The College

Memorandum on the Employment of Former Psychiatric Patients

Approved by Council 17 June 1980

Introduction

In 1978 a report entitled *Nobody Wants You* was published by MIND. Following this, a Working Party of the Public Policy Committee of the College* has studied the problem of the employment of former psychiatric patients and the present Memorandum has been approved by Council.

The MIND report consists of accounts of discrimination as perceived by 40 patients. The employers' viewpoints are not systematically sought nor reported, with the result that the report as a source of data cannot be regarded as other than biassed.

Nonetheless, it is recognized that, whatever the validity of its evidence, the report does point to areas of difficulty experienced by all those concerned with the employment of former patients. These difficulties are therefore considered under the headings suggested by the report, concentrating on the short-term psychiatric patient rather than the chronic or long-term, as this latter group is the subject of a special study by a Working Party of the Social and Community Psychiatry Section.

Applying for jobs after psychiatric illness

A patient's ability to work is not necessarily diminished in the long term even by a serious episode of mental illness. On the other hand, if there is some impairment it may be advisable to recommend a change of occupation. The question of employment will figure prominently among the difficulties which the patient has to face on his recovery. It is important for patients to recognize that they are put at a serious disadvantage if they apply for jobs before they have recovered from their illness. Their assessment of their abilities may not be realistic, whether they are returning to their previous occupation or applying for a new job. The need for assessment and rehabilitation with retraining, if required, cannot be overstated. The consultant psychiatrist should ensure that the patient receives all the assistance he needs in this respect. Getting back to work becomes harder the longer the patient is away and his chances of succeeding diminish rapidly after an absence of six months or more.

The biggest hurdle that a patient has to face, at the outset, is the interview for a job, but the problems begin earlier when he has to complete an application form which may request information regarding his health. We deprecate such enquiries unless the job description sets out any specific health requirements. The long-established practice may be difficult to change, but nevertheless it clearly puts the applicant at a disadvantage. The same applies to enquiries about the prescription of certain drugs. An affirmative answer without qualification can be misleading. MIND quotes several instances where reports of the prescription of antidepressants has had an adverse effect on the applicant's employment prospects. This point may be worth bringing to the notice of general practitioners (through the Royal College of General Practitioners). It may be pertinent to offer guidance to doctors on writing reports to prospective employers (in the absence of an Employment Medical Officer); these should be confined to a statement of the applicant's fitness for the job and should not contain details of any previous illness. Recent legislation giving protection of employment may have aggravated the situation by making some employers more discriminating in their selection of staff. The present high level of unemployment further discriminates against the applicant who discloses a history of psychiatric illness.

Disclosure of previous psychiatric illness

If information about psychiatric illness is essential, enquiries should be made only at the short-listing or final interview stage and only with the consent of the applicant. The enquiries should be specific and relevant to the job offered. The applicant must be told the contents of the report, and it should only be forwarded with his consent. (The right of the doctor to decline to give a report is noted.) The report should be addressed to the employer's medical officer and only in his absence to the employer himself.

The Employment Medical Advisory Service (EMAS) 1976 survey of occupational health services† shows that

**Members of the Working Party*:- Public Policy Committee: Drs Donal F. Early (Chairman); Brian Ward (Secretary); Cyril Davies. *Co-opted Representatives*:- Drs Alan Sippert (DHSS); E. G. Lucas (Health and Safety Executive); Betty Mitchell, formerly Medical Officer to Harrods (Occupational Health Service); Brenda Morris and Mrs S. N. Wansbrough (Social and Community Psychiatry Section—Working Party on Rehabilitation). *Observers*:- Mr Barry Giles and Mr Stanley Tolson (Manpower Services Commission—Employment Service Division).

†Occupational Health Services. *The Way Ahead.* A discussion document issued by the Health and Safety Commission, HMSO, 1978, ISBN 0 11 8830147 7.

only about 13 per cent of firms, which however represent 64 per cent of the work force, employ doctors and/or nurses. Of these firms about 75 per cent provide 'pre-employment or pre-placement medical examinations/screening procedures'. The provision of medical or nursing services is predominantly related to the size of the firm. Smaller firms with up to 250 employees usually do not have such a service, whereas more than 90 per cent of large firms with a work force of over 1000 provide a medical and/or nursing services. The reason for requiring a full medical history is to determine the suitability of the applicant to undertake the work effectively and for a reasonable period. If an applicant is considered to be fit for work he should qualify for a firm's sickness benefit scheme and should be accepted into an occupational pension scheme. A reduced benefit scheme for disabled employees may provide an answer for employers who are not prepared to offer the full scheme to former psychiatric patients and whose only recourse at the moment is not to offer them employment.

