Abstract

Purpose of Review: Work is a major determinant of mental health and a socially integrating force. To be excluded from the workforce creates material deprivation, erodes self-confidence, creates a sense of isolation and marginalization and is a key risk factor for mental disability. This review summarizes recent evidence pertaining to employment-related stigma and discrimination experienced by people with mental disabilities. A broad understanding of the stigmatization process is adopted, which includes cognitive, attitudinal, behavioural and structural disadvantages. **Recent Findings:** Stigma is both a proximate and a distal cause of employment inequity for people with a mental disability who experience direct discrimination because of prejudicial attitudes from employers and workmates and indirect discrimination owing to historical patterns of disadvantage, structural disincentives against competitive employment and generalized policy neglect. Against this background, modern mental health rehabilitation models and legislative philosophies, which focus on citizenship rights and full social participation, are to be welcomed. Yet, recent findings demonstrate that the legislation remains vulnerable to the very prejudicial attitudes they are intended to abate. **Summary:** Research conducted during the past year continues to highlight multiple attitudinal and structural barriers that prevent people with mental disabilities from becoming active participants in the competitive labour market.

Introduction

Stigma can be defined narrowly as a prejudicial attitude attributed to people who have a mental illness that may result in discriminatory practices, [1] or it can be used to reflect a broader social process with cognitive, attitudinal, behavioural and structural elements that interact to create and perpetuate social inequities, discriminatory treatment and disadvantage of people who have a mental disorder. [2] This review summarizes recent evidence pertaining to employment-related discrimination experienced by people with mental disabilities, using the broader understanding of the stigmatization process as it is more consistent with the day-to-day experiences of people who live with a mental disorder, the wide variety of intervention approaches used to combat stigma and discrimination, [3,4**] and the growing interest in human rights and social entitlements for people with mental disabilities. [5*]

Work is a major determinant of mental health and a socially integrating force that is highly valued. No single social activity conveys more of a sense of self-worth and social identity than work. To be excluded from the workforce not only creates material deprivation but also erodes self-confidence, creates a sense of isolation and marginalization and is a key risk factor for mental disability. For people with a serious mental disorder, employment is an important stepping-stone to recovery. It is a normalizing factor that provides daily structure and routine, meaningful goals, improves self-esteem and self-image, increases finances, alleviates poverty, provides opportunities to make friendships and obtain social support, enriches quality of life and decreases disability. People with mental disorders who are unemployed and who lack meaningful social roles are in a position of double jeopardy; on the one hand, being stigmatized because of their mental disorder (making it harder to gain competitive employment) and on the other hand, being stigmatized for their lack of occupation. [6-8]

Historically, competitive employment has not been a major focus of the mental health system. There has been a tendency to adopt minimal expectations and lower standards of achievement for people with a mental disorder. Sociostructural barriers and disincentives have also made it difficult for people with a mental disorder to get in and stay in the competitive workforce. [9] Modern mental health treatment philosophy is, however, based on the premise that people with mental disorders have the right to live and work in the community. To realize these goals, people

with mental disorders must be able to access appropriate community-based treatment and rehabilitation services and safe and affordable housing and should have equal access to employment opportunities that are commensurate with their skills, interest and training. All too often, stigma, expressed through a lack of political commitment to provide adequate services, community intolerance towards mentally ill people and employment inequity, makes this impossible. [10] As stigma is so pervasive and the consequences so profound, international organizations such as the World Health Organization and the World Psychiatric Association have identified stigma related to mental illness as the most significant challenge facing the field of mental health today. [11,12]

Stigma and Employment Equity

Past research has shown that most people with serious mental disorders are willing and able to work. [8,13] Yet, their unemployment rates remain inordinately high. For example, large-scale population surveys have consistently estimated the unemployment rate among people with mental disorders to be three to five times higher than their nondisabled counterparts. Sixty-one percent of working age adults with mental health disabilities are outside of the labour force, compared with only 20% of working-age adults in the general population. [14*] Employment rates also vary by diagnostic group from 40 to 60% for people reporting a major depressive disorder to 20-35% for those reporting an anxiety disorder. Unemployment rates for people with serious and persistent psychiatric disabilities (such as schizophrenia) are the highest, typically 80-90%. [15] As a result, people with serious mental disabilities constitute one of the largest groups of social security recipients. [16*,17**]

