



Economic and Social Empowerment for Persons with Lived Experience: Strengthening Autonomy, Recovery, and Participation in Mental Health Systems

“Voices of Experience Empowering Healing: Exploring Research, Innovation, and Systemic Change to Strengthen Voices of Lived Experience in Prevention, Promotion and Management of Mental Health Conditions.”

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ABSTRACT

Mental health recovery is increasingly understood as extending beyond symptom reduction to include social inclusion, economic security, autonomy, and meaningful participation. However, persons with lived experience (PWLE) of mental health conditions continue to experience unemployment, poverty, stigma, discrimination, and limited access to economic opportunities, which can undermine recovery and restrict meaningful participation in mental health systems. Against the theme, *“Voices of Experience Empowering Healing: Exploring Research, Innovation, and Systemic Change to Strengthen Voices of Lived Experience in Prevention, Promotion and Management of Mental Health Conditions,”* this paper examines how economic and social empowerment can strengthen the voices, autonomy, and recovery of PWLE and enhance their participation in mental health systems. The study adopted a qualitative literature synthesis approach, reviewing recent peer-reviewed studies, systematic reviews, policy documents, and relevant scholarly literature. Evidence was thematically analyzed according to four objectives addressing economic stability and recovery, structural barriers, empowerment interventions, and strategies for regional system integration. The analysis was informed by the Social Causation and Social Drift perspectives and Self-Determination Theory. Findings demonstrate a bidirectional relationship between economic stability and mental health recovery, while stigma, discrimination, unemployment, and inadequate workplace support remain significant barriers. Supported employment, Individual Placement and Support, peer-support approaches, vocational rehabilitation, and financial inclusion provide important pathways to economic autonomy and social participation. The paper concludes that economic and social empowerment should be integrated into recovery-oriented mental health systems to strengthen PWLE as active partners in prevention, promotion, management, and systemic transformation.

Keywords: Economic empowerment, mental health recovery, persons with lived experience (PWLE), supported employment and systemic policy reform.

1. INTRODUCTION

Globally, mental health is increasingly understood as a multidimensional public health and development issue shaped not only by clinical factors but also by social and economic conditions. International mental health reforms have therefore shifted progressively from a predominantly biomedical approach, focused on symptom reduction and clinical stabilization, toward recovery-oriented models that emphasize social inclusion, human rights, participation, and quality of life. Despite this shift, economic empowerment remains insufficiently integrated into mental health care and psychiatric rehabilitation. For persons with lived experience (PWLE) of mental health conditions, sustainable recovery often depends not only on access to medication and psychosocial support but also on secure livelihoods, employment, financial independence, and meaningful participation in society (Sartor, 2023).



In low- and middle-income countries, particularly across Africa, these challenges are intensified by poverty, unemployment, limited social protection, inadequate mental health services, and widespread stigma. PWLE may experience exclusion from education, employment, financial services, and community life, creating interconnected cycles of economic vulnerability and psychological distress. At the regional level, mental health systems continue to face resource constraints and limited integration of economic rehabilitation into routine services, despite growing recognition of the social determinants of mental health (Okesanya et al., 2026). Within this context, economic empowerment represents an important but underdeveloped dimension of psychiatric rehabilitation. Labour-market exclusion, discriminatory hiring practices, restricted access to credit, and welfare disincentives can limit the ability of PWLE to achieve financial autonomy and sustain recovery. Addressing these structural barriers requires a shift from viewing PWLE primarily as recipients of care toward recognizing them as economically active, self-determined participants in their communities. This study therefore examines the role of economic empowerment in mental health recovery and explores integrated approaches that can strengthen sustainable livelihoods, social inclusion, and long-term community reintegration for PWLE.

The study aims to examine systemic barriers to the economic and social inclusion of PWLE and identify actionable, peer-led approaches and policy reforms that can strengthen their economic autonomy, meaningful participation, and community leadership. Specifically, the study examines the relationship between economic stability, social inclusion, and mental health recovery; identifies structural and social barriers that limit economic participation, autonomy, and meaningful engagement; synthesizes evidence on innovative economic and social empowerment approaches, including supported employment, peer-led enterprises, vocational rehabilitation, and financial inclusion; and proposes actionable strategies for integrating economic and social empowerment into regional mental health systems. The study addresses a critical gap between clinical recovery and meaningful socioeconomic inclusion of PWLE. Although contemporary mental health approaches increasingly recognize the value of lived experience, recovery efforts may continue to prioritize symptom management while giving insufficient attention to financial autonomy, employment, education, and social participation (Davidson et al., 2008). Consequently, PWLE may remain vulnerable to poverty, stigma, marginalization, and economic dependence, while their potential contributions to mental health systems and community development remain underutilized. Participation may also become tokenistic when PWLE are not provided with meaningful, compensated, and sustainable opportunities to contribute to service delivery, policy development, and community leadership. Examining barriers to education, employment, fair compensation, financial inclusion, and broader economic participation is therefore essential to understanding how mental health systems can move beyond symbolic inclusion. By identifying peer-led economic and social empowerment approaches and relevant policy reforms, the study seeks to support a transition from passive inclusion to meaningful participation, self-determination, economic independence, and community leadership. In this way, PWLE are positioned not only as recipients of mental health services but also as active agents of recovery, innovation, prevention, promotion, management, and systemic change.

