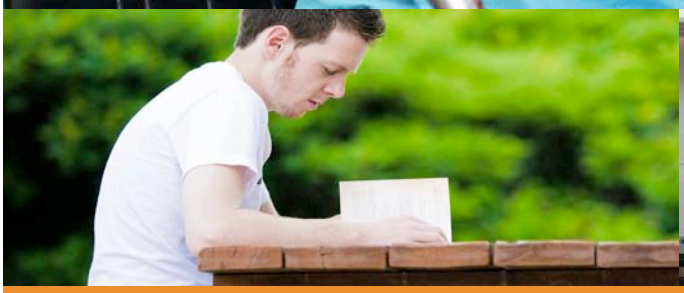

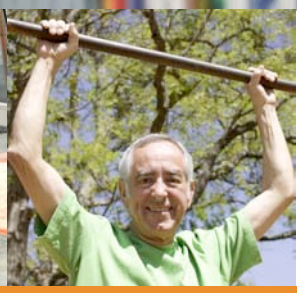

COLLABORATIVE RESEARCH GRANT INITIATIVE: MENTAL WELLNESS IN SENIORS AND PERSONS WITH DISABILITIES

Employment Backgrounder – Seniors and Persons with Disabilities

Lili Liu, PhD. – University of Alberta

Alberta Health Services
Alberta Mental Health Board

Alberta Mental Health
Research Partnership Program

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Background

This background paper examines the employment domain of the Alberta Health Services – Alberta Mental Health Board (AHS-AMHB) Collaborative Research Grant Initiative. The target populations are "seniors and persons with disabilities who have mental health issues and have difficulty gaining or maintaining employment". In this paper, "employment" is defined as paid work. Regardless of health condition, people in Western societies derive meaning from gainful employment (Liu, Hollis, Warren & Williamson, 2007). Work has therapeutic value among people with mental illness and can improve quality of life (Borga & Kristiansen, 2008; Twamley, Narvaez, Becker, Bartels & Jeste, 2008). However, employment is one way for individuals to "be productive". Other productive roles that are not associated with payment include volunteer work, caregiver roles, and student roles. Some individuals may not be paid, nevertheless, their work is valuable and can serve as training opportunities. For example, in 2000 the value of volunteer work was 1.4% of Canada's GDP or $14.0 billion (Statistics Canada, 2008). Although the scope of this paper is focused on paid employment, this should be considered within the larger context of productivity and the meaning of employment.

This literature scan examines employment issues and mental health in two populations: seniors and persons with disabilities who have mental health issues. Employment issues refer to gaining or maintaining employment. The following questions, based on the Potential Areas of Exploration described by the AHS – AMHB, provided guidance in the literature scan and are reviewed at the end of this paper.

1) What kinds of supports for employers and employees can be provided to assist in gaining and maintaining meaningful employment for seniors, and people with cognitive and/or physical disabilities who have mental health issues? Have legislated employment solutions in other jurisdictions been proven to work?
2) How can mental illness pose challenges to gaining and/or maintaining employment by seniors and persons with disabilities? (e.g. stigma, self disclosure).
3) Which indicators are appropriate for evaluating "satisfying" or "meaningful" employment for seniors and people with disabilities who have mental health issues?

SEARCH STRATEGY

Abstracts of literature published since 1998 were scanned for relevance to the Potential Areas of Exploration listed above, and if applicable to this backgrounder, the full papers were reviewed for content. The following keywords and databases were used to conduct this literature scan.

- Key words: "aging workforce", "mental health", "mental illness", "disability", "supported employment", "return to work".

- Databases: Scopus, Scirus, Ageline, Psychinfo, Web of Science, Cochrane and Proquest dissertation.

Employment and Seniors

DEMOGRAPHICS

Census data show that the number of persons aged 65 years and older has risen progressively and between 1956 and 2006, this number rose from 1,244,000 to 4,335,000. In terms of proportions of persons aged 65 years and older, the rates were stable from 1956 to 1966, at approximately 7.7%. The rates have been growing constantly since, from 8.1% in 1971 to 13.7% in 2006, and will be close to 19% by 2021. Baby Boomers, those born from 1947 to 1966, begin to turn 65 in 2012. It is projected that by 2016, the number of Canadians aged 65 years could reach 5,799,000 and exceed the number of children aged less than 15 years (Bélanger, Martel, & Malenfant, 2005). With global aging, Canada is one of the youngest countries in the world, and Alberta is one of the youngest provinces in the country. How the rest of the world deals with aging populations can be informative.

