Promoting the Importance of Work for Persons With Psychiatric Disabilities—The Role of the Psychiatric Nurse

by Kate R. Donegan, EdD; and Victoria K. Palmer-Erbs, PhD, RN, CS

Work is at the very core of contemporary life for most people, providing financial security, as well as personal identity. Who among us has not had the social experience of being asked, “What do you do?” Work gives an opportunity to take part in all the rewarding, frustrating, and even stressful events that are a part of everyday life, while providing opportunities for valuable social interactions (Fabian, 1992).

Casual social conversations that discuss work can elicit feelings of embarrassment and shame for those who are disabled, unemployed, or may have never worked. Mental health and rehabilitation providers who are working closely with persons coping with psychiatric conditions must take any necessary steps to adapt environmental supports designed to help individuals build or rebuild work lives for them.

Kate R. Donegan, EdD, is Director, Services Division for Matrix Research Institute (MRI) and the Matrix Research Institute/University of Pennsylvania Rehabilitation Research and Training Center on Work and Serious Mental Illness, Philadelphia; Victoria K. Palmer-Erbs, PhD, RN, CS, is Assistant Professor of Nursing, College of Nursing, University of Massachusetts Boston; and former NIDRR post-doctoral research fellow at the Boston University Center for Psychiatric Rehabilitation.

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Address correspondence to Victoria K. Palmer-Erbs,
PhD, RN, CS, 21 Coolidge Road, Arlington, MA 02174.
selves. In these lives, there should be less emphasis and effort placed on psychiatric labels, symptoms, and signs of disability and more attention to reclaiming “everyday lives” with opportunities for meaningful work or school (Palmer-Erbs & Unger, 1997; Spaniol, Gagne, & Koehler, 1997).

The Multiple Benefits of Employment
Numerous studies over the past 20 years have demonstrated that employment makes a significant contribution to relapse prevention, improved clinical outcomes, and improved self-image (Donegan & Raudenbush, 1995). Such outcomes included increased day-to-day symptom management and strengthened self-care skills (Moller, 1993); a reduction in rates of (re)hospitalization and the use of expensive crisis and emergency services (Bond & Boyer, 1988; Moller, 1997); reports of increased positive self-esteem and demonstrations of self-efficacy (Harding, Strauss, Hafaz, & Lieberman, 1987); and successes in integration/reintegration into communities of choice (McGurrin, 1994). There is also evidence that working individuals use fewer public mental health services. These strides in services delivery have resulted in an overall lowering of lifetime costs of care (Baron, 1998; Drake, McHugo, Becker, Anthony, & Clark, 1996; Razzano, 1993).

An emerging subsector
Recent, sometimes surprising, new facts have come to light concerning this silent, emerging subsector of the workforce. These facts are developing from a broad base of valid and reliable rehabilitation research. The National Institute of Mental Health estimates that at any time, 3 million working-age adults have severe mental illness in the United States. (Matrix Research Institute, 1997).

For the great majority of individuals with severe mental illness, work has been a difficult and often unattainable goal—between 85% and 95% of this population are unemployed at any one time. This is a staggering statistic for a predominantly young, and largely working-age population, and a statistic much larger than would be found among any other disability group (Matrix Research Institute, 1997).

Today, practice and research activities are forcing a re-examination of commonly held assumptions that persons with long-term mental illness cannot work or have no interest in meaningful work (Anthony, 1994; Rogers, MacDonald-Wilson, Danley, Martin, & Anthony, 1997; Russinova & Ellison, 1997). We employment makes a significant contribution to relapse prevention, improved clinical outcomes, and improved self-image. are learning, through nationally funded, field-initiated research projects, about the nature of the supports and services that individuals would need to build and maintain an attachment to the workforce (Danley & MacDonald-Wilson, 1995, 1996; Diska & Rogers, 1996; Rogers & MacDonald-Wilson, 1996).

Expanding Narrow Criteria
Some authors argue that it is necessary to start at the beginning with a restatement of the essential properties of work for use as a guide in developing and evaluating mental health and rehabilitation services. Work has been traditionally defined as having a particular set of characteristics. Work must be full-time, unsupported, continuous, and unaccommodated. These artificially narrow and traditional criteria of work have served to prevent significant numbers of individuals with disabilities from successfully rejoining the workforce (Baron, 1998).