Stigmatizing views held by employers make it difficult for people with mental disabilities to enter the competitive workforce. Employers are more likely to hire someone with a physical disability, [18] thus raising doubts about the effectiveness of disability quotas as a method of affirmative action for people with mental disorders. Surveys of US employers show that half of them are reluctant to hire someone with past psychiatric history or currently undergoing treatment for depression, and approximately 70% are reluctant to hire someone with a history of substance abuse or someone currently taking antipsychotic medication. [19] Half would rarely employ someone with a psychiatric disability and almost a quarter would dismiss someone who had not disclosed a mental illness. [20] It is important to note that these behaviours are in direct contravention to the Americans with Disability Act, which requires employers to make reasonable workplace accommodations for people with physical and mental disabilities. [21*]

People with mental disorders identify employment discrimination as one of their most frequent stigma experiences. [22*,23] Compared with individuals with physical disabilities, twice as many people with mental disabilities (the majority) expect to experience employment-related stigma. [23] One in three mental health consumers in the United States report being turned down for a job once their psychiatric status became known and in some cases, job offers were rescinded when a psychiatric history was revealed. [24,25] In Canada, 78% of consumers participating in a membership survey conducted by the Canadian Mental Health Association identified employment as one of the areas most affected by stigma. [26] Fear of stigma and rejection by prospective employers may undermine confidence and result in a poorer showing on job interviews. Over time, people with mental disorders may come to view themselves as unemployable and stop seeking work altogether. [24,27]

Having a psychiatric diagnosis can also seriously limit career advancement as employers are less likely to hire people with mental disorders into executive positions. [28] Research shows that people with psychiatric diagnoses are likely to be underemployed, in lower paying menial jobs or

in jobs that are incommensurate with their skills and interests. [24,29*] Of the 4600 people receiving supported employment in the State of Indiana, for example, only about one in 10 of the 66% who were employed after 3 months of service were employed in professional or technical jobs. Nine out of 10 were employed in lower paying jobs with poor benefits. [30*]

Much research shows that people with mental disabilities are more likely to be hired into the secondary labour market where jobs are unskilled, part-time and temporary, with high turnover and few benefits. Economic incentives for people with mental disorders to work full-time in the primary labour market are minimal. The money that they make often displaces or jeopardizes their disability benefits, creating a benefit trap. [31,32] Two recent studies [29*,33*] confirm that people with mental disorders who receive disability payments are less likely to be employed competitively and, if employed, likely to earn less. Participation in the secondary labour market may also be a function of a lack of education and training due to illness-related interruptions. If so, greater attention to helping people with mental disabilities advance their education and training, rather than focusing on immediate employment - the remit of most supported employment programmes [14*,34*,35*] - may reduce underemployment and improve job tenure. [17**]

Employees with mental health problems may also experience stigma and discrimination from coworkers once their mental illness becomes known. Workers who return to their jobs after an illness report returning to positions of reduced responsibility with enhanced supervision where they are socially marginalized and become targets for mean-spirited or negative comments from workmates who had previously been supportive and friendly. [24,25,36] Half of the competitive jobs acquired by people with a serious mental illness will end unsatisfactorily as a result of problems that occur once the job is in progress, largely as a result of interpersonal difficulties. [37]

