

# Barriers to Employment for Persons with Serious Mental Illness in Malaysia



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# Barriers to Employment for Persons with Serious Mental Illness in Malaysia *A Narrative Review*

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## Preface

*Employment is a universal human right enshrined in Article 23 of the United Nations Declaration of Human Rights which states that “Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment.”*

An inordinate amount of blame with respect to the high unemployment rates among people with serious mental illness (SMI) lie with them. Various beliefs include incompatibility of SMI and work i.e. that people with SMI are either unable or unwilling to work, and potential employers' concerns about productivity and human resource challenges when employing such persons may prevent them from doing so. There is currently a global shift in the practice of psychiatry away from an impairment –oriented model of psychiatric practice of towards an evidence-based recovery-orientated psychiatry (O'Hagan, M. 2001) (Brown and Kandirikirira, 2006). This paradigmatic shift is well publicized as the 'new' gold-standard at institutions of higher learning in Psychiatry as well as professional bodies governing the training of psychiatry. Recovery-orientated psychiatry is also being introduced in undergraduate as well as incorporated into post-graduate training programs (Higgins, 2008). It is now plainly understood that attaining remission is but a means to the end of achieving recovery in all its diverse forms. This book is an integrative review of the unique barriers to employment people with SMI in Malaysia face. This book is dedicated to all persons with SMI for whom gaining employment is an uphill task in no small measure due to the obstacles erected by the Medical Model of Disability and all mental health care workers who believe that employment among this population is tenable and indeed desirable and contribute to the pursuit of the same. If despite this knowledge mental health practitioners continue to be satisfied with mere remission and ignore important tangible parameters of recovery like employment, the mental health care system in Malaysia has failed in its duty towards persons with serious mental illnesses.

## **Acknowledgement**

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## **Dedication**

We would like to dedicate this book to every single person who have or are experiencing a serious mental illness. We would also like to dedicate this book to all the mental health care workers and family members of PSMI who tirelessly work for the progress towards the recovery journey.

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# Glossary of Terms

	Abbreviation	Term
1	SMI	Serious mental illness
2	PWPD	Persons with Psychiatric Disabilities
3	SOCSSO	Social Security Organization
4	CE	Competitive Employment
5	PWPD	Persons With Psychiatric Disability
6	SE	Supported Employment
7	IPS	Individual Placement and Support

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## CHAPTER 1

### Introduction

Serious mental illness (SMI) has a prevalence of about 1 in 17 people worldwide and includes illnesses like bipolar disorder and schizophrenia (World Health Organization, 2011). These illnesses typically have recurrent acute episodes characterized by exacerbation of symptoms throughout the lifetime of an affected individual. While psychiatric symptoms e.g. hallucinations and delusions are frequently distressing and debilitating, they typically peak during acute episodes and tend to remit partially or fully early with optimum treatment (Schinnar, Rothbard, Kanter & Jung, 1990). On the other hand, disabilities associated with SMI are more pervasive, tend to transcend episodes and profoundly affect the ability of persons with SMI to participate fully in domains of interpersonal and vocational functioning (World Health Organization, 1980).

As a result, having an SMI increases the chances of living below the poverty line (Murali & Oyeboode, 2004) and living on disability benefits (Ngui, Khasakhala, Ndeti & Roberts, 2010). In fact, in the US over thirty-three percent (33%) of those living on disability benefits are persons with SMI (McAlpine & Warner, 2000). Moreover, this same population have difficulty in procuring and sustaining employment. Persons with schizophrenia are 4 (four) times more likely to be unemployed as compared to healthy cohorts (World Health Organization, 2000)

Persons with SMI-related disabilities have been found to have low employment rates ranging from 8%-35% in UK, France and Germany (Marwaha et al., 2007). Even with optimal support, the median employment rate for persons with SMI ranges between 30-80% (Bond, 2004) with the worst rates in persons with schizophrenia which population the unemployment rate is between 80-90% (Crowther, Marshall, Bond, & Huxley, 2001). The large variability in employment rates reflects in part different definitions of competitive work outcomes, differing welfare systems and labor markets and as well as disability regulations (Corbiere et al., 2010). The employment rate for people with a SMI like schizophrenia in Malaysia has been found to approximate 50% (Aziz et al., 2008; Midin et al., 2011). This higher than average employment rate in Malaysians with schizophrenia however is not the true rate of employment as defined in western literature as it includes persons who are self-employed in menial tasks for very short periods and duration which do not generate adequate income to cover basic living expenses. Even these inflated

employment figures are far beyond the local unemployment rate in Malaysia which stands at 3.2% (as of as of February 2015) (Department of Statistics Malaysia, 2015).

## Unemployment and its ills

Persistent unemployment in persons with Psychiatric Disability places a burden on the local economy, socially as well as on the person who is unemployed (See Table 1)

**Table 1**

<b>Unemployment in Persons with Psychiatric Disabilities (PWPD)</b>		
<b>Economic burden</b>	<b>Social Burden</b>	<b>Personal Burden</b>
<ol style="list-style-type: none"> <li>1. Wastage of human resources – large untapped source of labor<sup>1</sup> and ↓ labor participation rate</li> <li>2. Low capital formation -loss of productive power</li> <li>3. Low living standard</li> <li>4. Economic Burden to societies and families</li> <li>5. SMI incurs the highest costs among the 5 NCD's. Worldwide Cost<sup>2</sup> 2010 (estimated)–  <b>USD \$ 2.5 trillion</b>  Projected Worldwide costs for 2030  <b>USD \$ 7.5 trillion<sup>1</sup>(WHO, 2008) <sup>2</sup> (WHO, 2010)</b></li> </ol>	<ol style="list-style-type: none"> <li>1. Wide gap between rich and poor</li> <li>2. Social unrest</li> <li>3. Petty crimes</li> </ol>	<ol style="list-style-type: none"> <li>1. Mental stress</li> <li>2. Loss of self esteem</li> <li>3. Poverty</li> </ol>

## CHAPTER 2

### Unemployment and Mental health conditions

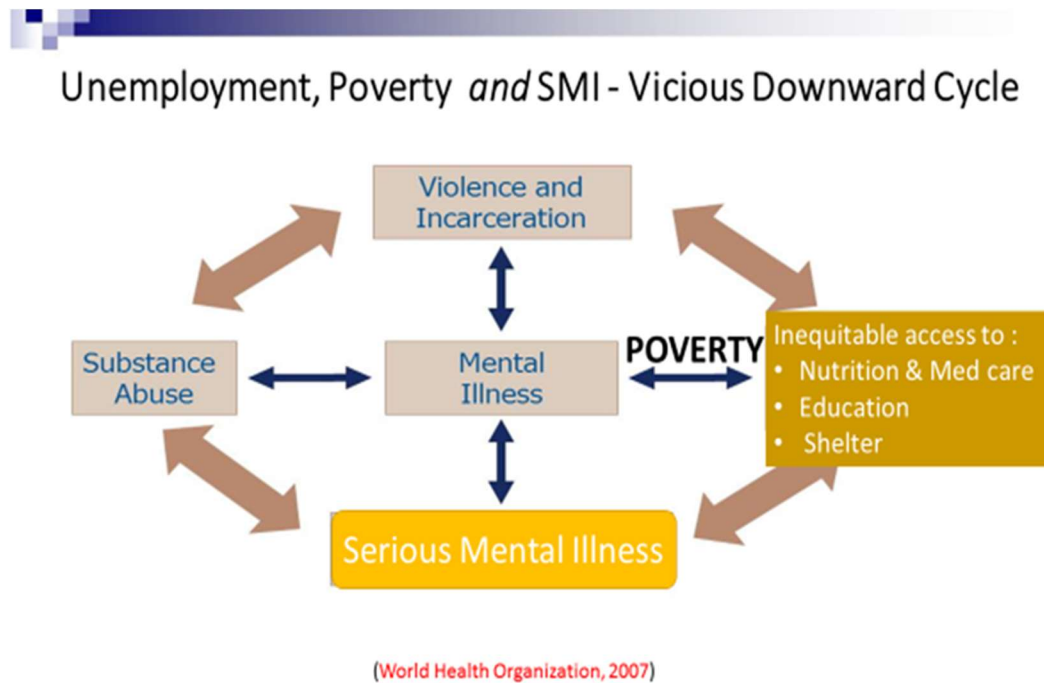
Mental illness is associated with a number of tangible and intangible consequences that extend far beyond the apparent symptoms of those afflicted by serious mental illness and extends to families and society (Department of Health, 2010). Mental illness incurs the highest costs in terms of economic burden among the five non-communicable diseases (NCD's) i.e. cardiovascular disease, cancer, chronic respiratory disease, and cancer. In total, the worldwide cost of mental health in 2010 was estimated to be nearly USD \$ 2.5 trillion and this is expected to triple in 2030 (Bloom et al., 2011).

### Vicious cycle of mental illness and poverty

To make matters worse, mental disorders are twice as common in the poor as compared to the rich (Patel, Araya, de Lima, Ludermit & Todd, 1999). In fact, those in the lowest socio-economic status (SES) are 8 (eight) times more likely to develop schizophrenia as compared to those in the highest SES (WHO, 2000). People with schizophrenia for example are four times more likely to be unemployed or partly employed as compared to healthy cohorts (Funk, Drew & Knapp, 2012).

Unemployment and poverty in turn are intricately and inseparably linked with serious mental illness in a vicious downward spiral. Having a SMI increases the risk of one descending into poverty and poverty in turn exacerbates SMI (World Health Organization, 2007). Poverty results in adversity in the following areas: lack of adequate and unequitable access to nutrition, education, shelter and livelihoods. These persons have the most need to health care but have the least access to it (See Fig 1)

**FIGURE 1**



The local and regional losses in productivity as a result of SMI is considerable given that persons with SMI form a largely hidden and untapped source of labor (World Health Organization, 2008). By not actively seeking employment, persons with SMI contribute to lower labor participation rate (the number of people who are either employed or are actively looking for work) which in Malaysia, stood at 67.2% as of Feb 2015 (Department of Statistics Malaysia, 2015)

Perkins and Rinaldi (2010) found 43 % of claimants in the UK for out of work disability benefits were people with a mental health condition. In Malaysia, the number of persons receiving invalidity pensions from the national Social Security Organization (SOC SO) more than doubled from 2005 to 2014 (7657 persons in 2005 to 18072 persons in 2014) but the number of Persons with Psychiatric Disabilities receiving invalidity pensions from SOC SO only increased from 230 persons in 2005 to 318 persons in 2014.