The growing body of first-person testimony from people who are living with serious psychiatric conditions or experiencing disability while working challenges the myth that receiving a diagnosis of mental illness must, in and of itself, lead to a lifetime of unemployment (Chamberlin, 1978, 1998; Deegan, 1996; Fisher, 1996; Francell, 1996; Freese, 1993; Manos, 1992, 1993; Masching, 1996; Mowbray, Moxley, Jasper, & Howell, 1997; Rogers, 1996, 1998; Russinova & Ellison, 1997; Williams, 1998).

Multiple sources of information concerning the work experiences of persons with mental illness are available through reviews of research studies, first-person testimonies, and reports of program outcomes. These data provide mental health and rehabilitation providers with a clearer picture of the overall therapeutic value of work in a person’s life.

What we see includes the need for new strategies for the provision of necessary supports, reasonable accommodations, and personal encouragement (Danley & Ellison, 1996a, b). In fact, educational programming, mental health and rehabilitation services, and individually tailored, ongoing supports for people with psychiatric conditions must be available for them to succeed in the world of work.

A growing field
The growing field of psychosocial rehabilitation (PSR) has emerged in the past 30 years. Researchers and services providers have developed a set of principles, best practices, and model programs (Anthony, Cohen, & Danley, 1998; Anthony, Cohen, & Farkas, 1990; Drake et al., 1996; Mowbray et al., 1997; Rogers, 1995). This work is designed to help individuals with serious psychiatric conditions live full, independent, and satisfying lives in community settings with as little intervention from mental health

At the very core of PSR is the emphasis on understanding the importance of work. From a Best Practices vocational rehabilitation point of view, any successful PSR program must provide participants with appropriate encouragement and practical problem-solving strategies, including assistance with pre-or post-employment supports. All these program features may need to be in place for participants to establish or re-establish ongoing attachments to the workforce (Baron, 1997; Danley & Ellison, 1996a, b; Danley & MacDonald-Wilson, 1996).

**The facts about mental illness and work**

Contrary to the beliefs of many mental health and rehabilitation providers—both inside and outside the therapeutic community—a diagnosis of serious mental illness is neither a reliable predictor of future potential for work, nor an indicator of inability to work, nor an implied recommendation that a person should not work (Anthony, 1994; Anthony et al., 1990; Spaniol & Koehler, 1994). It remains a fact that some of the symptoms of mental illness, such as its episodic, unpredictable nature, can make working or planning to return to work or school challenging. It is also a fact that symptoms vary from person to person, as does the capacity for managing symptoms and the level of supports required and available.

**Identifying Supports**

As mental health and rehabilitation providers, we can learn by listening carefully to persons who have lived with potentially disabling psychiatric conditions. What we will hear is that one of the most important factors in encouraging the development of a full life is the provision of readily available, naturally occurring, nonintrusive, and nonrestrictive supports. These supports are made available so that each person may continue with individualized choices and efforts.

These supports, which must include encouragement by members of the clinical and therapeutic community, as well as by significant others, must be both accessible and readily available to individuals when they are needed most. Such supports and services must be available, especially early in an illness and periodically throughout the course of recovery (Anthony, 1993). The availability of such appropriate supports can eliminate cycles of unemployment or underemployment, programs (Blankertz & Keller, 1997).

In addition, each individual needs to develop and maintain a social network of supportive and capable peers, along with the support of mental health and rehabilitation providers. These peers act as a resource for solving practical problems and discussing the many issues arising from life in the workplace.

The group can provide a safe opportunity for developing strategies about issues of disclosure, stress management, requests for reasonable accommodations as allowed by the Americans with Disabilities Act (ADA), and other work-related issues.

**Discouraging advice often offered**

The majority of persons with serious mental illness want to work. Recent surveys report that more than 70% of those surveyed rated work as an important goal (Rogers, Danley, & Anthony et al., 1992). This interest in work persists, despite the poor advice given at times by mental health and rehabilitation providers.