In order to avoid workplace stigma and discrimination, employees with mental health problems will usually go to great lengths to ensure that coworkers and managers do not find out about their illness, including avoiding employee assistance programmes and shunning effective treatment options. Indeed, the majority of employees who have mental health problems will fail to receive appropriate treatment. [26] For example, only about a third of employees with depression will consult a mental health professional, physician or employee assistance programme and as few as one in 10 of those who report occupational impairment will take medication to address this problem. Yet, the majority of those who are appropriately treated for depression will manifest improved work performance and reduced disability days sufficient to offset employer costs for treatment. [38] Compounding this problem is the fact that few managers have sufficient knowledge to recognize or skills to effectively manage mental health problems at the workplace. Similarly, few organizations have corporate plans to address workplace mental health and employment equity for people with mental disabilities. [39-41] To reduce stigma and discrimination associated with mental disorders and promote employment equity for people with mental disabilities, organizations will need to be proactive in identifying and managing mental health problems among their workers and in fostering an organizational culture that is supportive of mental health and psychosocial recovery. [42*,43*]

Employment Equity Legislation

Disability issues have figured prominently in the international policy agenda during the past two decades. The discourse has moved away from specialized (and segregated) solutions to emphasize social and legal obligations to employ people with physical and mental disabilities. Entry into employment is now widely considered to be crucial for the social integration of people

with disabilities and most economically advanced countries have enacted antidiscrimination legislation to support people with disabilities to become actively employed. [44,45**,46] The philosophical roots of contemporary antidiscrimination legislation are in a social model of disability that views disability as the product of society's attitudinal and structural barriers, rather than the result of an individual's physical or mental impairment. Employment equity acts that have adopted a social model of disability have increasingly converged around three key issues: the need to promote greater employment equity for persons with physical and psychiatric disabilities; the outlawing of occupational discrimination of disabled workers in recruitment, retention and promotion; and the requirement for employers to make reasonable accommodations for disabled employees. [44,47]

Employer attitudes play a central role in the success of antidiscrimination legislation, the extent to which disabled people are accepted into occupational life and the extent to which reasonable workplace accommodations are made. [48] Recent research shows that support from employers for equity and workplace accommodations has been poor, [48] and compliance with legislative requirements has been problematic. [49*] In the United States, for example, mental disorders are the second most common basis for charges of discrimination and workplace harassment under the Americans with Disabilities Act. [19] Of the 263 disability cases brought to trial in 2004, only 2% of the decisions (*n* = 6) favoured the employee, 74% (*n* = 194) favoured the employer and 24% (*n* = 63) were unresolved. A total of 54 cases (21%) were brought forward by people with a mental disability. Of these, 76% (*n* = 41) resulted in employer wins, 24% (*n* = 13) were unresolved and none favoured the employee. Eight cases involved people with substance disorders. Of these, 75% (*n* = 6) resulted in employer wins, 25% (*n* = 2) were not resolved and none favoured the employee. [50*] An inability to convince the court that a mental impairment resulted in a significant disability often precluded a claimant from being able to present a persuasive argument about an employer's discriminatory treatment or failure to provide reasonable accommodations. This was particularly true in cases in which the illness was episodic and the disability intermittent or when symptoms appeared to be well controlled. [21*]

A major dilemma for employees is whether to divulge a mental illness to their employer. In order to request workplace accommodations, employees or prospective employees must disclose the fact that they have a mental disorder that limits their capacity to work. Disclosure of a mental illness may, however, undermine employability, result in dismissal or jeopardize career advancement. The literature on disclosure is generally sparse. As yet, there is no consensus as to how disclosure should be managed to avoid stigma or to ensure that appropriate workplace accommodations are made. Mental health consumers often recommend withholding psychiatric information altogether as the only way to avoid stigma and discrimination. [36] Others have suggested that negative perceptions may be minimized by delaying disclosure until the employer and coworkers become comfortable with the employee and their work performance. [51*,52**] Recently, a number of different disclosure options have been described, ranging from full disclosure to selective (partial) disclosure, inadvertent disclosure, strategically timed disclosure and nondisclosure - but none with foolproof results. [51*]

The most significant benefits to consider in making the decision to disclose a psychiatric disability include eligibility for protection against discrimination under antidiscrimination legislation; access to workplace accommodations such as flexible hours, advocacy and support from a third party such as a job coach; access to employment as a peer counsellor in the mental health system; and a host of psychological benefits such as increased self-esteem and reduced stress associated with ongoing concealment. Risks include decreased employment options such as not being offered a job, having an offer of employment withdrawn, missing a promotion, being

fired, being laid off, not being provided with reasonable accommodations or being subject to greater supervision; social risks such as being subject to stigma, disrespect or outright harassment from coworkers; and psychological and health risks resulting from stress and distress. Although there are no best-practice guidelines for disclosure of disabilities, MacDonald-Wilson [52**] has offered a comprehensive review of literature summarizing the factors to consider as well as a helpful series of steps that can be followed to assist in making a decision to disclose and to manage the disclosure process.