Persons with Psychiatric Disabilities receiving invalidity pensions from SOC SO in 2014 therefore make up only 1.76 percent of the total SOC SO invalidity pensions (Mohammed, 2014)

Persons with Psychiatric Disabilities registration with the department of social welfare increased five times from 2004 to 2009 (Lee, Abdullah, & Mey, 2011). Other records indicate that the numbers of persons who have been certified as having a mental-illness related disability has steadily been rising from 19497 in 2013 to 26813 in 2015 (Statistical Data of Registration of Persons with Disabilities, 2015). Out of the total number of persons certified as having all types of disabilities in Malaysia in 2015, 7.84% of these were having mental-health related disability (Persons with Psychiatric Disabilities are referred to as Orang Kurang Upaya Mental or OKU (M) in the local Malay language terminology.

## CHAPTER 3

### The benefits of employment

Contrary to what many believe, the benefits of employment extend beyond the obvious fiscal returns. Working provides a sense of purpose, independence and structure to everyday life. Personal and social worth are inextricably bound to employment and results in improved self-esteem and sense of achievement (Lehman, 1995) (Winefield et al., 2002) (Bond, 2004). Work also provides an avenue for social contact and interaction as well as to expand the usually contracted social network of the person with SMI (See Table 2)

**Table 2 - Benefits of employment**

#### *Tangible*

- *Monetary income for daily living expenditure*
- *Stable Housing*

#### *Intangible*

- *Sense of purpose*
- *Independence*
- *Structure to everyday life*
- *Sense of personal and social worth*
- *Self-esteem*
- *Sense of achievement*
- *Avenue for social contact and interaction*
- *Social connectedness*

(Lehman, 1995), (Bond, 2000)

Although the unemployment rate for persons with SMI people tend to be very high, studies have consistently indicated that sixty to seventy percent (60-70 %) of such persons want to work but are unable to participate in open labor markets for various reasons (Promoting Independence and Recovery, 2007; A Guide to Evidence-based practice for adults with mental illness, 2005). More promising is that vocational interventions such as supported employment result in up to 60% success rate of attaining employment.

In spite of knowledge of this, little is done in way of helping people with SMI attain and sustain employment.

## **CHAPTER 4**

### **Aims and Methodology used in Integrative Review**

The aims of this integrative research review were:

- 1) To identify barriers to employment in persons with psychiatric disability from literature on the subject both internationally as well as locally.
- 2) To organize and present the above information coherently at a micro (intrapersonal and interpersonal), meso (living, community and work environments) and macro (societal and policy) levels
- 3) To describe these barriers in the unique local context
- 4) To discuss and recommend possible measures to increase employment in persons with psychiatric disability in a local context and reduce the unemployment gap

## **METHODS**

A search was conducted using EBSCOhost, Science Direct, Ref Works Search engine, MEDLINE and PsycINFO databases and Google Search and included white as well as grey literature. Search terms included 'employment' and 'mental illness', 'employment' and 'schizophrenia', 'return to work' and 'mental illness', 'return to work' and 'schizophrenia'

Further studies were found via related articles and article reference lists. The main time period covered was 1990–current but a few highly relevant earlier articles were also reviewed. The review material included evidence from meta-analyses or systematic reviews, evidence from randomized controlled trials (RCTs), evidence from quasi-experimental studies, evidence from observational studies or quantitative surveys and also evidences from expert opinion, case reports, focus groups or qualitative studies.



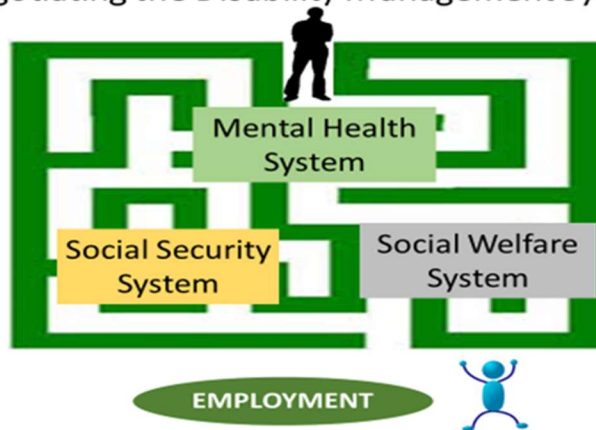
## CHAPTER 5

### Results and Findings- Barriers to employment for persons with serious mental illness

Gaining and securing employment is the product of a complex interaction between a person and his skills or abilities, his living and working environment and job requirements. In the case of a person with SMI and having psychiatric-related disability, employment involves additional levels and systems of interaction involving mental health, social welfare and social security systems. In Malaysia, as in most parts of the world, persons with SMI largely interact with and obtain services from three systems for their disability management. (Fig 2)

**FIGURE 2**

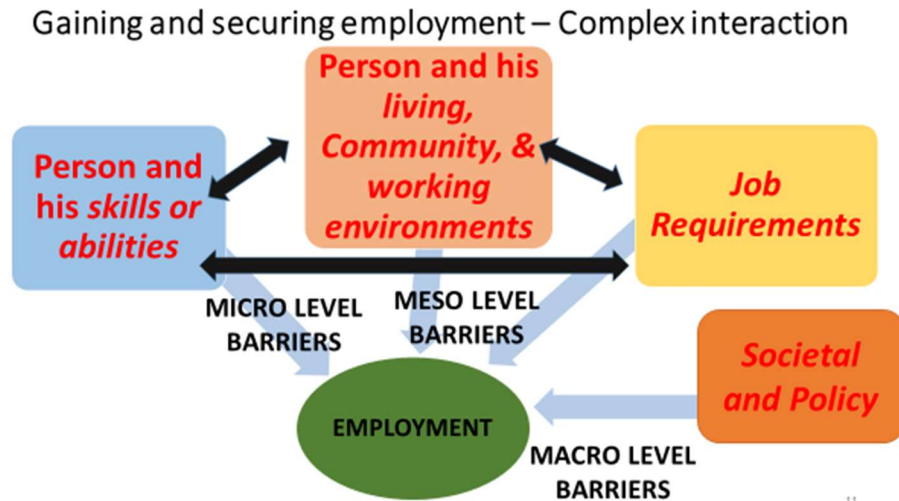
Negotiating the Disability Management Systems



Mental health services in Malaysia is provided for under the Ministry of Health and are largely hospital-based services. Social welfare services are provided for by the Social Welfare Department services under the Ministry of Women, Family and Community Development. Social Security Organization or SOCSO, a statutory Malaysian body providing social security schemes to all employees earning less than Ringgit Malaysia \$4000 per month.

Barriers to employment exists within and between in these very systems (Burns & Gordon, 2010) and are the subject of this review. (See Fig 3). For the purpose of discussion, barriers to employment in persons with psychiatric disability will be elaborated and discussed at three different levels; micro (intrapersonal and interpersonal) levels, meso (living, community and work environments) levels and macro (societal and policy) levels.

**FIGURE 3**



**\* Definitions of terms used in FIGURE 3**

**Micro Level barriers** refer to barriers at the level of the person and includes intrapersonal and interpersonal barriers.

**Meso Level barriers** refer to barriers at the persons Living, community and work environments.

**Macro Level barriers** refer to barriers at the societal and policy level

**Introduction**

Frequently the inability to attain or sustain employment is attributed to factors of poor motivation, illness characteristics and poor vocational performance in persons with SMI. While these factors may indeed contribute to challenges in choosing, getting and keeping jobs in persons with SMI, employment as an outcome in this population is the result of interactions between personal, social and employer factors. Any remedial efforts that

focusses on one to the exclusion of the others are bound to be inadequate and result in poor outcome.

### ***Micro level barriers to employment***

Micro level barriers refer to barriers at the level of the person and includes interpersonal interaction as well as intrapersonal factors as such cognitive processes and motivation. These barriers in turn can be examined in the three stages of seeking employment.

#### **Pre-employment stage barriers – Barriers to Choosing Employment**

##### **Low motivation to pursue employment**

Readiness to commence the journey to employment has been argued to hinge on the following four (4) 'readiness factors' i.e. felt need, commitment, internal and external knowledge (Cohen, Farkas, & Cohen, 1992). In the perspective of this theory, a person with SMI who is not ready to pursue employment will neither feel the need nor have the necessary commitment to work. He is also unlikely to be aware of his skills or resources or the requirements and demands of the labor environment. Low motivation refers to the presence of these elements combined with a lack of interest and readiness to seek or sustain employment.

Lack of motivation may also be driven by poor self-belief and expectations because of internalization of public stigma regarding persons with SMI's ability to function vocationally. Given the stigma associated with having a mental illness, concern about employers and co-workers knowing about the SMI may lead to feelings of inferiority and fear of rejection which precludes any attempt to even re-join the workforce (Stuart, 2006; Centre for Mental Health, 2013; Corrigan, 2003). Negative employment experiences and subsequent fear of failure have been found to contribute to low motivation (Shankar, Barlow & Khalema, 2011) as does low expectations of being employed reinforced by the personal experiences of others in a similar predicament (Centre for Mental Health, 2013).

Unfortunately, low motivation to pursue employment is also contributed to by the very system tasked to help persons with SMI. Mental health workers were found to communicate and reinforce the message that mental illness and employment were not compatible (Marwaha, Balachandran & Johnson, 2009) and the situation in Malaysia is not very different.

### Believe that work worsens mental illness

There is a generally held belief that employment is incompatible with mental illness (Woodside, Schell, & Allison-Hedges, 2006). Indeed, vocational pursuit in those with a diagnosis of mental illness is not only frowned upon but openly discouraged as is also believed to precipitate or worsen the illness. These societal perceptions may also be harbored by the potential employee and lead to avoidance of job seeking.