Some consumers report that they are encouraged by those in their immediate social network and others to avoid the stresses associated with work. This discouraging advice is softened with messages, such as “wait, at least for now” or “wait, until you are better.” These misguided, yet well-intentioned, delaying actions could result in feelings of helplessness, hopelessness, uselessness, and further separation and alienation from “normal” society (Rogers, 1995).

At times, individuals with serious psychiatric conditions may find themselves confused about how to begin to rebuild their lives. Breaking this cycle of confusion by discussing work-related materials and options has many benefits. Carefully planned interventions highlighting work may interrupt a life-long dependency on “highly structured programs” and may eliminate repeated returns to entry-level, “square one” activities sometimes required for eligibility in intervention and treatment programs.
**FIGURE 1**
Selected Models of Vocational Rehabilitation Services for Persons With Serious Psychiatric Disabilities

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<th>Supported Employment Programs (SE)</th>
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<td>This model has proven to be most successful in assisting persons with the most serious disabilities to attain and maintain an attachment to the workforce. It is individualized and provides on-site, 1:1 supports, job-coaching services, and occurs in competitive, “real work” settings; job-coach services are gradually faded and removed.</td>
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<th>Transitional Employment Programs (TE)</th>
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<td>This model offers a temporary work experience to individuals offering the same supports and services as SE. TE positions are contracted to a service program that fills openings and staffs positions to meet contractual obligations. No individual participants receive permanent TE positions: they must move on to competitive employment within an agreed-upon length of time. Staff often cover contract positions, working in the job for a day in cases of illness or with changes in participants’ schedules.</td>
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<th>Clubhouses</th>
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<td>Programs are “member directed” with members defined as individuals with serious mental illness. Clubhouse services and supports are provided to members according to the structure of the “work-ordered day.” Members have individual daily responsibilities and schedules to fulfill as preparation for entry or re-entry into the world of work. Membership in a clubhouse is lifelong and members provide each other ongoing support.</td>
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<th>Job Clubs</th>
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<td>There are two main types: in-house clubs and postprogram graduate clubs. Members discuss issues, uncertainties, and problems that they may face while seeking employment or maintaining employment gains. In-house clubs can provide practical guidance in résumé writing, for work exploration, opportunities to practice interviewing skills and, in some cases, vocational assessment and interest identification. Postprogram graduate clubs provide essential offsite support services, such as of working with new co-workers, adjusting to job requirements, handling issues of stigma and disclosure and feelings of isolation.</td>
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<th>Peer &amp; Natural Supports</th>
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<td>These circles of support are central to the continued success of individuals with serious psychiatric conditions who are attaining and maintaining employment. Circles expand connections beyond the usual family and friends to include wider community links to religious organizations, recreational/activity groups, public libraries, volunteer activities, peer support activities (such as job clubs, support groups that meet regularly, 1:1 relationships, “warm lines” for crisis intervention and supports, and Internet chat rooms).</td>
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by staff at local Social Security offices and other service sites.

Some consumers fear that, if they start any type of work or show any interest in work, they risk the immediate loss of all financial and medical benefits (Rogers et al., 1992). With the Work Incentives Provisions built into the Social Security system, individuals may begin a return to work without loss of benefits. However, despite the frequently reported lack of supports, and the threats about loss of financial and medical benefits, a great majority of persons diagnosed with potentially disabling psychiatric conditions want to work or prepare to go to work or school (Rogers et al.).

**Seeking a Remedy**
What can be done to remedy this situation? Unfortunately, many mental health and rehabilitation providers have not yet heard of the latest state-of-the-art, innovative vocational rehabilitation programs to assist individuals with the most serious mental illnesses. Successful programs report that they have placed more than 50% of program participants into competitive employment situations.

Competitive employment situations are defined as public or private employment situations that would be available to the general public. Some of the most innovative work programs involve moving participants into “real work for real pay” opportunities as quickly as possible. This rapid transition avoids the outdated practice of having individuals move through a highly structured, “continuum” of activities, or a series of stair-stepped services within programs. Innovative programs also provide participants with access to ongoing, long-term, readily available postemployment supports.

In keeping with a consumer-centered focus, ongoing supports are requested by the individual on an as-needed basis and delivered in any setting of the consumer’s choosing.

