Chapter 33

Work, Unemployment and Mental Health

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Introduction

Work or, more broadly, activity has been of interest to medical practitioners over the centuries.

Activity or exercise, rest, relaxation and leisure have been seen as health promoting and a core part of medical practice, from the Graeco-Roman tradition, Ayurveda and Chinese medicine to modern times. The place of work as physical labour in medical regimes is a more recent development, emerging towards the end of the eighteenth century and playing a significant role in the daily lives of inmates of the large asylums.[1] For psychiatric practice and the study of mental health/ill health in the twentieth century, the focus has been on the role of work in rehabilitation and the health risks associated with unemployment and the conditions of employment. In this chapter, we focus on these two areas.

Work, Employment and Leisure

What we mean by work is not easy to define; it is a shifting and contradictory concept that has varied over history and with the development of more complex societies.[2] Our contemporary view of work has its origins in the development of capitalism and the creation of a free labour market. This has dominated our conception of work and differentiated it from leisure and the home. It has allowed for the distinction between the employed and the unemployed (and children and retired people) but has also raised questions about work that does not receive renumeration, particularly that of housework and the work of carers. In practical terms, we may see 'work' as an activity that involves the exercise of skills and judgement, taking place within set limits prescribed by others.[3] It is something you 'do' for other people, whereas in most leisure activities you can 'please yourself'. 'Employment' is seen as work you get paid for, thus clarifying that many activities (childcare, housework, looking after elderly or sick relatives, for example) involve 'work' but do not usually attract formal payments and so are not 'employment'.

The Benefits of Work

Work may be viewed as being a uniquely human quality, essential not only for our material subsistence, growing needs and the wealth of nations but also for our psychological needs and sociability. It is a normative concept defined by the customs of society, but it is fundamentally relational and assists in defining who we are and our relation to others. It plays a central part in personal identity, gives a structure and purpose to the day and provides opportunities for socialisation and friendship. The social networks established in the workplace often extend beyond it and are a core component of social capital.

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The potential magnitude of these beneficial effects (and by implication their ill effects) is brought home to us when we consider that our working lives represent the single longest period of the human lifespan, amounting to some forty to fifty years. This is the greater part of our adult lives, a time when many are raising families with the consequent responsibilities of dependents and effects on subsequent generations.

Employment, Worklessness and Their Ill Effects

Changes to the working life of Britons brought about by the industrial revolution revealed dangers of work on physical health in the hazardous conditions of the factories and mines during the nineteenth and into the twentieth century. During the twentieth century, however, the effects of unemployment and working conditions on our mental health emerged.

Economic cycles and crises during the twentieth century brought with them periods of high unemployment. During the Great Depression in the late 1920s and 1930s we saw the social and psychological effects of mass and long-term unemployment. These were documented in the classic studies of Marie Jahoda and colleagues examining the effects of the closure of the 'Marienthal' factory on the population of the Austrian village of Gramatneusiedl in 1929 and the subsequent studies of mass unemployment in the United States.[4] The morale of people suffers during periods of prolonged unemployment, and those without employment experience emotional instability, depression, hopelessness and apathy. These psychological effects can, in a vicious cycle, reduce social engagement and the likelihood of future employment and may blur the distinction between those who are unemployed and those removed from the job market for health reasons.[5] They also contribute to other social and interpersonal problems, including family and domestic discord.

The rising rates of unemployment in the UK during the 1980s prompted a revival of studies on the health effects of worklessness. These provided further evidence of the link between unemployment and poor mental health.[6] Studies typically find higher rates of anxiety and depression, alcohol and substance use and alcohol-related deaths among the unemployed than among those in work, even after taking account of age and sex. Suicide rates, especially among the long-term unemployed, are greater than among those in work. This association between unemployment and poor mental health seems to be bidirectional – being made unemployed can be a direct cause of poor mental health but mental illness or poor mental health can result in loss of employment. Continuing poor mental health can be a barrier to regaining employment, but re-entry into employment can result in an improvement of mental health.