What is "old"?

How much is the perception of this impact related to the wide use of 65 years as a marker for "old" and 85 years for "oldest old"? Denton and Spencer (1999, 2000) have presented different scenarios of population aging and used markers based on life expectancy and mortality. Denton and Spencer (1999) use computations in life tables over four decades to demonstrate that if 65 was accepted as old in 1951 for males, the definition should be revised to be about 68.5 in 1991. If 65 is viewed as a *male-oriented* definition of old in 1951, the corresponding definition for females should be 67.5 in 1951, and 73 or 73.5 in 1991. Given the longer life span of both men and women over the last four decades, and the aging of populations globally, there will likely be an increasing number of older adults staying healthy and working beyond the age of 65 years. Chronological age does not adequately capture wide variation of functional abilities of older adults, many of whom are healthy into old age. However, instead of increasing the 65 year marker, which is the typical age for retirement, Canada has seen a *decrease* in this marker. For example, in 1965, the age at which one could receive Old Age Security decreased from 70 to 65, and in 1987, the youngest age for receipt of Canada Pension Plan benefits was lowered from 65 to 60 (Denton & Spencer, 2000). Rather than increasing, the modal age for retirement has been decreasing in developed countries (Denton & Spencer, 2000).

Older workers in Canada

The number of people aged 55 to 64 is at its highest, nearly 3.7 million in 2006 and consist of 16.9% of the working-age population, or about one worker in six, compared with 14.1% in 2001 (Statistics Canada, 2007). This proportion is projected to be over 20% of the working-age population by 2016, when one in five workers will be in the 55 to 64 age group. As workers generally leave the workforce between the ages of 55 and 64, the number of Canadians close to retirement is higher than ever. In 2006, the ratio of the number of people entering the labour market (15 to 24 years), to the number of people retiring (55 to 64 years) was 1.1. This ratio has declined from 2.3 in 1976. It is projected that in 10 years, the number of Canadians at the age when they can leave the work force will exceed the number who can begin working (Statistics Canada, 2007). These changes may present challenges for employers, such as high employee turnover, knowledge transfer, employee retention, health of older workers and continuous training (Statistics Canada, 2007).

Using the 2002 General Social Survey, Morisette, Schellenert and Silver (2004) analyzed data of 1681 respondents who recently retired. One third retired for health reasons and would not have continued working, another 1/3 were healthy when they retired and also would not have continued working. The final 1/3 were healthy when they retired but "would have continued working under different conditions". Although 60% of the retirees "indicated a willingness to continue working if certain incentives had existed" (p.16), this was an overestimate of the potential supply because capacity was limited by health conditions in some respondents, according to the authors. Therefore, the authors focused on the last 1/3 group of respondents as a proposed way of increasing labour in the workforce through incentives to continue working with no pension effects, e.g. shorter days, more vacation, part-time work and suitable caregiving. For those who did retire for "health reasons", perhaps the same incentives could be viewed as work place accommodations, thereby allowing some older adults to work despite health conditions.

Pre-retirement issues in older workers

The literature identifies issues that older workers may experience. Retirement-related job lock, or the "inability to leave a job due to financial or benefits needs" (p. 1976), was found to be common among older workers with occupational injuries (Benjamin, Pransky, & Savageau, 2008). These workers may wish to retire but are unable to for financial reasons, may be at risk for further injuries and declined work performance. Presenteeism, or declined productivity and work quality of employees who come to work ill, also occurs when employees cannot afford to take time off work (Koopman et al., 2002).

