Employment, social inclusion and mental health

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Whereas *un*employment is clearly linked to mental health problems, employment can improve quality of life, mental health, social networks and social inclusion. Yet in the UK only 15% of people with serious mental health problems are employed – despite an overwhelming consensus from surveys, case studies and personal accounts that users want to work. This paper aims to challenge common misconceptions surrounding employment, work and mental health problems. Drawing on a range of research evidence and legislative guidance it discusses significant barriers to work and proposes feasible solutions. The need for mental health staff and services to become involved in the provision of work opportunities is considered, as is the vital role they can play in changing communities. The potency of work as a vehicle for improving the social inclusion and community tenure of people with mental health problems is highlighted.

Keywords: employment, social disability, social inclusion, work

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Introduction

Social exclusion has become a key issue in the current UK government's endeavours to 'put people first'. The social exclusion unit define it in terms of outcome

> 'what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown' (Social Exclusion Unit, Cabinet Office 1998).

However, understanding of the process of social exclusion is increasing. The 1998 White Paper 'Modernising Mental Health' highlighted how the prejudice attached to mental ill health 'and the failure to understand its causes, leads to discrimination and social exclusion' (DoH 1998, p. 1.11). Certainly poverty, unemployment, social exclusion and mental health are intricately linked. In the UK, people with mental health problems have far fewer opportunities to work than the general population because of the many misperceptions and prejudices about their abilities and needs: they are not expected to work, and (particularly in times of high unemployment) they are not considered fit for work. This lack of work serves to further perpetuate the prevalent negative stereotypes and social exclusion associated with mental health problems: a visible lack of users within employment settings is erroneously perceived by the general public as 'evidence' that mental health problems prevent people from holding down a job. Thus, they are denied access to one of the most important routes (within a capitalist society) for achieving a positive community presence and a valued status within society.

The impact of unemployment

To appreciate the devastating individual effects that this situation has on each person, we need only ask ourselves: what does work offer any of us? Clearly, over and above the obvious financial benefits, work provides a sense of

purpose and belonging; an opportunity to contribute to shared goals; a social forum; status and recognition for our efforts and achievements. It is a fundamental component of how we define and perceive ourselves in the social world (Galloway 1991). Diagnosis with a mental illness commonly results in negative changes in selfperception, but achieving employment can encourage the development of realistic rather than pessimistic appraisals of the future (Fowler *et al*. 1995) – appraisals that are more likely to be associated with better clinical outcomes (McGlashan & Carpenter 1981, Birchwood *et al*. 1993). Just as unemployment can further 'incapacitate' a person struggling with the often bewildering experiences of psychosis, so can work 'recapacitate' the same person, while simultaneously tackling their social exclusion by providing them with an income, status, and social contacts.

The association between both suicide and high rates of depression with unemployment is well documented (e.g. Platt 1984, Bolton & Oatley 1987) as is the higher risk of suicide and depression among individuals with serious mental health problems (e.g. Birchwood *et al*. 1993). It follows that lack of work further increases the risk of morbidity and mortality for users (Evans & James 1998). Yet despite the clear benefits of work and the damaging effects of enforced unemployment, mental health workers continue to neglect work when considering the needs of people with serious mental health problems. This is reflected in the high unemployment rate of 85% found among people with serious mental health problems in both the UK (National Institute on Disability & Rehabilitation Research 1992) and the United States (Stein & Santos 1998). This rate has remained static for many years and interestingly is double that for people with severe physical disabilities (Stein & Santos 1998) – despite research that has shown that 30–40% of people with serious mental health problems are capable of working (Ekdawi & Conning 1994).

Users' views

People who use mental health services usually want to work, regardless of how 'severe' their symptoms and related social disabilities may appear. Surveys of needs and quality of life (e.g. Hatfield *et al*. 1992, Perkins & Repper 1996, Reid *et al*. 1993) find employment consistently identified as a priority need by users themselves. Furthermore, the unfulfilled desire for work is often not diminished by passing years. One of the present authors worked with a man in his sixties who achieved his ambition of obtaining (and successfully maintaining) a paid job after over 40 years in psychiatric institutions. Surveys of service users' views also highlight the negative ramifications of not working: lack of money; inactivity, not perceiving themselves as 'mentally well' (Reid *et al*. 1993) – all of which are tenets of social exclusion.