The geographical scope of the reviewed literature is predominantly anchored within high-income Western countries (specifically the United States, the United Kingdom, and Scandinavia), with a secondary subset of studies originating from middle-income urban settings in Australia and East Asia. As a result, the results mostly show highly organized formal economies with social welfare safety nets that are in place, albeit dispersed.

1.1 Problem Statement

Despite growing recognition of persons with lived experience (PWLE) as important partners in mental health systems, their voices and agency remain insufficiently reflected in economic and social decision-making. PWLE continue to experience unemployment, poverty, stigma, social exclusion, and discrimination, which limit their autonomy, participation, and ability to contribute meaningfully to mental health services and community development. Although recovery-oriented approaches increasingly promote lived experience, opportunities for PWLE to exercise economic independence and assume meaningful, compensated roles remain limited, particularly in low- and middle-income settings. Existing initiatives, including supported employment, vocational rehabilitation, peer-led enterprises, and financial inclusion, are often fragmented and



insufficiently integrated into mental health systems. This creates a critical gap in translating the recognition of lived experience into sustainable economic and social empowerment. Without systemic approaches that strengthen both livelihood opportunities and meaningful participation, PWLE risk remaining passive recipients of care rather than active partners in prevention, promotion, and management of mental health conditions. Therefore, the study examine how economic and social empowerment can strengthen the voices, autonomy, recovery, and meaningful participation of PWLE and inform systemic transformation of regional mental health services.

1.2 General objective

To examine how economic and social empowerment can strengthen the voices, autonomy, and recovery of persons with lived experience (PWLE) and enhance their participation in mental health systems.

1.3 Specific objectives

- To examine the relationship between economic stability, social inclusion, and mental health recovery among PWLE.
- To identify structural and social barriers that limit the economic participation, autonomy, and meaningful engagement of PWLE in mental health systems.
- To synthesize evidence on innovative economic and social empowerment approaches, including supported employment, peer-led enterprises, vocational rehabilitation, and financial inclusion.
- To propose actionable strategies for integrating economic and social empowerment into regional mental health systems and strengthening PWLE as active partners in prevention, promotion, and management of mental health conditions.

1.4 Research Questions

- i. What is the relationship between economic stability, social inclusion, and mental health recovery among persons with lived experiences?
- ii. What are the structural and social barriers that limit the economic participation, autonomy, and meaningful engagement of PWLE in mental health systems?
- iii. How effective are the innovative, economic and social empowerment approaches, including supported employment, peer-led enterprises, vocational rehabilitation, and financial inclusion to persons with lived experiences on mental health.
- iv. What are the proposed actionable strategies for integrating economic and social empowerment into regional mental health systems and strengthening PWLE as active partners in prevention, promotion, and management of mental health conditions?

2. LITERATURE REVIEW

2.1 Theoretical Framework

This study is guided by two complementary frameworks. The Social Causation and Social Drift Hypotheses, associated with Faris and Dunham (1939) and subsequent socioeconomic mobility research, explain the bidirectional relationship between socioeconomic disadvantage and mental health. Social causation suggests that poverty, economic insecurity, and chronic stress increase vulnerability to mental health conditions, while social drift proposes that mental health conditions can reduce employment, income, and socioeconomic status, reinforcing disadvantage (Parbst & Wheaton, 2023). Social drift explains downstream trajectories, which means that people with chronic mental health issues encounter obstacles that increase their marginalization by causing them to drift downhill socioeconomically. The two theoretical frameworks show a bidirectional, cyclical trap where economic hardship psychiatric vulnerability reinforce one another.



Self-Determination Theory (SDT), developed by Deci and Ryan (1985; 2000), emphasizes autonomy, competence, and relatedness as fundamental psychological needs. In this study, economic and social empowerment are viewed as mechanisms through which PWLE can strengthen these needs, enhance self-determination, and promote recovery, meaningful participation, and community leadership. Together, the frameworks explain both the cycle of socioeconomic disadvantage and mental health challenges and the potential of economic and social empowerment to support recovery and systemic change. When people are free to choose their financial and professional paths without being constrained by paternalistic rules, autonomy is achieved (Kazarian & O'Connor, 2026), while in adaptive workplaces, competence is promoted through organized skill development and mastery (Mujtaba, 2026) and in order to fulfill the desire for relatedness and combat the isolation brought on by both poverty and mental stigma, meaningful engagement guarantees that people attain actual socioeconomic integration and mutual support (Henderson et al., 2026).

