



Earning and learning among Australian community residents with psychiatric disorders

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ABSTRACT

At a population level the extent that psychiatric disorders and other health conditions disrupt participation in education and employment is rarely considered simultaneously and remains largely unknown. This is an important issue because policy makers are as concerned with educational attainment, school to work transitions, and workforce skills, as they are with overall labour force participation. We investigated earning or learning, and educational attainment, among Australian community residents by age group and by category of psychiatric disorder. Data files were provided by the Australian Bureau of Statistics (ABS) from a population survey conducted in 2003 using a multi-stage probability sample ($N=23,787$). Adults with schizophrenia, depression, and anxiety disorders were compared to (1) working age adults with other non-psychiatric health conditions and disabilities; and (2) healthy adults of working age. Participation in formal education and employment was extensively disrupted by all health conditions and by psychiatric disorders in particular. The extent of career-related disruption provides benchmarks for policy makers and service providers attempting to increase participation in formal education and in the labour force.

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1. Introduction

Advances in psychiatric treatments, continuing deinstitutionalisation, and the increasing availability of community-based mental health care have not addressed the widespread and chronic social exclusion found among community residents with severe mental illness. Systemic social and economic exclusion is demonstrated by high proportions of non-participation in the labour force and low proportions of people in competitive employment compared to healthy working age residents (King et al., 2006). On the other hand, enabling community residents to remain in school or to participate in the labour force contributes to human capital and economic development by increasing both labour force participation and skill levels in the labour force. Greater participation in earning and learning can have both immediate and long-term social and economic values to individuals and to the wider community. Whereas not completing school limits human capital development (Australian Government Productivity Commission, 2007) and is associated with non-participation in the labour force, long-term unemployment (Baron and Salzer, 2000, 2002; Waghorn et al., 2004a,b); lower career trajectories when employed, and greater reliance on social welfare

assistance (Baron and Salzer, 2000, 2002; Australian Government Productivity Commission, 2007).

At a population level, anxiety disorders, affective disorders (Waghorn and Chant, 2005) psychotic disorders (Waghorn et al., 2002), and schizophrenia (Waghorn et al., 2003, 2007, 2009a,b) in that order, have an increasingly negative impact on labour force activity throughout the working life, also impacting on educational attainment via early disorder onset and during pre-diagnostic phases of psychosis (McGorry et al., 2007). The gradient of the impact of these disorders on labour force participation is monotonic and increases with severity of diagnostic category. This disruption is seen in 2003 population level data (Waghorn et al., 2009a,b) by comparing proportions not in the labour force among community residents of working age with no health conditions or disabilities (19.8%); to those with anxiety disorders (47.2%); depressive disorders (57.4%); and schizophrenia (76.3%).

While there is no doubt that these disorders disrupt employment trajectories, it is unclear whether the same disorders are associated with similar disruption throughout secondary schooling, vocational training and higher education. Although the extent of disruption to both education and employment has been reported previously (Kessler et al., 1995; Isohanni et al., 2001; Mechanic et al., 2002; Marwaha and Johnson, 2004; Honkonen et al., 2007; Marwaha et al., 2007) this is rarely reported simultaneously for the same individuals with respect to healthy community residents as disruption

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benchmarks. Estimating the extent of career-related disruption has important policy implications in terms of: (1) access to secondary and higher education; (2) facilitating school to work transitions; (3) increasing workforce skills; and (4) responding to labour demand. It is also important to know why people are not at school or in employment. Not being employed carries less concern if the primary reason is enrollment in formal education or vocational training. In good economic times when labour demand increases, people not currently in the labour force and not currently undertaking formal education or vocational training, represent human resources that could be assisted back to school or work. Providing participation incentives while reducing disincentives, as well as providing suitable interventions such as supported education (Mowbray, 2004; Soydan, 2004; Waghorn et al., 2004b) and supported employment (Bond, 2004; Murphy et al., 2005; Burns et al., 2007; Bond et al., 2008) may be needed for those with health conditions or disabilities.

A recent administration of a large Australian population survey provided a rare opportunity to investigate this issue. We conducted a secondary investigation of education participation, educational attainment, labour force activity, and reasons for not participating in the labour force, among community residents with schizophrenia, affective disorders, anxiety disorders, and other psychiatric disorders. Comparison groups were adults of working age with health conditions and disabilities other than psychiatric disorders; and adults of working age with no long-term health conditions or disabilities. Due to the lack of prior population level studies of this type we had no a priori expectations for particular patterns of disruption to both education and employment by disorder category, except that similar to the impact on employment alone, we expected the disruption to increase with relative severity of diagnostic category. We aimed to quantify the extent of career-related disruption by age group and by type of health condition using population level prevalence estimates and standard errors. We also explored the reasons given for not being in the labour force, comparing those with health conditions to adult community residents with no health conditions or disabilities.

2. Method

2.1. Data source

The data source and methods have been reported previously (Waghorn et al., 2009a,b). Australian Bureau of Statistics (ABS) provided confidentialised data files from the fourth and fifth administrations of a five-yearly population survey conducted in Australia since 1981. The survey and data release are authorized by the Australian Federal *Census and Statistics Act, 1905*. The data file represented the Survey of Disability, Ageing and Carers 2003, conducted from June to December 2003, which incorporated a household sample of 23,787 people aged 15–64 years after confidentiality protections were applied (Australian Bureau of Statistics, 2005).

