international and New Zealand research on supported employment clearly shows that people with a wide variety of diagnoses and symptoms can attain competitive work if they receive effective support. More of an issue is maintaining continuous employment and involvement with support services when people are experiencing difficulties associated with managing work demands, symptoms and treatment (Becker et al, 1998).

Researchers differentiate between 'positive' symptoms in psychosis, such as hallucinations and thought disorders, and 'negative' symptoms of psychosis, such as withdrawal and lethargy (Anthony, 1984; Anthony et al, 1995; Bell & Lysaker, 1996; Hoffman & Kupper, 1997; Liberman et al, 1986; McDonald-Wilson et al, 2001; all as cited in Schneider et al, 2002). 'Positive' symptoms refer to an excess or distortion of normal functions, and 'negative' symptoms to a decrease in, or loss of, functions (Tsang et al, 2000). The consensus of studies reviewed by Tsang et al and Schneider et al (2000) is that 'positive' symptoms do not affect employment chances, but that 'negative' symptoms do make employment less likely. Overall, Tsang et al (2000) identified 10 studies which found symptoms to be a significant predictor of employment and 6 studies which did not find them significant.

Other research shows that experiencing symptoms of depression has a strong association with work loss and difficulties finding another job (Broadhead et al, 1990; Conti & Burton, 1994; Dewa & Lin, 2000; Kessler & Frank, 1997; Kouzis & Eaton, 1994, all as cited in McAlpine & Warner, 2002). This suggests that any treatment and/or support symptoms may improve a person's chances of getting work, provided there are no

associated side effects that make work difficult. However, the size of effect associated with type of symptom is not great. So while reducing negative symptoms may help overall, it will probably not make a huge impact unless accompanied by support and other positive changes.

Slade and Salkever (2001), as cited in Schneider et al, 2002) used data from longitudinal database of treatment and outcomes to demonstrate that the experience of negative symptoms of schizophrenia associated with a lower probability of being in work. This was true even after controlling for local differences in employment rates. One strength of this study is the longitudinal design, which gives a much greater assurance that symptoms are having an impact on employment, rather than the other way round. The authors modelled the difference in employment rates, that could be achieved by a reduction in symptoms through treatment, and predicted that a 20% decrease in symptoms would result in a 5% increase in employment rates of people with experience of schizophrenia, from 22% to 27%. The authors also noted that the availability of supported employment programmes could also assist people with more severe symptoms to attain work (Slade & Salkever, 2001, as cited in Schneider et al, 2002). This suggests that clinical staff working with employment staff to minimise symptoms could be an effective strategy to improve work performance and retention (Becker et al, 1998; Bond, 1998; Drake et al, 2003).

This finding is echoed by other studies of people with experience of schizophrenia including a six year longitudinal study by Breier et al (Breier, Schreiber, Dyer & Pickar, 1991, Fenton & McGlashan, 1991, both as cited in Cook & Razzano, 2000). The symptoms of flattening of emotions, difficulty with attention, avolition and alogia were found to be more strongly associated with work impairment than symptoms such as thought disturbance and hostile suspiciousness (Glynn, Randolph, Eth, Pax, Leong, Shaner & VanVort, 1992, as cited in Cook & Razzano, 2000). Higher levels of negative symptoms have also been found to be associated with poorer interview skills, being seen as less employable by independent judges, and being less likely to be referred to a job vacancy or vocational services (Charisiou, Jackson, Boyle, Burgess, Minas & Joshua, 1989b, as cited in Cook & Razzano, 2000). Fewer negative symptoms predicted better microbehaviours that led to improved interview performance and being viewed by the independent rather as more 'employable' in an independent analysis of the same data (Solinski, Jackson & Bell, 1992, as cited in Cook & Razzano, 2000).

It is important to make a distinction between the impact of symptoms on employment through normal channels, and on employment via supported employment services which provide ongoing support for workers. McGurk et al (2003) found that even in supported employment, individuals with experience of schizophrenia who had lower levels of negative symptoms tended to have higher earnings and more hours in work. Higher levels of positive symptoms were associated with more hours of on-job supports and more contacts. This suggests that client symptom patterns can give some indication to supported employment staff of the kinds of level of support clients might need.

