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The Idea of Occupational Justice and Difficulties with Its Implementation in Polish Conditions on the Example of People with Mental Disorders

Occupation is one of the basic human needs. The term refers to all activities that people need to, want to, and are expected to do. It includes activities of daily life related to self-care, productivity and leisure time, named, defined and having a value given to them by individuals and culture. Human beings are occupational beings, and occupation is an active element of human existence, necessary for health as it is understood in the broadest sense.

The right to pursue activities relevant to the individual, which is enshrined in the concept of occupational justice, is often not reflected by the opportunities available to individuals or groups facing various types of limitations, e.g., disabilities, mental disorders, social exclusion, etc. Limited awareness, unavailability of support, funding difficulties – this is the grim reality both for people struggling with certain difficulties and for those who look after their care.

In this article, the idea of occupational justice is contextualised within the Polish reality of health care and social care directed to people with mental disorders.

Keywords: occupation, occupational justice, occupational injustice, mental health.

Introduction

According to the idea of occupational therapy, every human being is an occupational being, regardless of his or her age, gender, race, health or level of fitness. Occupation is inscribed in a person's life, from birth to death (Reilly 1963). The opportunity to pursue occupation should be the right of every individual,

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regardless of their health, gender, age or other characteristics. Unfortunately, this ideal is not achieved in practice, especially for people who struggle with various types of limitations, including mental disorders.

The aim of this article is to present the idea of occupational justice and to analyse the situation of people with mental disorders in Poland in terms of equal access to occupation, based on available source materials.

In order to meet the objectives of the article, it is necessary to outline the scope of the meaning of the terms "occupation" and "occupational justice".

According to the World Federation of Occupational Therapists (WFOT 2012), occupation refers to all the things people need to, want to, and are expected to do. Occupation is therefore something that occupies people's time and attention. The term is used to describe activities of daily life that are named, organised, and have a specific value given to them by individuals and culture. They include everything that people do in terms of self-care and the enjoyment of life, as well as all the things that contribute to strengthening their communities socially and economically (Law et al. 1997: 32). Occupation is therefore a guided activity, taking into account the needs, abilities and preferences of the person doing it. In occupational therapy a distinction is made between self-care activities, e.g., washing, dressing, preparing meals, eating, and mobility, and leisure activities, e.g., playing sports, establishing and maintaining social relationships, pursuing hobbies; and productivity activities, e.g., working, studying.

Occupation is an active element of human activity that is necessary for broadly understood health and well-being. Occupational activity depends on the health of the individual. On the other hand, activity significantly affects health. According to the definition promoted by the World Health Organization (WHO), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This view of health takes into account not only its biological dimension, related to the functioning of the body, but also its mental dimension, relating to the functioning of the mind and emotions, and its social dimension, reflected in social participation. Health is therefore multidimensional, with its components influencing each other. It can be assumed that in a healthy person the components of health, i.e., physical, mental and social functioning, are in a state of balance and integration. Health is treated as a process of maintaining a dynamic balance between the demands of the environment (internal and external) and the potentials possessed by an individual (Juczynski 2016: 21). Nurturing health requires both effort and the appropriate skills to maintain the balance in the face of changes that are constantly taking place, both in the individual's environment and in his or her body. One of the factors directly related to health is precisely the individual's occupation. Performing an occupation has physical, mental, and social dimensions. For example, preparing a meal requires the use of physical

resources – the ability to move, a functioning upper limb (or equipment adapted in a way that a person with limitations could make use of it), etc. The psychological aspect plays here an important role – a sense of empowerment, satisfaction, etc. Equally important is the social dimension – the meal may be for relatives or it may be a work-related task. Occupation should be accessible to everyone, regardless of their individual characteristics, social standing or cultural background.

In occupational therapy, the idea of occupational justice, according to which every person should have the right and opportunity to engage in occupations that are important to them, is widely emphasised. The promotion or limitation of occupational justice (the right and opportunity to engage in an occupation), is linked to a number of structural and contextual factors. Structural factors include occupation-related determinants, such as: type of economy, regional/national/international policies) and occupational instruments or programmes (i.e., health and social support, education, employment). Contextual factors relate to age, gender, religion, sexual orientation, health status, disability, etc. The relationship between structural and contextual factors is reflected in conditions that either favour or limit occupational justice, the latter resulting in occupational injustice. However, the essence of occupational justice is precisely the individual's right to pursue an occupation, taking into account its meaning, the possibility of participating in it, the possibility of choosing the occupation and of maintaining the occupational balance (Townsend 2012).