Karasek's (1979) "job demand-job control" model is commonly used to examine the interaction between job demand and employees' sense of control in jobs. Elovainio et al. (2005) used Karasek's model and the Job Content Questionnaire to study whether thoughts of early retirement were related to job demands and job control among a group of 274 male and 2798 female Finnish health care employees aged 20 to 65 years. The researchers found that job demands and job control were independent predictors of early retirement, even when adjusted for age, gender, educational level and self-rated health. This association was stronger among people over 45 years old, i.e., poor job control and high job demands increased likelihood of thoughts about early retirement. This suggests that one way to reduce the number of people retiring early would be to address job control or related psychosocial factors, such as stress, that affect older workers. Equally important would be for employers or organizations to address job demands, i.e., reduce or adjust workload, in order to improve quality of work life and prevent unnecessary early retirement. The researchers expressed little optimism in this latter recommendation given the strong main effect of job demands in their analyses.

The importance of mental well-being among older workers is emphasized in the results of other research. For example, one study in Helsinki examined the association of mental health functioning, as measured on the SF-36, and intentions to retire early among 7,765 municipal workers aged 40 to 60 years (Harkonmäki, Lahelma, Martikainen, Rahkonen & Ventoinen, 2006). At the time of the study, the mean retirement age of the municipal sector was 57.5 years. According to the researchers, although the prevalence of mental illness had not increased over the past two decades, during the year of the study, mental disorders accounted for 42% of all disability pensions, an increase from 31% 10 years before. Harkonmäki et al. (2006) reported that employees with the poorest mental health functioning, as measured on the SF-36, were over six times more likely to report strong intentions to retire early than those with best mental health functioning, even when adjusted for physical health, socioeconomic status and spouse's employment status. They conclude that employer "strategies aimed at keeping people at work

longer should emphasize the importance of mental well-being and the prevention of poor mental health" (Harkonmarki et al., 2006, p. 190).

Barriers to employment in older adults with disabilities

Kooij, de Lange, Jansen and Dikkers (2008) applied a conceptual description of five meanings of age in order to promote an understanding of what motivates older workers to continue work or what factors are related to leaving work. These five meanings are: (a) chronological age (e.g. an older worker could be someone who is aged 40 years to over 75 years); (b) functional age, or performance-based (e.g. age-related changes in physical health can affect one's performance), (c) psychosocial, or subjective age (e.g. self and social perceptions of age and aging, stereotypes, stigma affect psychosocial experience of aging), (d) organizational age (e.g. aging in a job or organization, seniority, organizational tenure, institutional memory), and (e) lifespan concept of age (e.g. one's life stage, family status). These age-related factors inform theories about motivation to work among older adults. They can also help us understand the influences of one's social environment. For older workers who have disabilities, the first three meanings of aging pose additional challenges as performance limitations and stigma are disability-related as well as age-related.

Kampfea, Wadsworth, Mamboleoa and Schonbrun (2008) provide evidence to suggest that many older adults have the need and desire to work, but may require accommodations to disabilities. Their literature review suggests older adults sustain fewer disabling on-the-job injuries than younger adults, may display work performance superior to younger workers, display optimism, resilience, autonomy, adaptability, prior work experience, and provide institutional memory that is helpful to the employer (Kampfea et al., 2008). Even if certain older adults with disabilities desire and are capable of working, they can experience barriers in obtaining or maintaining employment. These barriers are biases against age and disability, i.e., (a) historical and legal definitions of retirement age, (b) stereotyping or ageism, (c) negative attitudes associated with disability, and (d) assumption that older adults have adequate funds for a comfortable lifestyle and do not need to work (Kampfea et al., 2008).

While the average age of retirement has declined, the variability of retirement age has been increasing; in addition, approximately one third of older people become reemployed after they retire (Marshall, 2001). The rise in number of older workers may be partially attributed to a shift, at least in the US, from a manufacturing economy to a service industry which more easily accommodates capacities of older adults with disabilities. Research is needed to shed light on factors to consider when matching work demands with older employee capacity. Occupational health studies have been typically conducted using younger subjects. Literature shows that challenging, nonalienated work among older adults is associated with less emotional and physical distress, whereas work stressors were correlated with "less hopeful outlook and poorer quality of life" (cited in Marshall, 2001, p. 433). There is very little research that examines the role of work conditions, such as technological innovations, on the health of older workers (Marshall, 2001).