For these innovations in vocational rehabilitation to be optimally successful, all mental health and rehabilitation
providers who have worked with an individual at any level of the recovery process, must play an active and positive role.

We must all encourage individuals in this important transition phase in their lives. They will deal with stressors and potential uncertainties in reclaiming, as far as possible, an “everyday life” in the community, including a return to a previous work life or the development of a new and meaningful “work life” (Figure 2).

Encouraging Best Practices in Vocational Rehabilitation

**Understanding the current system of services delivery**

Despite the fact that people with serious mental illness can and do work and that, when surveyed, a great majority indicate they want to work, widespread unemployment and underemployment persists among these otherwise qualified individuals. This presents a significant problem for individuals and society. One question for all mental health and rehabilitation providers, especially the psychiatric-mental health nurse, is how to best deliver the necessary information about work to individuals in their care.

What kinds of supports and encouragement are sufficient to launch a person along this path toward recovery and a work life of his or her own choosing? Before proposing strategies to address such questions, a number of other issues must be identified and acknowledged.

Mental health and rehabilitation providers first must strive to:
- recognize that the service delivery system, as it now exists, actively discourages an individual, removes all hope of entering the workforce or returning to work after a diagnosis of mental illness, despite stabilization of symptoms;
- note the tendency of respected members and leaders in the psychiatric and mental health community to ignore or downplay any discussions about or the possibilities of exploration of employment by persons in their care;
- acknowledge that the system of financial supports used by many with severe disabilities builds in significant disincentives to employment within SSI and SSDI benefits structure—mainly through threats of loss of benefits in general medical and psychiatric services.

**Strategies for Psychiatric-Mental Health Nursing**

**Best practices: Breaking the cycle of discouragement**

How can mental health and rehabilitation providers, including the psychiatric nurse, make changes in the services system as it is currently organized? How does one begin to break a systematic cycle of discouragement in well-established, and in some cases, well-intentioned services systems? Here are a few immediate steps that could be implemented today. Let us resolve to start the process by:

• encouraging all mental health and rehabilitation providers in early discussions about work on a daily basis in all services settings;
• engaging all individuals and their families quickly (prior to transfer or discharge from programs) in active discussions of prior work and educational experiences, and in the development of all posthospitalization plans;
• recognizing that the goal of early discussions keeps hope alive and may ultimately help an individual attain lifelong dreams, stick with plans for work or school, or decline the narrow and unfulfilling lifetime role of forced dependency as “patient,” or as a disempowered person;
• understanding that individuals may be very discouraged and frightened about discussions of work or school, fearing that the supports for them to take
**F I G U R E 3**

**Understanding SSI/SSDI: Common Myths and Realities**

**Frequently asked consumer questions and concerns**

**Question:** As soon as I start working, I will stop getting my SSI check!
**Response:** You can earn more than $1,000 a month before you do not receive an SSI check at all; the exact amount you can make will be different in each state. SSDI allows you to earn up to $199 a month with no effect to your benefits—for earning more than amount, you can make use of the “trial work month” (You have 9 months).

**Question:** I can make more money just collecting my SSI check; why should I work?
**Response:** The truth is, the first $85 you make does not effect your check at all; after that, the amount of your check only decreases by $1.00 for every $2.00 you make.

**Question:** I can’t go to work because I can’t afford to lose Medicaid!
**Response:** If you remain disabled, even if you earn too much to continue getting a check, you may be eligible to continue your full Medicaid coverage under section 1619(b) of the Social Security Act.

**Question:** I’m afraid that if my benefits stop and I go to work, I’ll get sick again and have a hard time getting back on benefits!
**Response:** If you go off benefits, and become in need of and eligible for benefits again within 1 year, you can be reinstated without reapplying.

**Question:** I can’t get ahead; I can’t get a good-paying job; I can’t afford to get training to help me get a good job!
**Response:** You can put away as much of your earnings as you need for school or training and have that money not count as earnings; therefore, your check amount would not decrease.