However, payment for work may also have more of an impact on outcomes than symptoms. When individuals with experience of schizophrenia were paid to work, their type and level of symptoms did not explain a significant amount of variance in hours worked. But being paid explained almost all the variance (Bell, Milstein & Lysaker, 1993).

With regard to diagnosis, there is definite evidence that people with experience of more severe mental illnesses, particularly schizophrenia, have lower rates of employment than people with other diagnoses (McAlpine & Warner, 2002; Perkins & Rinaldi, 2002). Poor employment outcomes are a consistent finding in research on the first episode of schizophrenia (Mason et al, 1995, as cited in Schneider et al, 2002). One study found that at first admission 53% of those with schizophrenia were employed versus 66% with a bipolar diagnosis and 75% with some other diagnosis. Even after demographic factors were controlled for, these differences were statistically significant (Cook & Razzano, 2000, as cited in Schneider et al, 2002). Unemployment of five years or more is also more likely for people with experience of psychosis than for people with experience of a mood disorder (Heinrichs & Bury, 1992, as cited in Schneider et al, 2002). People with experience of psychotic disorders also had less success with a job-finding club, but this was found to be due to demographic factors rather than diagnosis (Jacobs, Wissusik, Collier, Stackman & Burkeman, 1992).

In terms of types of psychosis, there is some evidence that Australians with experience of an affective psychosis have twice the likelihood of ongoing employment as those with other psychoses, although this difference does not seem to significantly affect current employment rates (Waghorn, Chant & Whiteford, 2002). There is also some evidence that people with a diagnosis of mood disorder tend to be earning more than those with other diagnoses (Banks et al, 2001, as cited in Schneider et al, 2002). One interesting study followed clients of three agencies and found that when their symptoms were controlled, a diagnosis of schizophrenia was no longer significant in predicting employment status. However, symptoms were still a significant predictor, suggesting that the type and intensity of symptoms are more significant than type of illness per se (Rogers, Anthony, Cohen & Davies, 1997, as cited in Cook & Razzano, 2000).

However, these findings may relate more to the amount of time spent in hospital and age at first hospitalisation, as well as to other factors such as education and past employment history than to actual diagnosis (Goldberg et al, 2001, Heinrichs & Bury, 1992; both as cited in Schneider et al, 2002; Jacobs, Wissuski, Collier, Stackman & Burkeman, 1992). Goldberg et al (2001) found that when diagnosis was controlled for, the number of hospitalisations and earlier age at first hospitalisation were more related to the likelihood of later unemployment than diagnosis was. Course of illness was identified as a predictor of both current and ongoing employment in an Australian study of employment of people with experience of psychosis. Waghorn, Chant and Whiteford (2002) found that a person who had a single episode of psychosis with a good or unknown recovery had five times the likelihood of being in employment currently as someone who had a chronic experience of psychosis. Given that 2 to 1 is considered a significant odds ratio, this ratio of 5 to 1 is extremely high. As chronicity of illness increased, and degree of recovery

decreased, the odds of being currently employed went down accordingly. In terms of ongoing (or 'durable') employment, the authors found that only the two most severe categories (chronic illness with no deterioration or clear deterioration) were significant predictors. They predicted about the same level of employment, just under half that of people with a single episode with good recovery, giving a two to one odds ratio (Waghorn et al, 2002).

The disruption to education and early work experience caused by multiple episodes of psychosis and hospitalisation could explain some of the variation in outcomes, as both levels of education and work experience has been found to have knock-on effects on later employability (Caspi et al, 1998; Russell & O'Connell, 2001; Seth-Purdie, 2000; Woodward & Fergusson, 2000). The implication of this is that early intervention with young people who experience mental illness that is severe enough to affect their education and employment is important to prevent later employment difficulties. There is some longitudinal evidence from the New Zealand setting that the experience of anxiety and depression do not impact significantly on education outcomes so it seems that of particular concern is the experience of psychoses, particularly when it is chronic (Maloney, 2003a; Waghorn, Chant & Whiteford, 2002). Also of concern are multiple diagnoses, as there is evidence that employment rates decline by about a third for people with three or more disorders compared to those with two or less (Ettner, Frank & Kessler, 1997). This may mean that people with a chronic history of mental illness or multiple diagnoses will need a higher level of clinical and employment support to find and stay in work.

