OCCUPATIONAL THERAPY AND EVIDENCED BASED SUPPORTED EMPLOYMENT IN MENTAL HEALTH AND ADDICTIONS: SHOWING THE WAY OR GETTING IN THE WAY?

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INTRODUCTION

Employment, that matches a person's skills, strengths and interests, is evidenced to improve mental and physical wellbeing (World Health Organisation, 2014). International literature suggests that between 70-90% of people who experience mental health and addiction issues worldwide want to work (Morgan, et al, 2017, Peterson, Gordon and Neale, 2017), a recent survey established that this figure is 80% in New Zealand (Statistics New Zealand, 2014). This is one of the highest 'want to work rates' of any group of people who experience health and disability issues. However the number of people who have a job and experience a mental health or addiction issues is estimated to be as low as 20% (Jonsdottir & Waghorn, 2015,). People diagnosed with psychosis face one of the highest disadvantages within this group with only an estimated 6% of this population currently in work (Jonsdottir & Waghorn, 2015; Morgan et at., 2016). People who identify as Maori face greater health, social and economic inequities than the general population including poorer mental health, higher rates of addiction, imprisonment and unemployment (Harris, et al, 2012; Marriot & Sim, 2015; Tauri, 2005). The reasons for this injustice are multifaceted and complex but their presence strengthens the need for culturally appropriate, evidenced based, high quality employment support provision in New Zealand for all people who have a mental health or addiction issue.

Occupational therapy and employment

The World Federation of Occupational Therapy (OT) (2015) defines the aims of OT as 'the use of occupation to develop, promote, maintain and restore function through participating in activities of daily life'. This philosophy is mirrored by the OT Board of New Zealand (2015) that states OTs should value recovery, its principles, and work within a socially inclusive framework that includes a person's employment aspirations. Work is a core occupation of working age adults, it provides a multitude of benefits including increased self-esteem, self-worth, confidence, sense of identity, social inclusion and citizenship (Hamer et al., 2014) as well as increasing a person's income and potentially lifting them out of poverty (Macintyre, 2018).

OT's are well placed to guide individuals on their vocational journey because they have the necessary skills and training to explore meaningful activities and their complexities alongside analysis of a person's role performance (Davis & Rinaldi, 2004, Priest & Bones, 2012). This suggests that supporting the work aspirations of people receiving care from mental health and addiction services should be a core component of the role of an OT (Smith et al, 2017).

Traditional vocational rehabilitation grew out of the closure of mental health institutions in the 1970's and 80's, occupational therapy was at the forefront of delivering these interventions (Marx et al., 1973). Activities included social skills training, confidence building, and occupations designed to improve a person's daily structure and routine. This approach is often referred to as train then place in the literature. It may also involve attending a narrow range of 'work focussed activities' such as horticulture programmes or production line work in factory style environments (Lockett, Waghorn & Kidd, 2018).. Typically this work is either unpaid or provided under the minimum wage exemption act (1983) which allows employers to pay people with a disability substantially less than the minimum wage on the grounds of poor productivity (Ministry of Business, Innovation and Employment, 2018).

A paradigm shift

In the late 1990's a group of researchers in the US noticed that there was a large variance in outcomes across vocational rehabilitation programmes. Together with practitioners, participants of employment support programmes and their families they set out to establish distinguishing features of high and low performing employment services. The practices that defined the high performing services were distilled into a new approach called Individual Placement with Support (IPS). There are eight practice principles, described in table 1, each of these principles are based on evidence of best practice and have been rigorously tested (Bond, 2004).

1	Zero exclusion	People are not excluded on the grounds of symptoms, illness, work history or perceived readiness, addiction or use of substances, criminal convictions, homelessness or any other factor.
2	Rapid job search	Job search starts within four weeks of programme entry.
3	Individually tailored	Job search is based on a person's individual preferences rather than what jobs are available or the opinion of the employment specialist.
4	Focus on competitive employment	All jobs pay at least the minimum wage, are not created for or specifically set aside for people with disabilities.
5	Financial guidance	This is provided to everyone to ensure they receive information that explains their individual situation and includes details about all of their government entitlements.
6	Job development	Employment specialists get to know employers in their local communities and build relationships with them to create a network of employers.
7	On-going support to employee and employer	Support is individualised to each person and their employer, it is provided for as long as it is required.
8	Integrated employment and clinical support	People who face multiple barriers to employment due to health or disability achieve the best results when employment and clinical supports work closely together.

Table 1: Eight IPS practice principles (Bond, 2004)

There are now over 20 randomised control trails (RCT's), eight systematic reviews including two Cochrane reviews and numerous real world examples published in the literature demonstrating that adherence to this approach increases a person's chance of getting and keeping a job by around threefold compared to traditional methods (Metcalfe, Drake & Bond, 2017). Participants also found work faster, kept jobs longer, worked more hours and earned more money than in traditional vocational rehabilitation programmes (Bond, Drake & Becker, 2008).

