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The Education and Training for Work of People with Mental Health Problems: Issues Arising from Recent Changes in Ireland

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Editorial Article –The Education and Training for Work of People with Mental Health Problems– Issues Arising from Recent Changes in Ireland

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Abstract

The value of vocational training and work is well established as an important contributor towards the successful rehabilitation and recovery maintenance of people who have had or have mental health problems. Recent changes to the statutory framework governing socially integrative disability policy have certain implications for the successful establishment and co-ordinated working of specialist vocational and educational schemes for people with mental health problems. This editorial article reviews the literature on employment, training and its value to mental health rehabilitation in order to examine these implications.

Introduction

Social exclusion is a major policy concern in many countries at present (Evans and Repper, 2000). It has been defined as the consequences for an individual of the interaction of unemployment, poor skills, low incomes, poor health and family disintegration (ibid.). It is recognised that societal reactions to individuals with mental health problems often leads to social exclusion, particularly in the areas of social contact and work (Department of Health, 1998) and well established that lack of work increases the risk of mortality and morbidity amongst people with mental health problems (Evans and Repper 2000; Mueser *et al.*, 1997). Work serves to reduce social exclusion and recapacitate individuals who are or have suffered from mental illness (Mueser *et al.*, 1997).

The importance of education and training in re-skilling people who have or are suffering from mental illness in preparation for taking up work is therefore central to their rehabilitation and re-integration into a normal life and social pattern. This article considers these issues in the light of the dissolution of the National Rehabilitation Board during the year 2000, which previously had responsibility for overseeing such

education and training, and the re-distribution of its functions amongst a number of agencies.

Disability and mental illness in Ireland

Disability involves physical or mental impairment of normal function. It is estimated that 10% (360,000) of the Irish population have a recognised disability, (Department of Justice, 1996; Mental Health Association of Ireland, 2000). Associated with such disability is the degree to which physically, cognitively or intellectually impaired individuals are often marginalised in Irish society (Dept of Justice, 1996). Indeed, often the medical aspect of the individual's disability is the least disabling aspect of their life compared to societal prejudice and structural difficulties that they confront. This has led to a greater emphasis on social conceptions of disability as the most important criteria through which approaches to intervention should be structured. Social constructions of disability are reflected in the developing policy in Ireland for support and intervention with mental health service users, for example the recent establishment of the National Disability Authority.

The publication of the Government's policy document on the Mental Health Services – Psychiatric Services; Planning for the Future (Government of Ireland, 1984), advocated the closure of traditional hospitals and initiated the transition from hospital to community based services as a national policy goal. Thus in 1999 there were 4469 inpatients resident in Irish psychiatric hospitals (Daly and Walsh, 2000) compared to 19,801 in 1963 (Browne *et al.*, 1999). This focus on community services is part of a broader international trend in mental health. This emphasises psycho social and social disability and access models rather than disease models alone through which to conceptualise difficulties and design interventions for people with mental health problems and those in remission (see Goodwin, 1997 and Mechanic, 1999). They stress the importance for users of maintaining contact with the community rather than segregating them from it. Underpinning this, as David Mechanic (1999) says, is a:

"...growing recognition that many of the disabilities experienced by persons with mental illness and with other impairments are as much the product of social expectations, social stigma, and exclusion from opportunities as they are a direct function of mental or physical impairments." (Mechanic, 1999:85).

Such a perspective on disability in general was endorsed in Ireland in 1996 by the Report of the Commission on the Status of People with Disabilities (Dept of Justice, 1996).

Within the community outside psychiatric hospitals there are 69 day hospitals and 108 day centres in 1997 with 2871 residential places in 1998 (Government of Ireland, 1999). Demand on community services is high (Browne *et al.*, 1999). However, incidence of mental illness in the community is difficult to assess (see Cleary, 1997 for a short discussion on this issue). Therefore, one has to rely on data on the in-patient population to gauge the range and extent of psychiatric disability in Ireland, though clearly this data focuses on the most serious manifestations of mental illness.