According to the World Federation of Occupational Therapists (WFOT 2006), every person has the right to have their participation in occupations supported, to be a full member of their family and community. Everyone has the right to participate in occupations that enable them to develop, that give them fulfilment and satisfaction and that are compatible with their beliefs and culture. The right to occupation takes into account civic, educational, creative, and spiritual activities and is based on the recognition that each person's contribution is of value to the whole community. Important threats to occupational justice include economic factors (poverty), illness, social discrimination, natural disasters, and armed conflict. Additionally, opinions about occupational justice are linked to religious beliefs, culture and as well as to environmental and institutional conditions (Misiorek 2019).

Adopting an occupational justice perspective allows for a deeper analysis of the situation of individuals and groups precisely in the context of this phenomenon. As already mentioned in order to better illustrate the issues at hand, this article chooses to describe the situation of people with mental disorders.

People with mental disorders in Poland

An attempt to describe the situation of people with mental disorders should start with a characterisation of this population. Unfortunately, the difficulty arises already when searching for definitions in legal documents. In the Polish Mental Health Protection Act currently in force (Rada Ministrów [Council of Ministers] 1994), there is no definition of "mental disorder" or "mentally ill person", despite the fact that these terms occur repeatedly in the text of the Act. Instead, it is stated that:

> Whenever the provisions of this Act provide for a person with a mental disorder, this refers to a person who: is mentally ill (exhibiting a psychotic disorder), has an intellectual disability, exhibits other disturbances of mental functions which, according to the state of medical knowledge, are classified as mental disorders, and the person requires health services or other forms of assistance and care necessary for living in a family and social environment (Rada Ministrów [Council of Ministers] 1994).

This description is very general and therefore open to various interpretations, which should not be the case.

In the *International Statistical Classification of Diseases* and *Related Health Problems* ICD-10, developed by the World Health Organization (WHO), currently in force in Poland[2], mental disorders are described in the chapter entitled *Classification of Mental and Behavioural Disorders*. They are divided into 14 diagnostic categories, examples of which include: affective disorders, neurotic disorders, disorders of psychological development, personality disorders, intellectual disabilities, etc.

Carried out between November 2010 and March 2011, the first epidemiological study of mental disorders in Poland was conducted on a random sample of more than 10,000 respondents aged 18–64 in accordance with the methodology of the World Health Organization (WHO) and in collaboration with the World Mental Health (WMH) Consortium, in which the Composite International Diagnostic Questionnaire (CIDI) was used. It was carried out as part of the "Epidemiology of Psychiatric Disorders and Availability of Psychiatric Health Care. EZOP – Poland" Project (Kiejna et al. 2015). The study report indicated that in the population studied, at least one disorder out of 18 defined in the classifications (ICD-10 and DSM-IV) could be diagnosed in 23.4% of people – Polish residents of working age – during their lifetime. The most common were substance abuse disorders (12.8%), including alcohol abuse and dependence (11.9%), and drug abuse and dependence (1.4%).

[2] On 1 January 2022, a revised version of the ICD classification numbered 11 was adopted. However, until it is officially translated, the provisions contained in the ICD-10 version remain in force. Poland, like other countries, was given a 5-year period to implement it and adapt it to the national system.

The next most prevalent group of disorders were neurotic disorders, among which specific phobias (4.3%) and social phobias (1.8%) were the most common. Overall, all forms of neurotic disorders affected approximately 10% of the study population (2.5 million Poles). Mood disorders – depression, dysthymia or mania – were jointly diagnosed in 3.5% of respondents (approximately 1 million Poles). Impulse-control disorders: oppositional defiant disorder, behavioural disorder, intermittent explosive disorder, attention deficit hyperactivity disorder (ADHD), were diagnosed in 3.5% of respondents (approximately 1 million Poles).

Another EZOP II study, entitled "Comprehensive Study on the State of Mental Health of the Population and Its Determinants" was carried out in 2018–2019 on a representative sample of 15,000 people. In the 2nd edition of the study children were also included in the sample, divided into age groups 0–6 years and 7–17 years (Moskalewicz, Wciórka 2021). The report indicates that disorders of psychological development affect as many as 400,000 of the youngest children, and more than 500,000 children in the age group 7–17 years have a history of mental health disorders. More than 8 million adults in Poland (1/4 of the population) experience various mental disorders. More often people affected by mental disorders are poorly educated, lonely, and those who have dropped out of the labour market.