2.2 Economic Stability, Social Inclusion, and Mental Health Recovery

Economic stability and mental health are closely interconnected, with employment representing an important pathway through which individuals can achieve income security, social participation, purpose, and autonomy. The relationship is also potentially bidirectional: economic insecurity and unemployment can increase psychological distress, while mental health conditions may constrain labour-market participation and reduce access to stable income. Recent evidence from Africa demonstrates the economic significance of this relationship. A 2024 study examining 45 African countries found that mental health disorders were negatively associated with economic growth and that the interaction between mental health disorders and labour productivity had significant negative effects on economic performance (Immurana et al., 2024). These findings reinforce the argument that mental health and economic participation should not be addressed as separate policy domains.

At the individual level, employment can contribute to recovery by providing financial resources, structured daily activity, social relationships, confidence, purpose, and a sense of belonging. The World Health Organization (WHO, 2022) recognizes employment as an important component of mental health promotion and recovery and recommends interventions that enable people living with mental health conditions to gain, retain, and participate meaningfully in work. WHO further emphasizes that decent work can provide a livelihood, purpose, positive relationships, social inclusion, and opportunities for people with mental health conditions to participate in community life.

The relationship between employment and recovery is particularly important for people with severe mental health conditions, who experience disproportionately high levels of labour-market exclusion. A large-scale study of people with schizophrenia and bipolar disorders found substantial levels of unemployment among service users and demonstrated that unemployment was associated with social and demographic inequalities as well as clinical factors (Chilman et al., 2024). This suggests that employment exclusion cannot be understood solely as a consequence of individual illness; broader social and structural conditions also influence economic participation.

Evidence from Africa further demonstrates the importance of social inclusion in shaping employment and recovery. A systematic review and meta-analysis found that internalized stigma is prevalent among people living with mental illness in Africa, with unemployment and poor social support identified among factors associated with higher levels of internalized stigma (Alemu et al., 2023). This relationship is important because economic exclusion may reinforce social isolation and diminished self-worth, while stigma may simultaneously reduce employment opportunities and willingness to participate in community and economic activities.

More recent evidence from Ghana similarly illustrates the consequences of stigma for social and economic participation. Gyamfi et al. (2025) found that people receiving mental health services experienced devaluation, social exclusion, unemployment, relationship disruption, and loss of self-esteem as consequences of mental-health-related stigma. These findings strengthen the argument that social inclusion is not merely an accompanying benefit of economic empowerment but an important mechanism through which economic



participation and recovery can reinforce one another. The evidence on supported employment further strengthens this relationship. A 2024 systematic mixed-methods umbrella review found that supported employment

interventions show promise across employment, quality of life, social functioning, clinical/service-utilization, and economic outcomes among people with severe mental illness (Patmisari et al., 2024). Importantly, evidence from low- and middle-income countries indicates that implementation must account for contextual barriers, including stigma, inaccessible vocational rehabilitation, policy disincentives, and unaccommodating workplaces. A scoping review of supported employment interventions in LMICs identified these community and systemic barriers as significant constraints on participation in decent work (Mavindidze et al., 2023).

The Kenyan context provides particularly relevant evidence for this study. Research examining the lived experiences of persons with mental disabilities in Kenya identified social exclusion and stigma, non-accommodative work environments, socioeconomic circumstances, and difficulties associated with work identity as important barriers to employment. The study also identified self-employment, reasonable workplace accommodation, social support, and social-development programmes as potential facilitators of economic participation (Ebuenyi et al., 2019). Although this evidence predates the most recent literature, it remains valuable because it provides context-specific evidence from Kenya and demonstrates that economic participation among PWLE is shaped by both individual circumstances and the wider social environment.

Overall, the literature supports a bidirectional and mutually reinforcing relationship between economic stability, social inclusion, and mental health recovery. Employment and financial security can strengthen autonomy, social participation, purpose, and quality of life, while unemployment, poverty, stigma, and exclusion can undermine recovery. However, the evidence also indicates that economic empowerment cannot be achieved through individual rehabilitation alone. Workplace practices, social protection, labour-market conditions, community attitudes, and access to appropriate employment support shape the extent to which PWLE can participate economically.