Males of working age have the highest rate of admissions overall and the highest rate of first admissions (Daly and Walsh, 2000). Amongst socio-economic groups, the highest rate of admissions is amongst unskilled workers, though for first admission non-manual workers are the highest. Overall, depression, alcoholism and schizophrenia accounted for two thirds of all admissions to psychiatric services in 1999 (Daly and Walsh, 2000). In the community, illnesses related to depression are the most prevalent, with an estimated incidence of 200,000, whilst the incidence of schizophrenia is estimated at 37,000 (Mental Health Association of Ireland, 2000).

The value of work for individuals with mental health difficulties

It is well established that work is a significant element in the maintenance and promotion of mental well-being (Szasz, 1974; Smith, 1985; Galloway, 1991; Oliver *et al.*, 1996). The focused and purposeful activity that employment provides gives structure, a social role, status, and integration into mainstream society for those who have or have had experience of mental health difficulties (Davidson *et al.*, 1998; Bachrach, 1997). Conversely, exclusion from employment ensures that the individual with a history of mental illness remains socially isolated and excluded from mainstream society, thus exacerbating their psychological and behavioural difficulties (Hiday, 1997). It is recognised that the current positive economic outlook in Ireland throws into sharper relief such issues of social exclusion as they relate to employment (Department of Education and Science, 1998).

It would appear that individuals with a history of mental health problems are more likely than the general population to find it difficult to get and keep a job (Tudor, 1996). For example, studies in the United Kingdom indicate that individuals with a mental illness are eight times more likely to be unemployed than the general population. (Perkins and Silver, 1994;). Perkins and Bird (1998) found in the London Borough of Wandsworth that unemployment rates amongst individuals with a history of mental health difficulties stood at 90%. Stein and Stantos (1998) found that those with a mental health disability are twice as likely to be unemployed compared to those with a physical disability. The difficulty of finding employment for such individuals

is further exacerbated when they possess few marketable skills or remain unskilled (Carrier and Tomlinson, 1994). Yet research demonstrates that 30 to 40 % of individuals with severe mental illness are capable of working in formal employment (Evans and Repper, 2000).

The psychological and behavioural consequences for individuals with a history of mental illness arising from unemployment are well documented (Warner, 1994). Unemployment leads to high levels of anxiety and depression and there is a significant correlation with suicide (Platt and Kreitman, 1984; Perkins, *et al.*, 1999). Alternatively, Warner (1994) has linked the significantly higher recovery rate for schizophrenia in third world countries with the ready availability of work for mentally ill individuals. Work also has a protective function in relation to the return of negative symptoms (Holloway and Carson, 1996).

Traditionally work for those with mental health problems was located within psychiatric hospitals or alternatively sheltered work schemes in the community (Holloway and Carson, 1996). Both of these have consistently been shown to be poor at reintegrating the mentally ill into mainstream society (Evans and Repper, 2000). Within our society independent, competitive employment is a highly valued social aspiration for the population in general (Mechanic, 1999). It is generally thought that individuals with mental health difficulties need to be shielded from the stresses of this competitive employment environment, and only gradually introduced to the mainstream work context, if at all (Burns and Guest, 1999). Such presumptions may mean that services contribute to the exclusion of persons with a mental illness or a mental illness in remission from mainstream aspirations in the area of work, rather than providing opportunities for participation in the normal world of work.

Numerous studies on needs and quality of life have consistently found individuals with a mental health disability identify that full time paid employment is a priority (Perkins and Repper, 1996). Recent projects in the USA have demonstrated that direct entry into open employment is not harmful and is highly effective in quickly re-integrating people with mental health difficulties into mainstream society (Mechanic, 1999; Bachrach, 1997). In this regard it is worth noting "that mental symptoms are often independent of work skills, and many handicapped patients are good reliable workers… even during periods of acute symptoms" (Mechanic, 1999:209).

