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Helping people with a mental illness obtain work: the Health Optimisation Program for Employment

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David J Castle Department of Psychiatry, University of Melbourne, St Vincent's Hospital, Fitzroy, VIC, Australia

Caroline Crosse Social Firms Australia, Melbourne, VIC, Australia

Dea Morgain Social Firms Australia, Melbourne, VIC, Australia

Caitlin McDowell La Trobe University Melbourne, VIC, and: Social Firms Australia, Melbourne, VIC, Australia

Susan Rossell Brain and Psychological Sciences Research Centre, Swinburne University, Melbourne, VIC, and; Monash Alfred Psychiatry Research Centre, Alfred Hospital and Monash University Central Clinical School, Clayton, VIC, Australia

Neil Thomas Brain and Psychological Sciences Research Centre, Swinburne University, Melbourne, VIC, and; Monash Alfred Psychiatry Research Centre, Alfred Hospital and Monash University Central Clinical School, Clayton, VIC, Australia

Andrea Phillipou Department of Psychiatry, St Vincent's Hospital, Fitzroy, VIC, Australia

Monica Gilbert Thomas Embling Hospital, Fairfield, VIC, Australia

Gaye Moore Department of Psychiatry, St Vincent's Hospital, Fitzroy, VIC, Australia

Ellie Fossey Department of Occupational Therapy, School of Primary Health Care, Monash University, Clayton, VIC, Australia

Carol Harvey Psychosocial Research Centre, Department of Psychiatry, University of Melbourne & North Western Mental Health, Melbourne, VIC, Australia

Abstract

Objective: Inclusion in work and education remains problematic for many people with a mental illness. We describe a structured programme – the Health Optimisation Program for Employment – that supported people with a mental illness to gain employment or commence studies.

Method: Twenty hours of the Health Optimisation Program for Employment were delivered to 600 individuals. Participants were asked to complete an evaluation survey encompassing vocational status and ratings of self-efficacy.

Results: Of the 364 participants who completed the baseline assessment, 168 responded to the evaluation survey 6 months after the delivery of the Health Optimisation Program for Employment. Of these, 21.5% had started a new job, while a further 42.8% were either volunteering or studying. Satisfaction with the programme was high and self-efficacy ratings improved significantly over the short term only.

Conclusions: The Health Optimisation Program for Employment requires further evaluation using rigorous scientific methodology but these initial results are encouraging in terms of vocational attainment for people with a mental illness, in the Australian context.

Keywords: mental illness, employment, psychoeducation, self-management, vocational rehabilitation, peer educator, self-efficacy

People with a mental illness frequently identify employment as an important goal in their recovery.[1] There is ample evidence that people with mental illness can work and that participation in employment has many benefits.[2,3] Nevertheless, Australians with mental illness continue to experience high rates of unemployment.[4]

Although the service system in Australia provides clinical, rehabilitation and employment support services to people with mental illness, there is often little communication and collaboration between the sectors.[5] Barriers to the integration of mental health and vocational

Corresponding author:
David J Castle, Department of Psychiatry, University of Melbourne, St Vincent's Hospital, PO Box 2900, Fitzroy, VIC 3065, Australia.
Email: david.castle@svha.org.au

services include differing funding bodies, contractual obligations and lack of incentives for collaboration between service sectors; stigma within the workplace is also problematic and many workplaces are ill-suited to people with a mental illness.[6] In addition, people with a mental illness frequently experience personal barriers such as their symptoms (including cognitive impairment), educational under-achievement, side effects of medication and a low sense of self-efficacy (defined as an individual's confidence that they can carry out the behaviours or tasks required to achieve a particular outcome).[7]

Many studies have investigated models of vocational support for people with a mental illness, such as Individual Placement and Support (IPS), the Clubhouse Model, Social Firms or Supported Education.[8] Of these, IPS is probably best suited and has best outcomes for people with serious mental illnesses such as schizophrenia. Regardless, there is currently limited research regarding mental health self-management programmes as an adjunct to support programmes for job seekers with a mental illness.

To address this gap, we adapted a validated mental health self-management package for people with a mental illness – the Optimal Health Program[9] – specifically to meet the needs of job seekers with a mental illness. This programme, called the Health Optimisation Program for Employment (HOPE), aims to: (1) increase the job-seekers' competency in managing their psychological and physical health; (2) improve collaborative relationships between the job-seeker and their therapeutic, rehabilitation and employment support services; (3) build self-efficacy in the job-seeker; (4) increase job-seekers' understanding of their rights and responsibilities, including managing disclosure and stigma, in the workplace; (5) improve the job-seekers' social functioning.