The recognition of a link between suicide rates and rapid social change and economic depression has been noted since the nineteenth century.[7] By now, we can be confident about the association between unemployment and suicidal behaviour and the tendency for suicide rates to increase during economic crises.[8] The longer the duration of unemployment, the greater the risk of suicide or suicide attempts.[9] There is evidence for a direct causal relationship between unemployment and suicide, although most of the effects are related to the presence of mental health conditions.[10] This relationship is complicated and, like many psychosocial phenomena, dependent on a range of socioeconomic factors, including the strength of social safety nets and the degree of social fragmentation.[11]

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The mental health conditions associated with unemployment are predominantly those that have become known as ‘common mental health’ disorders (or the studies used a measure of mental well-being). That these disorders were ‘common’ has been revealed by many population and primary care studies carried out since 1945. The emerging relationship between poor mental health, suicide and joblessness exposes the role of broad social, economic and political factors in determining the nation’s health.

While employment may be beneficial to health, what emerged in the late twentieth century was evidence that the exposure to a range of psychosocial hazards can also put workers at risk of poor mental health.[12] Jobs can be poorly paid or provide people with insufficient or overly long working hours. They may be temporary or insecure or place people at risk of job loss or redundancy. They may also provide exposure to conditions of low psychosocial quality that affect the mental health of workers. Several large population studies of workforces in Europe and Australia have contributed to this body of evidence and the two British Whitehall studies conducted on populations of UK civil servants showed that adverse psychosocial conditions were associated with less satisfaction and well-being, a greater prevalence of mental health conditions and predicted poor mental health over a five-year period.[13] Low psychosocial quality includes conditions of a ‘high-strain’ working environment where the high demands on workers are combined with conditions of low control, such as little autonomy and reduced decision-making or conditions in which the effort to perform the job is not met by commensurate rewards in terms of money, esteem, career opportunities or job security.

UK Health and Social Policy since 1945

The cross-national studies on unemployment (or recessions) on mental health and suicide have noted a modulating effect of the strength of national social security programmes: countries with the weakest welfare states showed a greater impact of unemployment on rates of suicide.[14]

The provision of services and income transfers by the state to meet the welfare needs of the UK population and the concomitant expenditure grew in the twentieth century. These provisions include personal social services; services for health, education and housing; and income transfers such as pensions and out-of-work payments. Following the Second World War, the UK established reforms to create a more comprehensive and universal welfare state with an increase in resources to extend benefits and coverage which were associated with a commitment to economic growth and full employment (see also Chapter 3). These were accompanied by improvements in provisions for people with disabilities, including those for people with mental health conditions and intellectual disabilities. These welfare state developments facilitated the rundown of the large asylums and the development of community-based facilities for people with severe and long-term mental health conditions and improved access to primary care for those with common mental health conditions (see also Chapters 23 and 30).[15]

The golden age of the UK’s welfare state declined in the 1970s, and the 1980s saw a period of retrenchment and recalibration with an abandonment of full employment and cuts to welfare provision, despite continuing growth in public expenditure. This was set against a background of increasing income and wealth inequality. In the late 1990s and 2000s, the New Labour government’s vision for welfare was for a system that enabled rather than provided. The challenge was to reduce worklessness and introduce new benefits and

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tax credits as well as work support schemes. The recession in 2008 and the election of the coalition government in 2010 brought in a period of austerity and the introduction of further welfare reforms in 2012. The squeeze on expenditure and the roll-out of the new benefits continue to this day.

Contemporary Changes to Conditions of Work and Employment

In high-income countries, the labour market has changed dramatically over the past seventy years. In Britain, many traditional, large national employers such as the coal mining and motor manufacturing industries that were at the heart of the economy are long gone, radically reduced in scale or have been sold to global corporations. These dominant industries have been largely replaced by financial, service and hospitality industries, with many manual labour tasks replaced by automation.