Some older workers enter the workforce with a disability or acquire a disability during their work years. Workers aging with a disability face different degrees of challenge depending on the types of disabilities. One study examined whether employees aging with a disability experienced new work problems related to functional declines, and whether their work problems were being accommodated (McNeal, Somerville & Wilson, 1999). Two groups of participants were interviewed; one group had postpolio (n=46) and the other group had spinal cord injury (n=50). Over 90% of the postpolio employees reported functional declines in recent years, and rated the

severity to be greater than when they began working. In contrast, only a few employees in the spinal cord injury group reported functional declines that were causing new work problems. Participants identified a total of 480 work problems. Employers refused to provide an accommodation for only 18 of these problems (McNeal et al., 1999). This study indicates that work place accommodation for an individual aging with a disability requires consideration of the course of the individual's condition, in addition to the aging process. Research is needed to examine the complex relationship between aging, disability, and work, and the extent to which work place accommodation affects the mental health of individuals aging with a disability.

Disability and Return to Work

Literature on return to work following a physical disability-related leave is associated with conditions such as back pain (Baldwin, Butler, Johnson & Côté, 2007; Schultz, Crook, Berkowitz, Milner & Meloche, 2005), musculoskeletal disorders (Schultz, Stowell, Feuerstein & Gatchel, 2007), head injury (Shames, Treger, Ring, & Giaquinto, 2007), chronic conditions such as systemic lupus erythematosus (Reisine, Fifield, Walsh & Reinn, 2003; Panopalis et al., 2007; Poole, Atanasoff, Pelsor, Sibbitt & Brooks, 2007) and fibromyalgia (Henriksson, Liedbert & Gerdle, 2005), and those who received treatments for conditions such as cancer (Nieuwenhuijsen, Bos-Ransdorp, Uitterhoeve, Sprangers & Verbeek, 2006) and HIV/AIDS (Bravemen, Kielhofner, Albrecht & Helfrich, 2006; Razzano, Hamilton & Perloff, 2006).

A large portion of the return-to-work literature addresses the client-professional interaction, as this is closely related to compensation and *predictors* of return-to-work. For example, researchers conducted a pilot study using interviews with patients who had low back pain to examine whether or not they agreed with their clinicians about their low back pain management, and if this affected outcome (Azoulay, Ehrmann-Feldman, Truchon & Rossignol, 2005). Almost all of the 35 clients (97.1%) agreed with their physiotherapists, while 28.6% disagreed with their physician. Those who disagreed with their physician were less satisfied with their management and catastrophized (a maladaptive behaviour on the Coping Strategies Questionnaire) more about their pain than those who agreed, but this was not associated with greater time off work, or greater self-perceived disability. Psychological distress, measured on the 12-item General Health Questionnaire (GHQ12), declined significantly in the entire sample compared to baseline. It would be interesting to further explore whether the GHQ12 (Goldberg et al., 1997) would be a valid tool to examine factors related to employee stress in the work place. In addition, little is understood about the detection and intervention of comorbid depression that occurs with disabilities in older adults. For example, 20% to 50% of musculoskeletal conditions are associated with depression, but detection depends on the scale used to screen for or assess depression (Suija, Kalda & Maaroos, 2009). Further, we understand little about how comorbid mental illnesses interact with factors in affected older adults who desire to return to work.

Workplace interventions and policies

One incentive for addressing early retirement is for employers to accommodate employees who care for elderly relatives. An aging population increases demand on adult children who are caregivers. To date, there is little research done on the psychological and emotional health of caregivers who are productive members of the workforce. Many employees who care for frail relatives are in the lower to mid “older adult” age range of 40 to over 75 years suggested by Kooij et al. (2008). Covinsky, Eng, Lui, Sands, and Seh (2001) conclude from their research that many caregivers, especially daughters and caregivers who live with the frail elders, reduce their work hours in order to cope with their caregiver roles. It is suggested that further research examine the burden of lost caregiver employment on those affected. Thus, evidence indicates that informal care and work can be incompatible roles that result in stress due to conflicting demands and expectations, and worry about meeting responsibilities adequately (Arksey, 2002). Employers may also face costs associated with lowered productivity, increased absenteeism and staff turnover.