This paper describes HOPE and its evaluation including participant satisfaction, self-efficacy and vocational outcomes.

Methods

HOPE is a 20-hour programme delivered over eight sessions with a booster (Table 1). During each session, participants are supported to develop a health and/or employment-related goal that could be achieved between sessions and to complete some homework related to the topics discussed.

In the study presented herein, HOPE was delivered by a trained facilitator and a peer educator. Facilitators were recruited from partner agencies engaged in assisting people gain employment and were trained by Social Firms Australia (SoFA) and Frameworks for Health at

Table 1. HOPE session outline

Session	*Content*
Introduction	• Provides an overview of HOPE, develops shared expectations, and builds rapport between participants and facilitators.
1	• Builds knowledge of health, behaviours that influence health and relationship between health and employment.
2	• Develops understanding of stress/vulnerability, early warning signs and coping mechanisms. • Introduces health plans.
3	• Develops understanding and skills to manage cumulative stress, sub-optimal health, vulnerable situations and early warning signs. • Introduces concept of building collaborative partnerships with treatment and support services.
4	• Explores what it means to experience an episode of illness as well as strategies (including medication) that can decrease risk of an episode.
5	• Develops skills to identify stressors and coping strategies; routines and plans in the context of preparing for a job.
6	• Develops skills to identify and solve problems and to manage discrimination and disclosure in the context of starting work.
7	• Develops capacity to engage collaborative partners to retain employment. • Develops action plans to manage vulnerable situations and stressors whilst working.
8	• Reviews understanding of health and relationship between work and health. Reviews goals, interests and strengths in the context of vocational aspirations.
Booster (provided 1 month after session 8)	• Reviews previous material and builds capacity to achieve longer term health and employment goals.

Table 2. Profile of job seekers with a mental illness who commenced the programme

Diagnosis	*Number (n=364)*	*Percentage*
Mood disorder (e.g. depression, bipolar)	167	45.9
Anxiety disorder	100	27.5
Psychotic disorder	96	26.4
No response	1	0.2
Accommodation		
Stable (permanent and secure)	281	77.2
Unstable (temporary)	72	19.8
No response	11	3.0
Lives with		
Family	134	36.8
Partner	23	6.3
Other adults/friends	78	21.4
Alone	120	33.0
No response	9	2.5
Children		
Living with children	48	13.2
Children live separately	61	16.8
No children	248	68.1
No response	7	1.9
Highest level of education		
Primary school	13	3.6
Secondary school	213	58.5
Post-secondary school	130	35.7
No response	8	2.2
Last employed		
<1 year ago	82	22.5
1–5 years ago	154	42.3
>5 years ago	81	22.3
Never	16	4.4
No response	31	8.5
Reason for leaving last job		
Health reasons	117	32.1
Terminated/'let go'	48	13.2
Short-term contract	30	8.2
Redundancy/restructure	23	6.3
Discrimination/harassment	9	2.5
unknown	137	37.7

St. Vincent's Hospital, Melbourne. SoFA was a not-for-profit organisation that developed a range of strategies to assist people with a mental illness to obtain and keep a job. The staff from the partner agencies undertook the facilitation as part of their ordinary role within their agency and received mentoring from SoFA. HOPE programmes were held at suitable community venues. Peer educators were people with lived experience of serious mental illness combined with recent work experience. They participated in an orientation and training programme, which involved learning about mental health, the service system, psycho-education and self-efficacy. The peer educators participated in the same HOPE training programme as the facilitators, received weekly supervision from SoFA and attended monthly team meetings.

Participation in the evaluation component was voluntary and did not affect access to the programme. Participants were invited to complete a paper-based survey at the introduction session, session 8, and 6 months after completion of the programme. The 6-month survey was distributed by post and completion was followed up with a phone call.

The survey collected information on demographics, employment history and service usage. Self-efficacy was assessed using the General Self-Efficacy Scale (GSES),[10] a 10-item scale measuring self-beliefs regarding ability to cope with a variety of life demands. Participants were also invited to complete a satisfaction survey at the booster session that addressed satisfaction with the programme, the venue and the facilitators. The survey was adapted from the Client Satisfaction Questionnaire (CSQ-8), an 8-item self-report instrument assessing satisfaction with health and human services.[11] Additionally, the survey included several open-ended questions which encouraged general comment about the programme. The project was approved by the University of Melbourne Human Research Ethics Committee.