2.3 Structural Barriers to Economic and Social Inclusion

Despite growing recognition of employment as an important component of mental health recovery, persons with lived experience (PWLE) continue to face substantial structural and social barriers to economic participation. These barriers extend beyond individual clinical characteristics and include stigma and discrimination, negative employer attitudes, inadequate workplace accommodations, insecure employment, limited social protection, inaccessible vocational services, and policy environments that may discourage employment. Evidence from Africa indicates that stigma, discrimination, negative employer attitudes, inadequate social support, and limited welfare provision can significantly constrain employment opportunities for people with mental health conditions (Ebuenyi et al., 2019; Gitonga et al., 2025; Read et al., 2024). These findings suggest that economic exclusion cannot be adequately explained by individual-level factors alone but must also be understood in relation to wider institutional and labour-market structures.

Stigma represents a particularly important barrier because it operates at individual, interpersonal, institutional, and labour-market levels. It can influence whether PWLE disclose their mental health conditions, whether employers are willing to recruit or retain them, and whether reasonable workplace accommodations are provided. The World Health Organization (WHO, 2024) identifies discrimination, exclusion, job insecurity, inadequate pay, limited career development, and poor workplace support among important workplace factors affecting mental health. People with severe mental health conditions are also disproportionately excluded from employment, reinforcing socioeconomic disadvantage and limiting opportunities for independence and social participation (World Health Organization [WHO], 2024).

Evidence from African settings illustrates how these barriers operate in practice. Research among people with lived experience of serious mental illness in Ghana and the occupied Palestinian territory found experiences of employment refusal following disclosure of mental health conditions, dismissal following relapse, workplace discrimination, and difficulties associated with demanding or inflexible work environments (Read et al., 2024).



Although informal employment may provide greater flexibility for some individuals, it can also be characterized by insecurity, low income, and limited employment protection. Similarly, qualitative evidence from Uganda demonstrates that stigma and discrimination can affect access to employment, employment retention, income generation, and the ability to meet basic needs among people living with mental health conditions (Nalugya et al., 2024). Such findings demonstrate that economic exclusion is partly produced through social attitudes and institutional practices rather than being solely a consequence of mental illness.

Workplace conditions can further determine whether employment contributes positively to recovery. The WHO (2022) emphasizes the importance of reasonable accommodations, including flexible working arrangements, modified duties, supportive supervision, and opportunities to attend health-related appointments. Without such accommodations, workplace pressures may contribute to psychological distress, exclusion, job loss, or withdrawal from employment. The absence of accommodations may also interact with stigma because workers may fear that requesting support will disclose their mental health status and expose them to discrimination. Consequently, promoting economic participation requires both inclusive employment practices and organizational environments that protect confidentiality, dignity, and equal opportunity (WHO, 2022).

Structural barriers also extend beyond employers and workplaces to social-protection and vocational-rehabilitation systems. Evidence from low- and middle-income countries (LMICs) identifies social exclusion, stigma, inaccessible vocational rehabilitation, policy disincentives, transportation difficulties, inadequate coordination between mental health and employment services, and unaccommodating work environments as barriers to employment among people with mental health conditions (Mavindidze et al., 2023). Similarly, evidence from supported employment research indicates that concerns about losing social benefits, inadequate employment services, and weak coordination between vocational and mental health systems can restrict participation in competitive employment (Patmisari et al., 2024). These barriers are particularly important in understanding economic empowerment because social-protection arrangements can unintentionally discourage employment where individuals fear losing essential benefits before achieving stable income.

The literature therefore indicates that improving economic participation among PWLE requires more than improving individual employability. Structural reforms are necessary to address discriminatory employment practices, strengthen workplace accommodations, improve vocational rehabilitation, and coordinate mental health and employment services. The WHO (2024) recommends approaches that promote inclusive workplaces, prevent discrimination and harassment, and support people with mental health conditions to remain in or return to employment. Such approaches recognize that sustainable employment depends on both individual capabilities and supportive institutional environments.

Meaningful participation of PWLE should also be understood as an important dimension of empowerment. When PWLE are positioned primarily as recipients of services, their influence over decisions affecting their lives may remain limited. Contemporary mental health policy increasingly recognizes lived experience as a form of expertise that can contribute to service design, implementation, evaluation, and system reform (WHO, 2025a). Meaningful participation should therefore extend beyond consultation to include opportunities for PWLE to occupy compensated roles as peer-support workers, advocates, employment specialists, trainers, researchers, and contributors to policy and programme development. Such participation can strengthen autonomy, recognition, social inclusion, and self-determination.

Overall, the literature demonstrates that structural and social barriers operate across multiple levels, from individual stigma and employer attitudes to workplace practices, vocational services, social-protection systems, and mental health policies. These barriers can reinforce economic dependence, social exclusion, and reduced autonomy among PWLE. Addressing them therefore requires a systems-oriented response combining anti-stigma interventions, inclusive employment policies, reasonable workplace accommodations, accessible vocational rehabilitation, appropriate social protection, and meaningful PWLE participation.