In the United States and the United Kingdom a number of work-related projects facilitate employment opportunities for individuals with mental health difficulties through the provision of training and support prior to and after finding employment (Bond *et al.*, 1997; Davidson *et al.*, 1998). Indeed, it is now established that work is

an integral element in the successful rehabilitation of individuals recovering from mental illness (Carrier and Kendall, 1997). It has been found that employment significantly reduces the rate of admission to psychiatric hospital and is important in maintaining symptom remission (Oliver *et al.*, 1996; Warner, 1994). Indeed, the capacity to work is viewed by many individuals as a *sine qua non* of recovery from mental health difficulties.

Employment of individuals with disability and the importance of education

In a number of countries around the world legislative measures have been implemented to ensure that individuals with disability are not disadvantaged on the basis of prejudice within the labour market. In the United States the American Disabilities Act (1992) outlaws discrimination in all aspects of employment on the basis of disability, including psychiatric disability. In the United Kingdom the Disability Discrimination Act (1995) makes similar if less extensive provisions.

Empowerment within mental health is based upon the notion of reducing dependency resulting from an individual's sense of powerlessness that arises from previous experience of discrimination and being valued negatively (Martin, 1997). Encapsulated within this perspective of empowerment is the notion of change and constructive movement. Preparation for employment is the cornerstone, therefore, in providing an individual with a sense of constructive movement out of mental illness and into mental well being and social acceptance. This can be achieved through provision of a range of educational opportunities that have a vocational aspect in preparing an individual to return to the workforce.

Successful outcome in rehabilitating mentally ill individuals to return to work depends on a number of variables. These include the nature of the mental health difficulty and the range of social skills possessed by an individual (Holloway and Carson, 1996). The range of supportive services necessary to help mentally ill individuals to return to work will depend on these variables. For many, support can be focused on advice and encouragement; others will need work assessment involving the identification of levels of occupational, aptitude and social skills ability and available educational programmes in order to seek employment (Holloway and Carson, 1996).

Within Ireland adult education is seen as integral to the concept of life-long learning and to underpin the economic and social well being of individuals and of society (Department of Education and Science, 1998). For people with disabilities it is recognised that training and education are the main mechanisms through which they can increase their employability (NRB, 1995). At the same time it is well-recognised

that in Ireland persons with disabilities have difficulties accessing education and
training which lead to employment (Department of Justice, 1996). Thus there is a
necessity to provide supportive opportunities where such education and training can
be provided.

Of particular importance in the preparation of mentally ill individuals for re-
integration in the community and work are vocational and pre-vocational training
programmes. Vocational Programmes are designed to help an individual achieve an
occupational goal. Alternatively, pre-vocational programmes are not focused on
preparing an individual to achieve an occupational goal but rather to facilitate social
integration through participation in a programme designed to enhance individual
living skills and independence (South Eastern Health Board, 1999).

It is recognised that many individuals in the general population in Ireland have
performed below their educational ability. Ireland has one of the lowest rates of adult
literacy and numeracy in the European Union, with 63% of the unemployed not
completing upper second-level education (Department of Education and Science,
1998). An ERSI study (Nolan and Callan, 1994) found that an adult without
qualifications headed three out of four households living in poverty. It is likely that
these rates will at the very least be reflected within the population of the mentally ill.
Certainly, high levels of poverty and mental illness are closely correlated (Johnson *et
al.*, 1997) with corresponding high economic costs for society (Weisbrod, 1993).
Participation in education and or vocational training programmes can therefore be
seen as both a socially integrative activity, in terms of mainstream social
development, as well as providing the mentally ill with skills that will enhance their
future employment prospects. This in turn proves beneficial for society in terms of
saving costs in treatment and lost productivity.

However, it is recognised that individuals with a mental health history living in the
community are difficult to engage in such programmes (Burns and Guest, 1999) or
require supportive services if once engaged they are to continue to participate in such
programmes. An effective and increasingly widespread approach to deal with these
issues of employment reintegration and vocational rehabilitation is the *clubhouse*
model ((Mastboom, 1992). The "Clubhouse" model is the most famous of a number
of models of work, employment and training that can now be found in the area of
psychiatric disability.