Results

In all, 600 individuals were referred HOPE. Of these, 364 (61%) consented to the evaluation and completed the baseline survey; 230 completed the end-of-programme satisfaction survey during session 8 and 168 responded to the 6 month post-programme assessment.

Participants were aged predominantly between 26–55 years (83.8%) and 52.5% were male. Approximately three-quarters (n=266) were born in Australia and five identified as Aboriginal or Torres Strait Islander. Further details are shown in Table 2. Most (42.6%) were referred by Disability Employment Services, 29.7% by clinical mental health services and 26.9% by psychosocial rehabilitation services.

Participants' primary diagnoses included psychotic conditions (26.6%), mood disorders (38.5%), anxiety disorders (5.8%) and 4.7% constituting other mental illnesses. The remaining 24.5% did not report their primary mental illness.

Of the 168 participants who completed the final survey, 36 (21.5%) reported that they had started a new job between commencing the programme and the 6 months follow-up. Of the 132 participants who had not started a job in the previous 6 months, 51 (44.5%) were looking for paid work, 37 (32%) were involved in volunteer work and 35 (30.5%) were studying. Thus, overall 64% were either employed, studying or involved in volunteer work.

The rate of employment at 6 months did not differ significantly between the different primary diagnosis groups (χ^2=4.16, p=0.244), nor did the activities undertaken if they had not gained employment (i.e. studying, volunteering or looking for work) (χ^2=2.47, p=0.872). The rate of participant drop-outs from baseline to 6 months also did not significantly differ depending on diagnosis (χ^2=2.11, p=0.551).

The rate of employment at 6 month follow-up did not differ significantly between short-term (defined as <5years since employment, at baseline) and long-term unemployed (last employed over 5 years previously or never worked) participants (22.8% vs. 15.0%, respectively; χ^2=1.059, p=0.303). Of those unemployed at 6 month follow-up, 20.8% of short-term unemployed participants were studying, 14.9% were volunteering and 19.8% reported that they were looking for work. In contrast, 22.5% of long-term unemployed participants were studying, 15.0% were volunteering and 10.0% reported that they were looking for work. Groups did not differ significantly in the rate of undertaking these activities (χ^2=2.043, p=0.563).

Mean rating on the GSES at baseline was 26.8 (SD=8.3), rising to 28.8 (SD=7.3) at the conclusion (p=0.017); this gain was not, however, maintained at the 6-month follow up (M=27.7, SD=6.4 (p=0.173).

The vast majority of participants who completed the CSQ-8 rated the programme as good to excellent (94%), and delivered the kind of service they wanted (95%); 78% stated it mostly or completely met their needs and 96% said they would refer a friend to the programme. All other items were endorsed at above 90%.

Participants were asked to describe what they found most helpful about HOPE. Responses ranged from specific activities such as 'goal setting and problem solving' to broader statements including 'finding out how to take more notice of myself and (what) is going on and to learn my early warning signs of when things are going down'. Responses to a question about what was least helpful included issues such as timetabling, length of sessions and length of the programme (both too long and too short).

Discussion

Two key results emerge from this study. First, some two-thirds of responding participants acquired a valued social role (work, volunteering, study) in the context of HOPE. This is especially encouraging in light of 69% of participants having been out of work for 12 months or more at baseline. Also of importance is that even the long-term unemployed appeared to benefit from the intervention.

Second, participants' self-efficacy ratings showed significant improvement, albeit this was attenuated at 6 month follow-up, possibly because of lack of reinforcement. Within HOPE, the development of self-efficacy was addressed in a number of ways. Participants were encouraged to undertake 'mastery experiences' by setting their own small goals each week and the achievement of these goals was shared, which promoted 'vicarious learning'.

The peer educator and facilitator encouraged and supported participants in setting and achieving their goals.

This paper emerges from the evaluation data collected as part of a service delivery project and it therefore has limitations, including the lack of a control group and limited completion of follow-up questionnaires, which might have introduced bias. Future evaluation of HOPE using a randomised controlled design is required. A more fine-grained assessment of the impact of diagnosis, educational level, level of cognitive functioning and psychiatric symptoms would be important. More detailed structured qualitative analyses would also enhance further studies. Having said this, the outcomes presented here contribute to the ongoing research into the effectiveness of self-management programmes and ways in which such programmes may contribute to improved employment outcomes for people living with a mental illness.

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Disclosure

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