### Low vocational maturity

SMI tend to occur at late adolescence and early adulthood, a critical period of development in one's life where vocational exposure and skills should be learnt. (Häfner, Nowotny, Löffler, Heiden, & Maurer, 1995). Some SMI like schizophrenia are preceded by prodromal periods of dysfunction and disability as evidenced by suboptimal psychosocial functioning. Irrespective of phase, persons with schizophrenia lack early and adequate experience in the labor force as compared to their peers. Lack of vocational maturity puts them at a disadvantage when it comes to job applications as they either lack a job history, have poor/negative job history, are underemployed, lack promotions or have not been able to successfully maintain employment. What is more alarming is the results of a meta-analysis by Leff et al. (2005) which showed that Persons with Psychiatric Disabilities had virtually no chance of securing competitive employment without any job development services.

### Limited Job scope

There is a lack of availability of a wide range of jobs to pique the interest of potential employees. Many positions available to Persons with Psychiatric Disabilities tend to be entry level positions. Jobs offered may not be the ones of interest or choice but is taken anyways based on availability and need for employment. A Malaysian study found that most those referred for job placements took up positions like cleaners, kitchen aids, security guards, or worked in a laundrette, factories, convenience stores or car washes (Wan Kasim, Midin, Abu Bakar, Sidi, H., Nik Jaafar, & Das, 2014)). These jobs typically are characterized by low job security, being temporary, contract or on an ad-hoc basis. Persons with Psychiatric Disabilities can also experience lower remuneration packages than their peers.

### Poor job search skills

People with SMI tend to have a lack of related skills which prepare them to secure successful employment. Job searching skills is one of the most essential skills in looking for job openings that potentially suitable for them. Seeking jobs through mainstream media available such as newspaper and internet could be one of the difficulties that they face due to cognitive and social limitations (CAMH & CMHA Ontario, 2010) as well as lack of exposure and opportunities.

### Poor experiential knowledge and lack of interview skills

Another readiness skills that person with SMI also have difficulty were interviewing skills that consists of preparation before interview and presenting self during interview. Some interviewing skills include communication skills, grooming and appearance, and writing a good resume. This is vital to create a good initial impression with potential employers (Bell & Weinstein, 2011).

### Uncertainty about disclosure

Unlike the provisions in the Americans with Disabilities Act (ADA, 1990) where disclosure may be made post-employment, job seekers with SMI in Malaysia are in a quandary. Most pre-employment application forms require declaration of pre-existing health conditions and declaring or choosing not to declare has both its advantages and disadvantages. Declaration of mental illness may result in not being called for an interview but disclosure or discovery of illness after employment could be perceived as fraud and subsequently lead to termination on the same grounds (Brohan et al., 2012)

### Poor academic Achievement/qualifications

SMI tend to occur at late adolescence and early adulthood and coincides with the period of receiving secondary and tertiary education. As such, SMI is very disruptive to the normal education or vocational training in young people.

Not surprisingly, the prevalence of mental disorders is highest among those with the lowest levels of education (World Health Organization, 2000). In a cross-national study involving some countries of North and Latin America as well as Europe, people with schizophrenia were 1/3rd more likely to drop out from high school. In Malaysia, less than one fifths completed primary school and less than one thirds completed secondary education (Aziz et al., 2008). In Malaysia, most employment opportunities require at least a lower college education (locally known as the Sijil Rendah Pelajaran (SRP) or Penilaian Menengah Rendah (PMR).

People with SMI face a disadvantage in employment application due to the lack of necessary prerequisite basic qualifications and may in turn be qualified for fewer type of employment opportunities. Having adequate qualifications is significantly associated with positive employment outcomes and widens choices for job-seekers (Marwaha et al., 2007)

#### Post-employment stage barriers – Barriers to keeping Employment

Cognitive deficits i.e. Poor concentration, pace and persistence hamper work performance and account for difficulties in sustaining employment (McGurk, & Meltzer, 2000) for some persons with SMI.

Being in employment requires making certain changes in one's attitudes and lifestyles to accommodate work demands and difficulties in transitioning have been proposed to account in part to personal barriers to sustaining employment (Contreras et al., 2012). Similarly, poor job matching in the search phase may result in lack of interest and motivation required to sustain employment (Mueser, Becker & Wolfe, 2001)

#### Stigma of mental illness – the long shadow

Persons with SMI who are in recovery without any visible symptomatology or abnormal behavior also face discrimination and rejection (Thornicroft, 2006) due to their 'chequered' past.

Stigma related to their diagnosis causes significant disabilities. Here, the disability is not a result of the person's impairment but rather as a resultant of attitudinal and systematic barriers inherent in organizations as posited by the Social Model of Disability (Carr, Darke, & Kuno, 2008, pg. 51)

The fear of their mental illness being known by their managers and co-employees may be so strong that People with SMI may even avoid any interaction with the mental healthcare system to their detriment (Stuart, 2006). This fear is perhaps justified in view that disclosure may jeopardize their career advancement and even lead to outright dismissal.

## **MESO LEVEL BARRIERS TO EMPLOYMENT**

### Introduction - Disability management practice level

Barriers to employment for Persons with Psychiatric Disabilities exists and are erected by the very systems tasked with addressing them. (Burns & Gordon, 2010). In Malaysia, PSMI largely interact with and obtain services from three systems for their disability management:

- 1) Mental health services under the Ministry of Health which are largely hospital-based services,
- 2) The Social Welfare Department services under the Ministry of Women, Family and Community Development and
- 3) Social Security Organization or SOCSO, a statutory Malaysian body providing social security schemes to employees.

### Lack of early systematic engagement into disability management

Despite the overwhelming evidence of the importance of getting and maintaining employment in Persons with Psychiatric Disabilities, there are still universally no concrete measures to ensure early systematic engagement into supported education or supported employment (Amnesty International, 2016). Mental health services are usually the first point of contact among the three important disability management services in Malaysia.

Perkins & Rinaldi (2010) have argued that while important, the three disability management systems have been ineffective in addressing the rising number of Persons with Psychiatric Disabilities. They attribute this to the flawed fundamental premise on which these systems operate i.e. the cure, care and then rehabilitate model.

Mental health services in Malaysia are largely impairment-orientated. The primary focus of psychiatric management is remission or amelioration of the impairment or symptoms. Social welfare and social security systems in turn depend on this medical model of disability in their decision making with regards to certifying psychiatric disability or work disability respectively. As a result of adopting this medical model of disability, there is poor assessment and management of the illness-related dysfunction and disability.

The Social Welfare Department is tasked with maintaining a register for Persons with Disabilities in Malaysia and refers persons claiming psychiatric disabilities to mental health services to provide assessment and certification of disability levels in three

domains namely social, cognitive and behavioral function (Department of Social Welfare Malaysia, 2011).

Social Security Organization or SOCSO on the other hand is a statutory body under the Ministry of Human Resources and was established in 1971 to provide social security protection in the form of Employment Injury Insurance Scheme for work-related injuries and the Invalidity Pension Scheme provides protection against invalidity due to any cause not connected with employment. The Employees Social Security Act 1969 covers all workers who earn less than RM4000.00 per month.

A Return to Work Program was implemented based on a pilot study conducted in 2005 where contributors with musculoskeletal disorders were sent for rehabilitation with the objective that the participants were able to return to work. A case management concept was utilized where persons with disabilities, case managers, job placement officers, rehabilitation specialists, employers and social institutions worked together towards designing a rehabilitation plan towards obtaining and sustaining employment (Return to Work Program (RTW) 2014). Since the RTW Program was implemented in 2007, there has been a shift in perception of employers in the employment of disabilities where there is currently a great demand from employers wanting to employ persons with disabilities. Back in 2007, it was often the Case Managers and Job Placement Officers calling employers to secure job opportunities, however employers frequently call the RTW Department for suitable candidates to work within their organizations. This RTW program was gradually extended to include Persons with Psychiatric Disabilities. From 2010 until 15th June 2015, 108 cases were referred to the program. 83.3 % (90 cases) from the 108 cases were motivated and committed to join the program. 46.7 % (42 cases) were successfully placed.

Mental health services also receive SOCSO referrals for purpose of evaluation if maximal medical improvement (MMI) has been achieved by contributors with Persons with Psychiatric Disabilities. A board comprised of at least two psychiatrists convene to evaluate and certify that MMI has been achieved and proceed to recommend rehabilitative measures and disability pension as the case requires.

Lack of coordination and communications between these three systems is a universal challenge not unique to the Malaysian scenario (Harvey, Brophy, Parsons, Moeller-Saxone, Grigg, & Siskind, 2016).), as is the lack of a single, go to agency which results in frustration for Persons with Psychiatric Disabilities who has to then negotiate between different systems at different locations and who in turn do not have bilateral communication with each other or have a central real-time database to refer to. Being disparate systems, there is also a lack of a common platform or single person who works with all three agencies to coordinate care.



## Reduced expectations to employment

Frequently expectations are low among disability management systems with regards to the ability of PSMI to attain gainful employment (Stuart, 2006; Centre for Mental Health, 2013), irrespective of their impairment status. A Malaysian study examining functional remission and employment status among persons with schizophrenia found that despite the high remission rate among the respondents (74% attained functional remission), only 1/5ths of them were employed at time of survey (Dahlan et al., 2014). This finding is consistent with that of a London community mental health team where only 5.5% of PSMI were employed as compared to 18.9% deemed to be capable of CE (Lloyd-Evans et al., 2014). There is also lowered expected and achieved standards of achievement in such populations which result in underemployment or partial employment in jobs that are ill suited, low-paying, non-competitive (Wan Kasim, Midin, Abu Bakar, Sidi, Nik Jaafar & Das, 2014) or unstimulating. Findings of this local study are consistent with a large study in the US which found that nine out of ten persons with SMI were employed in lower paying jobs with little security (Perkins, Born, Raines & Galka, 2005) and that persons with psychiatric disabilities are more likely to be employed in the secondary labour market (Stuart, 2006)

Partially because of reduced expectations, there is lack of the planning for and execution of a RTW endeavors on the whole. (Dahlan et al., 2014). Another possible reason is concerns that working results in worsening symptoms in persons with SMI.

## Differences in the approach and management of physical and psychiatric disability

An issue complicating disability management service delivery are the differences in the approach and management of physical and psychiatric disability. Return to Work (RTW) programs were first pioneered among people with physical disabilities to initiate and facilitate the process of re-entry into gainful employment. As such, RTW models for persons with SMI were adopted and adapted from these models but inherent differences between the two began became apparent. Certain characteristics about physical impairment and resulting disability were very different from psychiatric impairment and disability.