In more recent years, there has been a movement away from the standard employment model in which workers earn wages or salaries in a dependent employment relationship with their employers, jobs that usually offer a stable contract and employment as well as labour law and social security protection.[16] In high-income countries, including the UK, while the standard employment model is still dominant, there has been a move towards increasing labour market flexibility and a weakening of regulations and protective policies. Associated with this has been an increase in forms of ‘precarious’ employment which may include ‘flexible employment,’ ‘temporary work’, ‘casual work’, ‘zero hours contracts’ and ‘gig economy work’. In the UK, before the 2007 recession, we began to see an increase in ‘underemployment’ (employed persons who have not attained their full employment level) and a rise in ‘in-work poverty’ (households with incomes below the poverty line) which, along with precarious employment, has since increased. Working in insecure employment has a detrimental effect on psychological well-being and somatic health,[17] as does living below the poverty line.[18]

The labour market and the conditions of work or lack of work reflect and reinforce health inequalities and can have knock-on effects for future generations. High-pay conditions are protective of health, but poor-quality conditions in the workplace are more likely to be experienced by people from disadvantaged socioeconomic groups.[19] Certain jobs are more likely to expose people to these poor working environments, including elementary jobs, sales and customer services, plant and machine operatives and caring, leisure and other service occupations.[20] People who are in danger of unemployment are those who are looking for (or have previously worked in) jobs which carry the greatest risk to their health. There are stark regional differences in poor-quality work in England with the north of the country faring worst.[21]

Employment in People with Mental Health Conditions

People with mental health conditions are more likely than others in the general population to be out of work. Across the Organisation for Economic Cooperation and Development (OECD) countries, the employment rate of people with a mental disorder is between 55 per cent and 70 per cent, 10–15 per cent lower than for people without a mental disorder.[22]

While many people with common mental health conditions are in work, about 300,000 people with a long-term mental health condition lose their jobs every year in the UK and do so more frequently than those with physical health conditions.[23] People with mental health

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conditions now represent the largest group receiving out-of-work sickness benefits. One reason for this labour market disadvantage is that many people experience their first episode of a mental health problem in their teens or early adulthood, with serious and often enduring consequences for their education and employment prospects. Stigma and discrimination also contribute to these reduced employment opportunities (see also Chapter 27). In addition, they have a lower re-entry rate into the labour market, particularly in economic downturns.

Employment rates in people with common mental health conditions, while lower than the general population, are much higher than those with psychoses.[24] In the UK, between 10 per cent and 20 per cent of people with schizophrenia are in some form of employment.[25] These rates may have fallen over the years, as before 1990 employment rates of 20–30 per cent were reported.

Developments in Vocational Rehabilitation for People with Mental Health Problems

The view that occupation was an integral part of treatment and the subsequent development of vocational rehabilitation were influenced by the rise of 'moral treatment' in the early 1800s. However, despite the growth of patients working within the confines of nineteenth-century asylums, this was less about moral therapy and rehabilitation but more a matter of filling the patient's day, reducing idleness and providing free labour for the hospital farm, kitchens and laundry, with a view to reducing costs and raising funds for the running of the institution.[26]

This changed during the early-to-mid twentieth century as work became seen as enabling, valuable to good physical and mental health and part of a patient's rehabilitation. We saw the development of industrial workshops and creative therapies as well as the profession of occupational therapy.[27] The reforms after 1945 facilitated the idea that hospital-based work might be a stepping stone to eventual resettlement and were supported by research findings.[28] In the industrial workshops, which attempted to provide realistic conditions of employment, patients were paid for their labour and their work exceeded the expectations of staff. However, as the asylums diminished, the hospital workshops relocated to the community, patients' earnings were capped and workshop numbers dwindled. It became obvious that few people from these settings went on to get paid 'open' employment in the labour market.