It is worth noting that the EZOP II study was carried out before the COVID-19 pandemic. The pandemic and the associated sense of threat to one's own and loved ones' health and lives, feelings of insecurity, and other associated emotions may contribute to increased psychological distress, including depressive symptoms and anxiety in the general population affected by the pandemic, as confirmed by a number of findings from studies carried out in various countries (e.g., Jia et al. 2020; Mazza et al. 2020). Hence, it is speculated that if the EZOP study was repeated in the current year, the results could further highlight the magnitude of the problem.

Situation of people with mental disorders – an attempt at description from an occupational perspective

Mental health problems are related to other aspects of an individual's functioning: cognitive, motor, individual or social. In practice, this results in, for example, limitations in one's ability to perform work or daily activities, a reduction in the quality of one's work or having to put more effort into it. The consequences of mental disorders are experienced as troublesome, fostering unfair treatment or considered as a source of significant disruption in relationships with family and friends (after Niemczyk-Zając 2021).

An analysis of the situation of people with mental disorders from an occupational perspective may be facilitated by referring to one of the models used

in occupational therapy, the PEO model (Law 1996). The Person-Environment-Occupation (PEO) model emphasises occupational performance as shaped by the interaction between person, environment and occupation. Occupational performance can be measured objectively, but the individual's satisfaction with the task is also important. The person domain includes role, self-esteem, cultural background, personality, health, cognitive function, physical fitness and sensory abilities. The environmental domain includes the physical, cultural, institutional, social and socio-economic environment. Occupation, on the other hand, refers to the tasks that a person performs and through which they are able to support themselves, that allow them to express themselves and obtain fulfilment. These three domains are interdependent and mutually influence each other. This model can facilitate the understanding and analysis of problem domains that have their consequences precisely in the domain of occupational performance, which is a complex and dynamic phenomenon that changes in different periods of life and environmental circumstances.

Using the PEO model, an attempt can be made to describe the situation of people with mental disorders. Referring to the first domain of the model – the person – it is worth emphasising the fact that each individual is unique. The person is seen holistically as consisting of body, mind and spirit, and is characterised by many elements including self-concept, personality type, personal competences and cultural background. In the case of people with mental disorders, it is possible for them to experience various limitations, e.g., motor, cognitive or related to the area of social participation. This uniqueness also relates to the fact of experiencing the illness, its dominant symptoms, the level of acceptance or lack of acceptance, the motivation for treatment. There are no two identical individuals with schizophrenia or suffering from affective disorders, nor are there identical children with disabilities. Apart from individual factors, people are differentiated by their environmental context, family situation, and availability of support. These factors have their repercussions in the self-image inherent to the individual. Available research indicates that people with mental disorders are characterised by low self-esteem, unawareness of their own rights, low levels of education, reduced productivity, and poor social relationships (Kaszyński 2013). In these individuals, the occurrence of anxiety related to the disclosure of the illness (the so-called Goffmanian internalised stigma [Goffman 2007]) and reduced motivation to act have also been noted. The postponement of benefiting from available help or rejecting it, which can also be observed in this group of people, may be related to stereotypes related to mental disorders. The rigidity of social attitudes and related behaviours, characterised by distance and exclusion of the mentally ill, effectively discourage people with difficulties from talking about them and seeking support (according to the results of the EZOP II study). Equally complicated are the possibilities for people with mental disorders to perform social roles. Difficulties are already apparent at the

lowest levels of education. Article 1 of the Act on the Education System indicates that the school is obliged "to adapt the content, methods and organisation of teaching to the mental and physical abilities of students, as well as to provide the possibility of using psychological and pedagogical assistance and special forms of didactic work" (Rada Ministrów [Council of Ministers] 1991). Unfortunately, the implementation of this provision in practice leaves much to be desired. For example, the NIK (Supreme Audit Office) audit showed that in the 2020/2021 school year in some schools psychological and pedagogical assistance classes were either organised in an inappropriate manner or were not provided to all students who had such indications in the opinions or judgments of psychological and pedagogical counselling centres. It was also emphasised that groups which took part in didactic-compensatory and corrective-compensatory classes were too large, which made it difficult for teachers to achieve the set goals. NIK also expressed reservations about the working conditions in schools concerning, among other things, the poor equipment in the institutions and persistent overtime of teachers (NIK 2021). It is also worth emphasising that factors related to a given mental disorder can often result in a child requiring hospitalisation or staying at home, which has an impact on the child's limited fulfilment of his or her role as a pupil, colleague or class member. For adults, difficulties are related to the fulfilment of the role of a worker, which in occupational therapy is included in the area of occupational productivity. Observation of the situation of people with mental disorders in the labour market allows us to notice the insufficient protection of the rights of employees with mental disorders, the lack of economic and stimulating mechanisms for employing this category of people, the high level of unemployment in the local labour markets, as well as the lack or low level of knowledge among employers about the financial benefits associated with employing people with mental disorders (Kaszyński 2013).