The impairment in persons with SMI is not as apparent and tangible as compared to its physical counterpart's visibility and tangibility. The impairment in PSMI may wax and wane periodically, typically being exacerbated in acute episodes whereas impairment and dysfunction are relatively stable in persons with physical disabilities.

In terms of disability related to psychiatric illness, the level of impairments i.e. symptoms have little bearing on dysfunction and disability, which continue despite symptomatic remission.

In the following section, barriers specific to the three disability management systems will be discussed.

## 1) MENTAL HEALTH SYSTEM

Lack of Unemployment as a disability is a very serious and common disability in PSMI yet there seems to be a lack of priority and urgency given to the matter. Historically, the mental health system has been less than enthusiastic about competitive employment as an outcome for PSMI (Stuart, 2006). Several factors contribute to this apathy and this includes therapeutic pessimism.

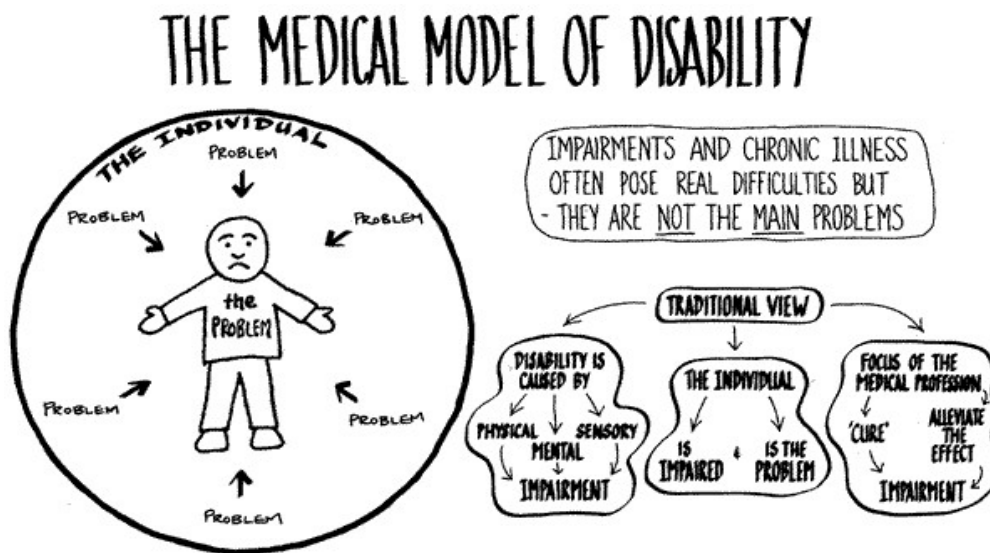
Therapeutic pessimism about work as an outcome reflects mental health professionals' attitudes regarding the feasibility and importance of employment in persons with mental illness (Marwaha, Balachandra, & Johnson, 2009). A contributing factor to these beliefs includes a lack of awareness of heterogeneity of illness/disability/outcomes (recovery) and contribute to less than enthusiastic approach (Woodside, Schell, & Allison-Hedges, 2006)

Even when PSMI want to work, their clinicians were found to discourage them from pursuing competitive employment and point them towards non-competitive ones (Bevan, Gulliford, Steadman, Taskila, Thomas, & Moise, 2013). Alarming, even the more optimistic of mental health care workers fail to encourage persons with SMI they deem capable of being in competitive employment (CE) towards vocational pursuits (Lloyd-Evans et al 2013)

## The Medical Model vs the Social Model of Disability

The very crux of the problem in the mental health system's management of dysfunction and disability is related to the underlying theoretical model it utilizes to understand and manage disability. Given the system's understanding of psychiatric illnesses as a group of medical disorders, the mental health system uses the Medical model of Disability. In such a model, the PSMI is disabled by and because of his impairment. As the 'problems' associated with his disability i.e. unemployment, homelessness is deemed to be secondary to his impairment, management of his impairment by way of rehabilitation is posited to be the 'cure'. Here the solution to the problems or disabilities are seen to be at the hands of psychiatrist and allied mental health professionals. (Carr, Darke, & Kuno, 2008 pg. 51)

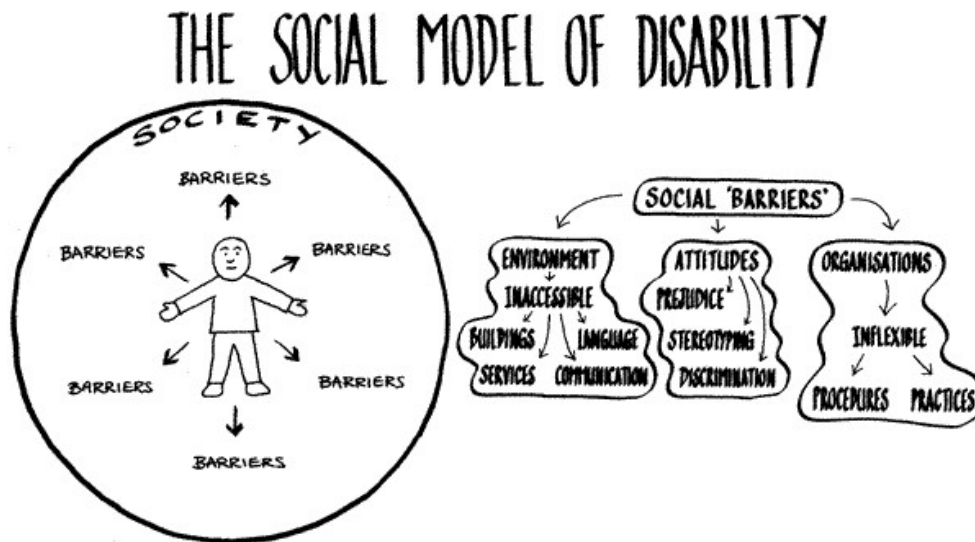
**FIGURE 4**



The Social Model of Disability, on the other hand, posits that problems or disabilities experienced by people with impairments are created and imposed by a society which seeks to systematically exclude people who are different from the majority (Carr, Darke, & Kuno, 2008 pg. 51). Disability arises as a result of the barriers erected by societal institutions as well as attitudinal and environmental barriers prevalent in everyday living. Disability is also a product of discriminatory practices by organizations as well as stigmatization of the impairments by society. Nowhere are these more apparent than in

the context of serious mental illness and disability. According to the Social Model of Disability, the key to enabling ability is to dismantle societal constructs and challenge discriminatory practices which form the barriers against full and equal social participation.

**FIGURE 5**



The next barrier presented by the mental health system to employment for PSMI is that of the scientific premise of management of psychiatric disorders.

Psychiatric illnesses are viewed as medical disorders and the focus of psychiatric management is thus on achieving and sustaining symptomatic remission by way of using medication and psychotherapy. The premise of an impairment-oriented paradigm is that amelioration or remission of the impairment(s) result in recovery from the disorder in spite of evidence to the same (Harding et al., 1987). An impairment-oriented paradigm results in lack of a cohesive overall guiding aim besides and beyond impairment. Another barrier closely related to an impairment-oriented paradigm is the flawed assumption of the necessity to achieve remission before dysfunction and disability is addressed.

Caveat of get well first - Treatment and rehabilitation Sequential rather than parallel

Evidence from SE supports rapid search for competitive work once the PSMI is motivated to engage in the process. However, in the current psychiatric management model in Malaysia, it is usual practice for clinicians to target achieving and sustaining symptomatic remission before any initiatives to target dysfunction and disabilities commence. In the management of a person with schizophrenia, management typically proceeds in a step wise hierarchical manner where the clinician sets as clinical targets of symptomatic

response, remission of symptoms (Andreasen, Carpenter, Kane, Lasser, Marder, & Weinberger, 2005), and thereafter clinical recovery.

#### Lack of skills and resources in dysfunction/disability assessment

Clinicians are the first and main point of contact with persons with SMI who experience impairment, dysfunction and disability. As a result of a predominantly impairment-oriented system of psychiatric services, clinicians are trained to recognize and manage impairment but do not receive formal training in the assessment and management of dysfunction and disability. This lack of awareness results in inadequate referrals to occupational therapists to improve functioning and reduce disability. Even when a referral is made, it is for traditional vocational rehabilitation (TVR) which places emphasis of getting a job without enough focus on skills and resources necessary to keep it. TVR comprises of vocational assessment & pre-vocational training that conducted in rehabilitation centers (Tsang, 2011) and is typically conducted by an occupational therapist. However, despite minimal effectiveness of TVR in maintaining employment, many rehabilitation centers continue to provide TVR as primary service for employment in SMI clients due to individual factors in the rehabilitation team (traditional concept & practice), shortage of manpower and also limited facilities. Sheltered workshops in the training phase is another intervention aimed at placing clients in competitive employment after a period of pre-vocational training, but follow up studies showed a success rate of only five to ten percent (Bond & Boyer, 1988) (Connors, Graham, & Pulso, 1987). This is because sheltered workshops tend to emphasis vocational skills to work usually in craft and production rather than preparing Persons with Psychiatric Disabilities to sustain competitive employment.

Additionally, conventional vocational rehabilitation emphasizes job placement without enough attention given to ensuring adequate support post-employment which includes provision and linkage to resources. Lack of skills and strategies necessary to cope with the SMI as well as with stresses on and off the job also contribute to sustaining employment (Fossey and Harvey, 2010)

In Malaysia, rehabilitation services for employment is delivered by occupational therapists after receiving referrals from clinics and wards from psychiatrists. Reason for referrals typically are for self-care training, and supported employment or work rehabilitation. There are however inadequate referrals for social skills training to improve readiness (such as interviewing skills and writing resume) which are essential in work rehabilitation.

