An exploration of the employment experiences, needs, and aspirations among unemployed men receiving mental health support living in the South Wales Valleys.

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An exploration of the employment experiences; needs and aspirations among unemployed men receiving mental health support, living in the South Wales Valleys

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Summary

A great deal of quantitative research has been carried out on unemployment and mental health; employment practice; and barriers to employment for people with mental health problems. Many researchers have described the need for more qualitative studies in this field of research, often with a particular emphasis on the *experiences* of people with severe mental illness with regard to employment; as well as consumer perspectives and perceptions on the facilitators and barriers to employment. This research used the abbreviated grounded theory version described by Willig (2001) to examine the employment experiences, needs and aspirations amongst people with severe and enduring mental health problems. 15 in-depth interviews were carried out with unemployed men receiving mental health support living in the South Wales Valleys. Transcripts from the interviews were analysed using a grounded theory approach, as outlined in Strauss & Corbin (1998). The proposed theory resulting from this research is that individuals with mental health problems who become unemployed follow a pathway of experiences which impact upon the meaning of work to them and their self concept. Following the onset of mental ill-health, the impact of mental health problems also affects identity. This results in an identity shift between the valued worker and the devalued 'mental patient,' and an identity struggle between the two identities. Implications for policy and practice include the need to consider the mental health support and vocational support which is currently provided, as well as considering ways in which to break the pathway to unemployment which people with mental health problems travel down. Suggestions for future research include examining the effectiveness of stress management programmes for people with mental health problems in the workplace, examining the effects of medication compliance and side effects on work performance; and a review of mental health and vocational service provision in Wales.

Declarations and Statements

DECLARATION

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STATEMENT 1

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Chapter 1: Introduction

1.1. Research context

A registered mental health charity, which provides a range of community based services for people experiencing severe and enduring mental health problems, gained funding for three years to undertake the Employment Opportunities Project. The registered mental health charity is a not-for-profit organisation which has been established in Wales for 16 years. The charity is the leading provider of community based support services for people with mental health problems in Wales.

The Employment Opportunities Project was funded by the Community Fund, now called the Big Lottery Fund, which is responsible for distributing half the money for good causes raised by the national lottery. The Employment Opportunities Project was separated into two parts, an 18-months research element carrying out research into mental health and employment in order to explore service users' employment experiences, needs and aspirations. The latter part of the project focused on service development by launching an employment support service developed in accordance with service user need and evidence-based practice. The framework for the employment support service was based on the results of the research findings and evidence from previous research on the successful components of an employment support service.

The Employment Opportunities Project had a specific aim of establishing an employment support service developed in accordance with service user need and evidence-based practice. However, the project also presented a unique opportunity to collect qualitative data from a group of 'under-researched' individuals, namely unemployed men receiving mental health support, living in areas of deprivation in the South Wales Valleys. The student (Helen Jones) was employed as the Research Officer to carry out the research element of this project, and thus was the 'investigator' for this study. The role of the investigator was to design and conduct the research, as well as to report on the research study. Therefore, this qualitative research study was undertaken as part of the Employment Opportunities Project.

By using a qualitative research method, a grounded theory approach, this study aims to explore the employment experiences, needs and aspirations among unemployed men receiving mental health support, living in the South Wales Valleys.

1.2. Mental health problems in the UK

According to research, mental health conditions and related mental health problems now account for the largest group of health problems in Britain (Blackwell *et al.*, 2001). One in seven adults have some sort of neurotic ill-health problem and about four in every 1,000 people suffer from a functional psychosis (Meltzer *et al.*, 1995). More recent research shows that one in four people will experience some kind of mental health problem (Blackwell *et al.*, 2001). Moreover, it seems that these figures may increase as all predictions indicate that the future will see a dramatic increase in mental health problems (Harnois & Gabriel, 2000). The forecast from the World

Health Organisation is that by 2020, depression will be second only to chronic heart disease as an international health burden (Webster, 2002).

1.3. Mental health, employment and unemployment

1.3.1. Employment and mental health

The benefits of work have long been recognised as according to Galen (172 AD) 'employment is Nature's best physician and is essential to human happiness.' Perkins and Repper (1996) argue that it is the second question we ask new people we meet (what is your name? what do you do?) and an important way in which we define ourselves. A report written for the Research and Development for Psychiatry Unit states that most of us, however much we complain about our jobs, would accept that work plays a major part in our lives (Nehring *et al.*, 1993).

More specifically, the reason that we consider work to be so important is because work affords us a social identity and status, a role and a meaning in life. It also provides social contacts and support, a sense of personal achievement and structures time (Perkins & Repper, 1996). Work gives many of us the benefits of financial reward. However, Evans and Repper (2000) stipulate that clearly over and above the obvious financial benefits, work provides a sense of purpose and belonging; an opportunity to contribute to shared goals; a social forum; status and recognition for our efforts and achievements.

Research carried out by Harnois and Gabriel (2000) for the World Health Organisation/ International Labour organisation, outlined five categories of

psychological experience that promote well-being, which employment is able to provide:

- Time structure (an absence of time structure can be a major psychological burden);
- Social contact;
- Collective effort and purpose (employment offers a social context outside the family);
- Social identity (employment is an important element in defining oneself);
- Regular activity (organising one's daily life)

Boardman (2001) argues that whilst work is important for everyone, it is particularly important for people with mental health problems. A great deal of research has been carried out on the effect of employment on mental health, particularly with people who have experienced mental health problems. Several studies have shown that in the majority of cases, employment has a positive effect on mental health. For people with severe mental health problems having a job can result in a reduction in symptoms (Bell *et al.*, 1993; 1996), fewer hospital admissions (Drake *et al.*, 1994; 1996), reduced service use (Rogers *et al.*, 1995), improved social skills (Lysaker & Bell, 1995), and compliance with medication (Freeman, 1993; Turton, 2001). Specifically, Grove (1999) asserts that many studies, including the study of people with a schizophrenic diagnosis in three large mental health hospitals, (Wing & Brown, 1970) have demonstrated that meaningful occupation is a critical factor in clinical improvement, improved social functioning and reduction of symptoms. Furthermore, a study of Irish social firms showed how work can be a significant factor in people staying out of hospital and reducing their use of medications and day

treatment centres (Grove, 1999). Boardman (2001) also argues that people with mental health problems are especially sensitive to the negative effects of unemployment and to the loss of structure, purpose and identity which work brings.

1.3.2. Unemployment and mental health

Considering there is a large evidence base demonstrating that work has a positive impact on mental health; it is not surprising that research shows that lack of work can have negative psychological consequences. Bartley (1994) goes as far as to say that "it is no longer seriously argued that there is no such relationship," as lower levels of psychological well-being are found in all studies which compare unemployed people, at all ages and in both sexes. Fryer (1999) asserts that the degree of consensus in the findings of poor mental health amongst unemployed people is very striking.

The relationship between unemployment and poor mental health has been recognised for several decades as Warr (1987) examined a considerable amount of research into job loss and continuing unemployment and concluded that in general, being unemployed significantly impairs mental health. Conversely, obtaining a job leads quickly to improvement (Warr, 1987). An example of the studies Warr (1987) examined in his book on unemployment and mental health provides evidence that the prevalence of identified neurosis is significantly greater among unemployed than employed people where onset had followed unemployment in the absence of any other apparent provoking condition (Finlay-Jones & Eckhardt, 1981).

More recently, these results have been replicated using a British sample as Perkins (1994) found that in one London borough, those who were unemployed were eight

times more likely than those in work to be referred to psychiatric services (Perkins & Repper, 1996).

Following Warr's contribution to this field, Owen and Watson (1995) carried out a literature review on unemployment and mental health including research criteria on the basis of the quality of its design, the significance of the data produced and its illustration of a variety of constructs within the relationship between unemployment and mental health. The review concentrated on British research and concluded that all the literature reviewed suggests a link between unemployment and poor mental health (Owen & Watson, 1995).

A more recent research article highlights that the negative psychological effects of unemployment are well documented: lowered self-esteem and confidence; social isolation; anxiety; depression; reduced life satisfaction; and hopelessness about the future (Proudfoot *et al.*, 1999).

Furthermore, a literature review carried out by Fryer (1999) concluded that unemployment itself can cause poor psychological health. Proudfoot *et al.* (1999) also argue that it has now been established that unemployment ***causes***, rather than merely relates to, poor psychological health.

A recent meta-analytic study by McKee-Ryan *et al.* (2005) provides unequivocal evidence that unemployed individuals have lower psychological and physical well-being than their employed counterparts. In this research, American researchers McKee-Ryan *et al.* (2005) used meta-analytic techniques to examine the impact of

unemployment on worker well-being across 104 empirical studies. This study is among the first to comprehensively evaluate the quantitative relationship between unemployment and well-being and the results showed that unemployment has, on average, a negative effect on mental health and the evidence is strongly suggestive of a causal relationship (McKee-Ryan *et al.*, 2005).

Despite the overwhelming amount of research finding that unemployment has a negative effect on psychological well-being, Warr (1987) examined research whereby a small number of unemployed men reported improved psychological health, usually because they are now free from the negative aspects of their job. Warr (1987) believes that health improvements are particularly likely to be reported by those who have only recently become unemployed. He goes on to argue that unemployment is in general seen to impair mental health, although this effect is not universal; indeed a small minority of people show gains in mental health after losing their job (Warr, 1987). This is reflected in Warr's subsequent Vitamin Model which attempts to explain the complexity of unemployment and mental health by outlining nine features of the environment which are negatively affected by unemployment (Warr, 1987).

The fact that the negative effects of unemployment are not universal has long been recognised by researchers, as Bakke (1934) first observed that some people become adapted to being unemployed, finding it less unpleasant than employment because they could only gain work in oppressive occupations, where monetary rewards were barely greater than those gained from social welfare. Empirical research demonstrates that the experience of the unemployed varies considerably depending

on a variety of factors including: the person's age; gender; income; social support; reason for job loss; commitment to employment; satisfaction with previous work; expectation of returning to work; and length of unemployment (Ezzy, 1993). These factors are said to 'moderate' the typically negative self-evaluative consequences of unemployment.

More recently, researchers Grzywacz and Dooley (2003) explored the complex relationship between unemployment and mental health by describing three approaches to existing literature in this field. They describe the approach which suggests that employment, not the *quality* of employment, is a primary concern to those without work and report that a substantial body of evidence clearly suggests that employment promotes improved physical and mental health. However, they argue that new evidence is emerging that challenges this basic framework. They go on to describe a second approach to research in this field which goes someway to exploring the effect of *inadequate* employment. Grzywacz and Dooley (2003) argue that studies on the effect of economically inadequate employment are much more recent and sparse. However, the few studies of this question have found inadequate employment's adverse effect to be more like those of job loss than continuing adequate employment. The third approach focuses on the psychological and social aspects of work where the overall adequacy of an employment arrangement is distinguished by the relative level of different features of jobs such as decision latitude, job demands, social support at work, the availability of money and other forms of remuneration. Grzywacz and Dooley (2003) report that in this model; the relative absence of desirable job characteristics creates psychological demands or

stress for the worker that undermines worker health. This latter school of thought is also the premise underlying Warr's vitamin model (Warr, 1987).

In order to examine these approaches to research on (un)employment and mental health, Grzywacz and Dooley (2003) used data from two large cross-sectional surveys and developed five different employment categories ('optimal,' 'economically good,' 'psychologically good,' 'barely adequate,' and 'inadequate employment'), and unemployment to form an employment continuum. The results showed that less than optimal employment arrangements were independently associated with poorer physical health.

In his article contrasting the literature on the social costs of job loss with literature on economically inadequate employment, Dooley (2003) offers an alternative to the dichotomous construct of employment versus unemployment- namely a continuum of working and non-working statuses including more and less adequate types of employment. This article highlights the importance of new literature on the social costs of **underemployment** (unemployment and economically inadequate employment) (Dooley, 2003).

As well as this, other recent research examines employment transitions and mental health instead of looking only at employment and unemployment, demonstrating that researchers are beginning to consider employment on a continuum. Recent research reports the results of a large population based longitudinal study using data from the British household panel survey (Thomas *et al.*, 2005) which examines the impact of changes between employment and various forms of non-employment on the

psychological well-being of men and women. This study found that employment transitions have varying relations with psychological distress depending on the type of transition either from employment to non-employment (for example employed to unemployed, retired, study, long-term illness, maternity leave or family care) or from non-employment to employment (for example unemployed to employed, retired to employed, study to employed, maternity leave to employed, family care to employed). The results from this study also contribute to the evidence which states that becoming unemployed is associated with increased psychological distress as all transitions from paid employment into either unemployment or long-term illness were associated with poor mental health (Thomas *et al.*, 2005).

Finally, in addition to the evidence for the relationship between unemployment and poor mental health, many studies have examined the relationship between unemployment and suicide. In their review of unemployment and mental health, Owen and Watson (1995) examine several studies providing evidence for the relationship between unemployment, suicide and attempted suicide (parasuicide) namely studies by Hawton and Rose (1986) and Platt and Kreitman (1985a). Other studies have also shown a significant relationship between unemployment and suicide (for example Platt & Hawton, 2000). A recent large cohort study found that being unemployed was associated with a twofold to threefold increased relative risk of death by suicide, compared with being employed (Blakely *et al.*, 2003). The data did not allow the authors to directly control for mental illness as a potential compounding factor which leads them to conclude that about half of this association might be attributable to confounding by mental illness. However, this study of the

entire New Zealand adult population found that not being employed is strongly associated with suicide (Blakely *et al.*, 2003).

1.3.3. Unemployment and physical health

As well as a correlation between psychological health and mortality rates through suicide, research has also shown that there is a relationship between unemployment and mortality through poor physical health. Once again, the significant relationship between unemployment and poor physical health has been known for several decades as Smith (1985) presented evidence using data from studies such as the Regional British Heart Study which demonstrated that the 'ill-unemployed' and the 'not ill-unemployed' were more likely to suffer from bronchitis, obstructive lung disease, and ischaemic heart disease, even after standardisation for age, social class, town of residence and smoking state.

Wilson and Walker (1993) carried out a literature review on unemployment and mental health which found that unemployed men and their families have increased mortality experience, particularly from suicide and lung cancer. These authors found that large British studies show substantial cross-sectional differences between the employed and the unemployed in the prevalence of chronic physical illness, including bronchitis, obstructive lung disease and ischaemic heart disease (Wilson & Walker, 1993).

More recently, Australian researchers Mathers and Schofield (1998) reviewed the literature on the health consequences of unemployment and concluded that despite occasional studies finding no association between unemployment and ill-health, the

balance of evidence suggests that unemployment, at least among adult men, has an association with poor physical health, and in particular with cardiovascular disease.

1.3.4. Unemployment, mental health and gender

Although the negative psychological impact of unemployment is well accepted, research shows that gender has an effect on this relationship as studies including gender as a variable have found the relationship between unemployment and psychological distress to be less significant among women, than among men (Owen & Watson, 1995). The reason for this appears to be based on the additional social roles women have as traditionally, it has been accepted that women experience no psychological distress as a result of being made redundant because they can adopt the role of 'housewife' (Owen & Watson, 1995).

Recent research has also found that family responsibilities play an important role as Artazcoz *et al.* (2004) found that unemployment has more of an effect on the mental health of men than on that of women and the gender differences in effects were related to family responsibilities and social class. The more pronounced effect of unemployment on men's mental health is accounted for by the presence of family responsibilities; marriage increased the risk of poor mental health among men in the manual group, whereas among women, being married and (primarily) living with children acted as a buffer.

However, a more recent large population based longitudinal study found that when examining the relationship between becoming unemployed and psychological distress, the strength of the association was similar for both sexes (Thomas *et al.*,

2005). This study also showed that transitions from paid employment into maternity leave or family care show a significant increase in psychological distress (Thomas *et al.*, 2005). These authors argue that separate analyses for men and women are not often found in the literature which suggests that further research may be required with regards to gender differences, mental health and unemployment.

1.3.5. Unemployment rates

Despite the body of evidence showing that employment can have a positive effect on mental health, particularly for people who have experienced mental health problems, unemployment rates among this group remains high. Several surveys of people with severe mental health problems have found, on average, only 10 per cent in employment (Turton, 2001). Other studies suggest an unemployment rate of 85 per cent for people with a psychiatric disability (Grove, 1999). An editorial by Boardman *et al.* (2003) cites figures suggesting that eight per cent of people with long term disabilities of working age in Great Britain have a mental health difficulty as their main problem and in this group 18 per cent were in employment in 2000. More recent figures from the Office for National Statistics in 2003 (in England) suggest that 24 per cent of adults with long term mental health problems are in work (Office of the Deputy Prime Minister, 2004). Grove crucially argues that the high levels of unemployment amongst people with mental health problems are a waste of lives and resources, as studies in the UK, US and Germany suggest that 30 per cent- 40 per cent of people in this group are capable of holding down a job (Grove, 1999).

