„PHD SCHOOL IN SOCIOLOGY”

RÉSUMÉ OF THE PHD THESIS

„Borbála Bányai”

„Institutions on the field of labour market rehabilitation”

„Patients with psychiatric diagnose on the labour market”

Ph.D. dissertation

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Budapest, 2013

Table of content

I. Research background, reason of the subject

Since the 1990s, medical, social and financial care, life quality and legal status of the chronically ill and the disabled and especially their social and labour market integration have been drawing more and more attention. In the literature, one of the most significant discussions on people living with chronic disease or disability is about poverty and the problem of social exclusion.

According to the Eurofound research, the opinion about people living with chronic disease or disability has not significantly changed since the development of harmonized EU strategies. Their situation in most European countries remains marginal (Grammenos 2003), stigmatized. In many cases they are isolated from social life and excluded from the world of labour. This has not changed despite gaining ground of the view that the disability is not a medical problem, but social and equality issue instead. "Disability Studies" was brought to life, with its central idea of "Nothing about us - without us!".

The question is obvious: What can be done to make those inactive people living with chronic disease and disapility become active members of labour market? When looking for solutions, serious problems and discrepancies occur, for example: social aid versus work incentives, social care network versus social integration, humanzied social-medical supervision versus personalized, supportive rehabilitation systems. Reasons of exclusion cannot be driven back directly to the disfunctions of society, care system or economy nor to the lack of individual responsibility, motivation or ability. From the individuals' point of view, living with chronic disease or disability means disadvantage and handicap in most of the cases. This is also present at the labour market, the productivity of many of them is limited, they have recuced capacity to work. These difficulties can't be handled easily by the employers or co-

workers. Their health, labour market posibilities and the lack of willingness of their integration leads them towards the social benefits and pension providing stable living. However their inactivity does not mean only low income and longterm poverty for them but social isolation as well (Jahoda 1981), „special outcast cast" (Krémer et al., 2010 p. 12), „secondary citizenship" (Szalai 2007).

In my dissertation I start from the assumption that the inactivity of disabled and chronically ill people is not only their personal damage but also a community problem affecting the whole economy (costs on social benefits could be decreased and those people could contrinbute to the gross national production. The dsabled's participation in the labour market reflects the nation's approach towards them, whether the nation feels them to be the part of the siciety[1]. One of the most important element of the integration of the disabled is to let them do „useful and appreciated" activities. (Verdes-Scharle-Váradi 2012, Harangozó et al. 2001).

With reference to the above mentioned the main aim of my research is to reveal the specialities of institutions affecting the labour market position of the disabled in Hungary.

I.1. Reasoning of the subject and the reference group

To introduce the situation at labour market I selected a special group, the group of patients diagnosed with psychiatric illnesses[2]. Through their example the rate and quality of social acceptance, the entrance to the labour market, and the operational mechanism of social security and regulating institutions maintaining exclusion. My other reasoning is that Hungarian non-medical litterature about psychiatric illnesses are quite

[1] When examining the labour market appearence of the handicapped, we must take into consideration their personal capabilities and qualifications and the rate of employment in that given country, the rate of inactives and the general situation of the labour market.
[2] In my dissertation I consider mentally ill those people who hold official diagnose. Hereinafter I am going to use this term.

few (Bugarszky Zsolt 2003, 2009; Szilágyi Gyula 2005, Légmán Anna 2011) however, it is not only a medical category but is connected by a lot of social phenomena. The actuality of the subject is also reasoned by the fact that OECD issued a special edition on the labour activity of mentally ill patients in 2012. According to their experience the mentally disabled became inactive in earlier ages as those with other disabilities. One reason of this is that these people fell of the education system earlier so they have lower qualification. The other main reason of their inactivity is that unlike other disabilities, mental disability is not „permanent", they have better and worse periods and this kind of incertanity is not tolerated by the employers. The permanent search for new jobs, and adaptation to the new workplace can be tireing for the affected ones as well (OECD 2012).