Providers' views

Despite some renewed interest in work among mental health service providers, many – if not most – mental health professionals and services fail to recognize the significance of work for people with serious mental health problems. Mental health services continue to focus on symptoms or impairments rather than the equally disabling social factors. As Grove (1999, p. 132) points out, they work on the implicit assumption that 'they are there to support people *out of work* rather than *in work*'. When services and practitioners do recognize the importance of 'work', they are still predominantly referring to an activity which does not involves wage earning as it is understood in ordinary, open or 'competitive' employment. Instead, many continue to advocate sheltered work settings as the route back to employment, despite the fact that sheltered facilities such as industrial therapy units have a poor record in resettling people in open employment (Wansborough 1983). Ironically, work is generally seen as falling outside the health remit yet not necessarily within the remit of social services (Perkins & Repper 1996).

The notion that users should not be encouraged to work may arise from genuine if somewhat misplaced concerns to 'protect' vulnerable people, but it is potentially damaging in several ways. Firstly, a lifestyle of leisure funded through state benefits will be extremely limited and place the person at risk from further social exclusion. Secondly, this viewpoint assumes that for individuals with serious mental health problems, the stresses of work, except perhaps in sheltered and segregated settings, outstrip the stresses of being unemployed and socially excluded. Third, it reflects the longstanding pessimism ('realism') about serious mental health problems and fails to recognize the potential success of vocational initiatives in terms of improved choices and opportunities for users, as well as improved rates of employment – and the subsequent benefits for mental health and quality of life.

Historical context

The current complacency regarding work and those with serious mental health problems makes it easy to forget that things were not always so. Strauss (1968) relates how the second century Greek physician, Galen recognized the therapeutic benefits that work could have on both physical and mental health problems, purporting that 'employment is nature's best physician and is essential to human happi-

ness'. In 1796, work was used as a therapeutic strategy for psychiatric disorders as part of the 'moral treatment' approach pioneered by the Quaker, William Tuke at the York Retreat, and his French counterpart Pinel, in Paris (Davison & Neale 1982). Smaller asylums adopting this approach achieved remarkable success in maintaining and developing employment skills (Davison & Neale 1982) only to be superseded by the development of the much larger mental hospitals as the twentieth century dawned.

In a review of vocational rehabilitation in the US, Bond (1992) identifies three main periods that are discernible in the development of UK mental health services. In the 1950s and 1960s, vocational activities were sited in hospitals and sheltered workshops which were quickly viewed as fulfilling the employment potential of psychiatric patients (Bond 1992). Remnants of this epoch are still widespread today: day hospitals, rehabilitative day treatment programmes, and, partial hospitalization programs (Stein & Santos 1998). Bond (1992) describes the 1970s and 1980s as 'the Dark Ages' because neither community mental health centres or generic vocational rehabilitation services accepted any responsibility for addressing the vocational rehabilitation needs of people with serious mental health problems. A few exceptions to this widespread neglect were the emerging psychosocial rehabilitation centers such as Fountain House in New York (Beard *et al*. 1982) which offered transitional employment. While transitional employment programs were a welcomed innovation in the face of stagnated rehabilitation services for serious mental health problems, such programmes are limited regarding their sustained impact on users social exclusion and unemployment. This is because 'transitional' approaches, by definition, lack full community integration and provide only timelimited, not permanent, jobservation.

In the US, Bond (1992) termed the current decade 'a Renaissance' as mental health started moving employment services from institutions to community or settings through a 'supported employment' approach. This reflects something of a paradigm shift in the rehabilitation of people with serious mental health problems: it is 'a movement away from an emphasis on prevocational training to directly placing people in real jobs and supporting them on the job' (Stein & Santos 1998, p. 114). It is precisely this move away from service based initiatives towards the provision of support 'becoming a part of the community' (Perkins & Repper 1996) that will increase users' chances of genuine social inclusion.