The second domain refers to the environment, which is considered very broadly and includes cultural, physical and socio-economic contexts. The environment therefore does not only mean the physical, residential conditions; the cultural background also refers to the immediate people, the local community and the wider society. The potential of the environment for change seems unlimited. Realism, however, dictates a modification of this belief – while making adaptations in the physical environment, e.g., adapting accommodation to a person's needs, is usually feasible, changing attitudes towards people with mental disorders is extremely difficult. According to the results of the EZOP II report, rigid and reluctant stereotypes can still characterise attitudes towards mentally ill people, mental disorders, and psychiatric care institutions. More than half of the Polish population does not accept the ill in their environment, and is also reluctant to see the establishment of mental health-related institutions in their place of residence (Moskalewicz, Wciórka 2021). The organisation of psychiatric care and the availability of mental health professionals can be described as insufficient.

Vocational rehabilitation is not integrated with clinical services, vocational activation programmes are characterised by low effectiveness, and there is a lack of work experience and internship spots for people with mental disorders (Kaszyński 2013).

The third domain of the model is occupation. It is considered essential to the person's internal needs with regards to self-care, productivity, and leisure time. Performing an occupation gives the individual a sense of being competent, self-reliant, and being able to do what is meaningful and needed. It is noteworthy that occupation is also related to the social roles performed by the individual – is stems from the role and also allows the individual to fulfil it. The need for occupation occurs at every stage of life regardless of a person's level of fitness or state of health. It is worth noting that in some situations, the physical "execution" of certain occupations may prove significantly challenging. Townend and Polatajko (2007) emphasise that in order to capture the broadest perspective of human occupation, occupational engagement should also be taken into account. For example, when observing people who are bedridden, it is difficult to observe the performance of an occupation in a strict sense, but what is important is what the person experiences and feels in relation to the occupation. Engagement can mean making choices, expressing one's will and exercising control over certain aspects of one's life (Misiorek 2019). A person who is bedridden, for example, is physically unable to perform an activity such as dressing, but may nevertheless be involved in it, e.g., by making choices about clothing, its colour, etc.

The above-mentioned components of the PEO model are dynamic and mutually influence each other. Understanding the essence of the different components and their relevance with regard to occupation is crucial for making effective interventions aimed at supporting people struggling with mental disorders.

The concept of occupational justice in the Polish context

In Poland, psychiatric health care comprises three basic organisational forms. The first of them is outpatient care, with its primary component being mental health clinics where active care is provided. Inpatient care includes hospitalisation. Indirect forms, on the other hand, involve treating a person without separating them from their environment and include day wards, community treatment facilities and hostels. Forms of social support are also available, such as specialised care services for people with mental disorders, community self-help homes and social care homes. Tasks related to vocational rehabilitation are carried out in occupational therapy workshops, and tasks related to socio-occupational rehabilitation are performed in vocational activity centres, among others (Niemczyk-Zając 2021).

The facilities mentioned above are just an example serving to illustrate that, in theory, help for people with mental disorders is available. In reality,

however, in certain situations both the health and social care systems are inefficient (Niemczyk-Zając 2021).

How is the idea of occupational justice implemented in Polish conditions? Do people with mental disorders have the right and the opportunity to be involved in occupations that are important to them?

The answers to the above questions are not unequivocal. On the one hand, every individual has constitutional rights, while on the other hand, the possibilities of exercising these rights are quite debatable. Examples of limitations concern the possibility of supporting the health of individuals whose condition either enables or limits the ability to perform an occupation. These limitations include, among other things, access to specialist physicians. According to data as of 30 April 2022 made available by the Supreme Medical Chamber in Warsaw, in Poland there are currently 5228 psychiatrists (including 531 child and adolescent psychiatrists), of which 4926 are practising specialists.