For example in 2014 in the largest tertiary care psychiatric hospital in Malaysia, a total of 7139 cases were referred to the Occupational Therapy unit but only 990 cases were

referred for work rehabilitation with the percentage of cases referred for social skills training comprising less than 5%. (Verbal report, Zairul, Contributing Author 2016)

According to latest statistic, there are only a total of 1400 registered OT's in Malaysia (Verbal report, Zairul, Contributing Author, 2016) with ratio of 1 occupational therapist to a population of 20 000, far below the ideal ratio of 5:10 000 (World Federation of Occupational Therapist). Additionally, not all OT's were competent in psychiatric rehabilitation work as this is a specialized area that requires additional training. There are not enough OT's in service in Malaysia, what more in psychiatry setting where they would be the best person to coordinate Supported Employment services. Furthermore, permanency is another obstacle as OT's are placed on a rotation basis yearly based on field of practice (such Orthopedics, Neurology, Pediatrics & Psychiatry) which place continuity of service delivery at risk.

#### Lack of fidelity/adherence to mental health policy

The Malaysian National Mental Health Policy (2011) Section 6.13.5 f (pg. 83) recommends job placement, specifically supported employment (SE) as part of Rehabilitation/ Recovery-oriented services. Supported Employment as per definition (Bond, Drake, & Becker, 2012) is not routine practice with most psychiatric units in Malaysia emphasizing more on the strategy of job placement and less on post-employment support.

Early in 2015, there has been some collaborative efforts between mental health services and SOCSO to develop supported employment. A Return to Work (RTW) program collaboration with SOCSO and 6 government hospitals across Malaysia was initiated recently with the aim to help clients with mental illness obtain and sustain competitive employment based on IPS principals. Beginning on April 2015, this multi-disciplinary approach program involves a series of assessment processes to evaluate a client's functional status and readiness to work including self-care, cognitive, social and motivation to work. This noble effort however is hampered by restriction of services offered to and provided for Persons with Psychiatric Disabilities with SOCSO contributions only. Those without were referred to occupational therapy units, which due to resource and skills limitations have poor fidelity to the Individual Placement and Support (IPS) model as outlined by compliance to a set of fidelity scales (Bond, Becker, & Drake, 2011). This resulted not in IPS as originally envisioned but a variant of job placement.

## 2) SOCIAL SECURITY SYSTEM (SOCSO)

In Malaysia, supported employment in the form of a Return to Work program is currently offered by the social security agency SOCSO for employees who have a permanent disability who made at least 12 contributions (Employees' Social Security Act 1969)

At present, the main gateway to enter into the RTW Program or the pilot project is that the Insured Persons would have to have an existing claim for invalidity or would have to submit a notification to apply for invalidity where a medical report would have to be included with the application. Invalidity here refers to a serious disablement of a permanent nature. In order to apply for invalidity pension, the PSMI must first be certified by at least one medical officer/psychiatrist that he has achieved maximum medical improvement (MMI) and that his condition cannot or is unlikely to improve any further. In the event that the first application is rejected, the appellate will be assessed by a convened board of at least two psychiatrists.

Unfortunately, persons who have never contributed to SOCSO or have not contributed the minimum of 12 contributions do not qualify for the RTW program unless they have a TPD. PSMI who apply for invalidity pension may do so because they experience serious disability in sustaining work and therefore are seeking some form of financial assistance to keep on providing for themselves and their families. However, by submitting an invalidity claim, the applicant needs to convince others and perhaps himself that he is an 'invalid' and not capable for work now or in the near future. This may encourage the development of a formidable psychological barrier to RTW.

SMI is characterized by acute episodes with a relapsing and remitting course. Disability as a result of both the course and outcome of having a SMI tend to be worsened by episodes but more or less episode independent of symptoms. Psychiatrists who form ad hoc medical boards are trained professionals in identifying impairment but given this impairment orientation, they may fail to identify dysfunction and disability. Hence persons with SMI without florid impairment may be certified as having no or minimum disability.

### 3) SOCIAL WELFARE SYSTEM

Persons with Psychiatric Disabilities frequently seek recourse from the Social Welfare Department for disability aid. In order to do so, they need to fulfil two caveats for being certified Persons with Psychiatric Disabilities;

1) the PSMI must have been receiving continuous treatment and follow-up for at least two years

2) the PSMI must have significant to severe impairment in three domains namely social, cognitive and behavioral function (Guidelines for the registration of Persons with Disabilities (2011) which is comparable to a score of thirty (30) and below on the Personal and Social Performance (PSP) scale which is a 100 point scale consisting of socially useful activities, personal and social relationships, self-care and disturbing or aggressive behavior (Morosini et al, 2000). In other words, in order to qualify for disability benefits, the PSMI must be exhibiting severe to very severe dysfunction and disability. While this is probably a safeguard against abuse of the system, it deprives Persons with Psychiatric Disabilities of invaluable disability aid in the interim period where the illness is disruptive and destabilizing, either in between episodes or at the threshold of remission.

### 4) OTHERS - BARRIERS TO EMPLOYMENT AT THE ORGANIZATIONAL/EMPLOYER LEVEL

Among the barriers to employment existing at the employer level towards all types of disabilities are concerns about accommodation. These concerns largely arise from inaccurate assumptions that accommodations are costly (training and supervising costs) and that hiring people with disabilities result in lower productivity and quality of work (Bruyère, Erickson & VanLooy, 2000). Even when companies are open to hiring PWD, employers are less willing to hire Persons with Psychiatric Disabilities as compared to those with physical disability (Long & Runch, 1983).

Exploratory sessions with employers on their thoughts about employing persons with serious mental illness yielded reluctance to hire was due to the apprehension of not knowing how to manage them in case there was an episode attack or relapse. It is frequently this apprehension that manifested in the stigma on employing SMI cases. Persons having a psychiatric disability are thus less likely than their physically disabled counterparts to attain competitive employment as they are competing for jobs on an unlevelled field. In addition to the above attitudes that regard PWD as liabilities rather



than assets, Persons with Psychiatric Disabilities face the additional barriers of stigma and work place discrimination.

As the third component of the disability management system with whom PWPDP interacts with in their pursuit of employment, organizations or employers have perhaps the largest contribution to make in terms of employment outcome. Conversely, employers can also form the largest obstacles to PWPDP. Again, these barriers in turn are examined in the perspective of pre-employment and post- employment stages.

#### Pre-employment stage barriers

Organizations and their managers' beliefs, attitudes and intended behavior towards employment of PWPDP are largely influenced by the stigma attached to mental illness. PWPDP are seen through the stereotypes of society therefore it is not surprisingly that Krupa et al. (2009) found that employers' perceptions of persons with mental illness approximated that of society i.e. assumptions of incompetence, dangerousness and unpredictability. Furthermore, these employers surveyed questioned the legitimacy of mental illness diagnosis, believed that work worsens their condition and that employing such persons were incompatible with the profit-orientation of the company.

Universally, human resource and front-line managers are also concerned that their companies lacked the resources and expertise to handle emergent mental health issues of PWPDP. They expressed valid concerns regarding their limitations in knowing when declining performance is related to illness and recognizing early warning signs of an impending relapse. They were also unsure on how to strike a balance between accommodating the PWPDP needs and that of their employers' demands (Shankar et. al. 2014)

There were also concerns about interpersonal volatility and potential of harming the reputation of the employer (Tsang, Angell , Corrigan , Lee , Shi, Lam et al., 2007). All these factors form significant barriers to hiring of PWPDP. It is not surprising then that only approximately 30% of potential employers were willing to employ PSMI who were taking antipsychotic medications (Link & Phelan, 2001).

#### Post-employment stage barriers

Managers with experience in or currently hiring PWPDP report frustration at the opacity related to the mental illness and fitness to work of their employees. This is compounded by the dearth of availability of information from mental health care workers due to doctor-patient confidentiality. Information about the PWPDP's limitations or restrictions in function

or ability are not forthcoming either. Contingency management for emergent mental health crises are also inadequately addressed and contact person's inaccessible (Shankar et al. 2014). SOCSO'S Return to Work Case Managers have reported that some HR managers in Malaysia had similar concerns. (SOCSO'S Return to Work Case Manager, personal communication, May 17, 2016).

### ***MACRO LEVEL BARRIERS TO EMPLOYMENT***

Heterogeneous and disparate disability management systems such as the mental health services, the Social Welfare Department and the Social Security Organization have been given the responsibility to work on different aspects of disabilities in persons with SMI. With particular regard to addressing vocational difficulties in PSMI, what is lacking is a centrally-funded interagency collaboration overseeing the development, implementation and regulation of policies promoting vocational rehabilitation (Harvey 2013). Employment for PWPDP universally are neither given the priority nor importance due (Rinaldi and Perkins, 2010) and remain stagnant due to Institutionalized discrimination. In Malaysia, despite the existence of the Malaysia's People with Disability Act, the rate of employment among persons with any type of disabilities are still lower than expected or desired (Ta & Leng, 2013)

## CHAPTER 6

### Conclusion and Recommendations

Employment is arguably a social activity that contributes tremendously to a person's social identity and self-worth (Stuart, 2006). Work can provide the much-needed heuristic structure, social contact, boost in self-image, provide a meaningful goal to pursuit and purpose in life many PSMI need to increase their ability. And yet unemployment rates amongst PWPD remain the highest in the world as compared to their other cohorts with disability and are far above county to county unemployment rates.

Employment is good for mental health (Perkins & Rinaldi, 2012) and indeed lack of it is detrimental to such persons who are searching and capable of it (Centre for Mental Health (2013). Addressing unemployment amongst Malaysians WPD must be given more importance to by all stakeholders involved.

In order to mitigate and reduce the disparity of employment in PWPD in Malaysia, it is important for all stakeholders to be aware that employment is the result of the dynamic interaction between intrapersonal and interpersonal factors in the job-seeker and his environment. For far too long the blame for unemployment among PWPD has unfairly been attributed solely to illness characteristics and impairment in this population. While these factors may indeed contribute to challenges in choosing, getting and keeping jobs in PWPD, any remedial effort that focusses solely on these intrinsic factors to the exclusion of the others are bound to be inadequate, futile and headed for much frustration for all concerned.

In Malaysia, PWPD largely interact with and obtain services from three systems for their disability management: Mental health services under the Ministry of Health which are largely hospital-based services, the Social Welfare Department services under the Ministry of Women, Family and Community Development and Social Security Organization or SOCSO, a statutory Malaysian body providing social security schemes to employees. All stakeholders involved must actively participate in a collaborative manner and contribute to the development of increasing the competitive employment rate in PWPD.