Cognitive functioning

Better cognitive functioning has been found to be associated with better employment outcomes and less need for employment support (Bell et al, 1995a, Van Os et al, 1995, as cited in Schneider et al, 2002; McGurk et al, 2003). Tsang et al (2000) identified four studies that found poor cognitive functioning to be a predictor of employment outcomes. Cognitive deficits, such as difficulty with attention span, difficulties in information processing, concept formation and less flexibility of abstract thought, are more commonly associated with experience of schizophrenia than with other mental illnesses (Tsang et al, 2000).

Cognitive functioning has also been found to be associated with social skills at work, which then affect work performance (Lysaker, Bell, Sito & Bioty, 1995, as cited in Tsang et al, 2002). In another study ventricular enlargement was found to lead to unemployment via its effect on cognitive functioning (Van Os et al, 1995, as cited in Tsang et al, 2000). McGurk et al (2003) found that better cognitive functioning was associated with earning more wages and working more hours. For clients with supported employment, better cognitive functioning was associated with requiring fewer hours of on-job supports (McGurk et al, 2003). However, there is some indication that worse executive (cognitive) functioning is associated with good work performance about as much as it is associated with poor work performance, suggesting that some people find

ways of compensating for difficulties with executive functioning (Lsyaker et al, 1995, as cited in Cook & Razzano, 2000).

There are some indications that atypical anti-psychotic medications may improve cognitive functioning in people with experience of schizophrenia (Bond & Meyer, 1999, as cited in Schneider et al, 2002). Meyer et al (2002) found that use of atypical antipsychotics was associated with better symptom control, but as this was a cross-sectional 'snapshot' study it could not establish what led to what (as cited in Schneider et al, 2002). Bond and Meyer (1999) concluded that the research was not rigorous enough to conclude anything definite about the impact of atypical antipsychotics on employability. However, supporting better cognitive functioning appears to be a useful goal in terms of improving work performance and retention, and reducing the need for employment support.

Factors and approaches which might aid retention in services and jobs

- **Key point summary – improving retention**
- Despite good rates of employment attainment there are still some difficulties with supported employment programmes in respect of people remaining with the job search process, and in work once it is found
- Research indicates that retention in job services might be improved through providing information sessions on what supported employment offers at the start, paying people to take part in supported employment, integrating clinical and employment services to make it easier for people to use them, and moving clients rapidly into the job search process rather than requiring them to train or do work experience first
- Aiding clients to develop good work habits, manage social interactions at work and manage psychiatric, medication and substance abuse problems once in work are indicated as promising strategies for increasing retention in work
- Integration of clinical and employment services is also indicated as a way of improving retention rates in work, and may help address problems with mental illness, medication and work tasks that are common reasons for early termination
- Workplace accommodations also hold promise for improving retention in work, particularly flexible hours
- Matching people with the type of work and conditions they prefer appears to enhance retention in work
- Training and support at the 3 to 6 month period in work is indicated for those who are experiencing difficulties, particularly those with less prior work experience.

It is clear that succeeding in paid work in the open market is not as hard for people with experience of mental illness as it has previously seemed, provided the right services and support are provided. However, even with the most effective support services retention in work has still been found to be a problem. Two studies showed an average of 9.4 and 13 weeks respectively before consumers quit, were fired or left for another job (Bond et al, 1997, Becker et al 1998). Dropout rates from supported employment programmes can also be high – up to 40% (Bustillo et al, 2001). So investigating what will improve retention both in support services and in work is a high priority in terms of improving work stability, earnings and future employability.

Retention in services

The first step to supporting people into competitive work is getting them involved with appropriate services, and keeping them involved until they find work. This may be days, weeks or months – one New Zealand service recorded an average wait of 80 days before

finding work (Warriner, 2003). So engaging clients is a very important part of the process.