MIND has suggested that applicants might be freed from an obligation to disclose a previous psychiatric illness after a period of three years. This remedy is not without its drawbacks. Undue stress may be caused as patients strive to qualify for exemption and they may actually avoid seeking help when they should in order to reach this goal.

Broad facts (not confidential details) of a health record may be revealed at interview, and employers may require a medical examination before making a firm offer of employment, or make the offer subject to a satisfactory medical report. The employer's medical officer should confine his report to the applicant's fitness to do the job. If the job entails elements or risks which must necessarily debar some applicants, the employer should state at the interview what these hazards are, allowing the applicant to withdraw and avoid unnecessary embarassment. In verifying the applicant's fitness for a job, the medical officer may ask (with the applicant's consent) for a specialist report or for a report from the general practitioner, but this should not be disclosed to the employer. Sometimes the medical officer encounters reluctance on the part of the applicant's doctor to give a report because of a fear that the information will be passed on; person to person liaison between occupational medical officers, psychiatrists and general practitioners should therefore be encouraged. The medical ethics relating to confidentiality need to be stressed to all concerned, and any procedures adopted must be based on these ethics.

The medical examination may not elicit all the relevant information and should not be assumed to do so. The employee's record during the first few months in the job is often a better guide. This period will also give the employer an opportunity to assess the employee's ability to concentrate and to see how he gets on with his colleagues. If he proves unsuitable, there is a good chance that he will wish to seek other employment, and the question of his previous psychiatric illness need play no part in the decision. Trial periods of employment can, of course, offer advantages to all concerned.

It is more difficult to make recommendations where the firm has no medical department. It should be appreciated, however, that the applicant must be given some idea of what is entailed in the job so as to enable him to consider his ability to carry it out satisfactorily. If the Disablement Rehabilitation Officer (DRO) is involved in the placing, the prospects can be readily assessed.

Some applicants, of course, may conceal information which they think might prejudice their employment prospects. We deprecate any threat of dismissal on these grounds.

There is inevitably a point at which the former psychiatric patient can no longer be protected—for example, in explaining a long absence from work. Psychiatric morbidity tends to militate against the patient's employment in the long term, but the national statistics are misleading in their present form, as they include absenteeism figures for alcoholism and alcohol-related disorders. If the true figures were identified and compared with those for cardiac illness, for example, resistance to employing people with a history of mental illness might be reduced. Unpublished data suggest that the percentage of former psychiatric patients unemployed and seeking work is in the region of 12 per cent; unemployed, intending to seek work—5 per cent; not intending to seek work or retired—50 per cent; with 25 per cent in ordinary paid employment and 4 per cent in sheltered employment, industrial therapy, work rehabilitation and 3 per cent on rehabilitation training courses. (Unpublished information—DHSS.)

Probationary periods and change to permanent posts

The Employment Protection Act makes no allowance for probationary periods, but there are arguments both in their favour and against. It could be considered discriminatory to insist on probation periods for some staff and not for others on the grounds of their medical history or for any other reason. There may also be difficulties if there is a suggestion that a probationary period should be extended. On the whole, we feel it could lead to avoidance of making an offer of a permanent post, leaving the employee in a very insecure position. If, on the other hand, the employee is considered unsuitable for the job at the end of the probationary period, the employer should be required to give reasons for not offering a permanent post.

The Manpower Services Commission's Job Introduction Scheme (JIS) is now to become permanent after a trial period during which a good proportion (27 per cent) of the placings were former psychiatric patients. The aim of the Scheme is to increase employment opportunities for disabled people by offering grants of £40 (from July, 1980) for a period of usually six weeks to employers who engage certain disabled people for a trial period of employment. This Scheme is available at the discretion of the DRO when a disabled

person is *prima facie* suitable for the job but the employer has reasonable doubts about his ability. Whilst it is not a general alternative to a probationary period of employment it can be used effectively where there are genuine doubts about a person's ability to undertake a specific job.