The focus or thrust of disability-related services should be two pronged;

#### 1) Efforts to increase the employment rates of PWPD

For persons with no or poor employment history, the focus of services in line with the psychiatric rehabilitation process would be readiness assessment and development, ascertain personal, social and vocational goals, identifying barriers to these goals and providing them with the support, skills training, linkages and resources to enable them to be better equipped to attain employment.

#### Supported Education and Training

That PWPD are employed and stagnant in low-paying non-rewarding jobs has been proposed to be consequent to a lack of education and training (Stuart, 2006). As such, greater emphasis should be directed at improving education and skill building instead of just focusing on rapid employment. This is provided for under the Persons with Disabilities Act 2008 Sec.28 under vocational training and lifelong learning

According to the recovery-oriented paradigm, the management of PWPD should include holistic assessment encompassing impairment, dysfunction, disability and the stigma and discrimination he faces. This contrasts with the more commonly practiced myopic management that focusses on getting employment placement without addressing peripheral barriers to employment for that person. All interventions that increase the chances of getting a job are considered including supported education, pre-vocational training, supported housing etc.

Vocational rehabilitation programs for PWPD have been recently introduced by the SOCSO Malaysia with the aim of returning to work of eligible contributors of social security. Regrettably, PWPD who are ineligible to receive social security benefits are excluded from this potentially beneficial supported employment program. These such persons then must rely on the impairment-oriented mental health system which does not have adequate knowledge, skills or resources in psychiatric rehabilitation.

#### 2) Efforts to help employed PWPD sustain employment and receive support

Reviews of vocational rehabilitation programs worldwide indicate a propensity of job placement efforts with less focus on post-employment support (Shankar et al., 2014) have

noted that most RTW programs focus on helping PWPD gain competitive employment. Those already in work but who might be struggling with their recovery process or employment-related issues receive less attention. This neglected population may well be at the threshold of unemployment and are a potential area for primary prevention in the form of workplace-based interventions, counselling and provision of reasonable accommodations. This will help reduce the apprehension among PWPD that they would not be able to cope with employment and that support will not be provided in a timely and adequate manner (Perkins & Rinaldi, 2012). What is direly required is for disability management systems and services to change their approach towards unemployment among PWPD.

Unemployment is not consequent to impairment as according to the Medical model of disability but rather related to dysfunction, vocational disability and discrimination. Most importantly of all, unemployment in SMI is best understood on the premise of the Social Model of Disability (Carr, Darke, & Kuno, 2008) whereby disability is a product of attitudinal barriers, systematic organizational discrimination, inequitable policies and weak regulation of existing acts.

Unemployment is a very real problem and not merely consequences of having SMI. More concerted efforts at early identification of employment difficulties and aggressively encouraging and supporting PWPD to attain competitive employment by all the stakeholders is direly required. In order to be effective, all stakeholders must be on the same page in this matter. Affirmative policies regarding unemployment among PWPD must be drafted, agreed upon and implemented with outcome measures to track and trend success rates (Persons with Disabilities Act 2008 Sec.28)

The best evidence for vocational rehabilitation targeted towards increasing competitive employment in PWPD has so far been supported employment (SE). RCT's on SE demonstrate a 20 percent to 40 percent increase in the competitive employment (Bond, 2004). Individual Placement and Support (IPS) stands out as the most researched quintessential model of SE. IPS facilitated the RTW of people with SMI in about 61% of the time as compared to 23% conventional VR models like sheltered workshops and transitional employment (Bond, Drake, & Becker, 2008).

RCT's on SE demonstrate a 20 percent to 40 percent increase in the competitive employment (Bond, 2004). The principal evidenced-based components of the IPS model include services which are focused on gaining competitive employment, eligibility based on consumer choice, rapid job search and integration of mental health and vocational teams (Bond, 2004)

Bond, Drake & Becker (2012) has reported good generalizability internationally for the IPS with lower dropout rates compared to other VR interventions. It also had the added advantage of quicker RTW, longer retention of employment and hours worked. These findings support an earlier multicenter RCT results where IPS resulted in greater success of attaining CE. In this trial, participants were more likely to work 40hrs or more per month and obtained higher earnings.

The authors propose that as one of only six evidence-based practices in psychiatry, Supported Employment be adopted for use in Malaysia by the disability-management services to increase rates of successful participation in competitive employment for PSMI.

We also propose that SE should be implemented as part of a recovery-orientated paradigm which addresses financial, housing, education, social support i.e. a combination of different strategies reflecting the dysfunction, disability and disadvantage. SMI like schizophrenia is characterized by marked heterogeneity in terms of manifestation and outcomes and requires multi-modal management and service levels.

With IPS as the fundamental treatment model and competitive employment as an outcome, Mental health services, the Social Welfare Department services and Social Security Organization disability-management services should be integrated and be provided in parallel as per Perkins & Rinaldi (2010) recommendations. SE programs with higher levels of service integration were more effective compared to those with lower alliance. In fact, PWPD who receive SE from highly integrated clinical and vocational services were two and a half times more likely to be in CE as compared to their counterparts receiving SE from fragmented service providers (Cook, Lehman, Drake, McFarlane, Gold, Leff, S., . . . Grey, ,2005). PWPD receiving SE from highly integrated clinical and vocational services were also almost twice as likely to work 40 or more hours per month.

In the following section, we will present recommendations to overcome barriers to employment of persons with SMI according to disability service levels.

## **MICRO LEVEL INTERVENTION**

### **GENERAL**

A holistic approach to unemployment in PSMI is to first recognize that unemployment is but one of the disabilities experienced by such persons. The mental health practitioner is to be aware that beside impairment, dysfunction, disability and disadvantage contribute immensely to the burden of disease or psychiatric morbidity as well as unemployment. Any psychiatric intervention that lacks adequate attention to dysfunction, disability and disadvantage is poor management resulting in frustration for all parties concerned. Using principles of psychiatric rehabilitation, the mental health practitioner views the individual person in the context of his or her specific environment and helps identify barriers unique to them. He assists people with SMI identify personal, social and vocational goals and then facilitates obtaining necessary skills and supports they need to reach their goals. The end goal of an effective psychiatric intervention strategy would be to increase the functioning, abilities, and advantages of people with SMI.

### **SPECIFIC**

In line with proven evidenced-based psychiatric rehabilitation principals, interventions are to be collaborative, person directed, and individualized. The mental health practitioner or team works together with the person with SMI to determine and develop readiness to pursue employment and other goals that are deemed important. Using motivational enhancement techniques, the goal would be to develop knowledge of competitive employment as a compatible, desirable, positive and tangible outcome, and develop interest and readiness to seek or sustain employment.

The mental health worker should assess and address issues of internalized stigma in the person with SMI using standardized self-administered questionnaires to routinely assess beliefs, attitudes and behavioral intentions in PSMI as stereotype awareness, stereotype confirmation and stereotype agreement are barriers to employment in PWPD.

### **Disclosure**

Stuart has argued that the decision for disclosure of mental health conditions by PWPD must be made only after the following safeguards are in place; protection against discrimination as result of such disclosure and provision of accommodations at the work place (Stuart, 2006). She also pointed out that disclosure results in reduced stress associated with ongoing concealment.

### Access to desired employment

Most jobs available to PWPD are entry-level jobs (Wan Kassim et al., 2014). As a result, PWPD don't have much choice in job selection according to their interest and aptitude although evidence demonstrates best outcomes when PWPD get employment of choice (Bond, 2004). There is also a dire need for current employment endeavours to move beyond job placement to job development which incorporates ongoing support services, work site assessment, job coaches for on-site skill training, support job security and tenure by ongoing follow-up, assessment and support of skills and resources both intrinsic and extrinsic to the person as well as to extend education and support to front-line managers and co-workers.

Leff, et al. (2005) in a meta-analysis of 7 RCTs from 7 different sites analysed the effects of job development and job support on competitive employment in persons with SMI. They found that job development initiatives increased the chances of attaining CE with participants receiving it being five times more likely to be competitively employed. More importantly perhaps is the finding that job development is an exceptionally effective service particularly for PWPD who have poor vocational history. The provision of ongoing job support also predicted PWPD staying longer in their first CE.

Fiscal incentives to work for PWPD who are already in the register of PWPD and concurrently working and earning less than RM \$ 1,200.00 are also provided and may serve to enhance motivation to work. Such persons are entitled to receive a disability allowance of RM \$350 per month.

## MESO LEVEL INTERVENTION

### GENERAL

Disability management services for PWPD in Malaysia is mainly provided for by mental health services, Social Welfare Department and, for those who are eligible, the Social Security Organization or SOCSO. These are three very different systems operated by different organizations with disparate goals driven by disparate philosophies. Weaknesses in coordination and communication are bound to exist between these agencies as is the scenario universally (Harvey, Modini, Christensen & Glozier, 2013).

King, Waghorn, Lloyd, McLeod, McMahan, & Leong (2006) have advocated certain measures to circumnavigate these pitfalls, among them by developing and strengthening inter-sectorial links between these different agencies. In fact, experts in the field of IPS have been skeptical that high fidelity to the model's premise would be possible without such interagency integration. One such measure that has been tried is to strengthen inter-



agency collaboration is the incorporation of expertise from outside the mental health system.

Having an employment specialist from either the social welfare services or social security on board the mental health care team could facilitate inter agency collaboration towards formulating, attaining and sustaining vocational goals that are desired by the PWPDP. The caveat here is that the ES must be highly integrated into the PWPDP treatment team to ensure effective and timely communications between mental health, social welfare and social security services (Rinaldi, Perkins, Glynn, Montibeller, Clenaghan, & Rutherford, 2008). This ideal is however difficult to achieve in practice given the disconnect between these services and their limited resources. Integrating an ES outside the MHS into it has shown to require inordinate amount of time and training, resources already scarce in an overburdened system (Waghorn, Collister, Killackey & Sherring, 2007).

Having an ES from mental health services would be one way to circumvent these challenges. A mental health service provider providing employment assistance in line with IPS must be able to communicate effectively with potential employers as well as members of the disability services team members. He must also be able to engage with PWSD to initiate and negotiate the employment choosing, seeking and securing process, at the same time assisting with negotiations with employers for accommodations as necessary and desired (Contreras et al., 2012). Once a job is secured, the employment specialist must then endeavour to assist and support both the employee and employer to optimise work performance and tenure.

