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2 weeks during December 2001 in the first instance, aimed at engaging general practitioners. We especially need your help with this and please contact the campaign administrator, Liz Cowan, if you would like to know more about it.

Finally, one major project has been developed to tackle the stigmatisation of people with mental illnesses by doctors. This project has been developed by a working party involving collaboration between our College, the Royal College of Physicians and the British Medical Association. The Royal College of General Practitioners has also been involved, as has the Department of Health and user representatives. The Royal College of Nursing has had an observer present. This report was formally published in July 2001 as College Council Report, CR91 (Royal College of Psychiatrists *et al*, 2001). Against a background of acknowledging that such stigmatisation and discrimination exists, the report makes a series of recommendations (Box 1) and many of these are now being implemented. It is clear to the management committee that doctors in all specialities, including psychiatry, can be at fault and we are delighted that so many other postgraduate professional bodies within medicine have seen fit to join us enthusiastically in this task. Clearly, this is an area where involvement of the

membership over the next few years can make a great difference.

In conclusion, I want to reiterate yet again that the management committee believes our campaign will now benefit greatly from energetic and professional input from the College's faculties, sections, special interest groups and divisions, and from the membership at large. Instruments and projects are now in place to facilitate this. The campaign needs to be owned and promoted by us all. Please contact the campaign office (tel: 020 7235 2351 ext 122; fax: 020 7235 1935; e-mail: lcowan@rcpsych.ac.uk) for more details and any guidance that you would welcome.

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BOB GROVE

Making work schemes work

The past 5 years have seen dramatically increased interest among users, professionals and the Government in enabling people with mental health problems to gain employment. Many new projects have been started, with a range of different approaches including supported employment, training and placement, transitional employment, social firms and cooperatives. There are a number of reasons for this increased interest.

First, users themselves want to work, as is confirmed in a whole range of quality of life and user surveys (Pozner *et al*, 1996a,b; Rinaldi & Hill, 2000). This aspiration is not confined to those who have recently lost their job but extends, according to one survey, to around half of those who have lost touch with the labour market over an extended period (Bates, 1996).

Second, employment improves the quality of people's lives – in more ways than relieving their poverty. Many studies have demonstrated that meaningful occupation is a critical factor in clinical improvement, improved social functioning and reduction of symptoms (Schneider, 1998). A study of Irish social firms showed how work can be a significant factor in people staying out of a hospital and reducing their use of medication and day treatment centres (McKeown *et al*, 1992). Studies also show that there are strong links between unemployment and mental ill health (Warr, 1987) and a prob-

able link with increased risk of suicide (Platt & Kreitman, 1984; Mueser *et al*, 1987).

Third, there is increasing political support for the view that high levels of unemployment among people with disabilities, including those with mental health problems, is unnecessarily wasteful of lives and a denial of civil rights. A special report for the Labour Force Survey of 2000 suggests that there is an unemployment rate of 82% for people with a psychiatric disability (Labour Source Survey Autumn 2000; <http://www.drc-gb.org/drc/InformationAndLegislation/Page354.asp>). This compares with studies in the UK, US and Germany that suggest that, given appropriate support, 30% or more of people with a diagnosis of severe mental disorder are capable of holding down a job (Ekdawi & Conning, 1994; Drake *et al*, 1996; Seyfried, 1995).

There are, however, serious barriers to employment that mental health service users have to overcome – some of them within mental health services themselves. Clinical and social care services often compound the very real problems of stigma and discrimination from employers and the general public by having as their basis the implicit assumption that they are there to support people out of work rather than in work. Many services are also poor value for money. Studies of the comparative costs of keeping people in hospitals and day centres as against supporting them in employment show that the



latter is less expensive, especially when the transformation from recipient of benefits to taxpayer is taken into account (McKeown *et al*, 1992; Schneider, 1996). A review in the US came to similar conclusions, finding that, even with intensive levels of individual support, “supported employment has considerable potential for reducing costs and improving client outcomes” (Clark *et al*, 1996, p. 75).

What works?

So – what is appropriate support? What is emerging quite strongly from the research evidence is that the supported employment model of vocational integration has been most effective in helping service users to get and keep paid employment. The concept of supported employment is very simple. A person is hired and paid by a real employer. The job will meet both the employee’s needs and skills and the employer’s requirements. The employee will be entitled to the full company entitlements and opportunities. From the beginning the employee and the employer will receive just enough help from a support organisation to ensure success.