Research context

Nearly three decades ago, Wing & Brown (1970) reported that lack of occupation was the only factor differentiating those inpatients with a diagnosis of schizophrenia who did not improve from those who did. More recently, Warner (1994) investigated the relationship between schizophrenia and the state of the economy, concluding that recovery rates from schizophrenia are lower during economic recessions and higher during wartime. Warner's hypothesis is that greater opportunities to work, together with more optimistic expectations, are more likely to result in better outcomes for people with serious mental health problems.

More recently, a longitudinal analysis of unemployed people with serious mental health problems in the US found that those who were working at the time of followup had lower levels of symptoms, higher levels of global functioning, better selfesteem and greater financial satisfaction than those who were still unemployed. These gains were maintained even when baseline levels of functioning were controlled for (Mueser *et al*. 1997). Using a randomized controlled trial design, Bell *et al*. (1996) demonstrated that improvement of symptoms is more likely when people with schizophrenia have paid work compared to unpaid work. Furthermore, subjects allocated to the 'paid' condition had a significantly lower rate of rehospitalization than 'no pay' subjects. All subjects who were working, regardless of pay, showed more total symptom improvement compared with those not working, leading the authors to conclude that participation in work activity was primarily responsible for symptom reduction.

In a study comparing working and nonworking people with serious mental health problems (Van-Dongen 1996) concluded that those who worked had greater satisfaction with their quality of life and significantly higher selfesteem than nonworkers. No particular patterns of symptoms nor diagnosis have been found to correlate with positive employment outcomes (Pozner *et al*. 1996) so there is no evidence to support the common assumption that efforts should be focused on getting the least symptomatic users work first. Even for people with persistent and severe psychotic symptoms, what appears to be far more significant in predicting success at work is their desire for work, their interpersonal skills, their work readiness and their employment history (National Institute on Disability & Rehabilitation Research 1992). Furthermore, contrary to common expectations, Becker *et al*. (1996) reported that people with serious mental health problems have realistic and stable job preferences that, if matched with competitive jobs, lead to increased job satisfaction and tenure.

Much of the American research is unanimous on one point: supported employment services offer greater promise than do sheltered or transitional employment approaches (Lehman 1995). Support needs to be provided in real workplaces with skilled support 'titrated' to meet the individual's fluctuating needs. Initiatives based on this

model have demonstrated superior outcomes even with some of the most vulnerable of users (Stein & Santos 1998). What sets supported employment approaches apart is that they focus from the onset on placing people in real and permanent jobs, regardless of their perceived level of disability. For most of the other approaches, this is the exception rather than the rule.

In a review of supported employment initiatives, Bond *et al*. (1997) found that on average 58% of users in these initiatives achieved competitive employment compared to only 21% for users receiving traditional vocational services. Users offered supported employment also tended to have higher earnings when they worked compared with those receiving traditional services and there was no evidence that supported employment led to higher stress levels nor to increased rehospitalization. The authors concluded that two features of supported employment programs have the most empirical support: the integration of mental health and vocational services within a single team and the avoidance of preplacement (rather than on-the-job) training (Bond *et al*. 1997). Such positive outcomes have driven a shift in the US from traditional day hospital or day center treatment to vocational rehabilitation and psychosocial programs. In a study comparing employment gains between users receiving day treatment and those receiving supported employment, Drake *et al*. (1994) concluded that eliminating day treatment and replacing it with a supported employment program improves integration into competitive jobs in the community.

Notwithstanding the considerable benefits of supported employment, it has not proved universally successful (cf. Fabian 1992, Clark *et al*. 1998): even in the US, this is a relatively new approach, which needs further development and adaptation for people with mental health problems coupled with research into what works for whom.

In the UK, however, supported employment initiatives clearly represent one of the key means by which health and social services can start to bridge the great void between what they currently offer and what users want. The UK mental health services that have developed supported employment initiatives are the exception rather than the rule, but they are vital sources of expertise and research and need to be recognized as resources for mental health services nationwide. As Grove (1999, p. 135) describes, 'supporting people into employment is a skilled job and requires many different types of competence'.

(He goes on to list skills such as assessment of clients, negotiation with employers, knowledge of training and education agencies, and a positive but realistic attitude):

> '. . . In short, workers need to be trained, properly supported and located in a culture which emphasises teamwork and interagency partnership'.