As for older workers themselves, Silverstein (2008) advocates for “… a need for implementation and evaluative research of programs and policies with four dimensions: the work environment,

work arrangements and work-life balance, health promotion and disease prevention, and social support. Employers who establish age-friendly workplaces that promote and support the work ability of employees as they age may gain in safety, productivity, competitiveness, and sustainable business practices." (p. 269)

Research on workplace accommodations for persons with physical disabilities is reported in the literature. For example, Wang, Badley and Gignac (2004) analyzed a Canadian survey and tested a model that included activity limitations and perceived need for workplace accommodations. The researchers found that activity limitation on work participation was indeed mediated by participants' self-perceived need for workplace accommodations. They conclude that "the provision of adequate workplace accommodations could enhance labor-force participation in people with disabilities" (p. 1517). Accommodations addressed in the interviews were mostly physical in nature, e.g., handrails, accessible parking, elevators, accessible washrooms. One item referred to flexible work hours. It was not examined *why* the perceived needs were not articulated to employers. The issue of discrimination in the workplace, even if it is only perceived, needs exploration to guide the development of best practices that will address policy. Westmorland and Williams (2002) address workplace discrimination in their paper directed to employers and policy makers.

The literature recognizes the need for employers and organizations to address stigma in the workplace. In his editorial on the common nature of depression and anxiety, Grove (2006) advocates workplaces to "normalize mental distress" (p. 292). Rather than focusing on the pathology, health professionals would help overcome stigma and barriers to employment if they could "speak about it as something which is known, normal and manageable" (p. 292). One approach has been proposed by Hatchard (2008) who demonstrates that the Model of Occupational Competence can be used to help clients to guide their dialogue with employers, co-workers and health professionals. Hatchard's case example describes how a 48 year old investment services employee was able to overcome fears of stigma in her work place and how her health professional could help empower her.

Serious Mental Illnesses

Approximately 20% of Canadians experience a “mental illness” some time in their lives (Health Canada, 2002). According to the Alberta Mental Health Board (Alberta Mental Health Board, n.d.), at least one in three Canadians will experience a “mental health problem” in their lifetime. The most prevalent cases of mental illness in Canada are mood disorders (8% will have major depression in their lifetime, 1% bipolar disorder, 12% anxiety disorders), schizophrenia (1% of population), personality disorders (6-9%) and eating disorders (3% of women, less in men) (Health Canada, 2002). In the last 50 years, deinstitutionalization of mental illness across Canada has required a community, social approach to meet the needs of people with mental illnesses. Between 1960 and 2000, the number of psychiatric beds in Alberta decreased from 3505 to 878, while the population increased from 133,200,000 to 292,600,000 (AMHB, 2007, p. 109). Homelessness, unemployment, poverty, victimization and criminalization, associated with deinstitutionalization have become community issues (Arboleda-Flórez, 2005) and carefully planned programs based on evidence and social model of care are needed. The *recovery model* where consumers participate in their interventions is replacing the *maintenance model* where patients passively accept their conditions and receive interventions (Anthony, 2003; Arboleda-Flórez, 2005).

The unemployment rate among people with mental illness ranges from 70-90% (CMHA, n.d.). This is a serious issue because many people with a mental illness want to be gainfully employed (Liu et al., 2007). The Canadian Mental Health Association (n.d.) states, “of all persons with disabilities, persons with mental illness face the highest degree of stigmatization in the workplace and the greatest barriers to employment”. Factors that contribute to barriers to employment include “gaps in work history, limited employment experience, lack of confidence, fear and anxiety, workplace discrimination and inflexibility, social stigma and the rigidity of existing income support/benefit programs” (CMHA, n.d.). Not only is productive work believed to “promote positive mental health”, but “meaningful, paid work is a basic human right for every citizen, and those who experience serious mental illness should have equal access to the fundamental elements of citizenship which include: housing, education, income and work … each individual has the right to be employed in a mainstream job, rather than being labeled as a client in a training program or a sheltered workshop” (CMHA, n.d.).