Providing information on what supported employment can do for clients appears to improve retention in services. Bond (1998) makes the point that supported employment interventions which start with two sessions of information on the services that will be provided tend to have lower dropout rates than other supported employment programmes. Payment for involvement in work seems to improve participation in employment so may also aid retention in supported employment services (Bell & Lysaker, 1996).

In a recent review, Drake, Becker, Bond and Mueser (2003) found that the integration of employment and clinical services results in better retention in job support services, although the impact on retention in work was not investigated. Integration of services also resulted in clinicians becoming more involved in the vocational process and employment specialists developing more clinical knowledge and skills. This meant that clinical as well as employment strategies can both be used to support the job finding process and job retention, just as Becker et al (1998) had earlier proposed. Bond (1998) notes that integration of services has been found far more difficult with multiple providers. Service teams that provide services directly have a better psychosocial outcomes and participation in employment services than those who broker services (Bond, 1998; Drake et al, 2003). The reason for this appears to be that clients do not suffer from bearing the burden of integrating services, which can involve being required to go from one physical location to another, make links with new staff members at the new location, and cope with miscommunication and duplication of efforts across the two teams (Bond, 1998; Drake et al, 2003).

Drake et al (2003) also found that when clients were required to undergo lengthy assessments, training or sheltered work experience before moving into a job service dropout rates tended to be higher. Rapid entry into job searching was associated with better retention rates in services.

The following strategies are suggested by the research to improve retention in employment services:

- Start supported employment interventions with two sessions of information about the services that will be provided to clients
- Pay clients for attending supported employment programmes
- Integrate clinical and employment services to make all services easier for clients to access
- Make movement into job searching rapid rather than requiring clients to undergo assessment, training or work experience beforehand.

Retention in work

Bond notes that:

Aspects of work environments have been found to be systematically related to job retention (Xie et al, 1997) (1998: page 18).

Retention in work has been found to be associated with work that has higher levels of change and variety. It has also been associated with jobs involving low levels of autonomy, where individuals have little opportunity to make decisions themselves (Xie et al, 1997, as cited in Schneider et al, 2002). Schneider et al note that this may be more related to stagnation than to staying longer due to job satisfaction, or to a tendency for people with experience of schizophrenia to do better in work that is less demanding (Muntaner et al, 1993, as cited in Schneider et al, 2002).

There is some evidence that making more accommodations on the job improves retention levels in work (Fabian, Waterworth & Ripke, 1993, as cited in Bond, 1998).

Another study found that people were more likely to stay in a job when they were satisfied with it, but after three months this effect became weaker, so job satisfaction was not quite as important a predictor of ongoing job retention (Resnick & Bond, 2001). Matching people with their preferred type of work increased the likelihood that a person would work longer hours (Becker et al, 1996, Mueser et al, 2001, both as cited in Schneider et al, 2002) and stay longer in their jobs (Xie et al, 1997, as cited in Schneider et al, 2002). However, a later study found that although job preferences were realistic and stable over time, matching jobs with preferences was not associated with higher satisfaction or longer tenure, although methodological issues mean this is not a reliable finding (Becker, Bebout & Drake, 1998).

Becker et al (1998), investigated the reasons that individuals who had been involved with a support employment programme, either left their jobs or were fired. They found that the main reasons were interpersonal problems (58%), problems related to mental illness (52%), and dissatisfaction with work (52%). However, early ratings of job satisfaction did not predict work ending, suggesting that:

Job terminations are largely due to adverse reactions and events that occur once a competitive job is in progress (Becker et al, 1998: 79).

New Zealand research finds the same trend. Warriner (2003) reported in respect of local supported employment programme :

Retention dips significantly at 3-6 months. This result supports anecdotal opinion that the period from three to six or nine months is the most critical in promoting retention. At this time the "honeymoon" period tends to end, and the daily grind

of having a job with its responsibilities, obligations and mundanity, tends to “kick in”. Commonly, the tasks required to do the job have been mastered; it is the relationships with colleagues, and the assimilation with the social environment and culture of the workplace that can lead to difficulties (page 15).

To counteract this trend, Warriner recommends that employment staff plan for this ‘dip’ stage, and have strategies in place when it happens. The AMHS Supported Employment Service in New Zealand made a point of doing this and found that while the number of people in work for less than three months, or three to six months, dropped from the beginning of the service, the numbers in employment for six to 12 months, or more increased in recent years (Warriner, 2003). The low rigour of their study needs to be taken into account, but certainly the findings echo the trends found by Becker et al (1998).