Although supported employment has been the focus of most attention; it is not the only useful and worthwhile model for providing work opportunities for people with serious mental health problems. Other models of vocational rehabilitation exist (see Table 1 below) and each approach has advantages and disadvantages that can be matched to the specific requirements of users seeking work. Every individual has slightly different needs and will require a different combination of supports to enable them to take up employment. Unfortunately, there is a definite lack of UK research and outcome data available to evaluate the effectiveness of these initiatives. Not only is there a dearth of data about individual models; there is also a lack of research comparing the relative benefits of different types of work initiatives and the financial benefits and costs of all types of work projects.

As Pozner *et al*. (1996, p. 16) state:

> 'The truth is that we [in the U. K.] simply do not know what is possible given the availability of more flexible job opportunities and intensive and long-term support. Nevertheless, it is safe to say that the proportion [of users] who could work given the right conditions is far higher than actually do at present. The majority have simply never had the chance'.

What is also clear, is that a proportion of the costs of establishing or expanding work opportunities can be offset against a reduced admission rate for those users who work (Warner 1994, Schneider 1997) – without taking into account the cost of benefits (when unemployed) versus the payment of tax (when employed). However, the assumption that paid work will necessarily *improve* the finances of individuals with serious mental health problems, and their families, must not be taken for granted. Many users opt for part-time work and most jobs they acquire on re-entering the jobs market tend to be on low pay. Starting paid work is not just a case of replacing unemployment or sickness benefit with a wage: it often means the instant removal of wideranging subsidies such as exemption from housing and prescription charges which low incomes are unlikely to replace. Therefore, there is a real risk that users working may find themselves worse off in real financial terms than those not (Polak & Warner 1996). Furthermore, if the person subsequently loses their job, they are likely to return to far lower a rate of benefit than prior to working. Instead of their previous level of benefit automatically being reinstated, they will have to submit totally fresh claims for additional disability benefits. In effect they are penalized for losing their job and will have to struggle to rebuild their entitlements, incurring yet further loss of income in the process.

Services and practitioners together with user groups need to canvas policy makers to address the remaining disin-

Table 1.
Models of work, employment and training for people with mental health problems

Type of model	Contents
Club Houses	Community resources run by users (the Clubhouse 'members'). Members are responsible for the upkeep of the Clubhouse and take on jobs within it depending on their needs. They can also experience work in competitive employment through Transitional Employment.
Employment Services	Dedicated staff team or agency assists users in finding and applying for jobs matched to their needs, abilities and interests.
Employment Agency	Similar to 'mainstream' employment agencies though tend to emphasize meeting users' specific work requirements over merely filling vacancies. Jobs often temporary rather than permanent. Jobs may be 'shared' between users.
Local Exchange Trading systems (LETs)	A community based, cash-free arrangement whereby a group of local users exchange skills, services, and goods.
Self-Employment/user run enterprises	Mainstream businesses run by individual, or groups of users.
Sheltered Employment	Offers paid work within commercial settings which have segregated workforces (i.e. entry is reserved for individuals with disabilities).
Sheltered Workshops and Industrial Therapy Units (ITUs)	Offer a variety of usually unpaid work activities within institutional based settings.
Social Firms/co-operatives	Community based businesses (e.g. cafes) often with integrated workforces (i.e. users and non-users) which pay competitive wages, share profits, and involve all workers in commercial and practical decisions.
Supported Employment	Involves individualized and ongoing input to enable users to identify; apply and interview for; train for; and continue to received the level of additional support they require for, predominantly competitive jobs.
Supported Training and Adult Education	Provision of community based or community linked vocational training and nonvocational education. Course arrangements vary: segregated classes may be offered or access to mainstream attendance may be supported by dedicated project workers or a 'buddy' system.
Transitional Employment	Offers time limited placements in open employment on a part-time basis, as a staged approach to preparing users to return to independent employment. (Often provided as part of the Clubhouse model).

centives in the benefits system. As a result of the benefits minefield, any vocational interventions (even with a view to unpaid work) must start with a detailed and expert analysis of the impact on the person's finances. Well meaning practitioners should not assume they have sufficient knowledge to navigate the intricacies of the ever-changing benefits system on a user's behalf – expert input will nearly always need to be sought. Equally unhelpful is simply advising users to contact local solicitor's offices who purport to offer assistance in benefit claims. Often such 'welfare advisors' have little or no understanding of the specific needs of claimants with serious mental health problems.