2.4 Evidence on Economic and Social Empowerment Interventions

Evidence from international research increasingly supports individualized and competitive employment appro-



aches as important mechanisms for economic and social empowerment among persons with lived experience (PWLE) of mental health conditions. Individual Placement and Support (IPS) is among the most established approaches, emphasizing rapid placement in competitive employment, individualized employment

preferences, integration of vocational and mental health services, and continuing employment support. Patmisari et al. (2024) found that supported employment interventions, particularly IPS, demonstrated positive employment outcomes and potential benefits for quality of life, social functioning, and other recovery-related outcomes. Similarly, the World Health Organization (WHO, 2022) recommends supported employment as an important component of recovery-oriented mental health services for people with severe mental health conditions and psychosocial disabilities.

The international evidence, however, needs to be interpreted within the context of low- and middle-income countries (LMICs), where labour-market conditions, social protection, mental health infrastructure, and employment opportunities may differ considerably. Mavindidze et al. (2023) found that evidence concerning supported employment in LMICs remains relatively limited, despite its potential to improve employment participation among people with mental health conditions. The authors identified contextual challenges associated with stigma, social exclusion, limited vocational services, inadequate employment opportunities, and weak coordination between mental health and employment systems. These findings indicate that evidence-based employment interventions require contextual adaptation rather than direct replication of models developed in high-income countries.

At the African regional level, economic empowerment must also be understood in relation to widespread unemployment, poverty, informal employment, limited social protection, and persistent stigma surrounding mental health conditions. The World Health Organization Regional Office for Africa (WHO AFRO, 2025) emphasizes the need to strengthen community-based and integrated mental health services while addressing the broader social determinants that influence mental health and social participation. Within this context, economic empowerment approaches need to extend beyond formal employment to include vocational skills development, entrepreneurship, self-employment, livelihood opportunities, financial literacy, and social protection.

Kenyan evidence provides an important country-specific perspective. Ebuenyi et al. (2019) examined the employability experiences of people with mental disabilities in Kenya and identified mental illness-related factors, social exclusion and stigma, work-identity challenges, non-accommodating work environments, and socioeconomic circumstances as important barriers to employment. The study also identified self-employment, reasonable workplace accommodation, social support, improved health services, and government action as potential facilitators of employment. These findings suggest that economic empowerment among PWLE in Kenya should not be restricted to formal wage employment but should also recognize self-employment and other livelihood pathways.

More recent Kenyan evidence reinforces the importance of addressing employer attitudes and workplace environments. Gitonga et al. (2025) examined employers' perspectives on employing people with psychosocial disabilities in a rural Kenyan setting and identified limited awareness, concerns about productivity and occupational risks, and uncertainty surrounding disclosure as barriers to employment. The study also indicated that appropriate training, workplace support, reasonable adjustments, and enabling policies could facilitate greater inclusion of people with psychosocial disabilities in employment. This evidence is particularly relevant to regional mental health systems because it demonstrates that successful economic participation requires interventions targeting both PWLE and employers.

Peer-led approaches represent another important pathway for economic and social empowerment. Paid peer-support roles enable individuals with lived experience to transform experiential knowledge into recognized and remunerated expertise. Gillard et al. (2024) found that paid peer-support approaches can contribute to recovery-oriented mental health services while creating opportunities for people with lived experience to participate meaningfully in service delivery. Such roles are important from an empowerment perspective because they can provide employment while simultaneously strengthening social identity, confidence, particip-



ation, and recognition of lived experience as a legitimate form of knowledge.

The importance of peer participation is also consistent with the broader international movement toward rights-based and recovery-oriented mental health systems. The World Health Organization (WHO, 2025a) empha-

sizes meaningful participation of people with lived experience in mental health policy, planning, implementation, monitoring, and evaluation. Consequently, PWLE should not be engaged only as beneficiaries or consultees but should increasingly have opportunities to serve as peer-support workers, advocates, trainers, researchers, employment specialists, and members of decision-making structures.

Vocational rehabilitation provides a complementary mechanism for strengthening economic participation. It may include occupational skills development, career preparation, job-search assistance, workplace adaptation, and continuing employment support. Although the evidence for vocational rehabilitation is less consistent than that for IPS, Patmisari et al. (2024) reported that vocational rehabilitation and training interventions can provide useful employment-related benefits, although outcomes vary according to programme design and implementation context. Vocational rehabilitation may therefore be particularly valuable when linked to actual labour-market opportunities and integrated with supported employment rather than operating as a prolonged alternative to competitive employment.

Financial inclusion and livelihood development provide an additional dimension of economic empowerment. Employment alone does not necessarily guarantee economic autonomy, particularly where individuals experience low wages, insecure employment, limited savings, debt, or restricted access to financial services. Financial literacy, savings, appropriate credit, enterprise development, productive assets, and income-generating activities can strengthen individuals' ability to convert employment and livelihood opportunities into sustainable economic security. The Government of Kenya (2025) recognizes economic empowerment within disability inclusion as involving access to education, skills development, employment, financial services, productive assets, and opportunities for financial independence. This provides an important policy basis for incorporating financial inclusion within broader mental health empowerment strategies in Kenya.