For further information, contact the Matrix Research Institute Social Security Advocacy Project, funded by the PEW foundation, and staffed by persons who have used the SSI and SSDI systems. Call the MRI MAPS Project at 215-438-8200.

such a huge risk may not exist;
- promoting local best practices through the development of a plan for return to work or school in partnership with each person and his or her significant others;
- learning about all of the rehabilitation options available within the surrounding community for those receiving services in your system, including details about types of employment programs, eligibility criteria, and key contact personnel;
- accessing resources and referral information to become more knowledgeable in assisting individuals in exploring vocational supports and services;
- recognizing that members of the immediate social network surrounding the consumer may not have current information about developments in vocational rehabilitation and are relying on you to provide such education in a partnership environment;
- valuing choices and noting that reluctance to engage in active plans for work or school may represent realistic and practical concerns of important significant others who may fear exposing the consumer to more “stressful,” unsupported situations—the types of stress that work or school activities might precipitate;
- remembering that the therapeutic community includes providers, family members, and friends who represent a large segment of the recovering individual’s life, often providing the most immediate resources and social network supports;
- providing readily available, accurate, state-of-the-art information, program literature, and specifics of program contacts with the Social Security Administration about the Work Incentives program (Figure 3); and
- providing readily available, accurate, state-of-the-art information, program literature and specifics about employment and other programs designed by and for consumers by successful peers and potential role models at the National Self-Help Clearinghouse (Rogers, 1996, 1998) and the National Empowerment Center (Chamberlin, 1998; Deegan 1996; Fisher, 1996).

**Contributions of the Psychiatric-Mental Health Nurse to Best Practices in Vocational Rehabilitation**

Many mental health and rehabilitation providers may not consider the fears associated with the loss of benefits or eligibility for benefits be a “clinical issue.” However, such a loss is of very real concern for individuals diagnosed with mental illness and their families. These concerns must not be downplayed or minimized. Financial concerns are often cited as a major contributing factor that further discourages
persons with mental illness from seeking employment, education, and training opportunities. How can nurses help with this potentially confusing situation? Here are a few steps that could be implemented today.

- Work to develop collaborative, individualized, self-managed plans that strive to promote independence and autonomy;
- Use empowerment strategies to promote self-monitoring and early detection of any symptom exacerbation;
- Provide state-of-the-art education about relapse prevention and the episodic nature of some psychiatric conditions; include details on understanding of the cyclical nature of serious mental illness, the active management of symptoms, stress management, lifestyle changes, and alternative therapies;
- Discuss any existing medication regimens that may interfere with activities of daily living and plans to return to work or school;
- Recognize that understanding and managing all of these necessary life changes and potential medication side effects is vital to an individual's success in attaining and maintaining employment or in returning to school; and
- Make reasonable, progressive plans, and encourage consumers to identify necessary supports and to seek necessary job accommodations, as needed.

**Actively Encourage**

Perhaps the most important activity in which the psychiatric-mental health nurse can engage is that of maintaining hope and optimism by providing active encouragement. Active encouragement helps to shape an individual's motivation toward thinking about, and planning for, employment and work or school-related activities (Palmer-Erbs & Unger, 1997).

The psychiatric-mental health nurse may be in the best position to offer any real supports as an individual begins to think about what he or she will do following an acute exacerbation of symptoms and stabilization efforts. This encouragement can be of the most basic type. For example, one way to build interest and motivation is to focus energies on the person's strengths and past accomplishments, no matter how small. Everyone needs to hear that life is about trial and error—it is possible to start on a program, encounter difficulties and challenges, and then mobilize supports to meet those challenges.

More in-depth encouragement can be offered in a discussion of additional community resources and referrals. Later, more encouragement could include discussions about state offices of vocational rehabilitation, mental health and rehabilitation provider agencies, peer-support groups, and other programs through which the individual may seek out vocational services and supports. Many of these services are provided at no cost to the individual.

As a part of everyday interactions with consumers, the psychiatric-mental health nurse can encourage individuals to begin to think about existing, familiar supports already available in the community. This is also the time to consider individual interests, long-term goals, and aspirations.

One recent study indicated that many individuals with serious psychiatric conditions are largely unaware that they are eligible for protection under the 1993 Americans with Disabilities Act (ADA). If eligible, they may request reasonable job accommodations that might enable them to return to work, or to remain employed, despite a periodic exacerbation of symptoms (Granger, 1997).