Changing service cultures

For services and practitioners to offer users the opportunities to work that they want, the continued dominance of an often inappropriate 'throughput' model must be challenged. Many sheltered employment schemes are still based on this model and so offer only timelimited placements and support (Perkins & Repper 1996). What is required instead are approaches based on meeting the highly individual, often fluctuating, needs of those people with serious mental health problems which have as an integral component, the need for work.

The social disability and access model (Perkins & Repper 1996) offers an alternative to the traditional biomedical paradigm which saw the individual patient and their symptoms as the sole focus of intervention. Instead of the latter perspective which advocates changing people to render them ready for work and employment, we must move towards 'the perspective…of changing work/employment to render it ready for the people who need it' (Perkins & Repper 1996, p. 195). From a social disability perspective, work is tailored to the specific needs arising from the social disabilities experienced by many people with ongoing serious mental health problems. This means that work projects and environments for users must be designed or modified to cater for difficulties such as 'erratic attendance, attention deficits and social problems in the same way as might occur for sight and mobility limitations' (Perkins & Repper 1996, p. 196). That is, they must provide a 'virtual' ramp (Hooper 1996) which assists users in negotiating the particular social, psychological and emotional obstacles stopping them from accessing a specific work setting – just as adaptations to the physical structure of work environments are common to assist people with physical or sensory disabilities. Examples of this include providing users whose concentration is reduced with a series of visual prompts to remind them of the sequence of particular tasks, or, ensuring a 'quiet room' is available for

a user to retreat to for a break should the pressure of social interaction become too stressful.

Addressing discrimination and prejudice

Many potential employers are reluctant to offer work opportunities because they consider they will be economically disadvantaged by what they believe to be higher levels of absenteeism of people with serious mental health problems. However, Perkins (1991) has demonstrated that the level of absenteeism of most workers with serious mental health problems attending an industrial unit is no greater than that of nurses in the same hospital. What was different was that the former group worked fewer complete weeks, i.e. were likely to have the odd day off here and there. The pattern of the nurses' absence by comparison was more likely to involve longer blocks of time.

While unpredictability of attendance may present a problematic situation in work settings for some users various adaptations, including flexible working patterns, an increase in the workforce, having a 'bank' of backup workers ready to step in at short notice, can be introduced to minimize the inconvenience to the organization. Use of such 'accommodation' strategies to ensure that work, particularly in open employment settings, remains accessible for someone with social disabilities, while common in America are rarely encountered in the UK. This may be owing partly to the concerted legislative push in the USA (the recent *Americans with Disabilities* act) which emphasizes the right of *all* citizens regardless of their particular disability to work and charges services and employers with providing work settings which adapt to each person's disabilities. In contrast, the British *Disability Discrimination Act 1996* has yet to make a significant impact in addressing the widespread prejudice and discrimination which militates against people with serious mental health problems having routine access to work settings that are modified to accommodate their particular needs.

For many users, the issue is not so much whether they will have lower attendance levels than their colleagues but rather whether they will even be considered as a potential candidate for a job. This everyday reality of discriminatory attitudes and behavior is one of the most serious problems faced by people with serious mental health problems (Read & Baker 1996). Discriminatory attitudes of employers and even some voluntary work providers are widespread. A study comparing the attitudes of employers towards prospective employees with a mental illness (depression) to those with a physical illness (diabetes) revealed overt discrimination against equally qualified and experienced candidates with depression (Glozier (1998). One can only speculate what results would have been obtained if the study compared profiles of people with a diagnosis of schizophrenia instead of depression.