Becker et al (1998) note that previous work experience over the past five years forms a buffer against being fired or quitting. They suggest that people with lower levels of work experience need particular support with the following:

- Developing dependability and job performance, not just at the beginning of the job but over time
- On the job social interactions
- Managing psychiatric, medical and substance abuse problems.

The authors note that:

This view of the complex difficulties that clients experience while working is quite consistent with how clients themselves describe the situation: managing work, illness, and interpersonal situations are intertwined (Becker et al, 1998: 79).

It may well be that individuals with less work history have simply had less experience of the type of juggling act that is required to manage symptoms, work tasks, work relationships and treatment all at the same time.

In addition to accommodations such as training, more support, more feedback and different working conditions, clients also requested flexible working hours to help them cope with managing everything that involved with working (Becker et al, 1998).

Given that managing symptoms and medication are quite common reasons for difficulties at work, Becker et al (1998) recommend that employment staff be integrated with treatment staff to coordinate planning ways to support people with these issues. Better employment outcomes have been found for services that integrate employment and other services compared to brokered models. Clinical service providers brokering to vocational services has been found to place the burden of integration on clients and lead to conflicting plans, miscommunication and dropouts (Bond, 1998). Given the link between managing symptoms and medication and early job termination, integration has the potential to improve retention in work (Becker et al, 1998).

On the basis of the research reviewed above, the following strategies appear indicated to improve retention rates in job placement services and in work:

- Assessing strengths and needs from the beginning of contact with employment services, and throughout employment, both of the individual and the job
- Not duplicating assessments, or making training, work experience or lengthy assessment prerequisites of finding competitive work
- Identifying potential sources of difficulty on the basis of assessment
- Formulating plans for training, support and coaching that meet the specific needs of the individual and the job/workplace
- Providing on the job accommodations as needed, particularly flexible hours
- Focusing on support with work-related social skills and managing symptoms, medication, relationships, and work tasks where they are indicated as needs
- Integrating clinical and employment services so that staff can work together to support individuals in gaining and staying in work
- Where relevant, providing the particular support that has been identified as useful for people with less work experience

Section Four: General principles of effectiveness

Consumer characteristics

Placement in work is more likely when the following characteristics of consumers are taken into account when providing services. This list is not meant to suggest that people with (or without) these characteristics should (or should not) not be eligible for work placement services, but that some people may require more support, specific types of support, or support at specific times, in order to stay in work and succeed. The main findings are:

- Individuals who have less work experience are less likely to succeed at work, suggesting that aiding people to gain more competitive work experience is a high priority, and that people with less work experience may need more support to succeed in work
- People with experience of mental illness who have more years in education and qualifications (secondary and post-secondary) are more likely to find work and earn more, so informing clients of employment opportunities and benefits, and supporting them in studying is indicated, particularly for those with less education
- Consumers who have better work-related social skills do better at work, suggesting that training in these skills could be beneficial for those who lack them, preferably once they are searching for work or in work and can apply these skills on the job. These skills include interview skills, grooming and presentation, relating to colleagues and supervisors on the job and coping with tasks at work that require social interaction
- Symptoms that impede work, such as withdrawal, lethargy and symptoms of depression are associated with worse work outcomes. Clinical and employment services working together may aid people to stay in work and perform at a higher level. In addition, clients with these symptoms may need more employment support to succeed at work
- Chronicity and severity of illness is associated with poorer work outcomes, suggesting that people may require higher levels of support both to stay in placement services and succeed at work, and attention to clinical issues may be particularly useful in aiding work outcomes for these individuals
- Attention to cognitive functioning issues, such as memory and attention, for people who have difficulties in this area, may aid retention in work and work performance
- Successfully managing the mix of mental illness symptoms, medication, interpersonal relationships at work and work tasks is associated with success at work, suggesting that providing tailored support and training in skills to help manage these tasks may improve work outcomes.