Taken together, the literature demonstrates that economic and social empowerment should be conceptualized as a multidimensional process rather than a single intervention. Supported employment and IPS can facilitate access to competitive employment; vocational rehabilitation can strengthen occupational skills; paid peer-support roles can transform lived experience into recognized and remunerated expertise; and financial inclusion and livelihood initiatives can strengthen economic resilience and autonomy (Gillard et al., 2024; Patmisari et al., 2024). In Kenya, these approaches need to be adapted to local labour-market conditions, including informal employment, self-employment, rural economic circumstances, stigma, and limited employer awareness (Ebuenyi et al., 2019; Gitonga et al., 2025).

A significant evidence gap nevertheless remains concerning the integration of these approaches within regional mental health systems. Existing research has largely examined supported employment, peer support, vocational rehabilitation, or financial inclusion as separate interventions, while less attention has been given to how these approaches can be combined within a coordinated regional system. This gap is particularly important in Kenya and other African settings, where mental health services operate within constrained socioeconomic and institutional environments. The literature therefore supports a shift from isolated interventions toward an integrated system in which employment, vocational rehabilitation, peer leadership, financial inclusion, and social protection are incorporated into recovery-oriented mental health services. Such an approach has the potential to strengthen PWLE as economically active citizens and as partners in the prevention, promotion, and management of mental health conditions.

2.5 Integrating Economic and Social Empowerment into Regional Mental Health Systems

The emerging literature indicates that economic and social empowerment should be integrated into mental health systems rather than implemented as separate welfare, employment, or livelihood programmes. Contemporary mental health policy increasingly recognizes that social and economic conditions, including



employment, education, poverty, housing, social protection, and social participation influence recovery. The World Health Organization (WHO, 2022) emphasizes recovery-oriented and person-centred approaches that promote social inclusion, participation, human rights, and access to employment and livelihood opportunities. This represents a shift from a predominantly clinical model of mental health care toward a broader approach in which recovery includes the ability of individuals to participate meaningfully in family, community, social, and economic life.

At the international level, integration requires stronger collaboration between mental health services and sectors responsible for employment, education, social protection, housing, and economic development. The World Health Organization (WHO, 2025a) emphasizes meaningful participation of people with lived experience in mental health policy and service development. Similarly, the WHO's global mental health action agenda recognizes the importance of addressing social determinants and strengthening community-based systems rather than relying exclusively on specialist clinical services (WHO, 2025b). Economic empowerment should therefore be embedded within routine mental health planning, assessment, referral, rehabilitation, and recovery programmes. Such integration is particularly important because employment and economic security can operate both as outcomes of recovery and mechanisms supporting recovery. Evidence on supported employment demonstrates that employment interventions can improve access to competitive work while potentially contributing to quality of life and social functioning (Patmisari et al., 2024). Consequently, mental health services should establish formal pathways linking clinical and psychosocial services with vocational rehabilitation, employment services, employers, financial institutions, and social-protection programmes. Rather than waiting until individuals are considered clinically "ready" for employment, recovery-oriented systems should incorporate employment and livelihood goals into individualized care and recovery planning.

At the African regional level, however, system integration faces significant challenges. Mental health services across many African countries continue to experience inadequate financing, shortages of specialized personnel, weak community-based infrastructure, stigma, and limited coordination between health and other social sectors. The World Health Organization Regional Office for Africa (WHO AFRO, 2025) identifies the need for stronger investment in mental health, community-based services, prevention, and integration of mental health into broader health and development systems. These challenges suggest that economic empowerment strategies in Africa should be designed around existing community structures and partnerships rather than depending exclusively on highly specialized services.

The African context also strengthens the case for multisectoral partnerships. Employment ministries, county and national governments, financial institutions, vocational training organizations, employers, community organizations, and organizations of persons with lived experience can contribute complementary resources. For example, mental health professionals may provide psychosocial support, vocational agencies may provide skills development, employers may provide employment opportunities and workplace accommodations, financial institutions may facilitate financial literacy and access to appropriate financial products, while PWLE organizations may provide peer support and advocacy. A coordinated system can therefore address the multiple dimensions of exclusion that cannot be resolved by mental health services alone.

Kenya provides an important policy and practice context for this systems approach. The Kenyan mental health policy environment increasingly recognizes community-based care, human rights, social inclusion, and participation as important components of mental health reform. The Ministry of Health (2015), through the *Kenya Mental Health Policy 2015–2030*, emphasizes integration of mental health into primary health care and strengthening community participation in mental health services. This provides an important foundation for incorporating economic and social empowerment within decentralized and community-oriented mental health services.