Despite several developments in the UK in the vocational rehabilitation field, research has shown that high unemployment rates still exist among people with

mental health problems. Perkins and Rinaldi (2002) carried out a study to examine trends in the vocational status of people with longer-term mental health problems in the London Borough of Wandsworth, using data collected over a 10 year period, and to compare these with local general employment rates. Unemployment among people with long-term mental health problems increased from 80 per cent in 1990 to 92 per cent in 1999; despite various developments in employment policy and practice in the field of mental health including: the development of effective models for supporting people with mental health problems in employment; the introduction of national policies such as the Disability Discrimination Act; and policy initiatives such as the New Deal for Disabled People (Perkins & Rinaldi, 2002).

As well as considering paid employment, research carried out in the UK has shown that many people with mental health problems do not engage in any kind of activity, voluntary or otherwise. Butterworth and Dean (2000) found in their survey that less than 50 per cent of mental health service users were engaging in any kind of meaningful activity.

As well as this, high unemployment rates are also prominent using a purely Welsh sample of mental health service users, as a study in Powys found that over 70 per cent of those interviewed were unemployed, with half of these being without a paid job for more than six years. Despite their unemployed status, over half of the respondents said that paid/ unpaid work and education and training activity is 'very important' in keeping well, and over three quarters said they would like to gain paid employment (Ng *et al.*, 2001).

Despite the high numbers out of work, many studies of people with mental health problems have found a growing number expressing the desire to work (Turton, 2001). Butterworth and Dean (2000) found that despite all the setbacks and disappointments that people experienced, 87 per cent of all those interviewed wished to return to work.

1.3.6. Demographic factors, psychiatric diagnosis and employment outcomes

As a result of the mismatch between high unemployment rates among people with mental health problems and users expressing a desire to work, several studies have attempted to predict employment outcomes in vocational rehabilitation. However, where demographic factors such as gender, ethnicity, age, education, marital status and so forth are concerned most studies have not found these factors to have a significant impact on work outcomes for clients with severe mental illness (Secker & Membrey, 2000). Furthermore, although some studies have reported a weak association between factors such as age and future vocational success, researchers have noted that this is related to employment participation for the general population and is not a particular feature of mental illness (Secker & Membrey, 2000).

Evidence also shows that neither diagnosis nor severity of symptoms or impairment has been found to be associated with vocational success (Secker *et al.*, 2001). After drawing on a range of research evidence, Evans and Repper (2000) state that there is no evidence to support the common assumption that efforts should be focused on getting the least symptomatic users into work first. Moreover, Evans and Repper (2000) also argue that even for people with persistent and severe psychotic

symptoms, what appears to be far more significant in predicting success at work is their desire for work, their interpersonal skills, their work readiness and their employment history. Consequently, it seems that most researchers agree that there is no relationship between a person's psychiatric diagnosis and their ability to succeed in vocational programmes (Secker & Membrey, 2000).

However, Bell and Lysaker (1995) argue that studies finding no correlation between work performance and symptoms may not be wholly accurate because global ratings of symptoms and vocational outcomes do not reveal how specific symptoms may affect specific aspects of concurrent functioning. They carried out a study on psychiatric symptoms and work performance with individuals with a diagnosis of schizophrenia or schizoaffective disorder and found that symptoms had a direct impact on work capacity. However; this relationship was not present with the positive components but mostly with the cognitive, negative, and hostility components of mental illness. As a result of this, Bell and Lysaker (1995) argue that functional assessment should not rely on global measures of symptoms as a useful predictor of work capacity. These authors conclude that further research is needed to understand how symptoms affect work (Bell & Lysaker, 1995).

More recently, a meta- analysis/ research synthesis of American research on the association between demographic factors, diagnostic factors and employment outcomes for people with psychiatric disabilities found very small effect sizes for age, gender, race and diagnosis as predictors of vocational outcome (Wewiorski & Fabian, 2004). The authors call for a research agenda that employs a variety of methods to explore all possible explanatory theories including theories that consider

age, gender, race, and diagnosis as possible determinants of vocational outcome (Wewiorski & Fabian, 2004).

1.4. Employment policy

As a result of the social and economic impact of mental ill-health, the UK government has shown an increased interest in enabling people with mental health problems to gain employment with the development of several initiatives and programmes in order to achieve this goal.

Among the government's initiatives are:

- **Workstep:** the reformed supported employment programme which offers job support to disabled people with complex work-related barriers
- **The New Deal for Disabled People (NDDP):** offers support for people on Incapacity Benefit to move into work through a network of job brokers
- **Access to work:** provides individually tailored support to remove disability-related barriers that would otherwise prevent take up or continuation of work

The government has also established the role of Disability Employment Advisers and offers work-focused interviews to Incapacity Benefit claimants, all aimed at helping people with mental health problems and others with barriers to work, back into employment. Other initiatives available for people with disabilities, offered by Jobcentre Plus include Employment Assessments, the Job Introduction Scheme, the Disability Symbol, Progress2Work and Pathways to Work; which are designed to

transform work opportunities for people making a claim for Incapacity Benefit. All of these initiatives are part of the government's Welfare to Work Policy which declares the government's aim as employment opportunity for all- "the modern definition of full employment" (HM Treasury, 2001).

The overall Welfare to Work policy has the potential to present opportunities to improve access to employment. However, there is some concern that the employment policies aimed at people with disabilities do not necessarily meet the needs of people with mental health problems. The Office of the Deputy Prime Minister (2004) reports that despite these new initiatives, "at present, Jobcentre Plus programmes are not always able to meet the particular needs of people with mental health problems." For example, WORKSTEP requires people to work for 16 or more hours per week and Access to Work requires a stable health condition, both of which may rule out people with mental health problems. The Department for Work and Pensions is considering greater tailoring of provision to meet individual needs, which should help meet the needs of this client group more effectively (Office of the Deputy Prime Minister, 2004).

As well as the Welfare to Work Policy, the UK government is also trying to tackle social exclusion among the long-term unemployed. The Department of Health brought out the National Service Framework for Mental Health (NSF, DoH 1999) in England and it requires health and social services to reduce discrimination and social exclusion, and increasing employment opportunities is highlighted as a means to this end (Secker *et al.*, 2001). In addition, the National Service Framework for England requires service providers to include action for employment, education, training or

other occupation within the care plans for people on the enhanced Care Programme Approach, introduced in 1993 as the framework underpinning practice in this field (Secker *et al.*, 2001).

Specifically within Wales, the Adult Mental Health Services for Wales; strategy document was published in September 2001 and it stated that as a direct result of some of these issues, the Welsh Assembly Government has designated mental health as one of the three key health priorities. Additionally, it sees this strategy as a ten-year plan to improve, modernise and develop mental health services in Wales to a position where they provide the best possible care for those with mental health problems. The Welsh Assembly Government is attempting to tackle the high unemployment rates among people with mental health problems, stating that all users with serious mental illness must be assessed in order to determine any need for support in retaining their current employment, obtaining employment or for additional training. The document states that "a comprehensive range of employment and occupational opportunities should be provided" (The National Assembly for Wales, 2001).

The National Service Framework (NSF) for Mental Health in Wales was developed and made available in April 2002 and it establishes the practical guidelines that will ensure consistent and comprehensive implementation of the Strategy's vision across Wales (Welsh Assembly Government, 2002). The National Service Framework for Wales sets standards for eight key activities along with 44 key actions for implementation. One of the standards identified within the National Service Framework is 'the promotion of opportunities for fulfilling and socially inclusive

patterns of daily life' (standard three). In addition, key action ten relates specifically to employment (including meaningful activity) which states that for users in employment/ meaningful activity, support should be made available to help them maintain their employment and that for users seeking new opportunities, a range of training, advice and support should be available (Welsh Assembly Government, 2002).

As well as this, the Office of the Deputy Prime Minister produced a comprehensive report on 'Mental Health and Social Exclusion,' which was a Social Exclusion Unit report in June 2004. This report explores the experience of mental health problems and specifically addresses issues such as stigma and discrimination, mental health and employment and overcoming the barriers to employment. The report includes a chapter on the UK government's action plan which sets out a 27 point action plan, bringing together the work of the government departments and other organisations, in a concerted effort to challenge attitudes and significantly improve opportunities and outcomes for this excluded group. Actions fall into six categories, one of which is employment. This action plan is for England only. However, where actions relate to retained matters, such as employment and benefits policy, they apply to all devolved administrations. The Social Exclusion Unit project also drew lessons from Wales, Scotland and Northern Ireland and they suggest that the report is likely to be relevant throughout the UK (Office of the Deputy Prime Minister, 2004).

1.5. Employment practice

Research has shown that the employment model used when supporting people with mental health problems into employment is extremely important in determining success. After carrying out a study on vocational outcomes, Blankertz and Robinson (1996) concluded that the focus of research should be on programmatic elements rather than on the client characteristics stressed in previous studies of vocational rehabilitation. Moreover, Secker *et al.* (2001) report that in several studies which set out to test individual characteristics in relation to vocational success; researchers found that the different approaches of the employment service agencies involved appeared to play a significant part in employment outcomes. Secker and Membrey (2000) also argue that "there is a growing consensus that it is the rehabilitation model and not the client that is the key to successful employment outcomes." These findings have clear implications for mental health services as they highlight the importance of adopting successful employment models for enabling people with mental health problems back into work.

O'Flynn and Craig (2001) argue that there is a general presumption that we do not know what 'model' of service is most effective and so which to promote. Boardman *et al.* (2003) also argue that there is widespread ignorance of the existing evidence about services and approaches that are effective in helping people with mental illness to work and keeping them in employment. However, during the past two decades there has been an expansion of employment iniatives for people with mental illness (Boardman *et al.*, 2003). O'Flynn and Craig (2001) organise employment models into three broad categories which are sheltered employment, social firms and

supported employment. A fourth model is also described here namely the clubhouse model of employment.

1.5.1. Sheltered employment

Sheltered employment is one of the most traditional forms of providing employment opportunities for people with mental health problems and these schemes began within hospitals as Industrial Therapy Units, but many have since moved into the community. Work is 'sheltered' primarily because it takes place in a protected environment, separate from the non-disabled working world (Schneider, 1998). The payment for the work carried out is generally minimal; as payment or hours worked do not reflect local norms since they are geared towards people receiving benefits (Schneider, 1998).

The principle of sheltered work settings is that they are based on a continuum concept whereby people are supposed to move from one level (for example day activity centre) to the next (for example sheltered workshop) and finally to graduate to competitive, open employment (Lutfiyya *et al.*, 1988). However, the number of people for whom open employment does become reality appears to be small as studies have repeatedly shown that a mere three to five per cent of all people in sheltered settings actually do move onto the next level in any given year (Lutfiyya *et al.*, 1988). Schneider (1998) also agrees that participants appear to have little hope of attaining open employment resulting in a static, segregated work force (Hammond *et al.*, 1998).

Sheltered workshops do not allow consumers to interact with non-mentally ill co-workers (Twamley *et al.*, 2003). The segregation of people with mental health problems within these settings may exacerbate social exclusion as these schemes tend to create a work setting exclusively made up of psychiatric patients, rather than helping people to become integrated into the community (Schneider, 1998). Workshops that involve simulated work tasks have been criticised for isolating patients and for failing to teach skills that are comparable to those needed for employment in the community (Twamley *et al.*, 2003).

However, many sheltered employment schemes still exist in the UK and the factory paradigm to which sheltered settings originally subscribed survives (Schneider, 1998). Grove (1999) reports that "many of the regular users of those services have said that when at their most vulnerable; they have greatly valued the workshops as safe havens of friendship, productive activity, with the chance to earn a little pocket money." Despite developments in employment programmes for people with mental health problems, there will still be people whose disability is too great to manage in open employment regardless of the extent of available support (O'Flynn & Craig, 2001). For these people, sheltered workshops providing benefits plus work in a segregated setting may still be optimal (O'Flynn & Craig, 2001).

1.5.2. Social firms

Social firms were developed originally in Germany (Schneider, 1998) and they "lie somewhere between rehabilitation units and open employment" (Mind, 2000).

The European Confederation of Co-operatives and Social Businesses cited in Social Firms UK (n.d.) defines a social firm:

- A social firm is a business created for the employment of people with a disability or other disadvantage in the labour market.
- It is a business which uses its market-oriented production of goods and services to pursue its social mission.
- A significant number of its employees will be people with a disability or other disadvantage in the labour market.
- Every worker is paid a market rate wage or salary appropriate to the work, whatever their productive capacity.
- Work opportunities would be equal between disadvantaged and non-disadvantaged employees. All employees have the same employment rights and obligations.

Social firms tend to have a very positive attitude towards their workers as the emphasis is on the potential and abilities of the worker rather than on potential problems and barriers (Harnois & Gabriel, 2000). Furthermore, one of the most important characteristics of a workplace in a social firm is the 'empowering atmosphere' for their employees with disabilities (Harnois & Gabriel, 2000).

The success of the social firm model can be seen from European research as this model has proven to be particularly successful in several European countries (Hammond *et al.*, 1998). Furthermore, they are growing fast in the USA particularly in the model known as affirmative businesses (Schneider, 1998). There are a number of social firms currently in existence as, using a broad definition of social firms, and

including Italian cooperatives, there are said to be in excess of 2000 social firms at this point in time in Europe offering employment to persons with psychiatric disabilities (Harnois & Gabriel, 2000).

Social firms which operate in the UK tend to be relatively small as they have only taken off comparatively recently (Grove, 1999). Despite this, social firms are increasing in number in Britain and provide a desirable component in the spectrum of mental health employment services (Grove, 1999). In fact, social firms are generally seen to be a very successful way of creating jobs for people with mental health problems as Grove (1999) states that ideally, comprehensive local employment services should contain a range of social enterprises which are fully integrated into the local economy.

There are some difficulties in establishing and running social firms because they are operating in the open labour market which makes these businesses vulnerable to commercial pressures. Grove (1999) states that "social firms require sophisticated commercial management skills to be successful." Balancing such pressures with the need to provide a supportive work environment can be difficult (Hammond *et al.*, 1998). It might also be difficult to acquire funding in the initial stages prior to becoming self-financing. In addition to these potential difficulties, it must be remembered that a social firm is not going to create a large number of jobs in a short time. Establishing a social firm can take time and the jobs available may not be suitable for everyone.

1.5.3. Supported employment

According to the federal definition in the U.S.A., supported employment means:

> "Competitive work in integrated work settings....consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability" (Bond *et al.*, 2001).

Crowther *et al.* (2001) summarise the core principles of supported employment:

a) the goal is competitive employment in work settings integrated into a community's economy;

b) clients are expected to obtain jobs directly, rather than after lengthy pre-employment training;

c) rehabilitation is an integral component of the treatment of mental health rather than a separate service;

d) services are based on client's preferences and choices;

e) assessment is continuous and based on real work experiences; and

f) follow on support is continued indefinitely.

The supported employment model has emerged over the past 15 years (Latimer, 2001) and has generated a lot of interest and enthusiasm among lead researchers in the field of vocational rehabilitation. In particular, there is a great deal of evidence to demonstrate the effectiveness of a particular form of supported employment- Individual Placement and Support (IPS)- in helping to facilitate positive employment outcomes for people with mental health problems. The Individual Placement and Support (IPS) model of supported employment is a standardisation of supported employment outlined by Becker and Drake (1993) which focuses on a 'place and

train,' rather than a 'train and place' model. Within the 'place and train' model, clients are expected to obtain jobs directly, rather than after lengthy pre-employment training. Therefore, once an individual has decided that they want to return to work, the 'place and train' model encourages people to embark on a rapid job search and placement, with preparation which is concurrent with job search, rather than prior to it. Placement is then followed by time unlimited support and workplace adjustment. Whilst vocational initiatives in Britain have traditionally been based on 'train and place' models such as industrial therapy and sheltered work, research shows that 'place and train' models (for example IPS) are more effective in enabling people to obtain competitive employment (Sayce & Morris, 1999; Secker *et al.*, 2001).

To examine the effectiveness of supported employment for people with severe mental illness, Bond *et al.* (1997) carried out a literature search for quantitative studies, primarily in the published literature. All of the studies suggested significant gains in obtaining employment for persons enrolled in supported employment programmes. Within the experimental studies, a mean of 58 per cent of clients in supported employment programmes achieved competitive employment, compared with 21 per cent for control subjects who typically received traditional vocational services (Bond *et al.,* 1997). This review also found no evidence that supported employment led to stress levels precipitating higher re-hospitalisation rates.

The authors also identified a number of components of supported employment which needed further consideration including access to supported employment, long-term career development and job retention. Specifically with regards to job retention for people with mental health problems, Bond *et al.* (1997) reported that between 41 and

77 per cent of clients terminate a supported employment placement within six months, and dropout rates of more than 40 per cent are common. This review led Bond *et al.* (1997) to conclude that supported employment appears to be a promising approach for people with severe mental illness, but more studies are needed, with close attention to programme implementation and long-term follow-up.