So in my dissertation I introduce the life of mentally disabled people not from medical but from sociological point of view. The sociological approach of the labour market integration of the mentally disabled peolple has not been researched despite the fact that the prevalence of mentally disabled has been multiplied since the 1980s among those who have reduced capacity of work. According to the research report of Social characteristics from 2008, the mental and behaviorial disorders are the third leading reason of reduced capacity of work and it is the first among people under 39. (Lakatos - Tokaji 2009, p. 72) This datum can confirm the other assumption of my dissertation that disabled people „legaly" become the inactive members of the nation after receiving the official diagnose so sooner or later they will need the social care system.

I believe if we could understand better the way of operation of the old istitutes and practices and the relationship among the prticipants, we could gain important statements about social constructions formed about the disabled and their participation in labour market. I would like to contribute to this by my research. I will also try to introduce the main participants and their activities on the field of possible changes of

intergation, namely how can mentally disableds reintegrated into the labour market and more active social life.

I.2. Theoretical background and the structure of the dissertation

The examination of the exclusion of the disabled and the chronically ill can be done most easily by the stigmatization and similar theories as these reflect to the individual, social and interpersonal aspects in the same time as well. In the first part of my dissertation I review the related main sociological theories and I will detail the historical customs of the image of the mental patients. I use the four models identified by Könczei-Hernádi (2011) as a guideline. In the interpretation of the *medical model*, disabled people are those who have some kind of mental diagnose. The XXI. century definition of health leads towards the direction where health and illness are not the exact opposite of each other, and that the definition of health (as the definition of normal) is rather social issue. This critical approach gains more and more space in health sociology as well (Barnes. Barnes, C. - Mercer, G. - Shakespeare, T. (1999): Exploring Disability: A Sociological Introduction. Cambridge, Polity 1999). Although in my opinion it is still the dominant approach in the care system in Hungary.

The basis of the *moral model* is the stigmatizing (either sorry or contemptuous) attitude (Hernádi-Könczei 2011 p. 10), according to which the disabled person should be either lamentable or despicable, but never equal for any chance. The background of this model are the stigma (Goffmann 1981), labelling, cognitive dissonance reduction (Festinger 2000), symbolic interactionalism theories.

The *social model* of the disabled can be driven from the processes of the social exclusion (Johnstone quoted by Lisznyai 2010 p. 18). The social processes, economical and social structures and cultural context are in its focus. From this aspect, the disabled person becomes disabled by the society that cannot accept them.

Together with the human right model, I detail the terms (disabled, handicapped, reduced capacity of work and psychiatric patient) defining the presence of the disabled on the labour market. Although these are terms defined by the law, their use is not unified in the common knowledge and their content is connected to various socialpolitic principles and social attitudes (Mabbett 2002). In this section I also introduce the recommendations of both WHO (Kullmann 2000) and ILO (ILO, 1997: 280 quoted by Horváth Mező 2004).

When talking about the disabled, the majority of social science literature describes the exclusion and its forms. I presented Sen's (2013) definition and attitude, according to which to understand the exclusion, it is neccesary to take into consideration both the passive (central financing of employment) and active (rejective attitude) processeses.

I held all these models together through the theory of social construction which – according to Schneider and Ingram (1993) - is the university of different categories ans stereotypes created by a given sociality (or politics or religion) towards a given group of people. These constructions are materialized within the language used in connection with the disabled (both in vernacular and legal terms) and in social institutions and processes as well. (Mabbett 2002, Horváth –Mező 2004, Szőlősi 2003, Grammenos 2003).

In this section I detail the historical roots of the relationship between „normals" and patients diagnosed with some mental illness mostly based upon the Hungarian studies of Lafferton (2004) and international studies of Porter (2003) and Foucault (2000).