In order to increase the number of SMI cases back to employment, the RTW Department realized that Case Management alone was no sufficient and there was push factor that was required to support SMI cases back to work. The push factor that is being referred to is the clinical support which can be offered to employers as an assurance that should a case with SMI has an attack or if the employers are doubtful on the employability of such cases, then clinical support may be rendered. With this in mind, a discussion was conducted with a tertiary psychiatric center on possible avenues on how the Health Ministry and SOCSO can work together on providing the clinical support while SOCSO focused on the labor market intervention that was either negotiating with employers to re-employ them or getting them new jobs altogether. The pilot project together with 6 hospitals commenced on 1st of April and is expected to be carried out for a duration of six months. While promising, even if an IPS-like program is implemented in Malaysia, the disability management systems and the ES must be aware of and take the following into account:

Job development and support throughout the 3 phases of choosing, getting and keeping a job; the episodic nature of relapses and the need to facilitate intra-episode work absence and thereafter re-entry into the job market; increase social support network including links with peer providers; identify and bridge the gaps in current service provision e.g. PSMI who are not eligible for SOCSO's RTW plan.

## **MESO LEVEL INTERVENTION**

### **SPECIFIC**

#### *Mental health system*

Malaysia is not very different from other developing nations in the Asia pacific in terms of disproportionate apportionment of resources towards mental health. Even though mental and behavioral disorders are estimated to account for 13% of the global burden of disease, the allocation towards mental health budget in the last decade was only 3% of the total allocation for health in Malaysia (World Psychiatric Association, 2005). To worsen matters is how that already insufficient allocation is spent. According to WHO, 80% of the mental health budget in developing countries is spent on mental hospitals that serve only 7% of patients (World Health Organization, 2011). This reflects an unequal amount of already scarce funding directed primarily towards treatment and operational overheads of mental institutions and hospitals as compared to funding for psychiatric rehabilitation efforts which include supported employment. What is required is a shift to a recovery-oriented paradigm in which funds are streamed to both remission of impairment and evidenced-based psycho-social interventions (Chisholm, Saxena, & Van Ommeren, 2006).

A reflection of psychiatry's deficit or impairment orientation is perhaps the outcome measures used to tract treatment success. The goal of psychiatric management has traditionally been on the amelioration or remission of impairment specific to the type of mental illness using psychotropics and/or psychotherapy. A good example can be found in the treatment of schizophrenia, an archetypical SMI. Strict criteria of symptomatic remission in schizophrenia has been proposed to be defined on the scores of a clinical-rated instrument of psychopathology, the PANSS. A score of 3 or less on the PANSS for the following items; P1, P2, P3, N1, N4, N6, G5 and G9 for at least six months was required before a person diagnosed with schizophrenia could be deemed to have attained remission (Andreasen et al., 2005). A more liberal criterion of recovery from schizophrenia has been previously proposed by Liberman & Kopelowicz (2002) who suggested that clinical criteria for recovery in schizophrenia is met when: remission or non-intrusive positive or negative symptoms is sustained over two years during which

time the PSMI is independent and has normative levels of social and occupational functioning.

A number of challenges arise in considering these clinical criteria for remission and recovery. First, the Andreasen et al., (2005) remission criteria was developed to evaluate efficacy and effectiveness of pharmacotherapy and used for research purposes. While enjoying considerable use in research, the PANSS is not routinely in used in clinical practice in Malaysia

Secondly, symptomatic remission is erroneously equated with functional restoration in persons with schizophrenia. Research has demonstrated that even if these symptoms were reduced by almost half, it would only result in an increase in employment rate by 8% (Slade & Salkever, 2001). Evidence that impairment is not correlated with social or occupational functioning is well supported in the landmark Vermont longitudinal study. Harding and her colleagues described PSMI with persisting impairments who were otherwise functioning adequately in their environment (Harding et al., 1987).

A reflection of psychiatry's deficit or impairment orientation in Malaysia is the use of percentage of patients readmitted to psychiatric ward within 3 months of their last discharge as a quality improvement activity using a national indicator approach. (Appendix 5)

We suggest instead the use of other parameters to objectively measure progress towards recovery i.e. the use of questionnaires such as the Recovery Assessment Scale or RAS (Giffort, Schmook, Woody, Vollendorf, and Gervain, 1995) ability to live independently or attaining competitive employment as outcomes. Adding reliable instruments will improve availability of data which in turn can be used for purposes of advocacy for recovery-oriented program planning and policy formations (Ngui, E. M., Khasakhala, L., Ndetej, D., & Roberts, L. W., 2010)

There is an urgent and pressing need to reform mental health services in line with the Ministry of Health's National Mental Health Policy (2011), specifically in reference to Section 6.13.5f (pg. 83) which mentions the need to incorporate psychiatric rehabilitation in every formulation of an individual care plan. As such, this formulation must include the identification of unique goals and barriers to persons with SMI and using evidenced-based psycho-social interventions to support them. The system's current emphasis on impairment must first be 'rehabilitated' and expand to include other evidenced-based psycho-social interventions. There is an urgent and pressing need to reform mental health

services in line with evidence-based interventions which unequivocally supports the universal shift to a recovery-oriented model. Mental health care providers of and at all levels to be educated about recovery-oriented practices and provided the education and skills concerning psychiatric rehabilitation. This call for a much needed paradigm shift originates from within reputed professional bodies tasked with the education and development of psychiatrists on both sides of the Atlantic (American Psychiatric Association and American Association of Community Psychiatrists, 2011) ( Royal College of Psychiatrists, 2007) and has already began to be disseminated in medical colleges and universities elsewhere (Feeney, Jordan & McCarron, (2013).

Malaysian psychiatrists must initiate this change and take a leading role in ensuring implementation. They could perhaps learn from their southern counterparts in Oceania who, together with policy makers, have developed a national framework for recovery-oriented services (Australian Health Ministers' Advisory Council, 2013).

What is required is a change in the current psychiatric management of sequentially-administered delivery of services along the lines of cure, care and rehabilitate which is premised on the faulty impairment model. Formulation of an individual care plan at the very onset of engagement with people with SMI will take in account not only remission of symptoms as an outcome but also increasing the functioning, abilities, and reducing disadvantages of such persons (Lieberman, Drake, Sederer, Belger, Keefe, Perkins & Stroup, 2008) and use readily available objective and subjective instruments to measure and tract recovery.

Sustained competitive employment is a positive indicator of a PWPD progress towards recovery. As such there is a dire need to change the beliefs, attitudes and behaviour of the Malaysian mental health care workers regarding the feasibility and importance of work (Marwaha et al., 2007). Clinical practice must always depend on the evidence-base which in the case of employment in persons with SMI is unequivocal. Contrary to clinicians' unfounded concerns about the pursuit and sustenance of CE work being untenably stressful for persons with SMI, Burns et al. (2009) in a RCT found that SE programs were not associated with increase of psychotic symptoms in persons with schizophrenia. On the contrary, another later multi-center international RCT found that being in competitive employment reduced psychopathology in persons with schizophrenia (Killian et al., 2012)

There is also a need for clarity on employment related programs in Malaysia. The current practice of referring PWPD for job placements without fidelity to the IPS model should not occur as there is good evidence from research that it is not effective and the attrition rate for job sustainability is high. Supported Employment for PWPD has as its premise not only vocational preparation and placement in competitive employment but also assistance in maintaining employment. Experts have noted that support in the maintaining employment is at least as critical in helping PWPD get jobs. (Becker, Drake, Bond, Xie, Dain & Harrison, 1998)

Development of allied mental health professionals (i.e. OT's, Psychologists, Psychiatric nurses/technicians)

There is a universal shortage of mental health-care workforce development globally (Ngui et al., 2010). Availability of mental health resources of a country are often measured as a ratio of psychiatrist per population. Equally important however are allied mental health professionals who are often on the frontlines of psychiatric disability management.

Occupational therapy, psychologists and psychiatric nurses are not peripheral services that exist to complement psychiatric services but form the core team of service delivery. Their contributions in psychiatric rehabilitation are invaluable: persons from allied mental health services pioneered the field, advanced psychosocial rehabilitation concepts, and developed, practice and research in the field. They are professionals who are integral to the mental health care team in addressing dysfunction and disability and indispensable in teaching skills and assisting with disability management.

Disability management services by allied mental health professionals are more cost effective, increases access, increases recovery-oriented practice by a multidisciplinary team. In what is known as task shifting, allied mental health professionals can be trained in the art and science of evidence-based psychosocial rehabilitation and thereafter be tasked to run SE and other recovery-oriented practices (Morris, McBain & Saxena, 2012). Allied mental health professionals can serve as employment specialist and transcend inter-sectorial barriers

They can be sent for training locally to be Job Coaches but with the required expertise in psychiatric disability management. There is a pressing need to lobby for more qualified occupational therapists in mental health services and, more importantly given to current limitation to human resources, to use current occupational therapists employed in psychiatric departments wisely by increasing effectiveness and relevance of referrals.

## MESO LEVEL INTERVENTION

### *Social security organization*

Malaysian's SOCSO's Return to Work Department has successfully placed some PWPDP within different employers when employers were given the assurance that the condition was controlled with medication and that the cases which SOCSO often placed were compliant with medication. Moreover, employers appreciated the Case Management support provided by SOCSO.

The authors suggest that the social security benefits system must additionally support transition to open employment and this includes allowing for relapses and therefore transitions in and out of work without withholding or withdrawal of disability benefits and financial aid (Perkins & Rinaldi 2002; Perkins & Rinaldi 2010)

Also, instead of encouraging PWPDP to apply for invalidity pension in the first place, SOCSO could create a change in their work process which allows for PWPDP to be supported by the RTW program before they reach the stage of vocational disability.

## MESO LEVEL INTERVENTION

### *Social Welfare organization*

At present, the department of social welfare spearheads a Job Coach Service program whereby qualified job coaches from Non-governmental organizations (NGO's) and Community Based Rehabilitation Centers support persons with disability to adapt and develop work-based competencies. While the service program is well developed for persons with non-psychiatric disabilities and has promising results, to the authors' best knowledge, there are no job coaches specialized in training PWPDP. The core Job Coach Trainers must then first be educated about the unique nature of psychiatric disabilities and receive training in psychiatric disability management.