One of the sources of evidence for the effectiveness of supported employment comes from day treatment conversion studies. Drake *et al.* (1999) report on two of these studies in their review of the research on the Individual Placement and Support (IPS) model. The initial study of IPS arose as a natural experiment in New Hampshire where a mental health centre decided to convert their rehabilitative day programme to an IPS supported employment programme. A nearby day treatment centre that did not plan to change its operations served as a comparison programme. Within the mental health centre which had converted to the IPS programme, competitive employment outcomes for day treatment attendees with severe mental illness improved significantly from 33 per cent to 56 per cent within one year (Drake *et al.*, 1994). The success of the IPS programme led the comparison centre to convert to the IPS supported employment programme and after a one year follow-up; they found a dramatic increase in competitive employment from 9 per cent to 40 per cent (Drake *et al.*, 1996). The review by Drake *et al.* (1999) also highlights one of the limitations of research into IPS in that the long-term course of jobs and of vocational careers in relation to IPS remains an unknown.

Further evidence for the effectiveness of supported employment comes from a systematic review by Crowther *et al.* (2001) which aimed to determine the most

effective way of helping people with severe mental illness to obtain competitive employment. The examination of 11 randomised controlled trials demonstrated that supported employment is more effective than prevocational training at helping people with severe mental illness to obtain competitive employment (Crowther *et al.*, 2001). People in supported employment earned more and worked more hours than those who had prevocational training. Generalisability is, however, limited by the fact that all the trials were conducted in the United States (Crowther *et al.*, 2001).

Bond *et al.* (2001) wrote an article which discusses supported employment as a recent approach to vocational rehabilitation that has proved to be consistently more effective than traditional approaches. The authors assert that supported employment is an evidence-based practice, based on converging findings from eight randomised controlled trials and three quasi-experimental studies (Bond *et al.*, 2001). No other vocational approach for people with severe mental illness has attained the status of evidence-based practice (Bond *et al.*, 2001). As well as describing supported employment, its effectiveness and critical components, the article also reviews the findings and limitations of current research and discusses implementation issues, including availability, barriers and strategies. Key implementation barriers include a lack of access to supported employment, and government barriers such as a lack of funding for vocational rehabilitation (Bond *et al.*, 2001).

A randomised controlled trial by Lehman *et al.* (2002) extends the evidence base for the effectiveness of supported employment by examining whether IPS improves the employment outcomes for people with severe mental illnesses compared with standard psychosocial rehabilitation. This study found that IPS programme

participants were more likely than the comparison patients to work and to be employed competitively. The average hours worked per month and average wages earned per month were greater for patients in the IPS programme than for those in the comparison group (Lehman *et al.*, 2002).

The above study was included in a literature review and meta-analysis of randomised controlled trials by Twamley *et al.* (2003) examining vocational rehabilitation in schizophrenia and other psychotic disorders. In their review, Twamley *et al.* (2003) used a more narrow emphasis on randomised controlled trials by reviewing vocational outcomes in the published, randomised controlled trials of work rehabilitation interventions for individuals with schizophrenia in order to focus more closely on investigations meeting "the highest standards of scientific evidence." Their review also included several articles published since the earlier reviews described above. Findings showed that supported employment programmes in general, and IPS specifically have produced consistently better outcomes than traditional vocational rehabilitation in terms of both competitive employment and employment of any type. However, Twamley *et al.* (2003) also report that although IPS/ supported employment appears to be the most effective type of work rehabilitation, nearly half (49 per cent) of IPS/ supported employment participants did not obtain competitive work at any time during the study. Consequently, they conclude that IPS/ supported employment is "on the right track," but also that further improvements should be made so the intervention will result in positive outcomes for more consumers.

Bond (2004) examined the practice of supported employment for individuals with severe mental illnesses and asserts that all the recent reviews of supported employment for consumers with severe mental illness point to the conclusion that it should be considered an evidence-based practice. Since the unequivocal evidence of the effectiveness of supported employment from the reviews described above, Bond (2004) reports that several additional studies, some of which were still in progress at the time of this review, offer further stringent tests of the effectiveness of supported employment by comparing it to strong alternatives (for example a diversified placement approach), while others offer enhancements of the basic model including IPS plus skills training, a motivational interviewing enhancement of IPS and a social network enhancement. To date, none of these innovations have demonstrated incremental utility over the evidence-based supported employment approach. Bond (2004) concludes that no other vocational model is as clearly defined, has been as widely studied, nor achieved a consistent pattern of positive outcomes regarding competitive employment.

A study by Mueser *et al.* (2004) noted that prior research has compared IPS to single-model exemplars, such as group skills training, sheltered workshops or prevocational training. However, Mueser *et al.* (2004) was the first controlled study of IPS to include a standard services condition in which clients had access to all the usual vocational services available to them. The relative effectiveness of IPS was also compared with a psychosocial programme using transitional employment. The results showed that clients who participated in the IPS programme had significantly better work outcomes, especially competitive work, than clients who participated in the psychosocial rehabilitation (PSR) programme or who received standard

vocational services (Mueser *et al.*, 2004). The study concludes by stating that considering the evidence supporting the IPS model, the time is ripe to turn attention to research on new issues about supported employment such as examining interventions that attempt to address factors that limit clients' response to supported employment, addressing the problem of short job tenure for many clients and looking at how clients can be more supported in pursuing and enhancing their career goals (Mueser *et al.*, 2004).

As a result of the conclusion from their review in 1999 (that the long-term course of jobs and vocational careers remains unknown), Salyers *et al.* (2004) carried out a ten-year follow-up study as an extension of the New Hampshire study described above. Salyers *et al.* (2004) attempted to locate all participants who had been defined as regular users of day treatment services and had been included in the one-year follow-ups in the original studies. The authors were able to locate 36 participants for this study and semi-structured interviews were carried out gathering information about demographic characteristics, facilitators of employment and clients' perceived effects of working. Results from this study led to the conclusion that the participants demonstrated substantial employment rates during the years that followed the conversion from a day treatment programme to a supported employment programme. Almost all the consumers reported that they were employed at some point during the ten-year follow-up period, and 17 consumers (47 per cent) were employed at the time of the ten-year follow-up interview. Of the participants who did work over the ten-year period, many of the jobs they held were long-term, with an average tenure of almost three years. In addition, participants noted many positive affects that working had on their lives, particularly in reference to their self-worth (Salyers *et al.*, 2004).

Despite the fact that supported employment requires that clients work for pay, preferably the prevailing wage (Drake *et al.*, 1999), the authors definition of "being employed" in this ten-year follow-up study appears to include paid work, volunteer positions, sheltered work and homemaking, as 92 per cent of participants reported having participated in *work activity* during the past ten years. However, the authors do note that the majority of the jobs were competitive, with consumers making at least minimum wage in a community setting (Salyers *et al.*, 2004).

This study is the first to look at the long-term impact of supported employment and the findings are encouraging in terms of rates of employment, particularly competitive employment and the benefits of working that clients perceived in other areas of their lives (Salyers *et al.*, 2004).

Other recent studies have explored various aspects of supported employment in greater detail, either with the inclusion of additional support, or by examining the effect of the conversion of a vocational programme from models other than day treatment.

McGurk *et al.* (2005) carried out a randomised controlled trial examining the effectiveness of cognitive training *and* supported employment versus supported employment only and found that employment outcomes over one year showed that clients who received the cognitive training alongside supported employment, were significantly more likely to work, worked more jobs, worked more hours and earned more wages than clients with supported employment only. However, not all

enhancements to the supported employment model have shown such promise. Mueser *et al.* (2005) carried out a randomised controlled trial evaluating whether a supplementary skills training programme improved work outcomes for clients enrolled in supported employment programmes. This study found that supplementary skills training did not improve work outcomes for clients who were receiving supported employment (Meuser *et al.*, 2005).

Other recent randomised controlled trials have focused on the identification of relationships between specific model features, types and amounts of vocational services (Cook *et al.*, 2005). The examination of individual features of employment models is important because the assumption that all aspects of a new approach are essential threatens greater understanding of effective care and risk imposing an excessive financial burden on the care system (O'Brien *et al.,* 2003). A randomised controlled trial by Cook *et al.* (2005) found that supported employment models in which psychiatric and vocational service delivery are highly integrated, produce better vocational outcomes than those with low levels of integration. Leff *et al.* (2005) carried out a meta-analysis study into the effects of job development and job support on competitive employment for people with severe mental illness. They found that job development is very effective when the goal is job acquisition. Job support is associated with retention of a first competitive employment, but the causal role is questionable. Leff *et al.* (2005) conclude by stating that their study only begins to unpack the 'black box' of vocational rehabilitation programmes and that the effects of patterns of services received on job acquisition and retention should be explored.

One of the key areas for further research which has been highlighted throughout the evidence for the effectiveness of supported employment is job retention. Bond *et al.* (1997) recognised that job tenure among clients with severe mental health problems in supported employment programmes is brief. One study which examined job tenure among 85 individuals with severe mental illness who were participating in supported employment programmes found that the average job lasted 70 days (Xie *et al.*, 1997). Although these researchers state that the study was based on a small sample and should be replicated in larger groups, they also conclude that "more must be learned about the factors that are related to early job terminations" (Xie *et al.*, 1997).

Thomas *et al.* (2002) carried out a literature review on the factors which create barriers to job retention and found that the major barriers to job retention revolve around four issues: the stigmatisation of mental illness and its implication for employers' attitudes and take up of support; lack of awareness of employment rights; problems on the job; and low expectations amongst both mental health professionals and those experiencing mental health problems.

As a result of the literature demonstrating that job tenure among people with mental health problems is brief, the UK government funded the Job Retention and Rehabilitation Pilot (JRRP) which was a randomised controlled trial designed to test three interventions aimed at increasing the return-to-work rate of people who were off sick from work. The trial ran from April 2003 for two years, in six areas in the UK. The study aimed to investigate what helps return to work and job retention for people who have been off work because of sickness, injury or disability, including those with mental health problems. Volunteers, who had been out of work for six to

26 weeks and were at risk of losing their jobs, were randomly assigned to one of four groups. One group offered additional help in the workplace (workplace intervention), another assisted with healthcare (health intervention), and the third combined the two (workplace and health). The forth group was the control group (Office of the Deputy Prime Minister, 2004). The research involved four components: the randomised controlled trial and three qualitative research studies with service users, with people in the control group, and with JRRP provider staff. This study was carried out by the Department of Work and Pensions, in conjunction with the Department of Health (Office of the Deputy Prime Minister, 2004).

Results from this study demonstrated that almost identical return-to-work rates were found for each of the four groups, as 44 per cent of those allocated to the health intervention group returned to work for at least 13 weeks; 45 per cent of those allocated to the workplace intervention; 44 per cent of those allocated to the combined intervention; and 45 per cent of those allocated to the control group. This implies that, overall; the JRR interventions had **no** impact on returns-to-work (Department for Work and Pensions, 2006).

However, what is also significant about this research is that the overall findings mask some sub group impacts, as for those who at the start of the trial reported they were off work sick with mental health problems, it appears that the interventions may have actually reduced the likelihood of a return to work (59 per cent of the control group returned to work, compared to just 47 per cent of those in one of the intervention groups). In contrast, the interventions may have been most helpful to the minority of those off work sick because of an injury (36 per cent of those in the control group

returned to work compared to 55 per cent of those in one of the intervention groups) (Department of Work and Pensions, 2006). One of the possible explanations for the findings which was put forward by the researchers is that the interventions offered were not always seen to be appropriate to the clients or to meet their needs fully and that the service providers did not always encourage clients to be proactive and to initiate contact (Department for Work and Pensions, 2006).

Wallace and Tauber (2004) have also carried out research attempting to address the problem of short job tenure. They carried out a randomised comparison study which compared participants' job retention in an IPS programme with job retention in an IPS programme with additional workplace skills training, designed to teach workers with mental illness the social and workplace skills needed to keep their jobs. The preliminary results showed that there was greater job retention among the participants who received the combination of IPS and the workplace fundamental skills module. Furthermore, the participants in this group were significantly more satisfied with their jobs (Wallace & Tauber, 2004). As a result of the large gap in research and practice on mental health and job retention (Thomas *et al.*, 2002), recent research studies are providing evidence which give some insight as to how this problem can be addressed.

Although the evidence on the effectiveness of supported employment is overwhelming, researchers have questioned the generalisability of the evidence (see Crowther *et al.*, 2001) because the vast majority of studies which demonstrate its effectiveness have been based in America. Very little research has been published on the effectiveness of the supported employment model for people with severe and

enduring mental health problems living in the UK. An editorial article by O'Flynn and Craig (2001) argues that there is very little quantitative research in the UK and results from Europe and the USA can probably not be generalised.

Crowther *et al.* (2001) argue that it remains uncertain whether supported employment will be more effective than prevocational training in countries with less dynamic economies and dissimilar welfare structures. These authors conclude that the UK government should encourage agencies concerned with vocational rehabilitation to develop and evaluate supported employment schemes similar to those in the United States (Crowther *et al.*, 2001).

O'Brien *et al.* (2003) also argue that because of the success of IPS in the USA, we cannot necessarily assume that this would be the case in Europe with its radically different employment and social welfare structure. Rigorous randomised controlled trials of direct IPS need to be conducted in the UK and in other European countries (O'Brien *et al.*, 2003).

Boardman *et al.* (2003) agree that supported employment schemes have not been evaluated in the UK, and these and other work based schemes need evaluating here. Indeed, Boardman *et al.* (2003) argue that vocational rehabilitation is poorly developed in the UK.

Some studies have been carried out on supported employment in the UK, particularly looking at access to supported employment programmes. An editorial by O'Flynn and Craig (2001) reports on surveys of employment provision in the UK which have

identified 135 organisations offering sheltered employment, 77 providing supported employment and around 50 social firms. O'Flynn and Craig (2001) argue that given there are about 500,000 people with mental illness in the UK and that on average around 75 per cent of people using mental health services are unemployed, it is clear that these work projects are only providing a limited and restricted service (O'Flynn & Craig, 2001).

Crowther and Marshall (2001) carried out an extensive survey of vocational rehabilitation services in the North West region of Britain which found that vocational schemes appear to have been developed in a haphazard manner. Services did not appear to have developed in line with any pre-defined approaches in the literature, with the identification of only one service following the specific supported employment model.

A randomised controlled trial was also carried out in the UK by O'Brien *et al.* (2003) investigating the impact of training Community Mental Health Team (CMHT) members in the practice of IPS, on the vocational status of long-term patients. They found that training in IPS at team level did not improve employment status and that a dedicated vocational worker appears to be essential for successful IPS in the UK (O'Brien *et al.*, 2003).

A cost effectiveness study commissioned by the Social Exclusion Unit within the Office of the Deputy Prime Minister concluded that supported employment and IPS projects were significantly more effective than other approaches in enabling people with mental health problems to find and keep open employment (Curran *et al.*,

2003). From this, the report on 'Mental Health and Social Exclusion' (Office of the Deputy Prime Minister, 2004) concludes that converting less effective programmes to supported employment could be cost-saving, or at least cost-neutral for local services and the government, and would have broader social benefits. Consequently, the government's action plan for England, as part of the report on 'Mental Health and Social Exclusion,' includes action point five which states that the Department of Health will work with the National Institute of Mental Health England (NIMHE), and in liaison with the Department for Work and Pensions, to implement evidence-based practice, in particular IPS (Office of the Deputy Prime Minister, 2004).

A recent review article by Curran *et al.* (2004) states that there are at least two UK projects underway currently that will generate new evidence for the effectiveness of supported employment within a British context. One is the UK arm of a six-country European Commission-funded randomised controlled trial investigating the cost-effectiveness of supported employment for people with severe mental illness, compared to existing vocational services. The second is a Wellcome Trust funded, randomised controlled trial of IPS (Curran *et al.*, 2004).

However, at the current time there is not enough evidence available to suggest whether the results from US studies will be replicated in other countries or whether similar long-term outcomes will be observed. Such evidence should begin to become available in the next few years as trials begin to report their findings (Curran *et al.*, 2004).

Additionally, Boardman *et al.* (2003) argue that no one model of service is right for everyone, and each approach may help different people at different times in their recovery and reintegration. Ideally, people should have access to a range of work, training and support which is relevant to their changing needs.

The report on 'Mental Health and Social Exclusion' (Office of the Deputy Prime Minister, 2004) also recognises that people with mental health problems need a range of employment options, as individual needs vary. Some will not be able to work in the open labour market, and will continue to need alternative work opportunities. However, evidence suggests that many more, currently denied the opportunity, could benefit from active support to find work and are capable of moving into work quickly without extensive training (Office of the Deputy Prime Minister, 2004).