In the United States, during the late 1970s, a new conceptual model emerged for the development of community-based treatment programmes for patients with mental health problems who would typically have been inpatients in large psychiatric hospitals. This took a multidisciplinary team approach and delivered integrated community-based treatment, rehabilitation and support services to help people with severe and persistent mental health problems to avoid psychiatric hospitalisation as well as to live independently in natural community settings. This approach gave patients sustained and intensive assistance in finding a job or a sheltered workshop. When in the job, staff retained contact with patients and their supervisors or employers to help with on-the-job problem-solving. Those who received this new approach spent significantly less time unemployed, spent more time in sheltered employment and earned a significantly higher income in open employment than those receiving the control intervention.[29] These new models of community-based treatment programmes seemed radical at the time but have since evolved into one of the most

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influential service delivery approaches in community mental health. Regrettably, when these new models of community-based treatment programmes were implemented in the UK, the presence of supporting people with longer-term mental health problems into work did not translate into practice.

Changes in the Emphasis of Vocational Rehabilitation

During the 1980s, also in the United States, new forms of vocational rehabilitation were being developed. These models of vocational rehabilitation were based on a 'train and place' approach – people with longer-term mental health problems would typically go through a stepwise approach of skills training and development in a segregated and sheltered environment, with a view that these new skills would enable them to gain and retain jobs in the open labour market. A variety of different models were developed ranging from pre-vocational training programmes through to clubhouses which were developed alongside other models of community mental health rehabilitation for people with longer-term mental health problems. The choose–get–keep model of rehabilitation began the shift from viewing work solely as a form of therapy to one that viewed it as a personal goal of the patient.[30] This approach defined the process both from the mental health practitioner's point of reference and from that of the person served. The practitioner's role was to facilitate rehabilitation: choosing, getting and keeping were what the individual did to attain their goals.

In 1993, Becker and Drake published the first manual of the Individual Placement and Support (IPS) approach to vocational rehabilitation.[31] The IPS approach is a form of supported employment and differed from previous approaches to vocational rehabilitation. Moving away from 'train and place', it adopted a 'place and train' approach, in which the primary goal of the approach was to directly find a job and then provide continued support. Its approach was fundamentally 'person-centred'. In 1996, the first randomised controlled trial (RCT) of the IPS approach was published and showed that people with longer-term mental health problems could be directly supported to gain and retain open employment without the use of pre-vocational training.[32] By 2001, a Cochrane systematic review of vocational rehabilitation for people with severe mental illness found that supported employment was significantly more effective than pre-vocational training,[33] and there are now twenty-seven RCTs supporting the efficacy of IPS compared to standard vocational rehabilitation.[34]

The ten-year plan of the National Service Framework for Mental Health contained several targets in which work was important, including 'action needed for employment, education or training or another occupation' (Standard 5) and the requirement of health and social services to 'combat discrimination against individuals and groups with mental health problems and promote their social inclusion'. The associated development of early intervention teams in the early 2000s provided a focus for vocational rehabilitation to support young people with a first episode of psychosis in education, training and employment.[35]

In 2003–4, the UK government undertook a cross-government review into mental health and social exclusion. The term 'social exclusion' was initially used as a simile for poverty but grew to acquire a wider interpretation. It encompassed unemployment, poor-quality housing or homelessness, limited social networks and restricted participation in social, economic and political life. The *Mental Health and Social Exclusion* report examined

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the connections between mental health problems and social exclusion.[36] It noted that mental health problems often led to and reinforced social exclusion, stigma and discrimination, owing to low expectations of what people with mental health problems can achieve; lack of clear responsibility for promoting vocational and social outcomes; lack of ongoing support to enable them to work; and barriers to engaging in the community. This report provided a catalyst for the development of vocational rehabilitation services for people with longer-term mental health problems and for the promotion of the IPS approach.