How can we address the barriers to employment for people with mental illness? The CMHA advocates for attitudinal change that addresses social stigma and financial disincentives. Legislative changes are also called for. For example, the current system discourages consumers from seeking out part-time work or volunteer work because they do not want to jeopardize their income support or disability pension. Routes to Work is a program funded by Human Resources Social Development Canada. The Opportunities Fund National Project (www.cmha.ca/bins/content_page.asp?cid=7-13-716-718&lang=1) works with eight local CMHA branches, including those in Medicine Hat and Lethbridge, to implement strategies to assist people with mental illnesses seek mainstream employment. Return to work strategies include: Pre-employment assessment and counseling, employment preparation and job search support, skills development training, educational upgrading, volunteering, job trials, transitional employment, and supported employment. Project site goals for 2008-2009 are listed on the website, www.cmha.ca/bins/content_page.asp?cid=7-13-716-718#work, and include “working with at least 215 consumers and assist at least 123 of these individuals to find competitive mainstream employment”. It remains to be determined whether this program is accessible to individuals with serious mental illness, and indicators of program success.

Liu et al. (2007) caution funders not to focus on supported-employment program participants' ability to find employment as soon as possible. Supported employment is defined as "competitive employment in an integrated setting with ongoing support services for individuals with the most serve disabilities" (Substance Abuse and Mental Health Services, Administration [SAMHSA], 2006) and based on the model described by Bond, Drake, Mueser, and Becker (1997). Liu et al. (2007) used a grounded theory approach with seven consumers with schizophrenia. Their data showed that "participating in work" was a product of "removing barriers to job seeking" and "readiness for job seeking" and "participants' effort in job seeking" (pg. 550). They suggested that supported-employment programs can produce meaningful outcomes even if they do not result in immediate employment. Individual readiness or personal preparedness is a factor that needs further attention in terms of assessment and intervention in the context of individual circumstances that may not be directly related to the supported-employment program. Clearly, research is needed to further develop the model described in this paper and to examine the effectiveness of supported-employment programs beyond simply obtaining employment.

Supported employment is one of several approaches used in work initiatives. In a paper that reviewed work initiatives over the past 10 years in Canada, Kirsh, Krupa, Cockburn and Gewurtz (2006) list over 10 types: clubhouse, agency-operated businesses, consumer/survivor businesses, affirmative businesses, supported employment, vocational rehabilitation (including vocational assessment and prevocational training), sheltered workshops, transitional employment, job/employment counselling, range of services and unknown/other. Sheltered workshops have declined while other initiatives such as affirmative businesses have become the preferred models. While the paper provides a good overview of the beliefs and philosophical underpinnings for work integration initiatives in Canada, to date there is minimal literature on the effectiveness of these work initiatives (Kirsh, 2006).

An example of one outcome-based study is one conducted by Krupa, Lagarde and Carmichael (2003). This study examined the outcomes of transforming sheltered workshops into affirmative businesses which are entrepreneurial ventures that utilize the strengths of consumers and create employment that accommodate the needs of the employees. This is in contrast to vocational rehabilitation which tries to get employees to "fit in" with existing employment situations. Examples of such businesses include a carwash, sewing venture, café and coffee shop. The highest rate in traditional sheltered workshops amounted to $1.00/hour (maximum of $750 per year), whereas employees of the affirmative businesses, also called "associates", made minimum wage or higher (mean annual income of $1,235.48, maximum of $7,552.95). A quarter of the associates earned income above the allowable monthly earnings for disability benefits, after which deductions from their pensions (75 cents on the earned dollar) threatens financial security and becomes a disincentive to work (Krupa et al., 2003). Despite the beneficial outcomes (work legitimacy, sense of ownership, illness reduction, respect, social opportunities and economic well-being), the tension posed by the financial ceiling limits the potential of affirmative businesses for people with severe mental illnesses. Further research is needed to identify ways to overcome this limitation. Krupa et al. (2003) also recommend future research to examine the association of affirmative businesses and reduction of need to access clinical services and hospitalization.

Employee and employer level interventions in workforce environments have been reviewed by Krupa (2007). She identified seven employee-level employment interventions: (1) early identification, diagnosis, and treatment, (2) assessment and planning, (3) self-awareness counselling, (4) coping skills training, (5) work hardening, (6) reasonable job accommodations, and (7) social network development. Employer interventions is a relatively new concept and

examples are screening strategies (e.g. for depression), training to increase awareness about work disabilities associated with mental illnesses, and education to change attitudes about mental illnesses and to develop policies to address stigma. The author recommends that disability management, which refers to "employer-directed programs and practices aimed at the prevention of disability and rapid return to work", be also applied to work disabilities associated with mental illnesses, and not only to physical conditions (Krupa, 2007, p. 344).