Challenges ahead

To succeed in addressing both the lack of work opportunities for users and the widespread discrimination, the social disability model provides a useful model. It places responsibility upon whole services and communities rather than upon the individual service user. However, a number of developments need to take place at different levels:

- Employment must become a fundamental part of every service users care plan: work history, experience and aspirations must be assessed along with a careful assessment of actual and potential difficulties in order to develop a support package that meets each user's specific work and employment choices and needs.
- Training in meeting the employment needs of people with mental health problems must be integrated with training in rehabilitation and treatment. Thus specific interventions should not be delivered purely for the sake of reducing symptoms, but in order to facilitate access to a fulfilling life – including work. A powerful illustration of the impact that psychosocial interventions can have on increasing the chances of users obtaining employment is described by Brooker *et al*. (1994). Their study involved training Community Psychiatric Nurses (CPNs) to deliver psychosocial interventions to people with schizophrenia and their families. The findings demonstrated that patients allocated to the intervention group were more likely than controls to have significantly improved levels of employment (as well as other positive outcomes) at 1 years follow-up.
- Both the stress vulnerability model (Nuechterlein & Dawson 1984) and family interventions studies (e.g. Tarrier *et al*. 1988) have highlighted the increased susceptibility to stress that individuals with serious mental health problems have. To counteract this vulnerability and so to reduce the risk of the demands of a job contributing to relapse, the potential stressors in the work environment need to be assessed and the individual needs to be helped to develop strategies to cope with these stressors. As with nonpsychotic individuals, workplace stress is not always just about excessively stimulating environments: jobs that are monotonous and place no demands on people's capabilities can be equally stressful. Ranking high in service users' lists of help wanted from services, is more information on identifying their own signs of

relapse, and ways of taking preventative action. Clearly identifying each user's early warning signs of relapse together with a robust action plan will dramatically increase the chances of deterioration being averted, thus enabling the person to remain working.

- Ideally, every multidisciplinary team serving people with serious mental health problems should include a vocational specialist – something which already occurs in ACT teams (Stein & Santos 1998). A similar model has been used to good effect in Community Connections, Nottingham (Bates 1999).
- Local mental health employment services need to be developed, based on the principles suggested by Pozner *et al*. (1996). These need to provide a mix of employment initiatives, supports and job creation measures (Grove 1999), including a strategy to employ people with mental health problems within mental health services.
- Mental health services need to demonstrate a commitment to the values that they espouse. They should set targets for employment of people with mental health problems, and create positive support structures to enable service users to work within the service.
- Effective working alliances need to be forged with local employment and educational/training organizations as well as local voluntary providers. Collaboration with learning disabilities services should be considered as these services often have a wellestablished record of supporting people with social disabilities in diverse work settings. Creative solutions must be generated to meet local demand. This may involve people other than qualified statutory staff (users, support workers, voluntary agency staff) being trained and employed as employment support or project workers in a variety of initiatives.
- Mental health services must take positive steps to confront discrimination and to present positive images of service users to educate local people about the work rights, needs, and contributions of people with serious mental health problems and to promote changes in public understanding and tolerance (cf. Repper *et al*. 1997; Repper 1999).
- For the situation to be tackled effectively, practitioners' and managers' lack of knowledge regarding the potential of people with mental health problems to work must be addressed as a matter of urgency. If specialist mental health services fail 'to get their act together' regarding the priority of work issues they cannot hope to influence the commissioning decisions of local primary care groups nor of health authorities. The fact that there is convincing evidence of the benefits of work, and there are models of improving employment prospects, for people with serious mental health problems, can be used to influence local and regional commissioning agendas. This influence should extend not only to the type of employment initiatives that are commissioned but also to the pivotal issue of staff training.

Since the barriers that exclude those with mental health problems from work are complex and manifold, so it follows that vocational rehabilitation will by necessity be multifaceted if it is to effectively tackle these barriers (Rutman 1994). There are no off-the-shelf solutions – instead each area must develop a comprehensive framework of vocational rehabilitation provision mapped onto local users' needs and preferences. An innovative example of such provision is the Network in Lewisham (O'Flynn & Ingamells 1997) which emphasizes users' empowerment and their participation in community resources and involves a partnership between several mental health services and community organizations. Network has developed a comprehensive range of work provision through 13 'partner projects' many of which are user led. Contrary to many professionals' views, work initiatives do not have to be largescale projects underpinned by massive investment in staff, equipment and resources. Growing evidence from both the US and the UK demonstrates that specialist mental health practitioners and services can be involved in instigating and providing a variety of successful work schemes. The essential prerequisite is a genuine commitment to increasing the access people with serious mental health problems have to real waged jobservation Fig. 1 provides a summary of successful initiatives that may provide inspiration and expertise for those mental health services seeking to develop useful and appropriate facilities.