A recent review of research into employment schemes for people with mental health problems shows that supported employment achieves superior results in terms of job outcomes and duration of employment than any other approach to vocational rehabilitation (Crowther *et al*, 2001). Bond and colleagues also carried out an extensive review of the research in this area and found 17 studies examining the effectiveness of supported employment programmes (Bond *et al*, 1997). In each study, the advantages of particular supported employment methods were clear. In comparison with more traditional vocational interventions, participants in these programmes had higher rates of employment, longer job tenure and higher earnings. The authors reported an average competitive employment rate of 55–58% for both experimental and non-experimental studies. They also report that the *Back-to-Work Program* in Washington DC achieved an employment rate of over 75%, with an average job tenure of 17 months.

Furthermore, there has been no evidence that supported employment precipitates hospitalisation rates by increasing service users’ stress levels. Studies reviewed by Bond and colleagues (1997) found that even long-term day patients can move into supported employment programmes with positive competitive employment outcomes and with no significant negative effects. They point out that “increases in employment rates were especially marked for regular attenders of day treatment” (p. 337).

Bond *et al*’s review (1997) included a number of studies examining the effectiveness of different supported employment programmes such as the assertive community treatment model, transitional employment (the clubhouse approach) and the job coach model. The model that emerges from the literature as the most promising programme so far is known as individual placement and support (IPS) (Becker & Drake, 1994). In

IPS the emphasis is on rapid placement in work with intensive support and training on the job. This contrasts with the train and place methodology that favours a step by step approach, but which has fewer sustained employment outcomes (Bond, 1998)

What else works?

It must of course be recognised that supported employment is not for everyone and that there should be a range of choices – including voluntary work, local exchange trading schemes (LETS – where members provide services for each other on a *quid pro quo* basis), etc. However, even where paid employment is concerned there need to be other options. What if there are no jobs or the local economy is unwilling to take on people with disabilities? Do users have to wait until employers’ attitudes change? That may mean waiting for a very long time.

One solution being developed in many parts of Europe, including the UK, is the social firm (Grove *et al*, 1997). These are sometimes described as modern versions of sheltered employment, but there are crucial differences that go beyond repackaging and changing the name. In a social firm the emphasis is on creating a successful business, which can support paid employment. The social firm operates entirely as a business but its business methods emphasise participation by employees in all aspects of the enterprise. Although it may offer training on a paid basis it is not primarily in the rehabilitation business, and its core staff, whether or not people with disabilities, are paid the going rate for the work. It is not a ghetto – only around half the staff will be people with disabilities and those who have disabilities may be in managerial positions.

Much of the evidence about the costs, benefits and effectiveness of social firms comes from Germany. However, there is increasing evidence from the UK to suggest that here too social firms can create sustainable jobs and that employees find them empowering places to work (Grove & Drurie, 1999).

Conclusions

There is enough evidence to suggest that the means exist to help considerably more service users than at present to obtain and hold down paid work. It is also clear that the many service users who say they want paid work are very probably being realistic – if only they can get the right support at the right time. The implications of this are far reaching. If it can be shown that many more people with severe mental health problems are employable than had previously been supposed, then many other assumptions about mental health services start to look insecure. Take day services for example; if it can be shown that there are cost-effective ways of supporting those people into work who want it, then the whole edifice of congregated, building-based social day services starts to fall. Not everyone wants paid work, but it is the writer’s experience that many people who are currently

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offered only social day care would also like to make active contributions to the communities in which they live. It has been long apparent that the era of 'one size fits all' services is over – but now we are beginning to see what can replace them.

The environment is also starting to change. The Disability Discrimination Act is already beginning to offer support to people with mental health problems. In the National Service Framework (Department of Health, 1999) it is a requirement for everyone to have "action for employment, education or another occupation" (Standard 4, p. 53) in their care plans. Other Government initiatives from outside the mental health system, for example New Deal for Disabled People (Secretary of State for Education and Employment, 2001) and Workstep (<http://www.employmentservice.gov.uk/english/employers/workstep.asp>), are providing a framework for partnership working across agency boundaries and holistic services. We are beginning to understand how to make employment a real possibility. The opportunity to give services users what they want and improve clinical outcomes at the same time has never been better. We must take it.

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