The role of the psychiatric-mental health nurse is a vital one and is best implemented within a supportive, encouraging, and educational context. Interventions are aimed at assisting the individual experiencing a serious mental illness in thinking about, in a positive way, plans for his or her future employment goals and aspirations.

At the same time, the psychiatric-mental health nurse is aware of the complex, competing issues involved. Each individual may be struggling with internal conflicts and fears, financial and family concerns, and a natural reluctance to begin the potentially difficult and challenging process of exploring possibilities associated with any return to work or school.

It is, therefore, important for the psychiatric-mental health nurse to be well-versed in addressing fears, reluctance, and resistance with an individual prior to discharge. Such discussions could include practical considerations about medication management and relapse prevention, where to turn for help when needed on or off the job, and other issues that would require preplanning to ensure an eventual, successful return to the workforce.

**Keep Current**

The psychiatric-mental health nurse must remain "current" as to the availability of local programs and supports by keeping an accurate file of brochures, local contact numbers, and persons available in the surrounding community. Nurses may also play a more active referral role when gathering information, placing telephone calls with the individual, or planning possi-
Having schizophrenia, which I have had since my 20s (I am now 33) does not mean that life has ended for me—it has not.

The path of my recovery began, oddly enough, during the early 1990s. I had been laid off as a proofreader for a large company in Philadelphia and the stress brought on my joblessness (after nearly 2 years of steady employment). This, coupled with the sluggish economy of that time, led to feelings of worthlessness within myself. After a year of unemployment, I suddenly began to have hallucinations and very bizarre thoughts until finally, the entire period culminated with my first stay in the psychiatric ward of a major hospital.

Aside from the shock of being in such a place, what stays in my mind regarding my first night in the ward is the reassuring care of several psychiatric nurses who told me that recovery from my illness was possible. Had it not been for those several caring psychiatric nurses, including one nurse who held my hand and gently comforted me during my first night, I never would have believed that I would be working and be doing as well as I am today. That nurse’s human touch and hopeful words did more to lift my spirits than anything I can remember.

That night, the nurses also told me to expect to return to work, to acknowledge my current state and face it, to not evade the seriousness of my illness, and to believe that I would regain the sense of myself that was lost.

Psychiatric nurses should be encouraged to give persons who are experiencing mental illness hope that a return from the disease is possible. Looking back, I recall that the nurses in the ward that night and throughout my stay told me to expect to recover from my illness, that returning to work was possible and to believe it was so. They were right.

Now, after 2 years of unemployment following the onset of my illness, to my great surprise, I am working again, and the best thing about working again after experiencing a mental illness is the sense of normalcy—of fulfillment, even—that I have.

Although at times it can be taxing, working has restored the self-confidence I lost once my mental illness and its aftermath took hold. Relating to people in the old way, accepting responsibility, and carrying out my duties just like anyone else, has given me the feeling that anything is possible for me. Individuals who have left the hospital after suffering from a mental illness should know that work can restore them.

Mark Williams has been a member of the administrative staff of Matrix Research Institute (MRI) in Philadelphia since 1994. Before joining MRI, he attended a psychiatric rehabilitation program in Philadelphia from 1992 to 1994.

This search for new best practices could be a daunting task. As psychiatric-mental health and rehabilitation professionals, we must be familiar with not only national journals and research findings, but with consumers’ and family members’ comments about experiences with work, and the changing state and national policy and resource funding issues. Psychiatric-mental health nurses are encouraged to recognize that layers of stigma and discrimination represent some of the most significant obstacles to a person’s return to work or school.
Conclusions
Psychiatric-mental health nurses and other mental health and rehabilitation providers are influential in helping people with serious psychiatric conditions return to satisfying lives in their communities. A component of this life includes an opportunity for individuals to return to gainful, worthwhile activity, such as meaningful work or school.

As the body of vocational rehabilitation literature grows, the significant therapeutic advantages to participation in work-related activities becomes apparent.

- Work presents opportunities for building self-esteem and self-confidence.
- Work moves the individual beyond the negative effects of stigma and psychiatric labeling.
- Work is a positive, productive diversion from constant symptom monitoring and symptom management.
- Work creates opportunities for increased social interactions and building a circle of support (Roberts; Roberts, Rotteveel, & Manos, 1995).