Two important developments occurred during this time. First, the Convention on the Rights of Persons with Disabilities was adopted on 13 December 2006. Rather than viewing persons with disabilities as 'objects' of charity, medical treatment and social protection, it saw persons with disabilities as 'subjects' with rights, who can claim those rights and make decisions based on their free and informed consent as well as being active members of society. The Convention dealt with the right to work and employment, stating that priority should be given to participation in the open labour market and all efforts should be done, through reasonable accommodations, to achieve this. The other development was the emergence of the recovery approach within mental health services in England.[37] At its heart, the recovery approach is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life. Many of the ideas underpinning the recovery philosophy were not new. The main impetus came from the consumer/survivor movement in the 1980s and 1990s. The emergence of the recovery approach brought a renewed focus on the personal goals that were important to those with longer-term mental health problems and a focus on functional outcomes for mental health services.

Yet, despite these developments, annual surveys conducted in England between 2004 and 2008 repeatedly showed that, of those who use mental health services and were unemployed, more than half would have liked help in gaining employment but mental health services had not offered such help.[38] By 2010, there was evidence that the IPS approach could be effectively implemented within mental health services in England.[39]

Conclusion

This brief look at work and mental health perhaps tells us more about developments in psychiatry and its relation to history and social and economic factors than is immediately obvious.

First, it reflects the change in what has come under the psychiatric gaze during the twentieth century. The predominant interest in the nineteenth century was in severe mental illness located in the asylums. In the twentieth century, particularly after 1950, this shifted to include those with more prevalent conditions, common mental health disorders. In the development of mental health services, this extended gaze has increased the tensions related to the planning of services, particularly when we consider the size of the financial cake and its apportioning.

Second, the predominant emphasis for those with severe and enduring conditions has been on vocational rehabilitation, viewing work as part of therapy. Historically, this has been based on a more optimistic view of outcomes for this groups of people, from moral therapy to post-war enthusiasm and the recovery movement. More recently, we have seen

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a shift from 'work' as therapy to 'work' as a human right. Recent developments in vocational rehabilitation, notably IPS, have a firm and well-established evidence base but remain poorly implemented.[40] For those with common mental health conditions, the realisation of their increasing costs to the welfare benefit bill led the New Labour government (and subsequent UK governments) to adopt a series of welfare reforms to move these groups back into work. The evidence for the efficacy of these approaches has been poor but they continue. The initial business case for IAPT (Independent Access to Psychological Treatment) assumed that the receipt of cognitive behavioural therapy (CBT) would result in people returning to work but few did (see also Chapter 11).

Third, we see how economic cycles or crises and changes in labour markets have significant effects on the mental health of populations and on rehabilitation services.[41] Improvement to vocational services for people with serious mental illness (SMI) may mean increased spending on community rehabilitation services; but improving the quality of the working environment and alleviating the effects of unemployment require improvements to occupational health services and a public health or preventative approach to reducing health inequalities to 'create fair employment and good work for all',[42] as well as wider employment and welfare benefit reforms. This means taking action to reverse the fundamental causes, prevent the harmful environmental influences and mitigate the negative impact on individuals.

Key Summary Points

- There is an association between unemployment, poor mental health and suicidal behaviour. There is a modulating effect of the strength of national social security programmes: countries with the weakest welfare states showed a greater impact of unemployment on rates of suicide.
- While employment may be beneficial to health, exposure to a range of psychosocial hazards can also put workers at risk of poor mental health.
- People with mental health conditions now represent the largest group receiving out-of-work sickness benefits. In the UK, rates of employment of people with schizophrenia may have fallen.
- Supported employment is significantly more effective than pre-vocational training. The initial business case for IAPT (Independent Access to Psychological Treatment) for common mental disorders assumed that the receipt of cognitive behavioural therapy (CBT) would result in people returning to work but few did.
- More recently, we have seen a shift from 'work' as therapy to 'work' as a human right. Annual surveys conducted in England between 2004 and 2008 repeatedly showed that, of those who use mental health services and were unemployed, more than half would have liked help in gaining employment but mental health services had not offered such help.

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