Workplace harassment

Work disability also occurs among employees who do not have severe mental illnesses, nevertheless, are affected by mental health issues that may or may not be associated with physical conditions. Workplace bullying, or mobbing, is defined as "repeated actions and practices of an unwanted nature that are directed against one or more employees" (Einarsen & Raknes, 1997; McKay, Arnold, Fratzl & Thomas, 2008; see Saunders, Huynh, & Goodman-Delanunty, 2007 for a study on definitions of workplace bullying). One recent study conducted in Rome linked suicide risk to work place harassment (Pompili et al., 2008). In a sample of 102 individuals exposed to mobbing, the sample showed significant psychopathology on the MMPI-2 and over half had some risk of suicide. Possibly, some individuals are more susceptible to stresses of work place harassment, or such situations may be related to the stigma of mental illnesses. More research is needed to clarify how mental health issues are associated with work place harassment; this would provide indications of prevention and intervention approaches.

Stigma in the workplace is a barrier for people with mental health issues (Stuart, 2006). Self-stigma refers to one's acceptance of social stigma so that one's self-image and self-efficacy is diminished (Corrigan & Watson, 2002). Self-stigma contributes to behaviours that can be barriers to equitable employment. For example, an employee may choose not to reveal his or her mental illness for fear that this would be perceived negatively by the employer. While legislation prevents an employer from asking an employee personal questions such as health condition, the paradox is that if such information is not shared, work place accommodations could not be made. When an employer makes reasonable accommodations, these can make it possible for an employee to remain in the workforce. The Mental Health First Aid program is an example of an intervention program that can be effective in the workplace (http://www.amhb.ab.ca/knowledge/workplace/Pages/MentalHealthFirstAidCanada.aspx). The program, founded by Betty Kitchener and Anthony Jorm from the University of Melbourne, was launched in Canada in October 2006. The founders report evidence to indicate that the Mental Health First Aid program is effective in reducing stigma and in enhancing mental health literacy among employers in various sectors and the general public. Current evaluations by the AHS-AMHB examine how well the program is received by participants. Formal research is needed to determine the effectiveness of the program in specific work situations and environments, for example, what level of impact does the program make on work environments that are not health-related but service the general public, such as retail sectors, the police force, and public transportation. Do employees and employers acquire the ability to recognize deterioration in an employee or client's mental health, such as adults with first time psychosis, and are they able to assist in preventing crises situations? This type of research could guide policy makers or specific professional organizations to develop best practice guidelines to address mental health issues in the workplace.

Workers with Developmental Disabilities

People with developmental disabilities may have physical disability in addition to intellectual or cognitive disability. Conditions begin at birth or during childhood and include attention deficit hyperactivity disorder, autism, Down syndrome, fetal alcohol syndrome, cerebral palsy and mental retardation. In one study, researchers followed 112 participants of a supported employment program which placed individuals in jobs such as custodian, food service, stocking, teachers' aid/clerical worker, data entry/copier, and hostess (Lemaire & Mallik, 2008). A total of 123 barriers to maintaining employment and reasons for termination were identified for 49 employees. These included inattention/difficulty staying on task, too much socialization/behaviour problems, learning/reading difficulties, legal history, mobility difficulties/transportation problems, relationship or problems with supervisor/paranoid or social phobia (Lemaire & Mallik, 2008).

Similar to the population with serious mental illness, this population has been experiencing a move from sheltered workshops to community-based employment opportunities. Siporin and Lysack (2004) conducted a qualitative study in which they examined the quality of life of three women with developmental disabilities who worked as housekeepers in different hotels through supported employment. The women were aged 41, 46 and 61 and each had previously worked in sheltered workshops. Results indicated that each participant experienced better quality of life in the supported employment program, although it was difficult to provide an appropriate level of challenge. The increased quality of life was attributed to the opportunities for the participants to make decisions about their own lives, achieve individual autonomy and choice in the supported employment.