Kenyan evidence also demonstrates that employment inclusion requires interventions at both individual and structural levels. Ebuenyi et al. (2019) identified stigma, social exclusion, non-accommodating workplaces, socioeconomic circumstances, and mental illness-related factors as barriers to employment among people with mental disabilities in Kenya. The study further identified self-employment, reasonable accommodation, social support, improved health services, and government action as potential facilitators. These findings imply that



regional mental health systems should incorporate employment preparation, employer engagement, workplace accommodation, entrepreneurship, and social support rather than focusing exclusively on clinical rehabilitation.

More recent Kenyan evidence further emphasizes the importance of employer engagement. **Gitonga et al. (2025)** found that employers in a rural Kenyan setting identified limited knowledge of psychosocial disabilities, concerns regarding productivity and occupational risks, and uncertainty surrounding disclosure as barriers to employing people with psychosocial disabilities. The findings also point to the potential value of awareness, workplace support, reasonable adjustments, and enabling policies. Consequently, regional mental health systems should not only prepare PWLE for employment but should also work with employers to create environments capable of retaining and supporting employees with mental health conditions.

A further component of system transformation is the institutionalization of PWLE leadership. Meaningful participation requires that people with lived experience have opportunities to influence policies, programmes, service delivery, research, monitoring, and evaluation. Gillard et al. (2024) demonstrate the potential contribution of paid peer-support roles to recovery-oriented mental health services. Similarly, the World Health Organization (WHO, 2025a) emphasizes that people with lived experience should participate meaningfully in mental health policy and service development. For regional systems, this means moving beyond unpaid consultation or symbolic representation toward compensated and decision-making roles for PWLE.

The economic dimension of PWLE participation is particularly important. When PWLE are employed as peer-support workers, advocates, trainers, researchers, or employment specialists, their experiential knowledge becomes a recognized and economically valued resource. Such arrangements can simultaneously promote employment, autonomy, social recognition, and service transformation. However, effective institutionalization requires clear job descriptions, remuneration, training, supervision, career progression, and organizational support (Gillard et al., 2024).

Financial and social protection systems should also be incorporated into the regional framework. Economic empowerment cannot depend solely on employment because some PWLE may experience fluctuating capacity for work, discrimination, or limited access to formal employment. Linking mental health services with social-protection programmes, financial literacy, savings initiatives, appropriate credit, enterprise development, and livelihood programmes can provide additional pathways toward economic resilience. The Government of Kenya (2025) emphasizes economic empowerment through access to education, skills, employment, financial services, productive assets, and opportunities for financial independence. This provides a policy basis for connecting mental health services with wider economic empowerment initiatives.

An integrated regional system should consequently establish clear referral and collaboration mechanisms. Mental health facilities could routinely assess employment, livelihood, financial stability, social participation, and vocational aspirations as part of recovery planning. Individuals requiring employment assistance could be linked to supported employment or vocational rehabilitation services. PWLE interested in peer roles could receive training and opportunities for paid participation. Those pursuing self-employment could be connected to appropriate enterprise development and financial services. Employers could receive information and support concerning workplace accommodations and inclusive recruitment. Such mechanisms would transform economic empowerment from an external intervention into a routine component of recovery-oriented mental health practice.

The literature nevertheless reveals an important implementation gap. Although there is increasing evidence supporting supported employment, peer support, vocational rehabilitation, and attention to social determinants, relatively little research demonstrates how these components can be systematically integrated within regional mental health systems in Kenya and other African contexts. The challenge is therefore no longer simply demonstrating that individual interventions can work, but determining how they can be coordinated, financed, implemented, monitored, and sustained within existing health and community systems.



Based on the evidence, a regional approach should therefore be built around five interconnected pillars: economic participation, social inclusion, PWLE leadership, multisectoral collaboration, and accountability. Economic participation should include supported employment, vocational rehabilitation, entrepreneurship, and financial inclusion; social inclusion should address stigma and discrimination; PWLE leadership should ensure meaningful and compensated participation; multisectoral collaboration should connect health with employment, education, social protection, finance, and community organizations; and accountability should include measurable indicators of employment, financial stability, social participation, and PWLE engagement.

Overall, the literature supports a transition from a model in which PWLE are primarily recipients of mental health services toward one in which they are recognized as partners, workers, advocates, leaders, and agents of recovery and system transformation. Integrating economic and social empowerment into regional mental health systems can therefore strengthen autonomy, improve meaningful participation, and create opportunities for PWLE to contribute directly to prevention, promotion, and management of mental health conditions. This provides the evidence base for the proposed regional framework and directly responds to.