The use of a probationary period before an employee can enter an occupational pension scheme is criticised on the grounds that if he is 'fit for employment', he should be considered fit for the scheme.

Keeping a job and dismissal on medical grounds

On this subject the examples given in the MIND report do not give enough detailed information. It is not known for instance, whether the patients concerned would have been helped by taking advice from DROs and Tribunals or whether they were in fact unsuitable for the jobs for which they were employed. The disabling effects of some psychiatric illnesses should not be overlooked, and although the possible adverse effects of their disclosure cannot be disregarded, we consider, as already stated, that the patient should be fully informed of any impairment. In some cases, knowledge that retirement is recommended on medical grounds could have a positive effect.

The Civil Service has a special procedure to deal with retirement on medical grounds. The Department concerned reaches a decision after seeking advice from the Civil Service (Department) Medical Advisory Service; the Advisory Service takes account of reports from Personnel and Welfare Officers and the individual's medical attendants and, if necessary, the results of an examination by a Local Medical Officer, a member of the Medical Advisory Service staff, an independent consultant or a Civil Service Commission psychiatric referee.

It is agreed that the examples of discrimination and hardship highlight the importance of statements of an employee's ability being directed to the special requirements of the job and emphasize again the need to keep the employee fully informed about the contents of any reports. It is recognized that sometimes dismissal on medical grounds would ensure pension rights, but that in some cases they were used instead of more accurate reasons of unsuitability which might involve the employer in long drawn out negotiations.

The College recommends that the procedure quoted in the MIND Report from the case of East Lindsey District Council v G. E. Daubney, 1977, IRLR 181 should be followed in principle if dismissal is to be on medical grounds:

> '... Unless there are wholly exceptional circumstances, before an employee is dismissed on ground of ill-health it is necessary that he should be consulted and the matter discussed with him, and that in one way or another steps should be taken by the employer to discover the true medical position ... if in every case employers take such steps it will be found in practice that all that is necessary has been done. Only in the rarest possible circumstances can a failure to consult be justified on the grounds that discussion and consultation would have been fruitless.'

Indiscriminate use should not be made of previous illness as an excuse for dismissal. It is however accepted that the employer must have some redress in the case of dangerous or eccentric behaviour both for his own protection and for that of the other employees.

Psychiatric illness as a barrier to promotion

Any employee who is overlooked when promotion is expected can blame discrimination, although it can be argued that psychiatric illness may impede promotion because promotion which brings new stresses, new relationships, may well put pressures on individuals and cause a recurrence of the psychiatric illness. Clearly a careful judgement has to be made with appropriate medical evidence, but even then there is no certainty. It must be accepted that there is always an element of competition in promotion.

Conclusions

The problems of re-employment of former psychiatric patients are recognized and appreciated. Too little is generally known or published about unemployment among this group and it would be helpful if this could be remedied.

The MIND report is dependent for its data on the individual approach of former patients, and the weaknesses of some of the cases which it has tried to support are all too apparent. This casts doubts on the feasibility of legislative reform to counteract so-called discrimination.

There is statistical evidence of the shortcomings of ex-patients, particularly in regard to absenteeism and propensity to relapse. Because of these problems, employers may fail to give appropriate consideration to applications from former psychiatric patients.

In our view the solution does not lie in legislative action which may lead to increased discrimination against psychiatric patients by setting them apart from other employees. We agree with MIND that the Trade Unions and professional associations could do more by direct negotiations with employers to improve their understanding of the problems. Prejudice is, however, not the sole prerogative of employers and is often by fellow employees.

Encouragement should be given to counselling and practical assistance in the form of assessment and rehabilitation programmes and retraining. More use should be made of existing facilities in hospital occupational and industrial therapy units for the assessment of patients before they look for employment. There should be more use of referral to Employment Rehabilitation Centres (ERCs) for short-term patients, and the recently introduced direct referral to employment medical advisers at the Centres may help to bring this about.

Medical and psychiatric reports, where these are necessary, should be statements of the prospective employee's fitness for a specific job and should be requested at interview and not at the time of application. The employee should know what is being said and be made aware of the implica-

tions of giving consent to the report going to the employer.