Clearly, consumers of mental health and rehabilitation services face many discouraging experiences and societal barriers every day. Many are told not to think about work, that they are not ready for work, or worst of all, that they will never be able to work again.

This devastating information, in combination with the realistic fear of the loss of medical and financial benefits provided through the Social Security system, prevents many individuals from pursuing vocational aspirations, school, and other training interests. Many fear not being able to work competitively, given traditional views of work (work without supports or needed accommodations).

The psychiatric-mental health nurse and other mental health and rehabilitation providers can offer crucial supports, as well as necessary resources. Such supports and resources may counter many discouraging experiences and build hope.

Move beyond traditional roles
Psychiatric-mental health nurses must move beyond their traditional roles as caregivers in institutional settings, learn the necessary information to be strong advocates and vocational generalists, and collaborate with those who are vocational specialists. Everyone plays a significant role in helping individuals define options, make choices, learn to manage potentially disabling conditions, avoid long-term hospitalizations, and realize their potential. It is never too early to begin preparing for a first job or returning to work or school activities; nor is it ever too late to plan for a well-earned, satisfying life in the community.

References
Appendix

The Center for Psychiatric Rehabilitation is affiliated with Sargent College of Health and Rehabilitation Sciences and the Department of Rehabilitation Counseling. The Center is a research, training, and service organization dedicated to improving the lives of persons who have psychiatric disabilities by improving the effectiveness of people, programs, and service systems.

The Center's work is guided by the most basic of rehabilitation values, that first and foremost, persons with psychiatric disabilities have the same goals and dreams as any other person. They want a decent place to live, suitable work, social activities, and friends to turn to in times of crisis. The mission of the Center is to increase knowledge in the field of psychiatric rehabilitation and to apply this body of knowledge to train treatment personnel, to develop effective rehabilitation programs, and to assist in organizing both personnel and programs into efficient and coordinated service delivery systems. The Center's work in the area of employment includes: cost-benefit analysis, vocational programming, and reasonable accommodations.

The Center, under the direction of William A. Anthony, PhD, has been jointly funded since 1979 as a Research and Training Center (RTC) in mental health by the National Institute on Disability and Rehabilitation Research (NIDRR) and the Center for Mental Health Services, Substance Abuse, and Mental Health Services Administration (SAMHSA). The Center has also been designated as a World Health Organization (WHO) Collaborating Center in Psychiatric Rehabilitation.

For further information on the Center's projects and materials, contact Resource Information Services, Center for Psychiatric Rehabilitation Sargent College of Health and Rehabilitation Sciences Boston University, 930 Commonwealth Avenue, Boston, MA 02215; 617-353-3549; fax: 617-353-7700; Web sites: http://www.bu.edu/SARP/PSYCH.

Matrix Research Institute (MRI) is a not-for-profit research and training center with more than 25 years of experience in the development and study of effective human services programs and the preparation of skilled human services personnel.

The Institute provides program evaluation and systems analysis, professional training and human resource development, public education, and consultation services across the mental health, mental retardation, aging, substance abuse, and physical and sensory disability fields.

Since its founding in 1973, the Institute has sought to improve the lives of people who face the special challenges of living and working independently in community settings.

A substantial portion of MRI's work is targeted at assessing and meeting the needs of persons with serious psychiatric disabilities. Over the past decade, MRI has focused particularly on the employment needs of persons with serious mental illness. Many current projects of the Institute were designed to heighten the priority attached to employment for these individuals, as well as to identify the most effective rehabilitative approaches to assist them in establishing a long-term attachment to the workforce.

MRI is also the site of the MRI University of Pennsylvania Rehabilitation Research and Training Center on Work and Mental Illness (Grant No. H133B3007).

For more information, contact either the Institute at 6008 Wayne Ave., Philadelphia, PA 19144; 215-438-8200; or MRI Services Division at 42 S.15th St., Suite #318, Philadelphia, PA 19102; 215-569-2240; Web site: http://www.matrixresearch.com; e-mail: workmri@aol.com.

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