A fidelity scale that measures a programmes adherence to the eight practice principles has been developed that demonstrates predictive validity (Kim, et al 2015). There is also a large international learning community collaborative that shares ideas and supports new sites to effectively use of the approach (Johnson-Kwochka, 2017). IPS is frequently referred to as "place then train" because it acknowledges that many people with a mental health or addiction issue may need assistance to develop work related skills but that this is best achieved 'on the job' through strong integration of employment and clinical care (O'Day et al, 2017). In this approach people are placed into jobs, then supported to keep them. IPS also focusses on assisting people into jobs that pay at least the minimum wage, which consumers state that they want as it provides them with the economic resources to alleviate the poverty that they may face and provides monetary reward for engagement in valued activity (Metcalfe, Drake and Bond, 2017). These jobs are open for anyone in the community to apply for so they promote social inclusion and prevent the 'othering' of this group of the population that can occur when they are put into segregated employment environments (Marmot et al, 2007; Hamer et al, 2017).

To date there are seven published examples of successful IPS application in New Zealand (Porteous & Waghorn, 2007; Browne et al., 2009; Porteous & Waghorn, 2009; Browne & Waghorn, 2010; Waghorn, et al., 2011; Kongs-Taylor, et al., 2013; Lockett, et al., 2013), however information pertaining to successful outcomes of IPS with people who identify as Maori is limited in these papers and internationally it is recognised that further research is needed to evidence successes for new populations (Drake & Bond, 2017). In 2017 Northland DHB established IPS in Kaipara district; the programme received specialist implementation support and paid particular attention to culture. This has resulted in around 50% of people engaging with and getting results from the programme identifying as Maori (Priest & Lockett, under review) demonstrating under the right conditions IPS is applicable for both Maori and non-Maori. Further examination of the critical factors for successful engagement and outcome's for Māori is being investigated by the author for their master's thesis.

The evidence for this approach is so robust that it is often described as 'evidenced based supported employment' (Bond, Drake & Becker, 2008) to distinguish it from other forms of supported employment. It is the only approach to supported employment that is recommended in New Zealand policy and practice guidelines (Galletly, et al, 2016; Ministry of Health, 2012). Despite this IPS is not available in routine practice (Lockett, Waghorn & Kidd, 2018) and examples of less effective, non-evidenced based practices that aren't individualised to the person are still delivered by OTs working in mental health and addiction (de Malmanche & Robertson, 2015; Soeker et al, 2018). These paper focus on the experiences of using alternative forms of employment services but they do not report the employment outcomes in a measurable way. Finding and keeping a job are the main reasons people seek employment support so it is vital to report on outcomes as well as experience.

DISCUSSION

Individual barriers

The low expectations which healthcare professionals have in regards to people with mental health and addiction issues are one of the greatest influences on whether a person will engage with employment support (Rinaldi et al, 2010). Some clinicians do not believe that anyone on their case list can get paid work despite irrefutable evidence to the contrary (Marwaha, Balachandra, & Johnson, 2009). This may be caused by the pervasiveness of the medical

model which emphasises symptoms and cure rather than recovery, functional ability and the social determinants of health (Shepherd, et al, 2012). Robertson and Collinson (2011) found that services are often focused on risk and risk management and shaped by rare and catastrophic events that do not reflect the everyday risk faced by most people with mental health issues. This can create an environment where practitioners retreat into conservative actions, interventions and recommendations.

Volunteering is often perceived as one such 'low risk' activity a clinician might recommend to someone who articulates a desire to work. However, many people who experience mental health and addiction issues are living in poverty (World Health Organisation, 2014; OECD, 2016) and express a desire to work because they need to earn money (Reddy Llerena, & Kern, 2016). This can lead to the person opting out of the clinicians recommended course of action and feeling dissatisfied (Areberg &Bejerholm, 2013). Consequently the clinician then concludes that the person was not able to complete this simple task so could not cope with the complexities of work, reinforcing the cycle of low expectations. It is a well recorded phenomenon that excluded populations are frequently blamed for the injustices they face, rather than exploring whether the systems and services provided are adequate for their needs (Penney, Barnes, & McCreanor, 2011; Corrigan, 2000). Clinicians may also make an assumption that volunteering leads to paid work, but for several decades research on volunteering demonstrates that the link is not straightforward. While it is of benefit for some, for others it is detrimental to employment prospects and earnings (Day & Devlin, 1998; Paine, McKay, & Moro, 2013).

The clinician's personal experience of work can also influence their perception of whether working is advisable, particularly if the clinician has experienced their own mental health issue due to work pressures (O'Connor, Neff, & Pitman, 2018). If a clinician feels burnt out, stressed and disillusioned with their job this can lead them to believe that working would be a poor choice for someone who may have lower levels of resilience (Burgard & Lin, 2013). In addition, Ray et al (2013) identified that mental health professionals can develop 'compassion fatigue' due to work place stress that can affect the quality of care they are then able to deliver.

Mental health workers are often concerned about the discrimination a person may face from employers or co-workers and feel ill-equipped to advise on what a person who experiences mental health or addiction issues may say about their particular issue to prospective employers (Shepherd et al., 2012). This is a real concern for many job seekers but is actually addressed by the IPS worker with a negotiated plan (Hielscher & Waghorn, 2015). However, clinicians may not be aware that this is one of the main tenents of an IPS programme.