1.5.4. The clubhouse model

A fourth model which is often considered when looking at employment models to assist people with mental health problems back into employment is the clubhouse model which began at Fountain House in Manhattan, New York in 1948 (Schneider, 1998). The clubhouse functions as a work-centred community which is separate from the mental health centre or institutional settings. The clubhouse principle is that members and staff work together in the entire running of the clubhouse. In partnership with staff, members carry out all activities necessary to run the clubhouse (Hammond *et al.*, 1998) and this includes cleaning, administration, book-keeping, catering, publishing a newsletter and outreach to non-attenders (Schneider, 1998). Members are responsible for the upkeep of the clubhouse and take on jobs within it depending on need (Evans & Repper, 2000). Although members are not paid for any

work done within the clubhouse, participation in the clubhouse work units may be seen as a form of constructive employment (Schneider, 1998). Additionally, members can develop their skills and confidence through this, with the hope that those who do want to return to paid work can do so through the transitional employment programme that the clubhouse runs.

The clubhouse offers its own transitional employment programme for members to work on job placements in business and industry. This idea also came from Fountain House whereby the members eventually took on jobs servicing the local business community by running messages, cleaning offices and thus the transitional employment (TEP) model evolved in the 1960s (Schneider, 1998).

Transitional employment actually offers paid employment opportunities as members are paid at least minimum wage, directly by the employer. Additionally, transitional employment placements are part-time and time-limited. The long-term aim of transitional employment placements is that after a series of placements, it is hoped that an individual will be ready to enter permanent employment (Hammond *et al.*, 1998). Once a member feels that they are ready to enter the open labour market, the clubhouse assists and supports members to secure, sustain and upgrade independent employment. Once members do achieve this position, members working full-time continue to have all clubhouse supports and opportunities, including advocacy, and assistance with housing, clinical, legal, financial, and personal issues, as well as evening and weekend programmes.

Advantages of this model include the social support offered by the clubhouse which should not be ignored in assessing the psychological benefits of this model (Schneider, 1998). Additionally, what makes this model quite distinctive is that the job itself is held by the clubhouse not the individual. This means that responsibility for meeting the job commitment extends to the clubhouse paid staff who train workers and also cover for people on placements when necessary, thus providing a guarantee to the employer that tasks will be completed (Schneider, 1998). Staff can provide workplace support and in the event of sickness absence, other clubhouse members can provide 'backup' (absence coverage) (Hammond *et al.*, 1998) which gives mental health service users peace of mind that they will not lose their jobs when taking time off due to ill-health.

There are also some disadvantages of this approach such as the fact that high levels of unemployment may make transitional employment placements difficult to find. Furthermore, jobs are time-limited and there may not be an appropriate placement to move on to which could mean low throughput to permanent employment. In addition, the placements are almost always entry-level jobs (that is unskilled, low level positions) which are inappropriate for many people (Hammond *et al.*, 1998).

The effectiveness of the clubhouse model in achieving positive vocational outcomes for people with mental health problems has been examined through a randomised controlled trial carried out to compare a vocationally integrated program of assertive community treatment (ACT) with a certified clubhouse in the delivery of supported employment services (Marcias *et al.*, 2006). In this trial employment rates, total work hours, and earnings for adults with serious mental illness interested in work were

compared with published benchmark figures for exemplary supported employment programs. The two programmes were then compared on service engagement, retention, and employment outcomes in regression analyses that controlled for background characteristics, programme preference, and vocational service receipt (Marcias *et al.*, 2006). The results showed that outcomes for both ACT and clubhouse participants met or exceeded most published outcomes for specialised supported employment teams demonstrating that vocationally integrated ACT and certified clubhouses can achieve employment outcomes similar to those of exemplary supported employment teams. The results also showed that certified clubhouses can effectively provide supported employment along with other rehabilitative services.

A second article also reported on the randomised controlled trial to determine whether the clubhouse model of community support and psychiatric rehabilitation can produce competitive employment outcomes that are comparable or superior to those of the Program of Assertive Community Treatment (PACT) model. Schonebaum *et al.* (2006) showed that participants from both the ACT and clubhouse models achieved high employment levels, with no significant differences in weekly employment or 30-month job placement rates over the course of the study. What is also significant about these results is that clubhouse participants earned significantly higher wages and remained competitively employed for significantly more weeks per job than ACT participants (Schonebaum *et al.*, 2006).

However, what is not clear from these articles is what method of support the clubhouses were using when moving beyond the transitional employment placements and it may be that these methods have similar characteristics to IPS. The finding that

the clubhouse model has positive outcomes in terms of increased job tenure is a key finding, particularly as poor job retention has been identified in previous studies where participants were enrolled on supported employment programmes (Thomas *et al.*, 2002; Xie *et al.*, 1997). Therefore, it would be useful to carry out further research on the role of the clubhouse in improving job tenure for participants enrolled in supported employment programmes.

1.6. Barriers to employment for people with mental health problems

Research has shown that despite various developments in employment policy and practice in the field of mental health, high unemployment rates still prevail (Perkins & Rinaldi, 2002). People with mental health problems face a significant number of barriers which contribute to the difficulties they face in gaining employment and help to explain the mismatch between high unemployment rates and their desire to work.

Findings from a study carried out in Powys, Wales found that many respondents reported discrimination by employers, the fear of discrimination, the lack of appropriate support services and little valued occupation opportunities as the main barriers which prevent them from re-entering supported or open employment and in taking up educational and vocational opportunities (Ng *et al.*, 2001).

The report on 'Mental Health and Social Exclusion' (Office of the Deputy Prime Minister, 2004) identified seven barriers to employment for people with mental health problems:

1) the impact of mental health problems on the individual (for example loss of motivation and confidence, side effects of medication);
2) fear that work will lead to worsening mental health;
3) low expectations of staff (health and social care, Jobcentre Plus staff);
4) employer attitudes;
5) people with mental health problems lacking awareness about available support;
6) benefit reviews (fear that looking for work will trigger a benefit review); and
7) financial implications of leaving benefits (concerns of being worse-off in work or the job not working out and having to reclaim).

Several researchers have identified barriers to employment for people with mental health problems with one of the most frequently cited barriers to obtaining paid employment being financial disincentives.

Turton (2001) highlights that the welfare benefits system has been repeatedly singled out as the main barrier to employment, training and study for people with mental health problems. Turton (2001) cites a study of supported employment schemes in Great Britain which found that 52 per cent of workers said that the benefits system was the main barrier to employment.

Specifically, *the unemployment trap* (or the benefits trap), when people find themselves not a great deal better-off, or worse-off, financially if they return to work, can act as a barrier to employment for people with mental health problems. As can *the poverty trap*, which occurs when a working person or family is little, no better-

off, or even worse-off as a result of earning additional income because earning more means they simultaneously pay more tax and receive less benefits (Turton, 2001).

As a result of the financial disincentives to work, the UK government has introduced some flexibility in the benefits system through the introduction of the 'linking rules' whereby people who leave Incapacity Benefit to move into work or training, and reclaim the benefit within one year for the same heath condition, will re-qualify for the same level of benefit (Office of the Deputy Prime Minister, 2004). Permitted work also aims to bridge the gap between benefits and full-time work by enabling people to work for up to 16 hours per week and remain on benefits. Despite these attempts to reduce the barriers to employment as a result of the benefits system, many of these rules are not widely understood and people are not always aware of them. Others may argue that these rules do not go far enough to reduce the barriers to employment for people with mental health problems, and that more needs to be done.

Another of the most frequently cited barriers for people with mental health problems entering the workplace is discrimination and the fear of discrimination. Evans and Repper (2000) argue that this everyday reality of discriminatory attitudes and behaviour is one of the most serious problems faced by people with mental health problems. These authors argue that in the UK, people with mental health problems have far fewer opportunities to work than the general population because of the many misperceptions and prejudices about their abilities and needs (Evans & Repper, 2000).

There have been several surveys which have been carried out by mental health organisations providing evidence for discrimination in the workplace. A survey carried out by Mind in 1996 found that of 778 people with mental health problems, 39 per cent said they had been denied a job, 15 per cent had been denied promotion, and 34 per cent had been dismissed or forced to resign because of their illness. A further 38 per cent reported being teased, harassed or intimidated at work, while 69 per cent had been put off applying for jobs because of unfair treatment (Gray, 1999, 2000).

A survey by Focus (2001) found that 95 per cent of respondents with mental health problems had said that their mental health had affected their work prospects and for some had made securing employment 'virtually impossible.'

A third survey by Warner for the Mental Health Foundation (2002) found that when looking for employment, nearly six in ten respondents (56 per cent) believed that they may have been turned down for a job because of their mental health difficulties. In addition, almost a third of all respondents (31 per cent) thought that they had definitely been turned down for a job for this reason (Warner, 2002).

Research by Blackwell *et al.* (2001) also shows that mental health service users who have successfully found a job experience stigma within the workplace which "is the result of a shocking lack of understanding and awareness- among employers, managers and employees in general- about the nature of mental illness and associated problems, and how to deal with them."

Despite the evidence from the above research, it must be noted that a great deal of the evidence is self-reported and based on mental health service users' perceptions of experiencing discrimination as opposed to empirical evidence. In addition, these studies do not produce rigorous scientific evidence as they are based on surveys predominantly by mental health organisations in the UK. However, the amount of self-reported discrimination is overwhelming and reported in numerous studies.

Furthermore, research amongst employers confirm the prevalence of discrimination towards people with mental health problems as fewer than four in ten employers would consider employing someone with a history of mental health problems, compared to more than six in ten for physical disability (Manning & White, 1995). The report on 'Mental Health and Social Exclusion' (Office of the Deputy Prime Minister, 2004) also outlines research studies finding that three quarters of employers believe that it would be difficult or impossible to employ someone with schizophrenia, even though schizophrenia can be controlled with medication and would not require physical adaptations to the work environment (Roberts *et al.*, 2004).

In a second well-known study in 1998, 200 personnel managers were asked to assess the employment prospects of two job applicants. The applicants had very similar Curriculum Vitae's, but one suffered from diabetes and the other had recovered from a period of depression. The applicant with the history of depression was judged as being 'significantly less employable' than the applicant with diabetes (Rice, 2001).

There are several other barriers to employment which have been reported by researchers including low expectations of mental health professionals (Thomas *et al.*, 2002) and the side effects of medication (Rutman, 1994).

1.7. Qualitative Research

There is a vast volume of literature on unemployment and mental health, employment practice and barriers to employment. The research described above is predominantly quantitative research however; some qualitative research has also been carried out in this field.

1.7.1. Unemployment and mental health: qualitative research

Many studies have demonstrated the relationship between employment and well-being among people with severe and enduring mental health problems. However, Canadian researcher Kirsh (2000) argues that despite the generally positive findings around the relationship of work to mental health consumers, little is known about the meaning of work to individuals with mental illness. Furthermore, as a result of complex and divergent results from previous research, the true meaning and impact of work on the lives of mental health consumers remains unclear (Kirsh, 2000).

Consequently, Kirsch (2000) examined the meaning of work and important elements of workplaces as perceived by mental health consumers. The research was part of a larger study, which included semi-structured interviews with 36 participants focusing on consumers' work-related experiences and perceptions. The text of the interviews was examined using an inductive approach and three themes emerged, one of which

was the meaningfulness of work to consumers. Results showed that mental health consumers described work as a vehicle which enabled fulfilment of numerous human needs. Descriptions were analysed and categorised into secondary themes namely: (a) work as a contribution to society; (b) work as distraction and "normalisation;" and (c) work as challenge, achievement and self-worth. This research supported other research highlighting the importance of employment to the health and quality of life for mental health consumers (Kirsch, 2000).

As well as the meaning work has for mental health consumers, a grounded theory study carried out in Australia adds to the body of qualitative, consumer-focused research, assessing or identifying the effects of mental illness on employment. Honey (2003) argues that to understand the complex and varying effects of mental illness and employment, it is necessary to take into account the way these are experienced by individuals. Honey (2002) carried out a qualitative research study with the broad aim of generating a theoretical formulation to describe the experiences of people with mental illness with regard to employment.

The article by Honey (2003) reports specifically on the impact of mental illness on employment. This study involved the recruitment of 41 users of psychiatric services who predominantly participated in unstructured in-depth interviews, which were supplemented by two focus groups. Honey (2003) identified many ways in which mental illness affects people's employment experiences and discusses them in three sections which represent the broad areas in which mental illness affects consumers' experiences and outcomes. Firstly, *the need to maintain mental health*; stress, fear of illness, getting sick and stress avoidance were major ways in which mental illness

affected employment experiences, with an overall goal of staying mentally healthy. However, this goal can conflict with obtaining and maintaining desired employment. Secondly, *difficulties with work performance*; participants discussed a number of ways in which their mental illness or the accompanying medications directly affected their ability to perform well in a job. These included a reduced ability to think clearly, lack of energy and difficulty interacting with other people in the work environment. Finally, Honey (2003) discusses *work confidence and work goals*; as many of the participants in the study lacked confidence in their work abilities and prospects due to their mental illness.

In an extension of this work, Honey (2004) reports from the larger grounded theory study on the nature of the benefits and drawbacks of employment from the perspectives of people with mental illness, illuminates the factors that influence these, and explores their impact on employment experiences and outcomes.

As a result of her findings, Honey (2004) proposes the theory that people with mental illness engage in an active process of weighing up the perceived benefits of employment against the perceived drawbacks of employment. Participants in the study experienced the benefits and drawbacks of employment in six domains namely: money, purposeful and meaningful activity, growth and development, social participation and belonging, self-esteem and mental health. Within each of the six domains, experiences and beliefs exist along a continuum from very negative to very positive. In the process of weighing up, people with mental illness take into account, and are influenced by their broader social context. Honey (2004) also argues that the outcome of the weighing-up process influences the decisions that people with mental

illness make about what actions to take with regard to employment and their satisfaction with their employment situations. From these findings, Honey (2004) developed a model which outlines the individual and contextual factors which influenced participants' perceptions of the benefits and drawbacks of employment. The author concludes by outlining the implications of the research and the various possible uses of the findings, including that vocational workers can use the model to understand better their clients' actions and experiences and to help clients clarify and articulate their decision-making process (Honey, 2004).

1.7.2. Employment policy and practice: qualitative research

There is a considerable amount of existing evidence about services and approaches that are effective in helping people with mental illness to work, particularly in the American literature. However, some researchers have argued that scant attention has been given to *individual* factors, such as worldview, perceptions of work, and perceptions of one's illness that may be associated with employment success (Cunningham *et al.*, 2000).

As a result, American researchers, Cunningham *et al.* (2000) used a comparative and qualitative approach to understand the factors associated with the ability of individuals with severe and persistent mental illness to successfully gain and maintain employment. Specifically, Cunningham *et al.* (2000) used qualitative research methods in the form of in-depth semi-structured interviews, to compare the experiences and perspectives of 17 individuals from three groups: those who have been successful obtaining and maintaining employment; those who have been successful obtaining, but not maintaining employment; and those who have not been

successful obtaining employment. Results showed that the three groups seemed to differ in three significant ways; (1) the ways the individuals talked about their illness, (2) the ways the individuals talked about work, and (3) the strategies they described for coping with bad days. The individuals who were most successful at gaining and maintaining employment tended to have a clear perspective on their illness and the place of the illness in their lives more generally. The authors conclude that their research has significant implications for agencies working to help people with severe and persistent mental illness obtain and maintain employment (Cunningham *et al.*, 2000).

In 2004, American researchers Henry and Lucca carried out a qualitative study which adds to the research on factors that influence employment success. Henry and Lucca (2004) argue that few studies have investigated the perspectives of those on the "front line" of services, and in particular, a consumer perspective and a focus on facilitators, as well as barriers has not been fully explored regarding employment for people with severe mental illness (Henry & Lucca, 2004). Consequently, these researchers carried out a qualitative study examining the facilitators and barriers to employment from the perspective of people with psychiatric disabilities and employment service providers (Henry & Lucca, 2004). This study used a grounded theory methodology whereby 44 mental health consumers participated in six focus groups, and 30 providers also participated in six focus groups; based on the facilitators and barriers to employment. The focus groups were audio recorded, and field notes were taken; the data were then analysed using grounded theory methods (Henry & Lucca, 2004). Results showed that quality consumer-provider relationships and individualised employment services are most instrumental in helping consumers

achieve employment goals. Participants also identified a range of environmental barriers, including issues related to the service system (for example lack of service coordination), entitlement programmes (the benefits system), non-human resources (for example cost of childcare, lack of public transport) and social stigma (Henry & Lucca, 2004). The authors conclude by building upon participants' recommendations related to key facilitators and barriers to generate implications for employment services (Henry & Lucca, 2004).