The instutitionalist approach that I detail in the second section provides a frame suitable for the understanding of the statics and dinamics of the situation of labour market. I considered certain processes and abstact formations as institutions and based on this I would call my dissertation a middle-age institutionalism (Gronning 2008). According to North (1990 quoted by Fiori 2011 p. 188) it is neccessary to observe institutions during a longer period in order to understand society and its changes. According to North (1990) this is important because

institutions change slowly and not fast. We should examine institutional change according to both formal and informal regualtings (North 1990), but according to Fiori (2011) the type of informal borders is more important in which the individuals' (and organizations') perceptions and mental constructions as roots of changes also appear. So by using the institutionalist approach when examining the employment of mental patients and disabled people, the structural facts and mental constructions can be connected and institutional changes can be noticed, so in my opinion this approach is can be characterized by the metodologist and theoretical advantage of the intermediate level merton theory (Merton 2002).

In my opinion the drivers of the changes are the civil/nonprofit orgatizations and their operators. According to Seibel „the nonprofit organizations do not just float freely in the social area but strictly embedded into the social and economical structure" (Seibel 1991, quoted by Bartal 2005 p. 102), so the civil/nonprofit organizations being familiar with the structure and formal guidelines may trigger gradual changes in interpersonal connections and organizational border areas.

In the third sections I introduce the operational mechanisms and domestic realization of the three main institutions (health care, retirement, employment) defining employment, possibly introducing its traditions as well. I separately detailed the complex role of the state (finance, employer, service provider) and its operation. The disfunctionality of the health system and the central employment support (Orosz 2001, Pulay 2009, Szalai 1986) and the interest for disability is well-documented (Major 1977, Monostori 2009). After the analysis of describing data I reached conclusions as Szalai (2007), or Scharle (2011), did, namely the aimes of the current politics are dysfunctional and encourageing exclusion. Regulations and operation of certain institutions have changed but these still do not lead towards integration. They could be described rather with the „unfavourable characteristics of integration" (Sen 2004) instead.

The resolution of the first three sections of my dissertation is that I manage to introduce the mechanisms of labour market exclusion and stigmatization, the possibilities of potential changes as historical process embedded into sthe structure of society and economics

After the review of thesis I present my research.

II. Methods used

During my research mostly I wanted to investigate how mentally ill patients appear on the labour market, which are those mechanisms that support exclusion from labour market or that withdraw the handicapped from the labour market. My research has two main pillars, a mostly descriptive and partly exploratory quantitative, and an explorative qualitative one.

Operationalization of health damage

When preparing the case study and presenting data is is important to know who do we consider disabled and what is the content of this term. In my dissertation I examined those people who had received diagnose with some psychiatric ilness, namely who have official certificate about being „disabled" so the society treats them accordingly.

Quantitavive data

Sources of descriptive analysis are from two direction. To evaluate international data I used the online database of ESS.

To introduce the typical life pattern and situation of the disabled in Hungary I used the database of TÁRKI and Nemzeti Család- és Szociálpolitikai Intézet prepared among people with reduced capacity of work. Regional stratification was made upon the 2008. Year data of Országos Nyugdíjfolyósító Intézet about those who receive pension under age or have reduced capacity of work. „2045 questionnaires were

made among 18-62 years old people living at home" (Gábos- Tátrai 2011 p.5). This happened at the end of 2010.

Qualitative data

I created case studies to understand the motivation and relationships of the participants, the mechanism of exclusion from the labour market and the social constructions behind it.

During my research I tried to find cases typical in Hungary and one extraordinary, although I met several institutional joints. By this the cases presented by me are not just to introduce a type of employment on the labour market, but to introduce a complex system valid always in the given context and time.

In my dissertation I present three cases:

1. Target organism employment within the frames of a residential social institution
2. Social employment with government daycare background
3. Open employment with foundation background providing community care

During my research I intended to observe the given situation from the point of view of every participants. To achieve this I returned to each stage several times and spent several days in the residential institution. I conducted interviews and I held the role of an observer. During my research I could see many documents, however these contained the same that my interviewees presented so I did not evaluated them separately.

