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Integration of mental and psychomotor training in vocational rehabilitation for persons with mental illness improves employment

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Abstract

Common mental health problems, such as depression, burnout, personality disorders, anxiety- and somatoform disorders are often associated with unemployment. Employment is for many people with a mental vulnerability not only a source of financial income, but employment also determines their social status and inclusion, identity and self-image.
In order to increase the employment rate of people with a mental vulnerability a centre for vocational rehabilitation in Belgium (AZERTIE) developed the I Care program.
The I Care program, a combination of psychomotor and mental training, resulted in a employment over than 50% of people with a mental vulnerability. After at least one year employment 90% was still at work. When we compare the employment rate (over than 50%) with the rate of the period before the start-up of the I Care program (10%), we can conclude that the I Care program increased the employment of this vulnerable group five-fold.

Keywords: vocational rehabilitation, mental and psychomotor training

Introduction:

An analysis of data from the National Co-morbidity Survey Replication, a US nationally representative household survey, found that overall impairment was significantly higher for mental disorders than for chronic medical disorders (Druss et al., 2009). Severe functional impairment was reported by 42% persons with mental

disorders and 24% with chronic medical disorders. Mental illnesses increase the risk of decreased workplace productivity and absenteeism resulting in lowered income, unemployment and social exclusion.

Common mental health problems, such as depression, burnout, personality disorders, anxiety- and somatoform disorders (physical symptoms caused by mental or emotional factors) are often associated with work absenteeism. In Belgium, mental illnesses are the leading cause of work absenteeism, namely in 46.99% of cases (Rijksinstituut voor ziekte- en invaliditeitsverzekering, 2013). The percentages of unemployed disabled as consequence of disorders of the musculoskeletal system (28.75%) and cardiovascular disease (6.67%) follow in the second and third place.

Employment is for many people not only a source of financial income, but employment also determines their social status and inclusion, identity and self-image. For people with a mental vulnerability this is no exception. However, to find and retain employment is for them not an easy task (Knaeps, 2015; Reme et al., 2015). In the Belgian healthcare sector, there is little attention to reintegrating former patients into the labour market. While resuming work right can contribute to the recovery. After all, to many people with mental vulnerabilities, the participation in the labour market is seen as a sign of recovery.

People with a mental vulnerability are typically characterized by low self-esteem, depression and anxiety symptoms, and decreased physical and mental resilience (Michon, 2006). This target group has more often than not somatic health problems, primary or secondary associated to the psychological vulnerability (De Hert et al., 2011). Many people with mental vulnerability experience a weak physical fitness, low exercise tolerance, fatigue and a reduced ability to focus, a reduced task tension and stress resistance and increased irritability. In these patients, a weak physical fitness and a low physical self-concept, combined with other barriers to participation in exercise, such as deficient self-motivation and self-enhancement strategies, psychosomatic complaints, lack of any internal locus of control concerning their health, deficit of energy, and general fatigue may lead to a vicious cycle of loss of self-confidence, decreased self-esteem, an increased avoidance of physical activity, and a general physical de-conditioning (Knapen et al., 2015). This downward spiral handicaps their working abilities and employment opportunities. Moreover, personal issues such as family and parenting problems, limited social skills, a low education level, loneliness, social isolation, transport and housing problems, and stigmatization complicate their re-integration into the labour market (Michon, 2006).

Success factors and impeding factors in the vocational rehabilitation.

The Centre for Research and Consultancy in Care of the KU Leuven (Belgium) carried out research on the vocational rehabilitation of individuals with psychological vulnerability (Knaeps, 2015). The researcher interviewed 24 work counsellors to their vision of the impeding factors and the success factors in vocational rehabilitation. As impeding factors mentioned the work counsellors low motivation, a limited self insight, lack of proper attitudes, serious psychological problems, lack of proper housing and transportation problems, while work readiness, adequate work attitude, self-insight, self-management skills, a good physical health and fitness, and a solid social network right contribute to success in vocational rehabilitation.

The I Care concept: integration of psychomotor and mental training in vocational rehabilitation

AZERTIE, a centre for vocational rehabilitation in Belgium, guides for over 30 years individuals with a work disability to various attendant functions such as general clerking, networking, administrating or programming.

The past 5 years AZERTIE noticed a strong increase in the number of individuals with a mental vulnerability.