As well as the qualitative research on the factors associated with successful employment outcomes, British researchers Secker *et al.* (2002) carried out a qualitative study exploring the approaches to, and experiences of, employment support from the perspectives of those involved. Secker *et al.* (2002) carried out semi-structured interviews with 17 employment project clients, their project workers and workplace managers from five employment support projects. They found that the five projects encompassed a continuum of approaches to employment support with two projects at the extremes of the continuum. These two projects were underpinned by contrasting models of the nature of recovery from mental health problems. Project A was clearly underpinned by a clinical model of recovery from mental health problems within which clients referred to the project were seen as needing to move from being ill to being more or less well again before getting a job. In contrast, Project D was based on a social model of recovery underpinned by an understanding of recovery as an ongoing, step by step social process. In this project, clients were not expected to have put their problems behind them before starting work, and clients' mental health problems were seen as potentially having ongoing implications for work.

After taking into account the strengths and limitations of these contrasting models, the authors conclude that the employment approach underpinned by the social model of recovery offers a more promising way forward for supported employment in Britain, although such approaches would be enhanced through greater liaison with mental health professionals (Secker *et al.*, 2002).

The study carried out by Secker *et al.* (2002) also found that regardless of whether clients' jobs broke down, retaining a job emerged as more challenging than finding it in the first place. As well as finding that the employment approach to job finding and follow-up support is central to retention, Secker and Membrey (2003) report on the findings from the same study in relation to the workplace factors that were associated with job retention. Secker and Membrey (2003) concluded that while specific adjustments such as flexibility about working hours and work schedules and job tasks were crucial, 'natural supports' were equally important. The evidence from this study indicates that natural supports revolving around learning opportunities, and supportive colleagues, workplace cultures and managers were also key to enabling clients to retain their job (Secker & Membrey, 2003).

A qualitative evaluative study carried out by Thomas *et al.* (2004) provides further evidence on the factors which facilitate job retention for people with mental health problems. In 2002, the Department for Work and Pensions and the Department of Health jointly funded a pilot project focusing specifically on job retention for people experiencing difficulties at work because of mental health problems. The project is being delivered by a job retention team based in Avon and Wiltshire Mental Health

Partnership Trust. The job retention team operates a case management model employing two case managers who offer a free service to people in employment currently experiencing mental health problems and at risk of losing their jobs as a result. All of the clients receive general case management and client-focused interventions (for example general supportive counselling from the case manager), and the majority also receive work-focused interventions (for example the case manager advocating for the client in the workplace). The ultimate aim of the pilot is to develop a model for job retention services across the UK (Thomas *et al.*, 2004). A qualitative evaluation of the project's first year of operation was carried out by conducting semi-structured interviews with 13 clients, five of their employers, six of their General Practitioners (GPs) in a focus group and the two case managers. Outcomes from the job retention pilot were that of the seven clients who had retained employment within their original organisation, three believed that they would have lost their job without the job retention team's involvement and the other four believed they would have had a more difficult and delayed return to work, which could have resulted in further sickness absence in the future. Of the six clients that did not return to their original employer, two of whom were still looking for work, five thought their mental health would have deteriorated further without the support of the job retention team. The authors of this article point out that there are limitations in the evaluation of this pilot and state that further longitudinal and much larger scale research is required before more general conclusions about the impact of job retention services can be drawn. However, they conclude that the results of this preliminary study are very promising and support the further extension of a job retention service for people with mental health problems based on the Avon model (Thomas *et al.*, 2004).

1.7.3. Experiences and barriers to employment: qualitative research

Research carried out in the UK demonstrates the barriers to employment, training and education faced by mental health service users from the service user's perspective. As part of the 'Care Programme to Work' project, Secker *et al.* (2001) carried out an extensive survey comprising of 156 interviews using questionnaires. The questionnaire responses were analysed to generate descriptive data using SPSS. This survey was followed up by eleven focus groups to explore vocational issues in more detail. To ensure that the views of groups under-represented in the interviews were collected, the study included a wide range of participants including older men, African and Caribbean mental health service users, Asian women and women and single parents. The researchers argue that as a result of the method of participant recruitment (self-selection); there may have been a bias towards those with an interest in vocational opportunities. However, in terms of background characteristics, the sample was not dissimilar to the target population and the level of interest expressed in vocational opportunities replicates the findings of previous studies (Secker *et al.*, 2001).

The focus groups considered two issues: the difficulties experienced in taking up education, training or work; and the solutions required to overcome those difficulties. A staged content analysis was used to identify the main themes to emerge from the focus groups. People with experience of using mental health services were recruited as interviewers and focus group leaders.

Results from the *survey* found that around five per cent of participants were in open employment, with only half involved in any vocational activity. Among the unemployed participants, 47 per cent were interested in some kind of work (including voluntary work or supported work) and 43 per cent had a tentative interest. Full-time open employment was the most frequently cited long-term goal and 62 per cent of participants definitely wanted help (and 20 per cent tentatively wanted help) in terms of vocational assistance, with the most frequently cited being help for mental health/ keep current service and advice on how benefits will be affected. The survey also identified the barriers to employment with the most frequently cited being employer attitudes, mental health problems and the benefits system (Secker *et al.*, 2001).

The results from the focus group element of this study provide evidence for the barriers to employment and invaluably, the solutions required to overcome those difficulties. Everyone who took part perceived the fear of losing benefits, coupled with a lack of impartial advice as a major barrier to employment, training and education. Many of the participants also described the stigma attached to mental-ill health and the resulting discrimination as a barrier. A lack of information about employment and educational opportunities was a persistent theme across all the focus groups. Other barriers were identified which seemed to have a greater impact on specific groups for example the older men and sheltered employment workers cited attitudes among employers as a barrier for them. Finally, participants in this study also proposed solutions which would assist in challenging these barriers and reliable advice and information were a high priority for all participants. Tackling stigma and

discrimination and the creation of employment, training and education opportunities were also seen as important (Secker *et al.*, 2001).

One of the findings from this study included an immediate concern for mental health services being the de-motivating effects of a mental health care system in which many users receive no help or advice about work at all. Overall, this study shows a need for an integrated approach to vocational guidance and support; strong links with employment and educational agencies with projects supporting diverse groups of users; for access to impartial benefits advice; and for mental health services themselves to take a lead in providing and promoting employment opportunities (Secker *et al.*, 2001).

In agreement with other researchers in this field, Killeen and O'Day (2004) also argue that until recently, little attention has been given to the experiences people with psychiatric disabilities have with regard to employment. Killeen and O'Day (2004) conducted a qualitative research study whereby semi-structured interviews were carried out with 32 individuals with psychiatric disabilities. This American study identified some of the barriers that participants found most difficult to overcome in their desire for employment including low expectations embedded in policies and programmes (for example from vocational rehabilitation counsellors), policy barriers (including the benefits system), and barriers to education and training (for example lack of funding). This research also describes the experiences of three of the study participants which exemplifies the heterogeneity and range of vocational needs found within the larger population of people with psychiatric disabilities. Finally, this study also identifies some of the common environmental factors in employed participants'

lives that may have contributed to their success including positive messages concerning future potential (for example from family members, teachers/ employers), access to education or training and peer and community support. The authors report that this population is an incredibly diverse group of individuals with a varying array of employment backgrounds, levels of education, as well as talents and abilities. Consequently, one of the main conclusions from this study is that instead of recommending one approach to employment counselling over another, they advise tailoring the approach to meet the individual's needs, taking into account educational background, work history, and individual career goals (Killeen & O'Day, 2004).

Kennedy-Jones *et al.* (2005) argued that if vocational outcomes are to be improved, a better understanding of the experience of work for people with a psychiatric disability is a compelling need. A recent qualitative study by Kennedy-Jones *et al.* (2005) attempts to fill this gap as the researchers carried out a qualitative research study using a narrative approach to explore how individuals with a mental illness made sense of their work-related experiences. The aim of the study was to explore how participants' past and present work-related experiences and vocationally orientated activities within a Clubhouse programme, supported the development or resumption of their worker-roles. Four Clubhouse members in open employment for at least six months completed in-depth, semi-structured interviews to reveal past and present work-related events, actions and experiences, and timelines of work-related and significant or notable events were also compiled. From the information gathered, draft worker-role narratives were created for each participant. Finally, follow-up interviews were carried out with each member checking to clarify details and to review the draft narrative.

The participants' narratives which were developed from this research described unique stories of the development of their worker-roles. Kennedy-Jones *et al.* (2005) found that within the four stories, there were four common 'impelling forces' contributing to a sense-of-self as a worker. The first was support from significant others, that is the importance of a significant other, a person or persons (such as managers at work, case managers and family members) who had actively contributed to the development or resumption of a worker-role for the participant. The second was the personal meaning of work as a theme reflected in each narrative was the benefit and significance of paid employment for these four individuals and the personal desire to seek and maintain paid employment. The third 'impelling force' was the experiences within the Clubhouse programme as all participants regarded the Clubhouse as a place where they felt welcome and accepted, which provided opportunities to develop social supports and social networks. The last theme was the ongoing struggle with illness which was woven within the participants' narratives in the form of ongoing disruptions to aspects of their lives and sense-of-self as workers. Kennedy-Jones *et al.* (2005) conclude by outlining the implications for occupational therapy practice. This study does have limitations which are outlined by the authors themselves based on the selected methodology in that past experiences may be highly selective, mental illness can disrupt a person's perspective or memory and the events and experiences may be idealised or romanticised when told retrospectively (Kennedy-Jones *et al.*, 2005). However, the authors conclude by stating that the findings contribute to the limited literature addressing consumers' views of employment experiences.

Marwaha and Johnson (2005) argue that the experiences of service users with severe mental illness in trying to obtain and keeping employment and the perceived barriers to working have been the focus of only a limited number of investigations. As well as this, many studies have interviewed people with a variety of psychiatric diagnoses. However, people with *severe* mental illness have lower employment rates and poorer occupational outcomes than those with other psychiatric problems. Marwaha and Johnson (2005) therefore suggest that this group may have different experiences and opinions.

As a result, they carried out a qualitative descriptive study in the UK examining the views and experiences of employment among a purposive sample of fifteen patients with severe mental illness. The study involved the thematic analysis of transcripts from fifteen semi-structured interviews with people with schizophrenia or bipolar disorder. Results showed that as in previous studies, when asked for a yes or no response, nearly everyone said they wanted to work. However, Marwaha and Johnson (2005) found that this was frequently followed by the expression of substantial doubts and these initial assurances may to some extent reflect the social desirability of work. The authors found that these initial statements about wanting to work could be described as public accounts, behind which a set of rather more complex and contradictory private accounts emerged on more detailed exploration. Marwaha and Johnson (2005) also argue that doubts about working and perceived barriers are important and seem to be confirmed by the observation that there was very little evidence of current active job-seeking among the participants.

The barriers to working that people with severe mental illness face were also identified by this study. Marwaha and Johnson (2005) distinguish between external and internal barriers. The external barriers people with severe mental illness face include enacted stigma and monetary disincentives. The internal barriers described by Marwaha and Johnson (2005) consist of people's attitudes and beliefs. It is likely that they are reflections of low self-esteem, a loss of motivation and acceptance of unemployment, worries and past experience (Marwaha & Johnson, 2005).

The authors highlight the limitations of the study which include selection bias for example, where those who agreed to be interviewed may have had particularly strong opinions about employment, that all participants were drawn from a single inner city area, and a small sample size (Marwaha & Johnson, 2005). Despite this, small sample sizes are characteristic of qualitative research in order to allow detailed exploration of participants' views and experiences. However, the authors conclude that there is a need for further research to fill the gap which has thus far existed in the evidence on this issue (Marwaha & Johnson, 2005).

1.8. Research aims and objectives

By using a qualitative research method, this study aims to explore the employment experiences, needs and aspirations among unemployed men receiving mental health support, living in areas of deprivation in the South Wales Valleys.

A qualitative approach to this research was chosen for a number of reasons. Within this field of work, there is an imbalance of approaches to research, with a larger

number of quantitative studies in comparison to those which take a qualitative approach.

This field of research lends itself well to a qualitative approach as if you are concerned with exploring people's life histories or everyday behaviour, then qualitative methods may be favoured (Silverman, 2001). Qualitative research can describe in detail what life is like on a daily, and indeed moment-to-moment basis for example to learn one's diagnosis, to interact with one's partner and relatives, to worry about taking medication and face death (Kazdin, 2003). Qualitative research is designed to describe, interpret, and understand human experience and to elaborate the meaning that this experience has to the participants (Kazdin, 2003). A qualitative approach is very relevant to many of the topics within psychology because of the frequent focus on individuals with special experiences, conditions or status (Kazdin, 2003). Consequently, in exploring the employment *experiences* among people with severe mental health problems, a qualitative approach can explore the issues in-depth and complement the quantitative literature in a unique and valuable way.

The focus on employment *experiences, needs and aspirations* was chosen because of a gap in research in these areas. In addition, this focus was broad enough to allow other issues to emerge. Many researchers have described the need for more qualitative studies in this field of research, often with a particular emphasis on the *experiences* of people with severe mental illness with regard to employment and unemployment (Honey, 2003; Kennedy-Jones *et al.*, 2005; Killeen & O'Day, 2004; Marwaha & Johnson, 2005) as well as consumer perspectives and perceptions on the

facilitators and barriers to employment (Cunningham *et al.*, 2000; Henry & Lucca, 2004).

The qualitative research in this field highlights gaps in research into employment and mental health, and a need for additional research in this area. There is a lack of qualitative research exploring the employment *experiences* of people with mental health problems. Killeen and O'Day (2004) argue that until recently, little attention has been given to the experiences people with psychiatric disabilities have with regard to employment. Similarly, Marwaha and Johnson (2005) argue that the experiences of service users with severe mental illness in trying to obtain and keep employment and the perceived barriers to working have been the focus of only a limited number of investigations. Kennedy-Jones *et al.* (2005) also argue that if the vocational outcomes are to be improved, a better understanding of the experience of work for people with a psychiatric disability is a compelling need.

Other researchers in this field of work have noted the gap in research which considers the *perspectives of people with mental health problems* towards employment issues. Cunningham *et al.* (2000) argue that scant attention has been given to *individual* factors, such as worldview, perceptions of work, and perceptions of one's illness that may be associated with employment success. Henry and Lucca (2004) also argue that few studies have investigated the perspectives of those on the "front line" of services, and in particular, a consumer perspective and a focus on facilitators, as well as barriers to employment for people with severe mental illness.

As well as this, by exploring the employment needs of people with mental health problems, this research will add to the limited number of studies (Henry & Lucca, 2004; Secker *et al.*, 2002; Secker *et al.*, 2003; Thomas *et al.*, 2004) which identify the employment *needs* of people with mental health problems from a qualitative perspective. Although people with mental health problems are not a homogenous group, by looking at the employment aspirations of this group, this research should begin to identify the hopes and desires of people with mental health problems in relation to employment, training and education.

As this research is using a qualitative approach to explore employment experiences, needs and aspirations, the investigator did not have preconceived ideas about the results of the study, and did not have an initial hypothesis to test. However, in the light of previous quantitative research in this field, it would be interesting to note if emergent issues reflect whether employment has a positive impact on mental health (Grove, 1999; Harnois & Gabriel, 2000; Turton, 2001) and whether conversely, unemployment has a negative impact on mental health (Fryer, 1999; Owen & Watson, 1995; Proudfoot *et al.*, 1999; Perkins & Repper, 1996; McKee-Ryan *et al.*, 2005; Warr, 1987). In addition, considering the fact that the UK government has developed initiatives and programmes to assist people with mental health problems with employment, it would be interesting to note whether employment policies and practices have resulted in a sufficient level of support being provided to people with mental health problems.

This research focussed on a sample of individuals with severe and enduring mental health problems, living in areas of deprivation in the South Wales Valleys. This

inclusion criterion for this research was partly opportunistic as the Employment Opportunities Project (see 1.1 Research Context) presented a unique opportunity to collect qualitative data from this group of individuals. However, this group is also an 'under-researched' group as to the investigator's knowledge; no previous research of this kind has taken place with unemployed men receiving mental health support, living in areas of deprivation in the South Wales Valleys.

Marwaha and Johnson (2005) have argued that whilst many studies have interviewed people with a variety of psychiatric diagnoses, people with *severe* mental illness have lower employment rates and poorer occupational outcomes than those with other psychiatric problems. These researchers therefore suggest that this group may have different experiences and opinions (Marwaha & Johnson, 2005) and this study should be able to add to the evidence base in this area.

Considering the fact that the one of the inclusion criteria for this research was 'living in areas of deprivation,' this should also add an additional dimension to this research. To the investigator's knowledge, very little research has been carried out with unemployed individuals with mental health problems, *living in areas of deprivation.* However, socio-economic class *could* be a confounding factor which affects the relationships between mental health and employment found in other research. Previous research has found that socio-economic class has some impact upon employment as among lower socio-economic classes, material needs tend to be strong and therefore, people are willing to take up any job (Sinha, 2001). In addition, in terms of employment policy and practice, research carried out in the North West of England found that the highest level of provision of places for employment

support services for people with mental health problems was in the area with the lowest deprivation and unemployment levels (Crowther & Marshall, 2001). It will therefore be interesting to note whether the findings of this research differ from other research in this field, which does not specifically include participants living in areas of social deprivation in the South Wales Valleys as one of the inclusion criteria.