The structure of the interviews are different. With mentally ill patients I created unstructured deep interview evaluated with non-biographical techniques.

With other participants (director of the social home, nurse, etc) I created structured or half-structured interviews.

Besides the above mentioned I created many more interviews with professionals related to the subject.

One of the most important questions of the labour market exclusion is why aren't mentally ill patents employed. Related to this topic I made interviews with different managing directors and regional leads of companies. According to my opinion it was extremely important to make these interviews with the employers as such discriminative behaviour would attract legal consequences.

III. Results of the dissertation

In my dissertation I studied the labour market situation of disabled and mentally ill people. Before 1989 it was possible even for these people to have some kind of jobs, however after this date the positions at open labour market for mentally ill or disabled people disappeared and the affected eployees were retired instead and by this, they were sent to the margins of the society.

1. .People living with some kind of disability or psychiatric diagnose spend less active time on the labour market compared to the healthy ones.

People living with some kind of disability or mental diagnose usually become inactive at their age of 50 as pensioners. Into the sample used for data evaluation we can find people between 18 and 62 among whom the 88% (504 person) of people living with mental problems were inactive, and 84% (1233 person) living with other disabilities were inactive at the time of sampling. Pension was identified as main income in 73% and 72% of the cases. The mentally ill included into the sample were average 51 years old spending average 21 years on the labour market, got retired at the average age of 48, so their inactive state begun sooner than the retirement.

2. Those with mental ilnesses can have several labour market carreer, however after being diagnosed, the majority become inactive.

According to the qualitative evaluation the labour market carrier brakes after receiving the official diagnose. The employee's status at the

workplace usually decreases and soon disappears. According to the experiences by the time the affected person turns to a doctor, they have already been tired by the periodical worsening of their status. They give up making themselves accepted or fighting for themselves against negative employer opinion so finally they rather choose poverty and inactivity instead. According to quantitative data the average appearence of the ilness is between 31-40, average 35 years old phase. In the light of the data this means that in case of a totally linear carrier, the average interviewee lost their job very soon, within 5 years from the beginning of their ilness. To understand the labour market carrier better I identified four groups:

- Problems started at young age, fast labour market exclusion, namely they become inactive at the age of 30.
- Problems started at young age, slow labour market exclusion, namely they become inactive by the age of 43.
- Problems started at middle age, immediate labour market exclusion, at the average age of 40-45.
- Problems started at middle age, slow labour market exclusion, namely they become inactive at the average age of 50, or they are still active.

3. The social construction related to the mentally ill patients are still rejective and this also appears in their labour market welcome as well. People living with psychiatric diagnose mostly work at closed or half-closed workplaces.

The attitude that mentally ill patients are false self and they require constant supervision and care has been developped long before in Hungary, whole institution network has been build upon this. It seems that this attitude is fixed, and the change of opinion of participants should harm the interests of many of them. Mentally ill patients are not welcome on the open labour market. If they are unable to continue working at their original workplace, they try to find a new job through their relatives and friends. These jobs are mostly closed or half-closed,

protected ones. Their exclusion from the open labour market is validated by the fact that during my research I could hardly find a company that would employsomebody with mental illness for a longer period.

4. *The exclusive labour market attitude and the change of the care system is not harmonized so they lead the affected ones away from integration. The legislations related to the people with reduced capacity of work rather lead them towards the half-closed labour market or inactivity.*

Exclusive and integrating approach can be found in the legislation in the same time so different kinds of realization is possible. It is possible to work in a phisically and socially closed , protected workplace. Besides this it is obligarory according the laws to maintain a partly governmentally financed labour mediation offices. However the maintenance of these labour mediation offices are realized from tender money so they are not considered to be permanent.