Conclusion

Work is both a health issue and a major determinant of social inclusion. Nowhere is this more apparent than when considering the needs and aspirations of people with serious mental health problems. Work for these people needs to be redefined as an entitlement and citizenship issue rather than as a form of treatment. Thus, while the therapeutic benefits of work can be reaped, the onus is clearly on practitioners, services, and communities to provide diverse work opportunities as a vehicle by which social inclusion can be achieved.

As Stein & Santos (1998, p. 112) put it:

> 'Work as an outcome is arguably the single most important marker of the success of any treatment/rehabilita-

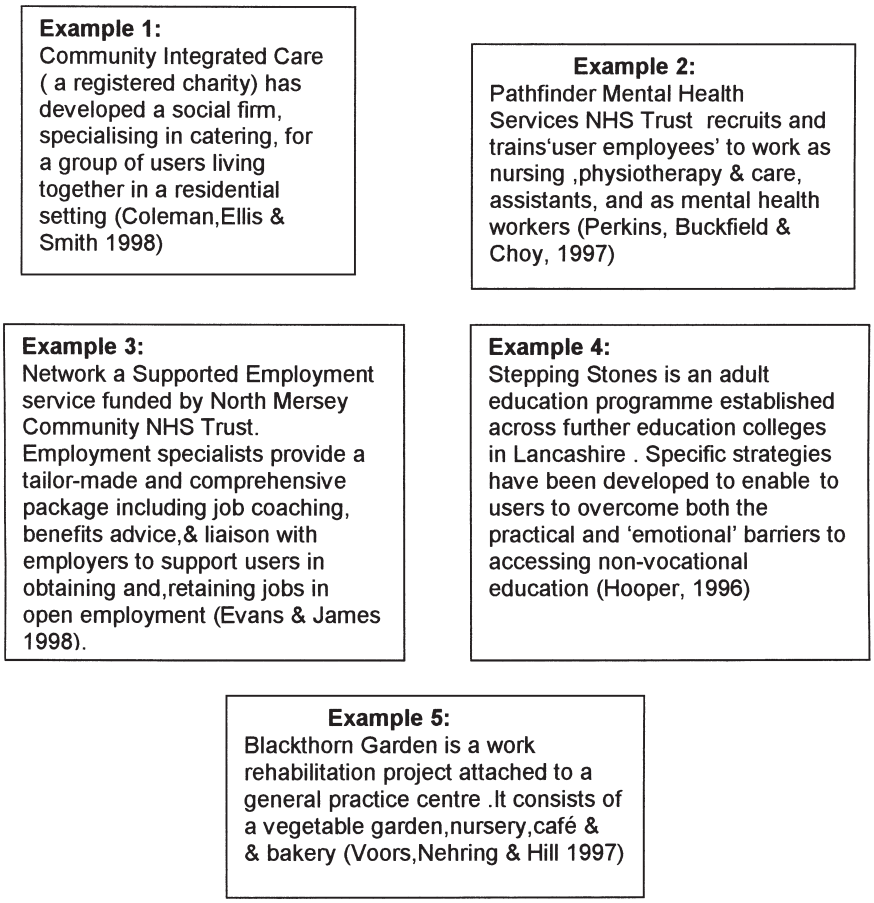

Figure 1
Examples of work, employment and training inititiatives.

tion system or program that markets itself as 'state of the art' in facilitating the community integration of persons with severe and persistent mental illness.'

Service users' accounts of recovery place certainly reflect the critical importance of community integration – or social inclusion:

> '. . . [T]he negative personal and societal attitudes surrounding mental illness often leave those who suffer from illness disconnected from themselves, from others, from their environment . . . and from meaning and purpose in life.' (Koehler & Spaniol 1994).

If practitioners, services, and communities grasp the emerging opportunities to collaborate with users to facilitate work for those who want it, this will foster a fundamental shift in the social status of users. Work is only one part of being valued and respected within society, but it is an important route to social inclusion. The challenge for service providers is to facilitate access for all people with mental health problems – however, disabling, to combat exclusionary attitudes and practice, and to engender acceptance and support.

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