> We had to examine the thought that we were becoming barriers to people starting work, rather than helpful, because we were determining when we felt they were ready to go to work – as if that was something we had ownership over.
>
> CMHC team manager, ADHB, (Kongs-Taylor, & Locket, 2016).

Individual Practitioner Solutions

Having an IPS worker in the team who is able to obtain a job for someone facing multiple barriers to employment, creates practice-based evidence that this is possible. Having regular feedback regarding examples of people who have obtained employment, alongside challenges to traditional beliefs (Memish, et al, 2017) and an approach that engenders hope further supports attitude change (Rinaldi, Miller & Perkins, 2010).

It is important for technicalities of the model to be fully understood. Frequent observation from practice is that clinicians are often waiting for a person they support to display behaviour that they consider work ready, such as getting up 'on time' in the morning This however is a poor indicator of employment success as the person may be more suited to working night shifts (Gilbert and Papworth, 2017). It is important that these options are explored

and explained to clinicians, some of whom may also have a limited understanding of the diversity of the labour market (Slade et al, 2014). Boutillier, et al., (2015) suggests that if mental health and addiction services are to adopt true recovery principles clinicians should completely abstain from giving advice and instead empower the person to decide on the course of action for themselves.

OT's are well place to support mental health and addiction team to change attitudes, values and discriminatory practices as well as supporting the application and delivery of IPS. There are two papers that describe how an OT can do this in detail (Waghorn, Lloyd & Clune, 2009, Priest & Bones, 2012). IPS is not part of routine undergraduate teaching so they may not be aware of the approach. It is the author's view that OT schools could incorporate teachings on this topic to provide OT's with information on the evidence base and its occupational injustice.

System and legislative barriers

Unlike other developed countries New Zealand ascribes to a national minimum wage exemption for people with disabilities. This allows a person's productivity to be measured against a set of timed tasks. If the person cannot complete these tasks they are then exempt from being paid the minimum wage. The assessment comprises of a set of timed tasks that may not match the job a person wishes to do, moreover the assessment is not evidenced based (Ministry of Business Innovation and Employment, 2018).

Arguably paying a person less because of a perceived lack of productivity is adding to their stigma and sense of 'other' or 'less than' the rest of the population. In contrast IPS ensures adaptions are applied to the environment or task to meet the individual's needs, abilities, strengths and talents (Waghorn et al., 2009). Coupled with a suitable job match and personalised in work supports IPS ensures the employer has a productive employee (Mueser et al., 2001) who justifiably earns a wage equal to that of their colleagues.

The other main issue is securing on-going funding for IPS programmes. IPS is evidenced to improve a person's health and therefore provide cost savings to the health service as well as reducing reliance on welfare benefits which provides cost benefits to the welfare system (Lockett, Waghorn & Kidd, 2018). The cost savings that a return to work provides two currently separate and fragmented systems means that neither wants to lead on funding for IPS (Lockett et al., 2018) and several of the New Zealand IPS sites in the literature are no longer in-existence due to withdrawal of funding (Priest & Lockett, under review).

System and legislative barrier solutions

Whilst the minimum wage exemption is legal in New Zealand but it has been questioned as to whether it is fair or ethical for some time (Mental Health Commission, 1999). Paying people less on the grounds of disability perpetuates a cycle of low expectations (Peterson et al., 2017) and could also detrimentally affect a person's motivation (Reddy et al., 2016). However OT's may not have considered or reflected on issues of parity and occupational justice in relation to this issue. It is the author's opinion that OT's in New Zealand requires education, training and information on this issue.

Lockett et al., (2018) suggest a range of welfare reforms that could support health and welfare working together to provide jointly funded IPS in New Zealand. This approach has been successfully used in some US sites but implementation is patchy (Mueser & Cook, 2016). A newly formed joint health and welfare unit in the UK has recently received a large investment for the sole purposes of providing joined up funding to expand IPS (Independant Mental Health Taskforce, 2016). New Zealand could follow these practices and significantly improve the lives of people with mental health and addiction issues by expanding IPS provision.

CONCLUSION

Occupational justice recognises the rights of individuals to participate in activities in an inclusive way, regardless of health, disability, social class, ethnicity or any other difference. People who experience mental health and addiction issues want to work but have low rates of employment despite the availability of a clearly defined, effective, measureable, evidenced based set of principles that could dramatically increase the number of people in work. This is an occupational injustice created and perpetuated by individual clinicians, the healthcare systems and legislative barriers.

OT's are well placed to tackle this through a range of actions. On an individual level they can learn about the evidence base, champion the issue in their workplace, revise any less effective practices they may be using to align them with the evidenced practice principles and support other to raise their expectations for this marginalised group of people. OT schools could review and withdraw from placements offered at traditional vocational rehabilitation to prevent a new generation being educated in less effective practices. OT schools could also assist in education at both under and post graduate levels. At a national level OT's could lobby government to end the use of the minimum wage exemption with all disabled people and offer creative, individualised solutions to ensure people who want to work are able to do so in a way that is inclusive, ethical and fair.

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