As a result of the appropriateness of the qualitative method, the need for more qualitative research in this field, particularly focusing on employment experiences, needs and aspirations and the gap in research in terms of the 'under-researched' sample, this study uses a qualitative approach to explore the employment experiences, needs and aspirations among unemployed men receiving mental health support, living in the South Wales Valleys.

Chapter 2- Qualitative Research and Methodological Issues

2.1. Qualitative research

When people speak of scientific or empirical research, they are usually referring to quantitative research. However, another approach is qualitative research which is a broad term that encompasses multiple approaches, disciplines and definitions (Kazdin, 2003). Despite the dominance of quantitative research, qualitative research is increasing in use in a wide range of academic and professional settings (Holliday, 2002).

Qualitative research is an approach to the subject matter of human experience and focuses on narrative accounts, description, interpretations, context and meaning. The goal is to describe, interpret and understand the phenomenon of interest (Kazdin, 2003). Through description and interpretation, our understanding of the phenomenon can be deepened. Silverman (2001) reports that if you are concerned with exploring people's life histories or everyday behaviour, then qualitative methods may be favoured. Holliday (2002) also notes that in many ways, qualitative research is what we all do in everyday life.

The data are primarily words and are derived from in-depth analysis of cases. From the data, interpretations, overarching constructs, and theory are generated to better

explain and understand how the participants experience the phenomenon of interest (Kazdin, 2003). The emphasis is on the participants and how they perceive and experience the world, therefore qualitative research is participant-focused. Qualitative research properly seeks answers to questions by examining various social settings and the individuals who inhabit these settings (Berg, 2001). Qualitative researchers, then, are most interested in how humans arrange themselves and their settings, and how inhabitants of these settings make sense of their surroundings through symbols, rituals, social structures, social roles and so forth (Berg, 2001).

The fact that qualitative researchers are concerned with meaning is reiterated by Willig (2001) who highlights that they are interested in how people make sense of the world and how they experience events. When defining qualitative research, Banister *et al.* (1994) also emphasise the role of the investigator stating that qualitative research is the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made.

Qualitative research represents a broad view that to understand human affairs, it is insufficient to rely on quantitative survey and statistics and necessary to delve deep into the subjective qualities that govern behaviour (Holliday, 2002).

2.1.1. Qualitative and quantitative research

Holliday (2002) asserts that it is fairly standard to introduce qualitative research by distinguishing it from quantitative research, because of the tendency to refer to the more familiar, traditional quantitative research. Qualitative data deals with meaning, whereas quantitative data deals with numbers (Dey, 1993). The main difference

between qualitative and quantitative research is identified by Dey (1993) who argues that it is easy to exaggerate the difference between qualitative and quantitative data analysis and indeed to counterpose one against the other. Dey (1993) postulates that this stems in part from the evolution of social science, most notably in its effort to emulate the success of the natural sciences through the adoption of quantitative techniques. Furthermore, qualitative research is often cast in the role of the junior partner in the research enterprise, and many of its exponents feel it should have more credibility (Dey, 1993). Berg (2001) also argues that in many social sciences, quantitative orientations are often given more respect. Kazdin (2003) reiterates this by stating that most scientists view quantitative research as *the* approach or the *only* approach.

However, qualitative researchers suggest that we should not assume that techniques used in quantitative research are the *only* way of establishing the validity of findings from qualitative or field research (Silverman, 2001). Qualitative research contributes an element to research that quantitative techniques cannot fulfil. Indeed, Berg (2001) argues that certain experiences cannot be meaningfully expressed by numbers. Kazdin (2003) also states that qualitative research yields data and information not likely to emerge from quantitative studies. Qualitative research looks at phenomena in ways that are intended to reveal many of the facets of human experience that the quantitative tradition has been designed to circumvent- the human experience, subjective views and how people represent (perceive, feel), and hence react to, their situations in context (Kazdin, 2003).

Moreover, many researchers believe that qualitative research and quantitative methods complement each other. Dey (1993) argues that there is no reason to exclude quantitative methods such as enumeration and statistical analysis from the qualitative toolkit. Qualitative researchers believe that we can learn as much from how meanings and numbers relate as we can from distinguishing them (Dey, 1993).

Silverman (2001) also reiterates this by commenting that there is no reason why qualitative researchers should not, where appropriate, use quantitative measures. Simple counting techniques which are theoretically derived and ideally based on participants' own categories, can offer a means to survey the whole corpus of data ordinarily lost in intensive qualitative research (Silverman, 2001). By doing this, researchers reduce the possibilities of anecdotalism, where research findings are revealed in a way in which research reports sometimes appeal to a few telling 'examples' of some apparent phenomenon, without any attempt to analyse less clear (or even contradictory) data (Silverman, 2001).

2.1.2. The validity and reliability of qualitative research methods

Dey (1993) asserts that qualitative data has become a fashionable term to use for any method other than the survey: participant observation, unstructured interviewing, group interviews, the collection of documentary materials and the like. Kazdin (2003) reiterates this by observing that the term 'qualitative research' can mean many things but more often than not, it is misused in clinical and counselling psychology as well as in other disciplines (psychiatry and sociology). The term has been inappropriately adopted to refer to any non-quantitative evaluation. However, qualitative research is rigorous, scientific, disciplined and replicable. Berg (2001)

argues that good qualitative research can be very rigorous; qualitative methods can (and should) be extremely systematic and have the ability to be reproduced by subsequent researchers. Qualitative research is a legitimate methodological approach in its own right and it seeks knowledge in ways that are systematic, replicable and cumulative (Kazdin, 2003). One way of ensuring this is to make the raw data available to others during the investigation to permit a check on how the information (for example transcripts) reflects the themes that have been identified (Kazdin, 2003). Central to qualitative research is the validity of the data, that is, that the analyses yields findings that are plausible, trustworthy and confirmable (Kazdin, 2003).

A concept which helps to ensure validity is triangulation. Triangulation involves the use of different methods and sources to check the integrity of, or extend inferences drawn from the data (Ritchie, 2003). Triangulation refers to using multiple procedures, sources, or perspectives to converge to support the conclusion (Kazdin, 2003). Triangulation may rely on separate bits of data; different methods of qualitative analyses; or qualitative and quantitative analyses of the same data; use of different theoretical frameworks; and different investigators. Triangulation can be achieved in different ways as the investigator can use multiple sources of data to reflect a multi-method approach to qualitative methods. However, the methods are designed to cover more than multiple assessment methods, but multiplicity or generality across many different aspects of the study, including the range of participants, investigators and subjects to derive conclusions (Kazdin, 2003). For many researchers, triangulation is restricted to the use of multiple data-gathering techniques (usually three) to investigate the same phenomenon (Berg, 2001). This is

interpreted as a means of mutual confirmation of measures and validation of findings (Berg, 2001). Triangulation is often cited as one of the central ways of 'validating' qualitative research evidence (Ritchie, 2003).

Qualitative researchers can also ensure that the analysis of the data is rigorous by using a second investigator to analyse the data and carry out an assessment of inter-rater reliability on a percentage of the data. This could be done by using a particular method of assessing inter-rater reliability such as Cohen's Kappa, which gives a mean inter-rater reliability score.

Holliday (2002) argues that qualitative research has the resource to be liberated from a tight step-by-step approach and the rigour in qualitative research is in the principled development of strategy to suit the scenario. Qualitative research has to *show its workings* every single time and researchers need to justify every move, demonstrating particularly how the overall strategy is appropriate to the social setting and the researcher (Holliday, 2002).

Kazdin (2003) discusses the generality of the results and considers the level of external validity to qualitative research findings. Indeed, experiences are always different because people bring to bear unique histories and perspectives. There are thematic similarities in many experiences for example falling in love, getting married, experiencing the death of a child or parent, recovering from trauma, and living with a disability, but they are never identical for two individuals. Despite this, we know that intense appreciation of the individual experience rings with great universality. Indeed, individuals who experience trauma often join and profit from

support groups with others who have shared this experience. However, Kazdin (2003) argues that although general themes may emerge, qualitative research is not intended to derive or discover *the* experience that categorises all people; rather the goal of qualitative research is to elaborate on the experience of one group or one individual.

Overall, qualitative research can make a special contribution to dominant research methods (Kazdin, 2003). Qualitative research makes a *unique contribution to knowledge and understanding* by elaborating the nature of experience and its meaning. A major contribution of qualitative research is the ability to bring phenomena to life and to do so in a systematic way (Kazdin, 2003).

2.1.3. Qualitative data

In terms of the data collected from qualitative research, Dey (1993) argues that we should note the richness and diversity of qualitative data since it encompasses virtually any kind of data including sounds, pictures, videos, music, songs, prose and poetry. More specifically, Kazdin (2003) identifies that qualitative data includes narrative descriptions, full text, lengthy interviews and accounts.

2.1.4. Methods in qualitative research

Qualitative research has its own methodology, including strategies for assessment and the basic information (data) used for a qualitative study can be obtained in many different ways. The salient methods and sources are described by Kazdin (2003) and include interviews, direct observations, statements of personal experience, documents, photographs, audio or video recordings and films. Snape and Spencer

(2003) note that certain data collection methods have also been identified with qualitative research such as observational methods, in-depth interviewing, group discussions, narratives and the analysis of documentary evidence. Silverman (2001) also reports that there are four major methods used by qualitative researchers and these are observation; analysing texts and documents; interviews and recording; and transcribing. Furthermore, these methods are often combined and each method can be used in either qualitative or quantitative research studies.

Silverman (2001) goes on to describe how interviews are commonly used in both methodologies; however, the types of questions used vary accordingly. Quantitative researchers administer interviews or questionnaires to random samples of the population and 'fixed choice' questions are preferred because the answers they produce lend themselves to simple tabulation (Silverman, 2001). In contrast, qualitative researchers are more likely to include open-ended questions because the aim is usually to gather an authentic understanding of people's experiences and it is believed that open-ended questions are the most effective route towards this end (Silverman, 2001).

Despite the fact that certain methods are associated with qualitative research, Snape and Spencer (2003) also argue that it is important to note that practitioners of qualitative research vary considerably in the extent to which they rely on particular methods of data collection. These researchers conclude that data collection methods used in qualitative research usually involve close contact between the researcher and the research participants, which is interactive and developmental, and allows for emergent issues to be explored (Snape & Spencer, 2003). Furthermore, whilst Green

and Thorogood (2004) report that there are some methods of data collection that are particularly associated with qualitative methods, they suggest that these methods can also be used in quantitative studies, so it is not merely the way in which data are collected that characterises a study as qualitative. The most basic way of characterising qualitative studies is that the aims are generally to seek answers to questions about the 'what,' 'how' or 'why' of a phenomenon, rather than questions about 'how many' or 'how much' (Green & Thorogood, 2004).

2.2. Approaches to qualitative research

There is no one kind of qualitative data analysis, but rather a variety of approaches, related to the different perspectives and purposes of researchers (Dey, 1993). Snape and Spencer (2003) also argue that it is important to recognise that there is no single, accepted way of doing qualitative research. Indeed, how researchers carry out qualitative research depends upon a range of factors including: their beliefs about the nature of the social world and what can be known about it (ontology), the nature of knowledge and how it can be acquired (epistemology), the purpose(s) and goals of the research, the characteristics of the research participants, the audience for the research, the funders of the research, and the position and environment of the researchers themselves (Snape & Spencer, 2003). Differences in the mix of these factors have led to distinctive approaches to qualitative research. Some of the approaches to qualitative research include discourse analysis, critical discourse analysis, grounded theory, content analysis and interpretative phenomenological analysis.

Furthermore, Dey (1993) argues that when engaged in research in practice; it often involves a range of methods producing a variety of data. Indeed, the analysis of qualitative research takes many different forms because there are multiple orientations and approaches to the information (Kazdin, 2003). A key approach is to interpret the meaning and to better understand the subject matter in context. This can be accomplished by looking for recurring themes or key concepts that emerge in people's descriptions of their experiences, identifying processes of a progression that seem to show the flow of experience, linking variables that emerge concurrently over time, and looking for consistencies and patterns in the material (Kazdin, 2003).

For this research, three of the main approaches to qualitative research were considered. Each of these is discussed below in more detail.

2.2.1. Grounded theory

Grounded theory was formally introduced by sociologists Barney Glaser and Anselm Strauss in the 'Discovery of Grounded Theory (1967).' Grounded theory emerged as an alternative strategy to more traditional approaches to scientific inquiry; which relied heavily on hypothesis testing, verificational techniques, and quantitative forms of analysis; which were particularly popular in the social sciences at that time (Babchuk, 1997). Grounded theory is a relatively old sociological method that has been introduced into psychology (Tesch, 1990). Grounded theory is a popular method, widely adopted in some disciplines such as nursing, and beginning to be used more frequently in psychology (Chamberlain, 1999).

More specifically, Babchuk (1997) notes that grounded theory is a qualitative method which derives its name from the practice of generating theory from research which is 'grounded' in data. The central idea of this approach is that a theory must emerge from the data or be 'grounded' in the data. What most differentiates grounded theory from other research approaches is that it the theory is explicitly *emergent*.

In fact, grounding concepts in data is the main feature of this method. The term 'grounded theory' refers to theory that was derived from data, systematically gathered and analysed through the research process (Strauss & Corbin, 1998). By grounded, it is meant that a theory must emerge or be developed from the data, and not from predetermined hypotheses or formulations (Chamberlain, 1999). This is a crucial feature of this method as a researcher does not begin a project with a preconceived theory in mind; rather the researcher begins with an area of study and allows the theory to emerge from the data (Strauss & Corbin, 1998). Because theory is directly derived from data, it is more likely to resemble "reality" than is theory derived by putting together a series of concepts based on experience or solely through speculation. Grounded theories, because they are drawn from data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action (Strauss & Corbin, 1998). Although grounding concepts in data is the main feature of grounded theory, creativity of researchers also is an essential ingredient as Strauss and Corbin (1998) argue that analysis is the interplay between researchers and data.

Chamberlain (1999) reports that the essential features of grounded theory are that it is grounded and theoretical. By theoretical, it is meant that a theory of the

phenomenon in question must be developed, and this must be more than a descriptive account. The researcher moves from a descriptive classification of events and facts to an abstract theory of the phenomenon that accounts for relationships and processes (Chamberlain, 1999). Willig (2001) also reports that grounded theory is both the process of category identification and integration (as method) and its product (as theory). Grounded theory as *theory* is the end product of the process; it provides us with an explanatory framework with which to understand the phenomenon under investigation. Chamberlain (1999) argues that theory can be developed at different levels of abstraction- varying from the descriptive to the substantive and beyond- to higher-order, formal theories; and grounded theory studies reflect this variation in practice.

Haig (1995) summarises the process of undertaking research using a grounded theory approach stating that grounded theory research begins by focusing on an area of study and gathering data from a variety of sources, including interviews and field observations. Once gathered, the data are analysed using coding and theoretical sampling procedures. Theories are then generated with the help of interpretive procedures, before finally being written up and presented. Haig (1995) also notes that the general goal of grounded theory research is to construct theories in order to understand phenomena.

Strauss and Corbin (1998) describe the approaches to analysis of qualitative data using grounded theory which often begins with microanalysis; a detailed line-by-line analysis aimed at generating initial categories and to suggest relationships among categories. Line-by-line analysis ensures that analysis is truly grounded and that

higher-level categories, and later on theoretical formulations, actually emerge from the data, rather than being imposed upon it (Willig, 2001). Through line-by-line coding, you can take an analytic stance toward your work and, simultaneously, keep close to your data (Charmaz, 2003). Line-by-line coding also helps you to refrain from inputting your motives, fears, or unresolved personal issues to your respondents and to your collected data, as well as forcing you to think about the material in new ways that may differ from your research participants' interpretations (Charmaz, 2003).

At the heart of grounded theory analysis is the coding process which consists of three types: open, axial and selective. Open coding is the analytical process through which concepts are identified and their properties and dimensions are discovered in data. Axial coding is the process of relating categories to their subcategories, termed "axial" because coding occurs around the axis of a category, linking categories at the level of properties and dimensions. Selective coding can be described as the process of integrating and refining the theory (Strauss & Corbin, 1998).

Although the analysis of data using grounded theory would usually begin with open coding, Strauss and Corbin (1998) report that coding is a dynamic and fluid process. Coding is a free flowing and creative process in which analysts move quickly back and forth between types of coding, using analytic techniques and procedures freely and in response to the analytic task before analysts.

Chamberlain (1999) also describes the coding used during the analysis of data. In initial coding, raw data are examined and reduced by identifying concepts or

categories and their properties. In later stages of the analysis, coding is directed at identifying more generic and abstract categories which are developed and integrated into the theory.

Essential for the development of theory using grounded theory is the use of analytic tools, or techniques and procedures such as asking questions and making theoretical comparisons.