Polish law does not sufficiently protect people with mental disorders against exclusion, in particular against discrimination on the labour market, and does not ensure access to education and the above-mentioned health services to an adequate extent (Moskalewicz, Wciórka 2021). Referring to the terminology specific to occupational therapy, one can consider limitations regarding occupations within the domain of productivity, which encompasses professional work and education.

The already-cited results of the EZOP II study highlight the disproportionate prevalence of social development disorders among children under 6 years of age living in urban versus rural areas (in rural areas the prevalence rate is twice as high), as well as the disproportionately high prevalence of disorders among children aged 7–17 in families receiving social care (Moskalewicz, Wciórka 2021). This situation should lead to decisive action directed at the provision of support and treatment, as well as the development of community health care directed at cooperation with the family and educational institutions, among others.

The vast majority of people with mental disorders do not receive or benefit from adequate assistance, which does not go hand in hand with the idea of occupational justice. The individual's right to exercise occupation is often already limited at the level of awareness by stereotypes. Most often, these stereotypes propagate ideas that people with disabilities pose a danger to those around them, are irresponsible and unpredictable, and are intellectually less able. These beliefs result in infantilising people with mental disorders, ignoring their rights and treating them with pity (Lejzerowicz, Książkiewicz 2012).

It is worth emphasising here the potential of occupational therapy, which in Poland remains untapped. The profession of occupational therapist is included in the group of medical professions, and persons holding a bachelor's degree have the necessary knowledge and skills to undertake effective activities directed precisely at the area of

human occupation. Reports in the Polish language regarding activities that occupational therapists, educated to the best world standards, can undertake are quite limited in number. There are, however, many foreign-language publications on the subject (Castro et al. 2016; Hammond 2004; Algeo, Aitken 2019). According to a review of the available global literature, the most common of the interventions used by occupational therapists is psychosocial intervention aimed at reducing the symptoms of the disorder, occupational recovery and social and occupational reintegration of people with mental disorders. Subsequently, psycho-educational interventions are applied which aim at acquiring disorder management skills, increasing social skills such as non-verbal communication, and enabling the patient to perform meaningful activities such as reading. Equally frequently implemented interventions include cognitive interventions aimed at improving cognitive function, exercise interventions directed at compensating for the cognitive impairments common in psychiatric disorders, increasing participants' knowledge and understanding of rules, and enhancing their teamwork skills (Rocamora-Montenegro 2021; Wilburn et al. 2021).

The presented considerations indicate a number of weaknesses related to the implementation of the idea of occupational justice for people with mental disorders in Polish conditions. The resulting effect, however, should not be stagnation, but the revision of actions taken and the generation of new effective solutions, so that everyone, including those struggling with illness as well as healthy people, can realise what is important to them, what they need and what gives their life meaning.

Summary

How can the idea of occupational justice be strengthened in Poland? It is worth thinking about some of the following postulates.

First justice requires social responsibility for enabling all members of society to perform occupations that are important to them (Townsend 2012). Responsibility is required at both the societal and institutional level, but also at the individual level by accepting that mental disorders are egalitarian and that those affected are and should be treated as full participants in society. This requires working towards replacing stereotypes, which is a difficult and long-term process. Although the durability of stereotypes and the failure (to date) to renounce them has been pointed out by researchers. Nevertheless researchers likewise seek ways to weaken the stereotypes as described, for example, in models of stereotype change theory of so-called "out groups" that take into account the potential for empathy (Finlay, Stephan 2000; Batson, Polycarpou 1997).

Second, changes are needed at the institutional level related to housing, employment, recreation and others, which means supporting the subjects and institutions

that operate in these areas, both by educating their representatives about the resources available to people with mental disorders and by providing the means to take decisive supportive measures, e.g., developing sheltered housing, supporting entities focused on providing employment to people with mental disorders or implementing social projects aimed at their inclusion.

Third, the development of occupational justice for people with mental disorders requires the development of targeted programmes and the creation of conditions for the real involvement of these people in occupations as well as the promotion of their social participation.

Undertaking the above-mentioned actions requires an adequate background, both in the form of appropriate legal regulations and financial resources, as well as the use of sound scientific knowledge, openness towards the other person, and behavioural changes. Humanity and mutual respect should be the basis of social relationships, no matter who the participants in that relationship are or what they are up against.

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