Initially the dropout of this target group was very high, over than 50% (20% for clients without psychological vulnerability), and the employment rate very low, approximately 10% (60% for clients without psychological vulnerability). In order to reduce the dropout and to increase the overall employment rate of this vulnerable group, the director and company doctor of AZERTIE developed the I CARE program. This program is intended for job-seekers with mental disorders, often associated with somatic diseases, that are after a long period of inactivity attempting to reintegrate into the formal labour circuit. From the start the I Care concept was based on the scientific evidence of psychomotor and mental training on the mental and somatic health of this very vulnerable group, under the maxim “doing what works" (Cooney et al., 2013; Knapen & Vancampfort, 2014; Silveira et al., 2013). The integration of psychomotor and mental training in the vocational rehabilitation of people with mental vulnerability is an example of good clinical practice for a structural collaboration between the work rehabilitation and the mental health care in Belgium. The I Care team aspires to an efficient and sustainable reintegration in the labour market.

Evidence-based approach with the focus on the success factors in the vocational rehabilitation

The I Care program strongly focuses on the most important personal success factors in the vocational rehabilitation of people with a mental vulnerability namely, work readiness, the work attitude, the mental and physical resilience, the self image and self efficacy, the severity of symptoms, an internal locus of control, and self-management skills (Knaeps, 2015; Michon, 2006; Reme et al., 2015). The eclectic I Care concept integrates the basic principles of the vocational rehabilitation, the recovery-oriented care, cognitive behavioural therapy, psychomotor therapy, and solution-oriented therapy.

Interdisciplinary collaboration and method

The interdisciplinary I Care team consists of the director of AZERTIE (clinical psychologist), a company doctor who is responsible for the inclusion of the clients, the medical follow-up and contacts with the treating physicians, and a psychomotor therapist/physical therapist and a clinical psychologist who are respectively responsible for the psychomotor and mental training. The I Care team members work closely with the job counsellors who accompany the clients during their training, internship and employment. The participants of the I Care program follow during their training and accompaniment three sessions per week mental training (1 h 30) and psychomotor training (1 h 30) over a period of 10 weeks. Psychomotor training includes individually adapted fitness training, stretching, yoga exercises and breathing exercises, education around dealing with pain and fatigue complaints, desk gymnastics and ergonomic advice. The mental training consists of various relaxation and stress management techniques, assertiveness training, coping skills with crisis situations, goal setting, verbal and non-verbal communication skills, job skills, and relapse prevention (Reme et al., 2015). The basic philosophy is 'a healthy mind in a healthy body'.

Objectives

The objectives of the I Care program are to increase and improve the work readiness, the labour attitude, the mental and physical resilience, self image, confidence, target and solution-oriented action, and social skills.

Research objectives

The primary objective of the study was to investigate the effectiveness of the I Care program on the inflow and maintained employment of people with a psychological vulnerability into the regular labour market.

The secondary objective was to evaluate the effectiveness of the I Care program on a number of psychological and physical variables.

Subjects

During the period from May 2010 until present 141 clients participated in the study. The group consisted of people with mood and anxiety disorders, burnout, autism spectrum syndrome, personality problems, psychosomatic disorders such as chronic fatigue and fibromyalgia. Fourteen clients suffered from psychotic disorders. However, these persons were stabilized. Most participants had somatic health problems as well, mainly musculoskeletal diseases and chronic pain. In a number of patients the psychological vulnerability was secondary related to a severe somatic pathology such as cancer. Written informed consent was obtained from all participants before entering the study.

Results

During the 10 weeks I Care program 27 of the 141 (19.15%) participants dropped out.
Immediately after the I Care program 8 of the clients (7.02%) found a suitable job. The remaining 106 clients followed after the I Care program additional training at AZERTIE of which 49 (46.23%) were employed within the year. Currently 24 clients are in training, of which 3 (12.50%) have a perspective on work. Thirty-three participants (23.40%) ended the training without any perspective on paid work.

At a follow up after at least one year employment 90% of the clients was still at work.

After the 10 week program the participants improved on the variables depression, anxiety disposition, self-esteem, coping style, cardio-respiratory fitness, and fatigue and pain perception. These results will be published elsewhere.

Conclusion

The integration of psychomotor and mental training in vocational rehabilitation of people with psychological vulnerability resulted in a total employment over than 50%. After at least one year employment 90% of the clients was still at work.

The major limitation of the study is the lack of a no-treatment control group. Therefore the results should be interpreted cautiously. Nevertheless, when we compare the total employment rate (over than 50%) with the rate of the period before the start-up of the I Care program (10%), we can conclude that the I Care program increased the employment of this vulnerable group five-fold. Moreover the dropout rate (19.15%) is significantly lower than before (> 50%). The dropout is even significantly lower than those of a global psychiatric-epidemiological study of the World Health Organization (n = 63678) which reports that nearly a third (31.7%) of all people with mental illness stop their treatment preliminary to the intends of the provider (Wells et al., 2013).

The team strives to optimize the I Care program by a systematic satisfaction survey and feedback from clients and a continuous internal evaluation by the team members.

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