Theoretical sampling is a key technique used in grounded theory where sampling takes place on the basis of emerging concepts (Strauss & Corbin, 1998). Sampling in grounded theory is associated with explicit sampling for information to refine and develop theory, rather than containing notions of representativeness or randomness (Chamberlain, 1999). Data collection is guided by theoretical sampling, or sampling on the basis of theoretically relevant constructs. Grounded theory involves an inter-relation of sampling and analysis which means that data collection and analysis are deliberately inter-related, and initial data analysis is used to direct further data collection (Chamberlain, 1999).

Making comparisons is also an important technique for both identifying and developing categories, and the constant comparative method is a hallmark of grounded theory studies (Chamberlain, 1999).

Analysing data using grounded theory also requires the researcher to write memos and do diagrams which should begin with initial analysis and continue throughout the research process (Strauss & Corbin, 1998). Memos and diagrams record the

progress, thoughts, feelings, and directions of the research and researcher- in fact, the entire gestalt of the research process (Strauss & Corbin, 1998). Memos are simply notes of ideas, interpretations and hypotheses written up throughout the analysis process (Chamberlain, 1999). Their use obliges the analyst to engage with the data and its interpretation, providing a strategy for examining the emerging categories critically for their properties and inter-relationships, and for developing the overall theory. Diagrams are used similarly, to assist in identifying relationships between categories, and to clarify the core category of the theory and its relation to other categories (Chamberlain, 1999).

Chamberlain (1999) notes that these processes, coding and the use of the constant comparative method, do not proceed independently, but are intertwined with other analytic processes such as questioning, memo writing and hypothesis formulation.

Chamberlain (1999) also reports that saturation is an essential component of a grounded theory. Saturation of the theory is considered to have occurred when no new categories are found which relate to the central issue or process being researched, and the theory can account for all the data that have been obtained. Data collection can cease when there are no gaps in the theory and all categories can be linked meaningfully together to provide a comprehensive explanation of the phenomenon (Chamberlain, 1999). Willig (2001) also describes that the process of data collection and data analysis in grounded theory continues until theoretical saturation has been achieved that is, the researcher continues to sample and code data until no new categories can be identified, and until new instances of variation for existing categories have ceased to emerge.

Since its introduction in the 1960s, grounded theory has been progressively developed in a way that is consistent with its original formulation, such that it is currently the most comprehensive qualitative research methodology available (Haig, 1995).

During the last 30 years, sociologists Glaser and Strauss have formulated and developed their grounded theory in great detail (Haig, 1995). However, Babchuk (1997) also argues that whereas many of the central components of grounded theory were outlined in 'The Discovery' paper, subsequent publications by Glaser and Strauss writing alone or with others, began to reflect important differences in how these scholars envisioned grounded theory and its use.

Eaves (2001) reports that in recent years, debates about the current status of grounded theory have been growing. At the centre of the debate is Strauss and Corbin's (1990) text, which has been criticised for deviating from the original method. Glaser felt that Strauss and Corbin were no longer doing grounded theory. Whilst some grounded theorists agree with this assertion, others argue that Strauss and Corbin have added to the initial work on grounded theory (Eaves, 2001).

Chamberlain (1999) also argues that we should be aware that grounded theory, like all other research methods, is a site of discussion about underlying assumptions and debate about what constitutes 'proper' practice, with perhaps one of the most obvious divisions in grounded theory approach resulting from a substantial debate between the two founders of the method, Barner Glaser and Anselm Strauss. Glaser suggested

that in their version, Strauss and Corbin (1990) had lost the essentials of the grounded theory method (Chamberlain, 1999).

Although this debate over current and future issues with regard to the grounded theory method is likely to go on for quite some time, Eaves (2001) illustrates the belief of one grounded theorist (Charmaz, 1983) who asserts that every researcher who uses the grounded theory method will tend to develop his or her own variations of the technique; although within the framework of the original methods. Chamberlain (1999) asserts that there is no right and wrong way to conduct grounded theory analyses, but there are relatively clear guidelines as to what can be considered a grounded theory. In addition to the debate on what constitutes true grounded theory, the growing body of grounded theory literature has been criticised for its lack of adherence to the method as explicated by its originators. However, Willig (2001) argues that because a number of versions of grounded theory have emerged, there is no *one* original and unambiguous version of the methodology that alone is entitled to the label 'Grounded Theory.'

As well as the disagreement between the originators, the grounded theory method itself has also been subject to several criticisms. The premise that theory directly derived from data is more likely to resemble "reality" than is theory derived by putting together a series of concepts based on experience or solely through speculation (Strauss & Corbin, 1998) is the topic of an ongoing debate about whether grounded theory represents a realist or relativist approach to research. The realist approach represents the view that reality exists independently of how researchers represent the world, whereas the relativist approach represents the view that reality is

relative to particular individuals, societies or conceptual schemes. The way in which researchers view this debate depends upon their epistemological positions. However, in practice, this has become a dominant theme in qualitative research namely the understanding of linguistic meaning within textual material (Madill *et al.*, 2000). The explication of meaning requires a certain level of inference however, and qualitative approaches can be criticised for the space they afford the subjectivity of the researcher (Madill *et al.*, 2000). This issue is a pertinent one within psychological science as psychology has been based traditionally in positivist epistemology and hence concerned to establish objective and reliable methods of investigation (Madill *et al.*, 2000).

To understand how this issue impacts upon qualitative research, Madill *et al.* (2000) explicated the ways in which objectivity and reliability are understood in qualitative analysis conducted from within three distinct epistemological frameworks: realism, contextual constructionism and radical constructionism. They concluded that qualitative researchers have a responsibility to make their epistemological position clear, conduct their research in a manner consistent with that position, and present their findings in a way that allows them to be evaluated appropriately (Madill *et al.*, 2000). Whilst this debate applies to qualitative research in general, Madill *et al.* (2000) argue that it may be particularly important with approaches such as grounded theory which can be applied within a realist of contextualist framework.

In relation to the same debate, Willig (2001) also reports that it has been argued that grounded theory subscribes to a positivist epistemology and that it sidesteps questions of reflexivity. Grounded theory works with induction, whereby

observations give rise to new ideas. However, one of the problems with induction is that it pays insufficient attention to the role of the researcher. It is assumed that the data speaks for itself. However, as critics of positivism have argued convincingly, all observations are made from a particular perspective and that whatever emerges from the analysis of a set of data is theoretically informed because all analysis is necessarily guided by the questions asked by the researcher (Willig, 2001). One way in which to overcome this is for grounded theory researchers to document, carefully and in detail, each phase of the research process. Willig (2001) notes that such documentation increases reflexivity throughout the research process and it demonstrates ways in which the researcher's assumptions, values, sampling decisions, analysis technique, interpretations of context, and so on have shaped the research.

Charmaz (2003) also reports that grounded theory contains both positivistic and interpretive elements. Its emphasis on using systematic techniques to study an external world remains consistent with positivism. Its stress on how people construct actions, meaning and intentions is in keeping with interpretative traditions. However, Charmaz (2003) argues that the researcher's disciplinary and theoretical proclivities, relationships and interaction with respondents all shape the collection, content, and analysis of data. Professional researchers already hold epistemological assumptions about the world, disciplinary perspectives, and often an intimate familiarity with the research topic and the pertinent literature. Yet every grounded theory researcher should remain as open as possible to new views during the research. In light of this, Charmaz (2003) asserts that grounded theory can bridge the traditional positivistic methods with interpretative methods in disciplines such as psychology that have

embraced quantification. These methods allow psychologists to study aspects of human experience that remain inaccessible with traditional verification methods (Charmaz, 2003).

Furthermore, Miles and Huberman (1994) argue that the conventional image of field research is one that keeps pre-structured designs to a minimum. They note that many social anthropologists and social phenomenologists prefer a loosely structured emergent inductively 'grounded' approach to gathering data. Miles and Huberman (1994) note that they agree with this up to a point but that highly inductive, loosely designed studies make good sense when experienced researchers have plenty of time and are exploring exotic cultures, understudied phenomena or very complex social phenomena. But if a researcher is new to qualitative studies and is looking at better understood phenomena within a familiar culture or subculture, a loose inductive design may be a waste of time (Miles & Huberman, 1994).

Pandit (1996) also describes a fundamental problem with the overall approach of grounded theory in that it requires certain qualities of the researcher such as confidence, creativity and experience. Accordingly the approach does not favour the novice researcher (Pandit, 1996). Chamberlain (1999) also reports that the most common problems experienced in grounded theory research are with studies that fail to go beyond a purely descriptive level to generate theory, or conversely, with studies that fail to ground the theory adequately in the data. It could be argued that only confident and experienced researchers would have the skills to achieve both of these aims.

Having said this, Chamberlain (1999) reports that grounded theory appears to have a particular appeal for researchers who are relatively new to qualitative research, possibly because several texts which describe the method are readily available and perhaps more importantly, because several texts which document detailed procedures for conducting grounded theory research exist.

As well as this, grounded theory is also based on the philosophy of carrying out research without pre-existing constructs. A lack of familiarity with the phenomenon and setting and a single disciplinary grounding are considered assets when using the grounded theory approach (Miles & Huberman, 1994). Certainly, there are advantages to this as it allows for a fertile 'decentering.' However, it can also lead to relatively naïve, easily misled, and easily distracted fieldwork, along with the collection of far too much data (Miles & Huberman, 1994). Furthermore, these researchers also believe that this approach can lead to the plastering of a ready-made explanation on phenomena that could be construed in more interesting ways.

Silverman (2001) also argues that grounded theory has been criticised for its failure to acknowledge implicit theories which guide work at an early stage and states that it is clearer about the generation of theories than about their test. Used unintelligently, it can also degenerate into a fairly empty building of categories (Silverman, 2001).

Despite the criticisms of grounded theory, many of the principles underlying its construction were employed in the studies that yielded the material for Miles and Huberman's book 'Qualitative Data Analysis (1984)' and Strauss felt that these authors misunderstood some of the grounded theory technology (Tesch, 1990).

Having highlighted some of the main criticisms of using grounded theory, it must be noted that the philosophy behind its core features is one of great sense in that its intention is to reduce the possibility of a researcher's preconceptions affecting the findings by allowing the theory to *emerge* from the data. Chamberlain (1999) argues that of course it is impossible for a researcher to select and develop a question to research without having some understandings of the field, but grounded theory emphasises that the researcher must be alert to the influence of these and not allow them to contaminate the theory which is developed.

Chamberlain (1999) also argues that grounded theory has much to offer as a qualitative research technique in health psychology. Grounded theory has been used successfully to investigate many topics of relevance to health psychology; and it can accommodate many different epistemological and ontological positions. Chamberlain (1999) concludes by stating that grounded theory has considerable potential for adaptation and that health psychologists could utilise this method more widely, adapting it to suit their particular needs for specific research projects.

2.2.2. Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is a newly developed, and indeed developing, methodological tool used by psychologists whose focus is on understanding individuals' experiences (Shaw, 2001). IPA is capable of answering in-depth questions regarding the nature of individuals' experiences, something which has previously been missing from psychology (Shaw, 2001).

The method itself stems from phenomenology which is a philosophical approach focusing on the world as it is subjectively experienced by individuals within their particular social, cultural and historical contexts (Grigoriou, 2004). The approach is phenomenological in that it involves detailed examination of the participant's lifeworld; it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself (Smith & Osborn, 2003).

The aim of IPA is to explore in detail how participants are making sense of their personal and social world, and the main currency for an IPA study is the meaning particular experiences, events, states hold for participants (Smith & Osborn, 2003). In terms of its theoretical position, IPA aims to explore in detail, participants' personal lived experiences and how they make sense of them. It is phenomenological in its concern with individuals' perceptions of objects or events, but IPA also recognises the central role for the analyst in making sense of that personal experience and thus, is strongly connected to the interpretive or hermeneutic tradition (Smith, 2004).

Shaw (2001) reports a definition of IPA identified by Smith *et al.* (1999):

> "The approach is phenomenological in that it is concerned with an individual's personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself. [..] Access [to the participant's personal world] depends on, and is complicated by, the researcher's own conceptions and indeed these are required in order to make sense of that other personal world through a process of interpretative activity; hence the term interpretative phenomenological analysis is used to signal these two facets of the approach" (Smith, Jarman & Osborn, 1999).

Willig (2001) reports that IPA is a version of the phenomenological method, which accepts the impossibility of gaining direct access to research participants' lives. Even though IPA aims to explore the research participant's experience from his or her perspective, it recognises that such an exploration must necessarily implicate the researcher's own view of the world as well as the nature of the interaction between researcher and participant. As a result, the phenomenological analysis produced by the researcher is always an interpretation of the participant's experience (Willig, 2001).

IPA emphasises that the research exercise is a dynamic process with an active role for the researcher in that process (Smith & Osborn, 2003). In order for analysts to unravel the meaning of participants' experiences, they need to interpret meaningfully how the participants make sense of the world. Such interpretations are based on the researchers' own conceptions, beliefs, expectations and experiences. In this respect, IPA requires reflexivity from the researcher who is expected to explicitly present his or her own perspectives, thus illuminating the analysis (Grigoriou, 2004). Researchers own conceptions are required in order to make sense of that other personal world through a process of interpretative activity (Smith & Osborn, 2003). Thus a two-stage interpretation process, or a double hermeneutic, is involved. The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2003).

The role of the analyst in IPA is very important as highlighted by Shaw (2001) who states that rather than being passive in the analysis of data, IPA demands that the researcher plays an active role in making sense of the accounts collated (Shaw,

2001). However, the researcher's interpretation must not at any point go beyond what is said by participants; this would become the story of the researcher rather than that of the participants (Shaw, 2001).

Overall, one might say that IPA operates at a level which is clearly grounded in the text but which also moves beyond the text to a more interpretative and psychological level (Smith, 2004).

The characteristic features of IPA are: ***idiographic:*** starting with the detailed examination of one case until a degree of closure or gestalt has been achieved, then moving on to a detailed analysis of the second case, and so on through the corpus of cases; ***inductive:*** IPA researchers employ techniques which are flexible enough to allow unanticipated topics or themes to emerge during analysis. Thus IPA researchers do not attempt to verify or negate specific hypotheses established on the basis of extant literature; rather they construct broader research questions which lead to the collection of expansive data; and ***interrogative:*** IPA shares constructs with mainstream psychology and is able therefore to engage in a constructive dialogue with such work. Indeed, a key aim of IPA is to make a contribution to psychology through interrogating or illuminating existing research (Smith, 2004).

Other key characteristics of IPA are described by Smith and Osborn (2003). Research questions in IPA projects are usually framed broadly and openly and there is no attempt to test a predetermined hypothesis of the researcher; rather the aim is to explore, flexible and in detail, an area of concern (Smith & Osborn, 2003). IPA studies are conducted on small samples because the detailed case-by-case analysis of

individual transcripts takes a long time, and the aim of the study is to say something in detail about the perceptions and understanding of this particular group (Smith & Osborn, 2003). While it is possible to obtain data suitable for IPA analysis in a number of ways- such as personal accounts and diaries- probably the best way to collect data for an IPA study is with the semi-structured interview (Smith & Osborn, 2003).

The analysis itself involves the investigator engaging in an interpretative relationship with the transcript from each semi-structured interview (Smith & Osborn, 2003). For studies which involve more than one participant, researchers should begin analysis by looking in detail at the transcript of one interview before moving on to examine the others, case-by-case. This follows an idiographic approach to analysis, beginning with particular examples and only slowly working up to more general categorisation or claims (Smith & Osborn, 2003). When doing IPA, researchers undertake a series of steps that allows the researcher to identify themes and integrate them into meaningful clusters, first within and then across cases (Willig, 2001).

Willig (2001) describes the stages of IPA in four stages. The first stage involves the reading and re-reading of the text. At this stage, the researcher produces wide-ranging and unfocused notes that reflect the initial thoughts and observations he or she may wish to record in response to the text.

The second stage of analysis requires the researcher to identify and label themes that characterise each section of the text. Theme titles are conceptual and they should

capture something about the essential quality of what is represented by the text (Willig, 2001).

The third stage involves an attempt to introduce structure into the analysis. The researcher lists the themes identified in stage two and thinks about them in relation to one another. Some of the themes will form natural clusters of concepts that share meanings or references, whereas others will be characterised by hierarchical relationships with one another. Clusters of themes need to be given labels that capture their essence (Willig, 2001).

Willig (2001) describes the fourth stage of analysis which involves the production of a summary table of the structured themes, together with quotations that illustrate each theme. The summary table should only include those themes that capture something about the quality of the participant's experience of the phenomenon under investigation. Whilst IPA is described in four stages, Smith *et al.* (1999) also report that analysis is a cyclical process where researchers should be prepared to go through the stages a number of times.