Conclusion

Stigma is both a proximate and a distal cause of employment inequity for people with a mental disability who experience direct discrimination because of prejudicial attitudes from employers and workmates and indirect discrimination owing to historical patterns of disadvantage, structural disincentives against competitive employment and generalized policy neglect. Against this background, modern mental health rehabilitation models and legislative philosophies, which focus on citizenship rights and full social participation, are to be welcomed. Yet, recent findings demonstrate that the legislation remains vulnerable to the very prejudicial attitudes they are intended to abate. Research conducted during the past year continues to highlight the multiple attitudinal and structural barriers that prevent people with mental disabilities from becoming active participants in the competitive labour market.

References

Papers of particular interest, published within the annual period of review, have been highlighted as: * of special interest ** of outstanding interest Additional references related to this topic can also be found in the Current World Literature section in this issue (p. 550).

Corrigan PW. Mental health stigma as social attribution: implications for research methods and attitude change. Psychol Sci Pract 2000; 7: 48-67.

Link B, Phelan JC. Conceptualizing stigma. Annu Rev Sociol 2001; 27: 363-385.

Sartorius N. Iatrogenic stigma of mental illness. Br J Psychiatry 2002; 324: 1470-1471.

Sartorius N, Schulze H. Reducing stigma due to mental illness: a report from a global program of the World Psyc Association. Cambridge: Cambridge University Press; 2005. ** This article is a compendium of the models and approaches to stigma used by the World Psychiatric Association's global programme to reduce stigma because schizophrenia, summarizing the results from more than 20 countries.

Arboleda-Flórez J. Stigma and discrimination: an overview. World Psychiatry 2005; 4 (Suppl 1):8-10. * An overv the social and historical roots and current manifestations of stigma and discrimination related to mental illness.

Becker DR, Drake RE, Naughton WJ. Supported employment for people with co-occurring disorders. Psychiatr R J 2005; 28:332-338.

Ackerman GW, McReynolds CJ. Strategies to promote successful employment of people with psychiatric disabil Appl Rehabil Couns 2005; 36: 35-40.

Morgan G. We want to be able to work. Mental Health Today October 2005; 32-34.

Marrone JF, Follwy S, Selleck V. How mental health and welfare to work interact: the role of hope, sanctions, engagement, and support. Am J Psychiatr Rehabil 2005; 8:81-101.

Bell S. What does the 'right to health' have to offer mental health patients? Int J Law Psychiatry 2005; 28:141-15

World Health Organization. The World Health report 2001 - mental health: new understanding and hope. Geneva World Health Organization; 2001.

Sartorius N. The World Psychiatric Association global programme against stigma and discrimination because of schizophrenia. In: Crisp AH, editor. Every family in the land [revised edition]. London: Royal Society of Medicine 2004. pp. 373-375.

Marcias CLT, DeCario Q, Wang J, et al. Work interest as a predictor of competitive employment: policy implicati psychiatric rehabilitation. Adm Policy Ment Health 2001; 28:279-297.

Cook JA, Leff HS, Blyler CR, et al. Results of a multisite randomized trial of supported employment interventions individuals with severe mental illness. Arch Gen Psychiatry 2005; 62:505-512. * A randomized controlled trial of outpatients with severe mental illness from seven states in the United States showing the effectiveness of suppo employment programmes in helping participants achieve competitive employment.

Crowther RE, Marchall M, Bond GR, et al. Helping people with severe mental illness to obtain work: systematic r BMJ 2001; 322:204-208.