First established in 1948 in the USA (Anderson, 1982), clubhouse programmes are
designed to meet the needs of people suffering from chronic serious mental illness
who have social skills deficits. Schemes usually consist of a prevocational day

programme leading to transitional employment (Oliver *et al.* 1996). In addition, clubhouses provide outreach, as well as weekend and nighttime vocational training. The philosophy of the Clubhouse approach is based on the view "that mental illness is not the whole of a person and that people with the illness retain normal, healthy needs, capabilities, and aspirations." (Anderson, 1982:1). However, it recognises the reality for the individual of dealing with the difficulties of mental illness in sustaining employment and provides overt interventions that offer focused support and reinforce clients' remaining social and employment skills.

A number of studies have either examined the variety of Clubhouse programmes currently in existence (Mastboom, 1993 cited in Oliver *et al.* 1996) or looked at their economic and quality of life effects (Rosenfield and Neese-Todd, 1993; Oliver *et al.* 1996). Rosenfield and Neese-Todd, (1993) state that participants in clubhouse schemes report improvements in their social relationships and finances. Oliver *et al.* (1996) report improvements in participants sense of "personal safety, positive self-esteem and their overall well-being" (p.222).

Thus overall, the establishment of vocational training and employment schemes to assist users is an essential element in the social conception of disability as a corrective intervention. It is recognised within mental health as having a positive effect on both mental state and quality of life. Within Ireland there are a number of schemes and centres, which provide such training to people with physical and intellectual disabilities in general, though schemes specifically geared to the needs of those with mental health difficulties though well established are comparatively new. For example, there are a number of vocational training and employment schemes for people with mental health problems in the South Eastern Health Board Region (Wells, *in press*).

The National Rehabilitation Board and The National Disability Authority

The National Rehabilitation Board (N.R.B.), founded in 1967, was the statutory agency charged with the co-ordination of vocational training programmes for people with disabilities, so as "to enable and empower people with disabilities to live the life of their choice to their fullest potential" (NRB, 1995:1). It had a central office in Dublin and regional offices around the country that acted as resource centres and provided local advice to vocational schemes. The N.R.B. was statutorily charged with the accreditation of training centres for disabled people that received funding from the European Social Fund (though it is notable that whilst it set standards it had no accrediting or monitoring authority outside the specific area of E.S.F. funded projects). The accrediting of centres was done through N.R.B.'s National Accreditation Committee (N.A.C). A set of training content and structure requirements to assist centres in the design of training programmes were laid out in a

Training Programme Specification (T.P.S.) (NRB, 1995). The National Accreditation Committee also ensured those providing training were adequately trained and that qualifications awarded to disabled people were appropriate and nationally recognised (NRB.ie, 2000). Established programmes were assessed against *The Standard for Vocational Training (S1/95)* (NRB, 1995(a)) and given either a fail, a pass as an 'Approved Centre' or approval as a 'Centre of Excellence'.

Thus the N.R.B. had three functions. It had a strategic role in the formulation of policy in the broad field of equal rights and disability. It had a campaigning role in dealing with prejudice towards the disabled. Finally, it had a accreditation, monitoring and co-ordinating role in relation to employment and vocational ESF supported training programmes for those with a disability.

In 1996 the Commission on the Status of People with Disabilities (the membership of which largely comprised of people with various disabilities) published its recommendations as to how the State should promote equal rights for the disabled (Commission on the Status of People with Disabilities, 1996). The report advocated a philosophy based on equal rights and equality of opportunity in both the social and economic spheres of life. As such it argued for an integrative approach in which people with disabilities would be catered for in the mainstream rather than segregated through specialist schemes. The Government accepted this underpinning principle to inform all future policy with regard people with disabilities. Thus agencies such as FÁS and the Health Boards would be required to pursue integrative policies with regard people with disabilities in the future.