Training services

Based on research on both general training programmes and training specifically with people with experience of mental illness, training is most likely to enhance employment outcomes (i.e. competitive work placement, retention in work, earnings) when it has the following characteristics. The evidence for this is not as strong as the evidence for employment services. To enhance employment outcomes:

- Provide training that is linked to local employers and the skills needed for work in the local marketplace
- Include a high level of work-related content rather than ‘generic’ work training
- Emphasise consumer preference and choice in training and work choice (i.e. do not place an individual in training simply because there are vacancies for people with those skills)
- Train in social skills related to the work-place in particular, including interview skills, grooming and presentation, and skills needed to get on well with others in the job
- Provide training once job searching or employment is underway, rather than prior to job searching
- Make training time-limited whenever it occurs, not to the point of ‘work readiness’ or other open-ended criteria
- Match training to the needs of the individual and the needs of the job, including the tasks and any difficulties that the person has in the workplace
- Use training staff who are committed to placing and keeping people with experience of mental illness in competitive work
- Pay people for their involvement in training
- Use cognitive interventions and teach skills to solve problems, cope with work stress and interact successfully with colleagues and supervisors.

Supported education

There is little rigorous research in this area, and the evidence is the weakest of all areas. This dearth of research makes it difficult to comment on what makes education services investigated through the present review most effective. Based on the Mowbray and Collins 2002 review, the following principles are tentatively suggested:

- Increasing educational involvement and qualifications has the potential to improve employability, work options and earnings
- Students take part in study out of personal preference rather than being coerced to do so
- Choosing courses and qualifications to embark on is done as part of the career planning process
- Students take part in courses that lead to academic or vocational qualifications that are recognised by themselves and employers, preferably in mainstream settings

- Supported education is based on alliances between five key stakeholders: mental health systems, academic institutions, vocational rehabilitation agencies, family members and consumers
- Staff involved in supported education have knowledge of supported education as a type of rehabilitation
- Supported education staff provide services relating to education issues, while mental health treatment is provided by clinical staff
- Staff (clinical, employment and education) have positive attitudes towards the ability of people with experience of mental illness to study and take part in competitive work
- Assessment of students' mental health, educational and rehabilitation needs takes place
- Barriers to education are identified and addressed, including policy, resource and administrative barriers, as well as the challenges of people coping with psychiatric illness
- Support is provided by staff and/or peers, on campus or off campus
- Support includes helping people cope with stress, providing information on courses, finances and assistance, giving practical help (e.g. helping fill out forms, helping people gain social acceptance in educational settings, and liaising with support staff at academic institutions to make sure students get all the services they are entitled to and need).

Employment services

The research evidence in this area is strongest of all, although not all the following points are based on equally strong research. The strongest findings are:

- supported employment services are more effective in placing people into work than other types of service, including sheltered work, training, or Clubhouses
- support from both employment and clinical staff is provided to clients for at least one to two years
- consumers actively participate in employment services and support
- vocational services are integrated with mental health services rather than clinical services brokering clients to separate employment services
- services that accelerate individuals straight into competitive work rather than delaying employment to take part in training or work crews
- services aim to place people in competitive employment as a priority
- improving work experience and adjustment increases employability.

The following points are based on less rigorous research, contradictory research or need more research to become strong points:

- consumers choose the type of work/training/education they want to be involved in, and work the hours they choose
- people receive ongoing, time-unlimited support once they are gain work
- people are matched with jobs that suit their preferences, symptoms and diagnosis

- employment does not make consumers financially worse off as a result of working, due to loss of benefits that are not compensated for by employment
- starting supported employment with two sessions of information about the service can improve retention in services
- providing complementary interventions (e.g. family therapy, cognitive-behaviour therapy) may aid employment outcomes
- assessment of clients is continuous throughout job search and placement
- increased support, at the three to nine month point in placement, can improve retention in work, particularly for people with lower levels of work experience.

Glossary of Common Terms and Abbreviations

Accommodations – also known as workplace accommodations, these are reasonable adjustments to work conditions and environment that aid a person with a disability in carrying out the work.

Benefits – welfare entitlements such as sickness benefit and invalids benefit. Sickness benefits are applicable in situations of temporary inability to work due to illness, whereas invalid's benefits are applicable to long-term work incapacity due to illness or disability.