Another program organized and run successfully by the social welfare department is the Disability Equality Training (DET) program. DET is aimed at improving the understanding and perception of the public towards PWD from the aspect of the social disability model. PWD who are trained speakers help the public to understand the source and mechanism of disability in terms of social isolation, social exclusivity and the experience of discrimination. Again, to the authors' best knowledge there are no Disability Equality

Training (DET) program on psychiatric disability. Gaps in this area is particularly important to address given the potential of education and contact-based education to alter the negative beliefs and attitudes of the public towards PSMI (Mino, Yasuda, Tsuda,& Shimodera, 2001)

A third recommendation is concerning the provision of vocational training for PWPD. Currently, the Industrial training and Rehabilitation center in Bangi, Selangor (PLPP) provides rehabilitation and vocational training services to people with disabilities (PWD) other than psychiatric disabilities. The authors recommend that such training be extended to all PWD irrespective of disability. We also suggest such centers to serve as vocational skills development and training centers for all PWPD who have as a result of early onset of illness been deprived of such skills necessary to improve their opportunities to secure and sustain competitive employment.

## MESO LEVEL INTERVENTION

### Organizational/Employer Level

The PWPD success in attaining and sustaining employment is largely dependent on the receptiveness and supportiveness of an organizations work environment from human resource personnel to their future manager and colleagues. Employer beliefs and attitudes towards PSMI are one of the central determining factors towards employment as a successful goal (Stuart, 2007) As such, educating employers and organizations about mental illness addresses deeply entrenched faulty beliefs, negative attitudes as well as reduces discriminatory behavior crucial in the campaign to increase employment in PWPD. After all, in a recent study utilizing a qualitative exploratory study design, 85% of employers agreed that their organization should hire and accommodate PSMI (Shankar et al. 2014) indicating perhaps a behavioral intention of willingness to hire.

### Education

Employees are universally hired based on their abilities, skills, aptitude and attitude. However when it comes to the hiring of PWPD, their disabilities tend to be in the foreground when being considered for employment instead of these positive attributes. Employers are to be encouraged to hire PWPD based on their abilities and skills (Brooke, Green, , O'Brien, , White, and Armstrong, 2000) as they would any other person with or without disability. Employers needs to come to terms with erroneous beliefs and attitudes

they may perceive from societal stigma. This includes presuppositions that work is incompatible with PSMI or that hiring PWPD is inconsistent with the profit-orientation of the company (Krupa, Kirsh, Cockburn, & Gewurtz, 2009)

#### Address concerns and support needs of employers

The employment specialist (ES) must also acknowledge the concerns employers have about recognizing early warning signs of an impending relapse and contingency plans to address the same. The ES can also help employers to develop and maintain organizational practices and environment that promotes and supports good mental health practices. Perhaps a manager of human resource or the PWPD's immediate superior can be identified as the local resource person the PWPD can go to for support and assistance. Establishing and maintaining bilateral lines of communications between employer and job specialist is imperative so that any emergent issues can be expediently identified and effectively tackled.

#### Advocate for reasonable accommodations

The Persons with Disabilities Act 2008 Sec.28 specifies that the employer of persons with disabilities will endeavor to provide '...access to employment on equal basis...' and '...just and favorable...' conditions of work. While not specifically mentioning accommodations, the act is implicit that the employer should provide reasonable accommodations similar with the Americans with Disability Act 2000 (United States Department of Justice, 1990). Reasonable accommodation in the ADA is defined as '...as any change or adjustment to a job, the work environment, or the way things usually are done that would allow a person with disabilities to apply for and sustain a job...' While accommodations in the physically disabled may be in the form of building an access ramp and disabled-friendly toilets, accommodations for PWPD are practically free of costs. They include flexible-work timing, time-off for doctor's appointments, less distracting environments, job coaches etc.

#### Training

Training an identified member of the organization who heads the workplace mental health program, usually someone from human resource or front-line manager will help to address lack of knowledge and skills in managing employees with SMI. Disability Equality Training (DET) is an example of a training program jointly conducted by the Social Welfare Department and the Japan International Cooperation Agency (JICA) in an effort to help employers understand the source and mechanism of disability as according to the social disability model. Among the local private organizations that have successfully undergone



this training is Skytrax's World's Best Low Cost Airline eight times in a row, Air Asia ("AirAsia triumphs at World Airline Awards," 2016) as well as the National Railways.

#### Hiring PWPDP as a good business practice

Governments can incentivize hiring of people with disabilities by providing an economic impetus in the form of state and federal assistance, tax credits. In Malaysia, employers are entitled to claim double income tax deduction and other deductions (Income Tax Act 53, 1967)

#### Increase employers' positive experience with employees PWPDP

Research has demonstrated that employers with positive experience of employees with PD as characterized by their consistent attendance, positive attitudes, longer job tenure, and co-worker integration and partnership were more likely to hire PWPDP. (Morgan and Alexander, 2005)

The more PWPDP are encouraged to join the workforce, the better the SE services provided to them, the greater the chances of positive employment outcomes mentioned above are going to take place. It is also vital to identify and maintain a database of PWPDP friendly employers and organizations (Gilbride, Stensrud, Vandergoot, & Golden ,2003).as such employers' especially large corporations with many franchisees or branches may prove to be a veritable source of employment opportunities. With such a database, the likelihood of future employment of PWPDP may also be increased by the testimony and recommendations of employers to their fellow industry networks.

#### Incentivize - Funds for disability training programs

In Malaysia, a company is allowed a double deduction for expenditure related to training an individual with disability who is not a pre-existing employee with the aim of increasing the individual's employment prospects with that company (Rule 6 of the Income Tax (Deduction for Approved Training) Rules 1992 [P.U. (A) 61/1992). The caveat here is that such training programs need to be ones approved by from the Ministry of Finance and at present, there is no approved for the training programs or training institutions for psychiatric disability. In order to support persons with disabilities, employers are encouraged to either hire a job coach or train their middle management to become a job

coach with PWD using the Job Coach Service Subsidy allowance. Financial assistance to employers employing PWD under a contract of service is disbursed by the Human Resource Development Fund (HRDF) under the SBL Scheme of the Ministry of Human resources (The Employer Circular No 3/2010 HRDF)

A good healthy working environment is vital so as to be able to provide a natural support for persons with disability. The employment specialist or job coach must strive to educate the employers about the need for a work environment that is in general conducive to good mental health for all the employees and in particular, supportive for the PWP World Health Organization. (2000). Such an environment will increase work productivity, employee engagement and is simply good practice for the organization.

## **MACRO LEVEL INTERVENTION**

### **GENERAL**

The government of the day via just and equitable policies, parliamentary acts and enforcement of regulations must support initiatives to attain and sustain competitive employment of PWP. Political will is needed to initiate top down planning and execution of services as two separate ministries and a corporatized social security service is involved. One of the necessary measures would be to set up a national multi-disciplinary advisory committee involving all stakeholders involved in the employment of PWP (Contreras, 2012) Having such a platform would facilitate better collaboration and integration between mental health services and other mental health disability-employment system experts. This is integral to the development of sound policies and enactments which addresses weaknesses in the current system.

In Malaysia, the National Council for persons with Disabilities was established as provided for under Section 3, the Persons with Disabilities Act 2008 (See Webpage link) The National Council for persons with Disabilities (NCPWD) is tasked with overseeing implementation of national policy in relation to PWD and make recommendations thereof. The council members consist of, among others, representatives from the government agencies concerned with the welfare of PWD i.e. the social welfare department and the ministry of health. The council in turn has established six committees to assist with its role and functions. The committee on Quality Life Care, Education and Works is chaired by

the secretary generals of the ministries of health, education and human resource respectively.

It is suggested that members of these three committees organize and coordinate efforts to increase the quality of life of PWPd by adopting a recovery-oriented approach to the management of such persons which would include Supported Education and skills training efforts as well as supported employment for PWPd. These efforts should include objective indicators and a reasonable timeframe for measuring and monitoring adherence and compliance to these yet-to-be determined and disseminated standards of care. Quality improvement initiatives should include affirmative action policies to improve education and skills training as well as securing and maintaining competitive employment by using a National Indicator Approach (NIA) to define clear targets and track progress towards achieving the same. The committee can review, revise and regulate policies or enactments regarding PWPd using the Persons with Disabilities Act 2008, International Labor Organization ratification, the Mental Health Act 2001 and the Mental Health Regulations 2010 and the National Mental Health Policy.

#### Advocating for rights of consumers

Equal employment opportunities to PWD are provided for in section IV – Para 29 Persons with disabilities act 2008 (ACT 685). As Malaysia is a signatory and ratifies the United Nation Convention on the Rights of Persons with Disabilities, the Government has pledged that 1 % of Public sector jobs be reserved for persons with disability.

Malaysia is a signatory of and ratifies the United Nation Convention on The Rights of Persons with Disabilities. In line with this, the Government has pledged that 1 % of Public sector jobs be reserved for persons with disability (Implementation of Service Circular 3/2008). It is also recommended that 1% Private sector jobs be reserved for persons with disability.

Ta & Leng (2013) have suggested that the existing Malaysia's People with Disability Act should be revised or that Malaysia have an anti-discrimination act similar to that of the Americans with Disability Act 1990 (ADA) or that of the United Kingdom's Disability Discrimination Act 1995 (DDA). This are arguably regulatory measures to ensure parity in employment of PWPd in Malaysia as per accorded in section IV – Para 29 Persons with disabilities act 2008 (ACT 685).

Interventions that target unemployment in PWPB without consideration of antecedent and perpetuating socio-economic factors are inefficacious interventions based on a flawed disease model. A recovery-oriented systemic approach to the problem on the other hand considers the social disability model and complements the consumer-centric individual placement and support principals. Measures recommended include the regulation to ensure provision of accessible education and vocational training programs in line with Section IV Para 28 of the Malaysian Law Act 685 Persons with Disability Act 2008. (ACT 685IV – Para 28 Persons with disabilities act 2008) and concordant with international recommendations (Amnesty International, 2016).

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