Sanderson K, Andrews G. Common mental disorders in the workforce: recent findings from descriptive and socia epidemiology. Can J Psychiatry 2006; 51:63-75. * A structured literature review of studies describing the preval of mental disorders in working populations showing the high burden associated with depression and anxiety disc

Murphy AA, Mullen MG, Spagnolo B. Enhancing individual placement and support: promoting job tenure by integ natural supports and supported education. Am J Psychiatr Rehabil 2005; 8:37-61. ** A clear and comprehensiv discussion of the limitations of supported employment programmes for achieving job tenure, which casts signific doubt on the effectiveness of these programmes in helping people with mental disorders develop sustainable job the primary labour market.

Long E, Runch B. Combating stigma through work for the mentally restored. Hosp Community Psychiatry 1983; 20.

Scheid TL. Employment of individuals with mental disabilities: business response to the ADA's challenge. Behav Law 1999; 17:73-91.

Manning C, White PD. Attitudes of employers to the mentally ill. Psychiatr Bull 1995; 19:541-543.

Paetzold RL. Mental illness and reasonable accommodations at work: definition of a mental disability under the A Psychiatr Serv 2005; 56: 1188-1190. * A legal analysis of court rulings under the Americans with Disability Act showing the difficulty associated with demonstrating that mental disorders constitute disabilities under the definit the act for purposes of acquiring workplace accommodations.

Gaebel W, Bauman AE, Zäske H. Intervening in a multilevel network: progress of the German Open the Doors projects. World Psychiatry 2005; 4 (Suppl 1): 16-20. * A comprehensive overview of the approaches and results German site of the World Psychiatric Association's global programme to fight stigma and discrimination due to schizophrenia.

Roeloffs CC, Sherbourne J, Unützer A, et al. Stigma and depression among primary care patients. Gen Hosp Psychiatry 2003; 25:311-315.

Wahl OF. Mental health consumers' experiences of stigma. Schizophr Bull 1999; 25:467-478.

Wahl OF. Telling is risky business. Piscataway, NJ: Rutgers University Press; 1999.

Stuart H. Stigma and work. Healthc Pap 2004; 5:100-111.

Link B. Mental patient status, work, and income: an examination of the effects of a psychiatric label. Am Sociol R 1982; 47:202-215.

Nicholas G. Workplace effects on the stigmatization of depression. J Occup Environ Med 1998; 40:793-800.

Rosenheck R, Leslie D, Keefe R, et al. Barriers to employment for people with schizophrenia. Am J Psychiatry 2 163:411-417. * This article presents a study of 1400 patients with a diagnosis of schizophrenia who participated multisite drug trial showing that employment may be impeded by benefit traps associated with disability payment

Perkins DV, Born DL, Raines JA, et al. Program evaluation from an ecological perspective: supported employme services for persons with serious psychiatric disabilities. Psychiatric Rehabilitation Journal 2005; 28:217-224. * large-scale study of 4600 clients who used supported employment programmes in the state of Indiana examines effectiveness, client satisfaction with and costs of supported employment programmes.

Catalano R, Drake RE, Becker DR, et al. Labour market conditions and employment of the mentally ill. J Ment H Policy Econ 1999; 2:51-54.

Clark RE, Dain BJ, Zie H, et al. The economic benefits of supported employment for persons with mental illness. Ment Health Policy 1998; 1:63-71.

Chandler D, Meisel J, Jordan P, et al. Mental health, employment, and welfare tenure. J Community Psychol 200 33:587-609. * This article presents a study of 632 recipients of temporary assistance for needy families in Califo showing that those with mental health problems are less likely to work and to work fewer hours per week, even a the implementation of welfare-to-work policies.

Corrigan PW, McCracken SG. Place first, then train: an alternative to the medical model of psychiatric rehabilitat Social Work 2005; 50:31-39. * This article provides a good overview of competing rehabilitation models of supp employment emphasizing the effectiveness of models that fast-track employment placements.