Career development – process in which consumers explore their interests and experiences to identify personal work and career preferences, and attempt to match these preferences with jobs and/or training.

Clinical staff – individuals involved in the medical and clinical support of consumers e.g. case manager, psychiatrist, nurse, psychologist, substance abuse counsellor.

Clubhouse – a service provided by an integrated group of staff and mental health consumers at an established venue where people with experience of mental illness meet for social activity, mutual support and a variety of work experience. There are opportunities to take part in unpaid work ('work-ordered day') and to participate in temporary work in jobs owned by the Clubhouse ('transitional employment') as well as to take advantage of other services and training.

Clubhouse work-ordered day – members of the Clubhouse take part in unpaid work activities at the Clubhouse, on crews managing and maintaining the Clubhouse and its various activities. The aim is to prepare members for competitive employment and to help support people into Transitional Employment (TE), a more competitive form of work.

Competitive employment – paid work performed on a full- or part-time basis in the general workforce, with standard employment conditions regardless of disability, and paid at market rates, usually permanent in nature.

Employment benefits – benefits received as part of an employment package, including paid annual and sick leave.

Individual Placement and Support (IPS) – a standardised version of supported employment which is based on six key principles drawn from research on supported employment.

Job placement – process for matching the consumer's chosen employment and career goals to a competitive employment opportunity in the community.

Ongoing, or follow-along, support – time unlimited services that are provided to a client in order to find work and support ongoing employment and career growth.

Pre-vocational training – generic training intended to achieve ‘work readiness’ prior to searching for work, where consumers are taught vocational skills.

Sheltered work – employment in a work-like setting that is in some way protected or sheltered. For example, only or mainly people with a disability may be employed. Pay is usually below market rates.

Social firm – a business created for the employment of people who are disadvantaged in the labour market, with at least 30% of employees fitting this description. Pay is usually at market rates and all staff receive equal opportunities in the workplace. Includes cooperatives and community businesses.

Supported education (SEd) – provision of support and advice to people with experience of a disability who want to undertake education or training. Education can be provided specifically for people with a disability at separate campuses or separate classes on mainstream campuses, or support can be provided to enable people to take part in mainstream education.

Supported employment (SE)– ongoing support to find and maintain paid, competitive employment (whether full-time or part-time) at market rates and standard conditions of employment.

Transitional employment – temporary positions which ‘belong’ to the agency (often a Clubhouse), not to mental health consumers, designed as a series of learning/developmental experiences to enhance work skills and experience. Consumers can move in and out of these jobs as they are able to work, and work hours that suit them.

Vocational training – clients are taught vocational skills and attain vocational qualifications. Projects are often located in colleges or training centres, or involve workplace training.

Work crews – small groups of people with experience of disabilities who undertake work such as building, decorating, gardening or furniture removal, sometimes as part of a wider mental health or employment service. More common in the US than in New Zealand.

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Appendix One: Process used for gathering and analysing information

Articles for review were identified via a search of databases by key words related to supported employment, training and supported education. They were also identified through bibliographies of review articles. Four major, recent reviews were used as a source of much of the information – two systematic reviews of supported employment by Crowther, Marshall, Bond and Huxley (2001, 2003), a review by McAlpine and Warner (2002) for the Center for Research on the Organization and Financing of Care for the Severely Mentally Ill at Rutgers University, and a review for the National Institute of Mental Health in England by Schneider, Heyman and Turton (2002). Original studies were also consulted, particularly those relevant to New Zealand. Further small searches by key word were carried out as needed. Priority was given to studies that were recent, and used a randomised controlled trial design, and to results that were replicated by a number of such studies. Information on benefits in New Zealand was sought from the relevant Ministry of Social Development staff in the areas of research, policy and practice in the field. Peer reviews were carried out by Dr Gary Bond, Chancellor's Professor of Indiana University, Dr Justine Schneider of Durham University in the UK and lead author of the NIMHE review, Hilary Lapsley of the NZ Mental Health Commission, Debbie Peterson of the NZ Mental Health Foundation and members of the reference group (who were all providers of employment services).