The ABS protected the confidentiality of individuals surveyed by removing households with rare combinations of demographic and health conditions from the data file, and where necessary, aggregating variables to suppress identifiable details. Hence, data provided for this investigation may not exactly match that reported elsewhere by the ABS. Other than reducing the total sample size of 0.4% in 2003, confidentiality protections did not limit these analyses, except that the range of anxiety International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) codes had to be narrowed compared to previous reports from the 1998 survey administration (Waghorn and Chant, 2005).

2.2. Sampling

The SDAC design and operation are also detailed elsewhere (Australian Bureau of Statistics, 2005; Waghorn et al., 2009a,b). The survey administration took place in urban and rural areas in all states and territories, except in remote and sparsely settled parts of Australia. Statistical adjustments for not sampling remote residents in the Northern Territory were applied because unlike other states, approximately 20% of Northern Territory residents live in remote areas. Participants included all people except prisoners, non-Australian diplomatic personnel, and members of non-Australian defence forces stationed in Australia. The survey sample was selected using multi-stage sampling techniques based on population census collection districts.

There were two different components to the survey, a household component and a cared accommodation component. Because our focus was on labour force activity, only the household component was utilised. The cared accommodation component involved

high level of care services (long-stay hospitals and nursing homes) and used a different method for collecting information, based on staff reports rather than on interviews with residents, family or carers. Education and labour force activities were not assessed in the cared accommodation component of the survey. The household component covered 14,019 private dwellings (approximately one per 400 in Australia) and 303 non-private dwellings in 2003. Non-private dwellings included hotels, motels, boarding houses, educational and religious institutions, guest houses, construction camps, short-term caravan parks, youth camps and camping grounds, staff quarters, and self-care components of retirement villages. Non-private dwellings were selected separately from private dwellings to ensure adequate representation. Each non-private dwelling was given a chance of selection proportional to the average number of people accommodated. Individual level population weights were provided by the ABS to enable the estimation of population prevalence.

2.3. Survey responses

Information was obtained from 89.8% of private dwellings in 2003. Full responses were obtained from 36,241 individuals in the household component of the survey. Confidentiality protections reduced this sample to 36,088. Details of responses in 2003 from individuals in non-private dwellings, and details of partial individual responses were not available from the ABS at the time of writing.

Our secondary analysis captured people of working age (15–64 years) in mutually exclusive diagnostic categories: well controls ($n = 19,242$); other ICD-10 long-term health conditions (unwell controls, $n = 3017$); those with ICD-10 anxiety disorders (excluding co-morbid depression) ($n = 830$), those with ICD-10 depression (including co-morbid anxiety) ($n = 623$), schizophrenia (including co-morbid depression and co-morbid anxiety) ($n = 75$), and other ICD-10 psychiatric disorders ($n = 246$). Application of ABS population weights as recommended (Australian Bureau of Statistics, 2005) produced population prevalence estimates of community residents of working age (15–64 years) in all categories of interest.

2.4. Identifying people with schizophrenia, depression and anxiety

During interviews all categories of health conditions were systematically investigated and coded according to the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) (World Health Organization, 1993; National Centre for Classification in Health, 2002). A large proportion of health conditions were coded automatically in the field using computer-assisted ICD-10 pick lists. Experienced ABS household interviewers (who were not medically trained) were given a 3 day training in the computer-assisted interview schedule and the ICD-10 classification system. The 2003 schedule was updated from previous administrations in 1998, 1993, 1988, and 1981.

Schizophrenia, affective, and anxiety disorders were identified in three possible ways: by self-report, with a responsible adult of the household, or by another responsible adult person assisting with the interview. Other responsible persons typically included legal guardians, parents, first degree relatives, and adults with formal caring responsibilities. The mental health condition section began with the question: “Does anyone in the household need to be helped or supervised in doing things because of a mental illness or condition?” This question was followed by a structured combination of open and closed questions to reveal the nature of disabilities, spectrum of underlying health conditions, and activity restrictions and limitations. Multiple interviews with respect to the same person were frequently required to complete the schedule.

The classification of anxiety disorders used in previous investigations of the 1998 survey data (Waghorn and Chant, 2005) had to be redefined to match the more restricted range of ICD-10 anxiety condition codes available in the 2003 survey. Obsessive compulsive disorder (ICD-10 code F42) was excluded because it was aggregated by the ABS with other non-anxiety related conditions as a new confidentiality protection measure. Other neurotic and stress related disorders and somatoform disorders were excluded because they were aggregated with somatoform disorders. The resulting anxiety disorder category included: phobias (agoraphobia, social phobia and specific phobia, F40); panic disorder and generalized anxiety disorder (F41); acute stress disorder, and posttraumatic stress disorder (F43). Depression and affective disorders included mania (F30), bipolar affective disorder (F31), depression (F32–33), persistent mood disorders (F34), and other affective disorders (F38–39), excluding post-natal depression. Schizophrenia was defined by ICD-10 code F20. Other psychotic disorders could not be examined in the 2003 survey for comparison to previous reports, because these condition codes were aggregated with other mixed mental and behavioural disorders by the ABS as a confidentiality protection measure.

During household interviews, text fields were used for any disorders reported which did not appear to match items on the pick lists. Codes for all text entries were determined post-interview by more experienced ICD-10 coders. This was necessary because some disorders were collected under more general descriptive categories within the pick lists. For instance, acute stress disorder (F43.0) and posttraumatic stress disorder (F43.1) were both coded under the description ‘nervous tension/stress’. To ensure coding accuracy, all interviews were checked until each interviewer achieved a 90% agreement or higher with an experienced coder. Sample monitoring of coding continued throughout the data collection phase. The interview protocol for the 2003 survey is available from the ABS (Australian Bureau of Statistics, 2005).

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