As part of the general changes initiated by this report in 1999 the Dail passed the National Disability Authority Act. This established a new central authority, with 30 staff, to replace the NRB, with responsibility for developing an integrated approach to issues of disability including education and vocational training. The Authority came into operation in June 2000. Its principal functions include the national co-ordination and development of disability policy, conducting research on the planning, delivery and monitoring of disability programmes and services; providing advice on the development of programmes and services; monitoring the implementation of standards and codes of practice and to support the development and implementation of standards (NDA, 2000).

It can be seen from this brief list that the NDA encompasses many of the functions that were previously within the remit of the NRB. However, there are two elements that were part of this remit that appear to be missing. The first is the local regional structure established by the NRB. The NDA will have a general monitoring role,

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providing advice from a central location. In contrast, the NRB had a network of local offices providing close to hand expertise and monitoring. The NDA is primarily therefore, a centralised body with no regional structure to underpin it. The loss of such a structure means that a concentration of locally available expertise is no longer available and instead spread thinly through other organisations such as FAS or the Health Boards. The short to medium term consequence of this is that the ability to bring together and exchange a range of views on the training and employment needs of people with mental health problems will be more difficult.

Secondly, the issue of whether there should be a specialist agency to assess vocational and pre-vocational training schemes with powers of accreditation does not appear to be in the remit of the NDA. Of course in part this is perfectly logical from the underpinning philosophy of equal rights and full social integration. However, whilst this may be appropriate in relation to the physically disabled, there are issues in relation to people with mental health disabilities that may not make such an approach as suitable. For example, people who have suffered from mental illness are often stigmatised and isolated by the wider community in ways the physically disabled are not (Tudor, 1996; Richardson *et al.*, 2000). People with mental health problems find it difficult to remain within more general programmes and as a result are wel-known to be difficult to engage in vocational training (Burns and Guest, 1999). Thus there is a need to design and deliver high quality vocational programmes to meet the specific needs of those with mental health problems. Whether such programmes in the future will be authoritatively evaluated by an effective independent body it seems to me is a rather open question at present.

Many of the previous regional functions carried out by the NRB are to be left to the Health Boards to either provide or monitor. Indeed, most Health Boards have either appointed or are in the process of appointing officers with a specific remit for disability training. The problem with this is that it is open to question as to just how well prepared the Health Boards are to take up the regional role previously occupied by the NRB. It is only now that a number of Health Boards are appointing officers with a specific remit to co-ordinate local disability services and programmes. The nature of Health Boards as large bureaucracies responsible to central government is likely to mean that such officers will have agendas and responsibilities over a wide range of areas. This means that their expertise is likely to be generic rather than specific. Accessibility to such individuals and their freedom of action will also likely be constrained by policy and managerial issues that have a particular impact on people with mental health problems, given the areas "politicised" nature, as a result (Wells, 19997). In addition there is likely to be a conflict of interest in Health Boards having a monitoring role whilst at the same time themselves providing programmes, such as industrial therapy, for people with mental health problems.

Conclusion

It is clear that vocational training and employment not only serve an integrative
function in relation to the rehabilitation of people with mental health problems, but
also a normative one in relation to their contribution to mental well-being. The NRB,
through its local offices, developed an expertise in the field of vocational training for
people with mental health problems. Through its accreditation role it was also in an
influential position to ensure consistency across schemes nationally, whilst providing
a source of quality expertise locally. It is not clear at present how this quality and
consistency function will be maintained. It appears that there might be a danger that
such expertise will be *diluted* and inevitably become focused on people with physical
disabilities and mild to moderate learning disabilities, not least because of the
difficulty of engaging people with mental health problems in programmes of training
(Burns and Guest, 1999). How this is to be avoided is for people with mental health
difficulties wanting to return to employment and those providing specialist vocational
programmes an important issue that needs resolution.

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