The rate of employment is very low among people with developmental disabilities, and for those who are employed, the income is limited (Yamaki & Fujiura, 2002). Despite the psychological and emotional benefits of engaging in work, people with developmental disabilities face barriers related to social security policies and regulations (Siporin and Lysack, 2004). Finally, individuals with developmental disabilities *and* mental illness experience additional barriers in the workforce. Clinically, they present two sets of potentially heterogeneous conditions and a challenge to diagnosis and treat (Barnhill, 2008; Tang et al, 2008). In the community, individuals with dual diagnosis may be at more risk for discrimination because their behaviours may not be easily understood as either developmental or mental health disabilities.

Summary

At the beginning of this paper, three potential areas of exploration related to employment for seniors and persons with disabilities were proposed. These are revisited here:

1. Supports for employers and employees
   In the area of employment for older adults, early retirement appears to be related to job demand-job control tensions, at least for a proportion of employees who experience age-related changes that may be affecting their performance capacity. The literature points out that the 65 year old marker is arbitrary and proposes that we consider other meanings of aging, including “organizational aging”, which recognizes the knowledge and experience that older employees acquire over the course of their working years in a particular job or organization. Employers who wish to postpone retirement among valuable employees may need to enact work place accommodations or incentives. These changes require support from policy makers so that stigma is addressed from a social standpoint. People with physical disabilities, serious mental illness and developmental disabilities continue to face stigma and discrimination in the workforce. Employers and employees require policies that will address economic disadvantages in the workforce. Although social assistance and support are available through disability-specific programs on local and national levels, to date there has been minimal research that examines their effectiveness. Therefore, little is known about best practice in these program interventions.

2. Mental illness compounds the challenges faced by seniors and persons with disabilities who seek and try to maintain employment. Mental illness is commonly associated with self-stigma in addition to discrimination that results in inequitable employment. Individuals with developmental disabilities and mental illness experience stigma associated with dual diagnosis. When seniors and persons with disabilities experience mental illness, they face stigma associated with their mental illness, in addition to stigma associated with aging and disability.

3. Appropriate indicators are needed for evaluating “satisfying” or “meaningful” employment for seniors and people with disabilities who have mental health issues. With the exception of papers on “return-to-work”, the literature strongly suggests that indicators for successful employment programs should focus on quality of life that is associated with the ability to participate in seeking, gaining and maintaining employment. This includes a sense of control, social benefits, and training through volunteer work opportunities and further education.

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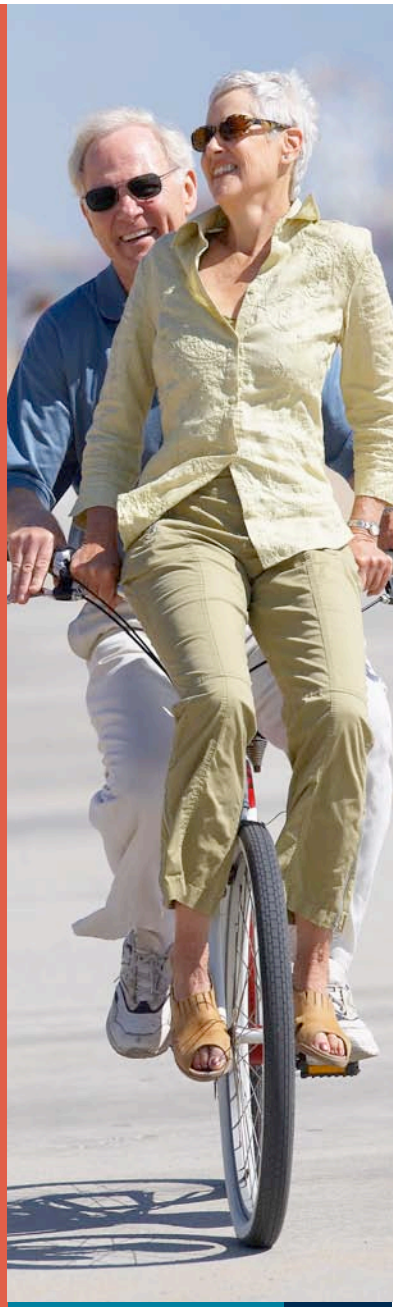

CONTACT INFORMATION

Alberta Health Services - Alberta Mental Health Board
Edmonton General Continuing Care Centre
8th Floor, R Wing
11111 Jasper Avenue
Edmonton, AB T5K 0L4 Tel: 780.342.8800 Fax: 780.342.8801 www.mentalhealthresearch.ca