Cook JA, Lehman AF, Drake R, et al. Integration of psychiatric and vocational services: a multisite randomized, controlled trial of supported employment. Am J Psychiatry 2005; 162:1948-1956. * Results of a randomized tria involving 1273 people with severe mental illness at seven sites in the United States showing the effectiveness of integrated psychiatric and vocational service delivery models on employment outcomes.

Schulze B, Angermeyer MC. Subjective experiences of stigma. A focus group study of schizophrenia patients, th relatives and mental health professionals. Soc Sci Med 2003; 56:299-312.

Becker DR, Drake RE, Bond GR, et al. Job terminations among persons with severe mental illness participating supported employment. Community Ment Health J 1998; 34:71-82.

Zhang M, Rost KM, Fortney JC, Smith GR. A community study of depression treatment and employment earning Psychiatr Serv 1999; 59:1209-1213.

Harnois G, Bagriel P. Mental health and work: impact, issues and good practices. Geneva: World Health Organiz and the International Labour Organization; 2000.

Mercer Human Resource Consulting Group. Few Canadian employers addressing workplace mental health issu 2004. http://www.mercerhr.com/pressrelease/details.jhtml/dynamic/idContent/1148145. [Accessed 2 March 2005

Gray P. Mental health in the workplace: tackling the effects of stress. London, UK: The Mental Health Foundatio 2000.

Tsutsumi A, Takao S, Mineyama S, et al. Effects of a supervisory education for positive mental health the workp quasi-experimental study. J Occup Health 2005; 47:226-235. * A study showing that mental health education fo supervisors improves mental health outcomes in workers but only in areas where one third or more of the superv personnel participated in the educational programme.

Spicer RS, Miller TR. Impact of a workplace peer-focused substance abuse prevention and early intervention pro Alcohol Clin Exp Res 2005; 29: 609-611. * A study demonstrating the impact of a peer intervention programme substance abuse on workplace injuries.

Lunt N, Thornton P. disability and employment: towards an understanding of discourse and policy. Disabil Soc 1 9:223-238.

Roulstone A, Warren J. Applying a barriers approach to monitoring disabled people's employment: implications f Disability Discrimination Act 2005. Disabil Soc 2006; 21:1125-1131. ** An excellent overview of the rationale be the UK Disability Discrimination Act of 2005 highlighting how the act subscribes to a social model of disability an importance of disability employment monitoring.

Commission of the European Communities. Communication from the Commission to the Council, the European parliament, The European Economic and Social Committee and The Committee of the Regions. Equal opportun for people with disabilities: a European Action Plan. Brussels; 2003.

Goss D, Goss F, Adam-Smith D. Disability and employment: a comparative critique of UK legislation. Int J Hum I Manag 2000; 11:807-821.

Vilchinsky N, Findler L. Attitudes toward Israel's Equal Rights for People with Disabilities Law: a multiperspective approach. Rehabil Psychol 2004; 49:309-316.

Heijbel B, Josephson M, Jensen I, Vingärd E. Employer, insurance, and health system response to long-term sic leave in the public sector: policy implications. J Occup Rehabil 2005; 15:167-176. * A survey of worker sick leav Sweden with the expressed purpose of showing that employers have failed to comply with explicit requirements

employment equity legislation.

Allbright AL. 2004 employment decisions under the ADA Title I - survey update. Ment Phys Disabil Law Rep 200
29:513-516. * A review of employment decisions under the Americans with Disabilities Act providing figures on
outcome of decisions for claimants with mental disabilities.

Goldberg SG, Killeen MB, O'Day B. The disclosure conundrum: how people with psychiatric disabilities navigate
employment. Psychol Public Policy Law 2005; 11:463-500. * This qualitative study outlines different forms of dis
disclosure points to the ad-hoc nature of most decisions and the lack of professional mental health and rehabilita
input.

MacDonald-Wilson KL. Managing disclosure of psychiatric disabilities to employers. J Appl Rehabil Couns 2005;
36:11-21. ** A comprehensive review of the disclosure literature outlining the risks and benefits that must be
considered in making such a decision. Two step-by-step guides are offered for professionals wishing to help clie
work through the process of disclosure.