Change towards integration into the labour market is also urged by the unsustainable pension system. However the data about quantitative evaluation underlines the trend of early retirement. According to my experiences the reason behind this is within the informal borders of forming institutions. These are embedded into the society and can be changed very slowly (North 1990). This means that changing the pension system is not enough to help the open labour market participation of the disabled and mentally ill as they brake into informal borders of the rejective attitude of social and health care providers.

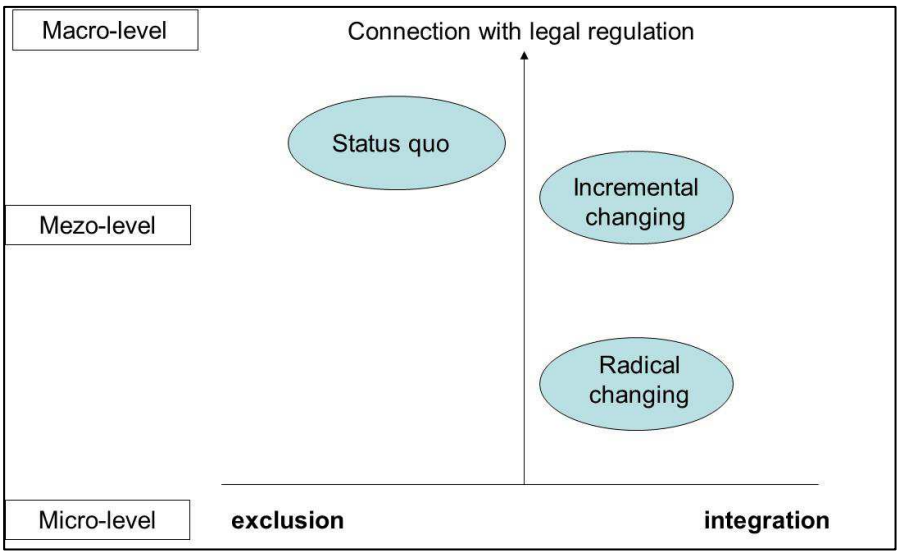
5. *The integrated employment of the mentally ill as a goal is not clear even acoording to the affected and people dealing with them.*

According to the interviewed professionals it can be feasible only in that case if the employers's and employees' welcome is not rejective or negative, if the general economical and labour market situation is not tense and the mentalli ill feel themselves capable for working. However this is not the case in Hungary. The labour market situation is not calm,

nor balanced, nor tolerant and the labour market has rejective mechanisms. Almost all the directors of companies whom I interviewed were negative and rejective related to the mentally ill.

The labour market reintegration of the mentally ill has a fixed institutional practice. The social participants are interested in the further exclusion and rejection of the disabled from the labour market and in the maintenance of the status quo, however some new players with new attitudes helping integration has already appeared.

1. figure Changes of the labour market and the possibilities of stability



6.1. *Maintaining the status quo means maintaining the close employment forms operating within the social residental institutions. For those who have reduced capacity of work, protected employment is still the dominant form of employment in Hungary. The reason behind this roots in the interest of these institutions and the dysfunction of salary support.*

Target organizational jobs and residential institutions are isolated so real reintegration of the affected ones into the open labour market is not possible. The interest of these institutions is to maintain the status quo as they receive financial support from the government. This all means that on micro level, the exclusion is preserved, the affected are closed from the open labour market and „normal" life.

6.2. The key of the changes leading the affected ones towards the integration is the new attitude of those who maintain these institutions.

The incremental change is realized by the daycare institution presented by me. These can adapt to the changes if there's any if it is suitable for the affected ones. The professionals of this institution can change the system within its frames, namely to renew the institutional habits and customs (Ebbinghaus 2005). For the sake of the integration the institution changes. Instead of one institution (daycare) they create two of them (creation of a foundation) – so they will have the possibility to support their clients on the labour market.

6.3. The incremental change appears also in the employment through the half-open social employers. This way of employment is rather integrative, however their maintenance is uncertain and not rentable.