The encouragement of a more enlightened approach through a programme of education for employers and employees would obviate the need for legislation to protect the patient's interests, especially as legislation on matters of discrimination is of doubtful efficacy.

The Year in Scotland

Activities of the Scottish Division

There are 352 College members north of the Border, a number close to the ideal village community—too small for impersonality, too large for boredom—and the activities of the Scottish Division are in consequence lively. About 50 members managed to attend each quarterly meeting during the 1979/80 season, with attendance rising to around 100 at our annual dinner in December.

In September we made our way across the Scott country to Dingleton Hospital, Melrose, so celebrated for its achievements in multidisciplinary community-based psychiatry, and heard an intriguing presentation of the trials and triumphs of this approach from Dr Dan Jones and his staff. The advantage, they told us, lay in an impressively low rate of hospital admissions for preventable crises; the problems arose through the heavy burden of responsibility carried by some non-medical staff. Certainly Dingleton seemed to have built up magnificent community relationships, aided by a network of voluntary helpers. Those of us who work in city hospitals wondered how far such support might be forthcoming in our own more impersonal environments.

The December meeting was held at Gartnavel Royal Hospital, Glasgow, and concerned itself with undergraduate and postgraduate psychiatric education. Professors from the four Scottish medical schools outlined the varied approaches of their teaching programmes, and the question of recruitment to psychiatry was discussed. Dr Bewley, as Dean, gave the College's point of view on postgraduate training; Dr Chris Freeman was stimulating, and far from sycophantic, in presenting some comments from trainees; and Dr Kaye gave a talk on his experiences in conducting the College Approval exercise in Scotland. Discussion grew heated, even impassioned. During the evening everyone mellowed over an excellent annual dinner in the impressive, if borrowed, setting of the portrait-hung banqueting hall of the Royal College of Physicians and Surgeons of Glasgow. Professor and Mrs Pond had kindly come from London to welcome 18 new recruits who had passed the Membership examination during the previous year and who, by hospitable tradition of the Scottish Division, were getting this, their first annual dinner, free. Another guest of honour was Mr Russell Fairgrieve, Under-Secretary of State for Health and Social Services at the Scottish Office, whose inside knowledge of Health Service financial plans was eagerly sought in a characteristically sparkling address by Dr Balfour Sclare. As we listened we little thought it would be the last time many of us would hear him.* Mr Fairgrieve's reply was well-considered and, under the circumstances, as reassuring as might be. Dr Gerald Timbury's entertaining closing speech and a recital of Edwardian part-songs by the Arcadian singers (unfortunately but pardonably misprinted as 'Orcadian' on the menu card) agreeably rounded off the evening.

The March meeting was held at the Royal Dundee Liff Hospital, where local members had prepared an excellent clinical programme for us. Discussing current themes in the Dundee psychiatric service, speakers described psychiatric morbidity in elderly surgical patients, non-organic gastrointestinal illness and the psychiatric aspects of female sterilization. Dr Naylor took the topic of red cell membrane transport in manic-depressive illness and made it seem straightforward and surprisingly understandable. For some years now there has been a happy partnership in Dundee between the adult psychiatric and mental handicap service, and in the afternoon the papers dealt with clinical and research aspects of mental subnormality.

The highlight of the year is always our two-day summer meeting in June. This year's rallying point was the Argyll and Bute Hospital at Lochgilphead on the Kintyre peninsula. It turned out, for most of us, to be a rallying point in the literal sense as we skidded and aquaplaned our collective way along 80-odd miles of inundated lochside roads in a force 5 gale. One member, braver than the rest, attempted to sail to the meeting but was forced to turn back in the Sound of Bute. Another enquired about steamer services and was disconcerted to learn that they had been withdrawn 25 years earlier. All efforts were rewarded when we reached the hospital and the warm welcome provided by Dr Macnab and his staff. Safely cocooned from the continuing downpour and the faintly-heard cries of panic-stricken seagulls, we heard talks by Dr Betty Yule and Dr Maurice Baird on the contrasts between psychiatric practice in the West Highlands and elsewhere; by Dr Hugo Gallacher on systems theory in

*See Obituary, June *Bulletin*, p. 90