3. METHODOLOGY

This study adopted a qualitative literature synthesis approach to examine how economic and social empowerment can strengthen autonomy, recovery, and participation among persons with lived experience (PWLE) of mental health conditions. Recent peer-reviewed studies, systematic reviews, policy documents, and relevant scholarly literature were examined, focusing on economic stability, employment, social inclusion, supported employment, peer support, vocational rehabilitation, and financial inclusion. The review prioritized contemporary evidence while retaining foundational theoretical literature where necessary.

Four major electronic databases were used to conduct a thorough literature search: PubMed, PsycINFO, Scopus, and Google Scholar. Only peer-reviewed English-language research published that specifically examined the relationship between economic or occupational interventions and psychiatric recovery met the selection criteria. Studies that assessed at least one of four models—financial inclusion initiatives, peer-led businesses, supported employment, or vocational rehabilitation—were included. Excluded were purely clinical trials with no socioeconomic outcomes and theoretical publications with unclear contexts. The first line-by-line coding of the results was abstracted into descriptive themes for the thematic analysis, which used a qualitative synthesis approach. These themes were then axially divided into structural models, implementation barriers, and stakeholder outcomes.

The literature was analyzed thematically according to the study objectives. The synthesis examined the relationship between socioeconomic conditions and mental health recovery; structural and social barriers to economic participation; evidence concerning supported employment, peer-led approaches, vocational rehabilitation, and financial inclusion; and implications for integrating economic empowerment within regional mental health systems. The analysis was informed by the Social Causation and Social Drift perspectives and Self-Determination Theory, particularly the concepts of autonomy, competence, and relatedness (Deci & Ryan, 2000; Vansteenkiste et al., 2020). Evidence was compared across studies to identify areas of convergence, divergence, and gaps in implementation. The resulting synthesis was used to develop contextually relevant strategies for strengthening economic autonomy, meaningful participation, peer leadership, and recovery-oriented mental health services.

4. KEY FINDINGS & DISCUSSIONS

While supported employment, peer-led businesses, vocational rehabilitation, and financial inclusion initiatives all seek to break the cycle of poverty and mental illness, a critical review of the literature shows that they have different advantages and practical challenges. The findings were synthesized according to the four specific objectives and the evidence established in the literature review.



4.1 To examine the relationship between economic stability, social inclusion, and mental health recovery among PWLE.

The synthesis establishes a bidirectional relationship between economic stability and mental health recovery. Unemployment and economic insecurity can adversely affect mental health, while mental health conditions may subsequently constrain employment and economic security. Consistent with WHO (2022), economic and vocational inclusion therefore emerge as important components of recovery, autonomy, social participation, and quality of life.

4.2 To identify structural and social barriers that limit the economic participation, autonomy, and meaningful engagement of PWLE in mental health systems.

The evidence identifies stigma, discrimination, job insecurity, inadequate workplace support, and limited career development as persistent barriers. WHO (2024) indicates that these barriers are structural and require institutional, workplace, and social-protection responses.

4.3 To synthesize evidence on innovative economic and social empowerment approaches, including supported employment, peer-led enterprises, vocational rehabilitation, and financial inclusion.

The evidence supports individualized competitive employment, particularly IPS, while peer-support approaches provide opportunities for PWLE to contribute expertise and strengthen participation (Gillard et al., 2024; Patmisari et al., 2024; Whitworth et al., 2024).

4.4 To propose actionable strategies for integrating economic and social empowerment into regional mental health systems and strengthening PWLE as active partners in prevention, promotion, and management of mental health conditions.

The synthesis supports integrating employment, vocational and financial inclusion, peer leadership, social protection, and meaningful PWLE participation into regional mental health systems (WHO, 2025a, 2025b).

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The study concludes that economic and social empowerment is a critical pathway for strengthening the autonomy, recovery, social inclusion, and meaningful participation of persons with lived experience (PWLE). The reviewed evidences emphasize how integrating economic interventions with mental health frameworks greatly enhances both material stability and psychiatric rehabilitation. However, these findings must be read through the prism of formal economies with pre-existing welfare infrastructures because the evaluated literature is largely centered inside wealthy Western urban areas. Future research must expand into low- and middle-income nations as well as rural areas due to informal economies and different cultural conceptions of labor and community.

5.2. Recommendations

Regional mental health systems should incorporate supported employment, vocational rehabilitation, financial inclusion, and livelihood support into recovery-oriented services.

Policymakers and employers should strengthen anti-discrimination measures, workplace accommodations, employment protection, and social protection mechanisms to promote sustainable economic participation.

PWLE should be formally engaged as peer-support workers, employment specialists, advocates, and partners in programme and policy design.

Regional mental health systems should establish partnerships among health, employment, education, social



protection, financial, and community actors, while monitoring employment, economic participation, social inclusion, and PWLE engagement as indicators of recovery and system performance.

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