At social employers besides the administrative staff everybody has reduced capacity of work. They work at places created and maintainde especially for them. This institution concentrates better to their financial and family needs as well, they try to ease their participation in social and economic life as well. These institutions fulfill local needs, they could not survive on the open market so their exsistance cannot be considered permanent. They depend on the government and they are considered to provide half-open employment.

6.4. People representing changes that lead to integration create civil/nonprofit organisations to institutionalize their actions.

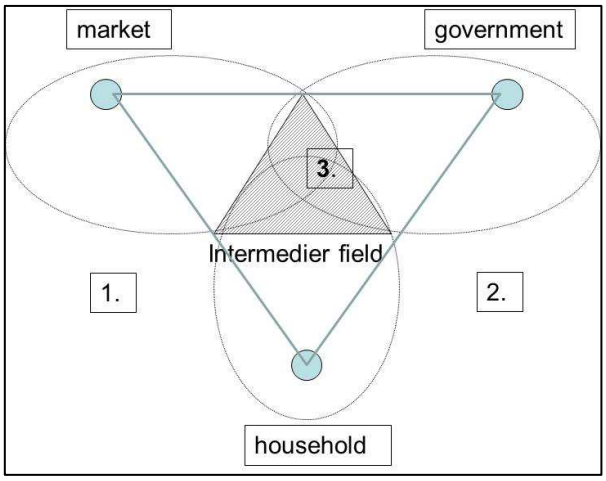
I consider this action as radikal action. The foundation try to stay independent from the government. They would like to stop the „patient status" by serving labour market and social reintegration by creating a brand new point of view in the life and judgement of the mentally ill patients. Of course they are happy to use the possibilities provided by the government if it fits to their goals.

6. The key of effectiveness of changes is the relationship among institutions. This can be derived from interpersonal covers that is a special phenomena in Hungary.

To present the renewal attitude and possible changes I used the well-being concept of Adalbert Evers (1995), where civil/nonprofit sphere is an intermittent area among the government, the market and the households. Improving the Evers – table I would like to present the diversity and colourfulness of the labour market rehabilitation of the mentally ill patients. By these changes helping integration can be captured.

In Hungary after 1989 decentralisation started at many areas and in the social sphare as well. One of the methods for this is the outsourcing of some central tasks to the local governments and communities.

2. figure: Relationships among local government, market, private and civil/nonprofit spheres in the labour market reintegration of the mentally ill people



In the original picture next to the market and households we had the state instead but I changed it to local government. Intermediate area refers to the civil/nonprofit sphere which I did not intend to present as these organisations might not be permanent or independent. This all is neccessary because in case of local governments the changing institutions are more active.

6.1. The private labour mediation office was brought to life by an affected family who provided their own money to maintain the organization. In this case the household human stock and the company

stock found each other and they maintain the company since then together.

However the foundation has agreements with the local government, the foundation can stay alive without the local government, though. So in this case the cooperation of the market, profession and private sector is the factor that keeps the foundation representing the intermediate area operational.

6.2. In the local government's care office there is also a labour mediation office and a foundation. This was brought to life by loval governmental employees and some professionals. The operation of the foundation is strongly connected to the care office. In many cases the employees of the local government work for the care office and vice versa. Place of work is obviously the same.

6.3. The relationship among the local government, the civil/nonprofit sphere and market sphere is embodied by the social employer. Social employer is operated by an organization brought to life by the Mayor in 1996. The premises of the organization belong to the local government but the organization does not have to pay rental fee, only the operational costs. The organization has to directly report to the local government.

The orders of the social employer are from the market sector, but its operation is not rentable so its income is supported by the local government. The aim of the employment is not the profit but rather the drainage of the local labour market tension.

The employer does not only provide work for the affected people but helps them in many other ways preventing their isolation and poverty in the meantime.

These relationships are very important as these foundations presented by me can help the labour market integration of the mentally ill and/or disabled people. Namely the single interpersonal covers can transform into organizational connections and informal relations can transform

into formals so institutions helpiung labour market integration can be brought to life.

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