Following the process of analysis, a single transcript can be written up as a case study in its own right or more often, the analysis can move on to incorporate interviews with a number of different individuals (Smith & Osborn, 2003). One can either use the themes from the first case to help orient the subsequent analysis or put the table of themes for participant one aside and work on transcript two from scratch. Whichever approach is adopted, one needs to be disciplined to discern repeating patterns but also acknowledge new issues emerging as one works through the

transcripts (Smith & Osborn, 2003). If new themes emerge in subsequent interviews, they should be tested against earlier transcripts. Perhaps the new themes could enlighten, modify or become either subordinate or super-ordinate to a previously elicited one (Smith *et al.*, 1999). Once each transcript has been analysed by the interpretative process, a final table of super-ordinate themes should be constructed (Smith & Osborn, 2003).

With regards to the use of IPA within psychology, Willig (2001) argues that the systematic nature of its analytic procedure and the provision of detailed descriptions of the analytic process have meant that IPA has become an increasingly attractive research method for psychologists. IPA was initially adopted within the domain of health psychology in order to analyse qualitative data reflecting participants' experiences (Grigoriou, 2004). Widespread use of IPA as an analytical tool is evident within recent health psychology literature (Shaw, 2001). IPA has been gaining attention in health psychology. Indeed, Smith (2004) addresses the question 'Is IPA a health psychology method?' However, this approach is gaining increasing attention from other areas of psychology as IPA has also been used in social and counselling psychology research because it allows researchers to explore participants' experiences (Grigoriou, 2004).

One of the reasons why IPA may have gained so much attention in health psychology is because of its ability to gain an in-depth understanding of those aspects of experience that are significant to individuals who live and deal with conditions such as epilepsy every day (Shaw, 2001). Many papers are concerned with aspects of therapeutic intervention, many are concerned with participants

dealing with issues around health and illness, and the new genetics is emerging as an important, more specific site of work (Smith, 1994).

Shaw (2001) wrote a paper which shows many of the benefits of using IPA, particularly in health psychology. It is argued that IPA has numerous benefits with perhaps the greatest asset being its ability to reveal unanticipated phenomena. Rather than beginning a project with a predetermined set of ideas about the nature of an experience, IPA allows the researcher to begin with an open mind and, more fundamentally, it allows participants to tell their own stories about their experience without being biased by the predetermined notions that research presents to them. In this sense, the research becomes very much the work of the participants and also has the potential to uncover constructs that have not been previously developed by other theorists or researchers (Shaw, 2001). IPA researchers are able to investigate phenomena from a new perspective by learning from those who are experiencing it, rather than from theories that may be many years old. Hence the research immediately becomes contemporary and therefore relevant to individuals' current lived experiences (Shaw, 2001).

Another valuable benefit of IPA is its capacity to investigate human experience within a cultural context. It places emphasis upon the contextual factors that are at work within an individual's life which may directly or indirectly play a part in the meaning-making process (Shaw, 2001).

IPA clearly has many benefits when applying it as a qualitative approach to health psychology. However, some critics might argue that IPA has limited use outside the

health psychology field as to date; its uses have been very predominantly linked to health. Indeed, Smith (2004) notes that whilst there is enormous diversity in the topics being addressed in IPA studies, there are also clusters and patterns which are evident.

Furthermore, in terms of methodology and sampling, it is only possible to do the detailed nuanced analysis associated with IPA on a small sample and many studies have samples of five to ten (Smith, 2004).

Willig (2001) also argues that that IPA suffers from several conceptual and practical limitations such as the role of language, as IPA works with texts and therefore assumes that language provides participants with the necessary tools to capture that experience. In other words, IPA relies upon the representation validity of language. Willig (2001) argues that IPA's conceptualisation of language can be criticised for not paying enough attention to its constitutive role. Willig (2001) also argues that phenomenology as a social scientific method, relies upon participants' descriptions of their experiences, which raises difficult questions about the extent to which participants' accounts constitute suitable material for phenomenological analysis. Willig (2001) argues that phenomenological research methods are not suitable for the study of experiences of those who may not be able to articulate them in the sophisticated method required by the method. Willig (2001) also asserts that phenomenological research describes and documents the lived experience of participants but it does not attempt to explain it. It could be argued that an exclusive focus on appearances, without regard for their cause or origin, limits our understanding of phenomena (Willig, 2001).

As well as this, Smith (2004) also notes in his paper reflecting on the use of this approach, that most IPA studies conducted so far have been based on individual semi-structured interviews with English speaking adults. The question arises therefore, as to whether IPA can be conducted with participants from other groups and using other data collection methods (Smith, 2004).

Smith (2004) also notes that a critique sometimes thrown at qualitative research methods in general is that they demand reflexive articulate qualities that are more likely to be found in middle-class groups. However, Smith (2004) asserts that from experience, there is no correlation between the socio-economic status of the participant and the richness of the data obtained.

In addition, Smith's discussion of these issues is very thorough and justifiably notes that there is plenty of scope to push the boundaries in terms of populations and data collection methods. Smith (2004) reports some of the possibilities for doing this in his paper, which includes a section on the future developments of IPA.

Shaw (2001) illustrates that IPA is still in the developing stages. The application of the suggestions within Smith's (2004) paper will undoubtedly contribute to dispelling some of the initial concerns the author has. To date, the approach has nevertheless gained huge ground, especially within the domain of health psychology (Shaw, 2001). The value of its use is also demonstrated by the fact that IPA has begun to attract attention in social, clinical and counselling psychology.

2.2.3. Content Analysis

The history of content analysis as a research technique dates from the beginning of the twentieth century, although scattered studies going as far back as the 1940s have been cited (Dovring, 1954). During this time, the method has gone through a number of phases (Holst, 1969).

The technique has largely grown as a result of the uses to which it has been put, and these have changed considerably over the years (Carney, 1972). Holst (1969) reports that newspapers continue to be the source most frequently examined. Krippendorff (1980) also suggests that mass communication is the traditional domain of content analysis. However, content analysis can be used for many different purposes including to code open-ended questions in surveys, to compare media or 'levels' of communication and to determine the psychological state of persons or groups (Weber, 1990).

Furthermore, content analysis has a tradition in sociology however; it is shared with journalism, political science and social psychology (Tesch, 1990). Content analysis has a long history of use in communication, journalism, sociology, psychology and business (Neuendorf, 2002).

Definitions of content analysis have tended to change over time with developments in the technique and with application of the tool itself to new problems and types of materials (Holst, 1969).

There are numerous definitions of content analysis including Berelson's (1952) definition of:

> "A research technique for the objective, systematic quantitative description of the manifest content of communication."

Several researchers state that content analysis is largely numeric and cannot properly be called a type of qualitative research (Tesch, 1990). However, despite many researchers describing content analysis as a quantitative method (Silverman, 2001), many others argue that analysts can make inferences on non-quantitative evidence (Carney, 1972). In addition, its conclusions are not statistical; they are substantive and content analysis has grown to include qualitative strategies (Tesch, 1990).

When using content analysis, researchers establish a set of categories and then count the number of instances that fall into each category (Silverman, 2001). However, analysts argue that content analysis is not just a frequency count and that much 'pattern fitting' is practised by comparing a complex set of inter-related words or views with various other model sets to identify a mode of perception or reasoning (Carney, 1972). This author goes on to state that a content analyst always aims to compare the data extracted against some norm, standard or theory so as to draw conclusions.

Furthermore, there are several other definitions of content analysis which recognise that the process does not limit data extraction to quantitative measurement including:

> "Content analysis is any technique for making inferences by objectively and systematically identifying specified characteristics of messages (Lindzey, Aronson & Addison-Wesley, 1968)."

Carney (1972) concludes by stating that content analysis, is a general-purpose analytical infrastructure elaborated for a wide range of uses.

Krippendorff (1980) defines content analysis as "a research technique for making replicable and valid inferences from data to their context."

Holst (1969) concludes that definitions of content analysis reveal broad agreement on the requirements of **objectivity:** an explicit set of rules minimises the possibility that the findings reflect the analysts' subjective predispositions; **system:** the inclusion and the exclusion of content or categories is done according to consistently applied rules; and **generality:** the findings must have theoretical relevance. Holst (1969) also argues that the requirements of objectivity, system and generality are not unique to content analysis, as they are necessary conditions for all scientific inquiry.

In discussing whether the use of content analysis solely involves quantitative frequency counts of the data, Holst argues (1969) that all content analysis is concerned with comparison, the type of comparison being dictated by the investigator's theory. Weber (1990) states that the best content analytic studies use both qualitative and quantitative operations on texts. Thus content analysis methods combine what are usually thought to be antithetical methods of analysis (Weber, 1990).

Holst (1969) reiterates this by indicating that the content analyst should use qualitative and quantitative methods to supplement each other. By moving back and

forth between these approaches, the investigator is most likely to gain insight into the meaning of the data (Holst, 1969). This can be done by combining frequency techniques (for example frequency of themes) with non-frequency techniques (for example presence of themes).

Content analysis as a research technique is as equally concerned with ensuring that it pays attention to both reliability and validity, as other scientific methods. Indeed, content analysis pays particular attention to the issue of reliability of its measures- ensuring that different researchers use them in the same way- and to the validity of its findings- through precise counts of word use (Silverman, 2001).

In terms of reliability, Silverman (2001) maintains that the crucial requirement is that the categories are sufficiently precise to enable different coders to arrive at the same results when the same body of material is examined. Weber (1990) reiterates this by stating that to make valid inferences from the text, it is important that the classification procedure be reliable in the sense of being consistent; different people should code the text in the same way.

In terms of validity, the classification procedure must generate variables that are valid to the extent that it measures or represents what the investigator intends to measure (Weber, 1990). One set of problems concerns the consistency or reliability of text classifications, as reliability problems can grow out of the ambiguity of word meanings, category definitions or other coding rules. However, classification by multiple human coders permits the quantitative assessment of achieved reliability (Weber, 1990).

Furthermore, Weber (1990) argues that the central problems of content analysis originate mainly in the data-reduction process by which many of the words of texts are classified into much fewer content categories. However, it could be argued that this is the intention of the majority of methods of inquiry. This is reiterated by Weber (1990) who asserts that the richness and details within texts, precludes analysis without data reduction. The key to content analysis, in fact to all methods of inquiry, is choosing a strategy for information loss that yields substantially interesting and theoretically useful generalisations while reducing the amount of information analysed and reported by the investigator.

Weber (1990) concludes by arguing that some problems with content analysis are well known; others require further investigation. However, existing techniques of content analysis lead to valid and theoretically interesting results. Indeed, Silverman (2001) agrees that content analysis is an accepted method of textual investigation.

2.3. Qualitative approach for this research

After having considered the various qualitative approaches described above, it was considered that grounded theory would be the most suitable approach for this research. This approach was chosen for a number of reasons. However, the main reason for the identification of grounded theory as being the most appropriate qualitative approach for this research is because of its emphasis on generating theory from research which is *grounded* in data. When using grounded theory, the researcher does not begin a project with a preconceived theory in mind, rather

grounded theory encourages researchers to put aside preconceived ideas and discover what is most important to participants (Honey, 2003).

In terms of the employment experiences, needs and aspirations of people with mental health problems, these are issues which are surrounded by pre-existing constructs, partly due to the portrayal of people with mental health problems in an unfavourable light, particularly in the mass media (Harnois & Gabriel, 2000). There is a great deal of public misperception of mental illness, which in turn is often due to misunderstanding, and lack of knowledge (The National Assembly for Wales, 2001). This can lead to sensationalised media coverage and increased interest in this field of work. As a result of this, it was considered to be of particular importance to minimise the likelihood of becoming influenced by pre-existing constructs by allowing the theory to emerge from the data.

Finally, this research includes a group of traditionally under-researched individuals, namely unemployed men receiving mental health support, living in the South Wales Valleys. The South Wales Valleys can be described as important centres of Welsh culture because of the distinct culture that exists in these areas, which may have implications for inhabitants' attitudes towards employment, training and education. Although a great deal of research on unemployment and mental health has been carried out, to the investigator's knowledge, research which includes unemployed men living in the South Wales Valleys has not been carried out before and is therefore an understudied area of research. As grounded theory is particularly useful for exploring understudied phenomena or very complex social phenomena (Miles

and Huberman, 1994), grounded theory would seem the most appropriate approach to use.

However, this research did not use a full grounded theory approach. Rather it is an exploratory study as the grounded theory approach only features in the analytic techniques used to analyse the data. This study collected data in a novel area of research in order to identify preliminary themes and to allow a tentative overarching theory to emerge. This study did not use the full grounded theory approach as the research involved the one-off collection of data and theoretical sampling was not used, which makes it an exploratory study at this stage. As this study was carried out as part of the Employment Opportunities Project (see chapter 1: Introduction), theoretical sampling was not practical or feasible.

The grounded theory approach used for this research is similar to that described by Willig (2001) namely, the *abbreviated version* of grounded theory. In the *full version* of grounded theory, the researcher collects some data, explores the data through initial open coding, establishes tentative linkages between categories, and then returns to the field to collect further data. Data collection is progressively focused and informed by the emerging theory (Willig, 2001). In contrast, the *abbreviated version* of grounded theory works with the original data only. Here, interview transcripts or other documents are analysed following the principles of grounded theory; however, *theoretical sensitivity*, *theoretical saturation* and *negative case analysis* can only be implemented within the texts that are being analysed. The abbreviated version of grounded theory should only be used when time or resource constraints prevent the implementation of the full version of grounded theory

(Willig, 2001). Research studies which use the abbreviated version of grounded theory should be cautious when coming to analyse the data as Willig (2001) argues that line-by-line analysis is particularly important when this version is being used as here, the depth of analysis generated by line-by-line coding is needed to compensate for the loss of breadth that accompanies the researcher's dependence upon the original data set. Willig (2001) reports that the abbreviated version of grounded theory has been used more recently by researchers as a method of data analysis only; whereby interview transcripts have been subjected to grounded theory inspired coding in order to produce a systematic representation of the participant's experience and understanding of the phenomenon under investigation.

As this study was carried out as part of the Employment Opportunities Project, (see chapter 1: Introduction) time constraints were imposed on the data collection. Therefore, the abbreviated version of grounded theory was used for this research.

Chapter 3: Ethical considerations

Ethical considerations should be at the forefront of any research study. The Research Governance Framework for Health and Social Care in Wales (The National Assembly for Wales, 2001) states that "The dignity, rights, safety and well-being of participants must be the primary consideration in any research study."

The Research Governance Framework for Health and Social Care in Wales (The National Assembly for Wales, 2001) has a section on Research Ethics which outlines the key ethical considerations which need to be recognised when carrying out research in health and social care in Wales.

The British Psychological Society also has Ethical Principles for conducting Research with Human Participants. These state that psychological investigators are potentially interested in all aspects of human behaviour and conscious experience. However, for ethical reasons, some areas of human experience and behaviour may be beyond the reach of experiment, observation or other form of psychological investigation. Ethical guidelines are necessary to clarify the conditions under which psychological research is acceptable.

The British Psychological Society (www.bps.org.uk) states that in all circumstances, investigators must consider the ethical implications and psychological consequences for the participants in their research. The essential principle is that the investigation

should be considered from the standpoint of all participants; foreseeable threats to their psychological well-being, health, values or dignity should be eliminated.

The World Medical Association also has the Declaration of Helsinki as a statement of ethical principles to provide guidance to physicians and other participants in medical research involving human subjects. Although the principles are designed for medical research, many of the principles are relevant for researchers undertaking non-medical research.

The Declaration of Helsinki states that medical research is subject to ethical standards that promotes respect for all human beings and protects their health and rights. It also states that research investigators should be aware of the ethical, legal and regulatory requirements for research on human subjects in their own countries, as well as applicable international requirements. The Declaration asserts that the research protocol should always contain a statement of the ethical considerations involved and should indicate that there is compliance with the principles enunciated in this Declaration (World Medical Association, 2004).

In order to examine the ethical considerations for this research study, it is important to first outline the key considerations which should be taken into account, followed by an account of how this research addresses them.

3.1. Ethical approval

The Assembly requires that all research involving patients, service users, care professionals or volunteers, or their organs, tissue or data, is reviewed independently to ensure that it meets its ethical standards (The National Assembly for Wales, 2001).

The World Medical Association (2004) also asserts that with medical research studies, the research protocol should be submitted for consideration, comment, guidance, and where appropriate, approval to a specially appointed ethical review committee, which must be independent of the investigator, the sponsor or any other kind of undue influence.

In order to ensure that all research is reviewed independently to ensure that it meets ethical standards, NHS Research Ethics Committees (RECs) have been established throughout England and Wales for many years with the purpose of safeguarding the rights, dignity and welfare of people participating in research in the NHS. Potential research participants at NHS organisations in the UK will come under the protection of a REC. The REC is entirely independent of the researcher and the organisations funding and hosting the research.

3.1.1. Ethical approval for this research

The research protocol for this study was not submitted to an NHS Research Ethics Committee prior to the research commencing because whilst the Research Governance Framework for Health and Social Care (The National Assembly for Wales, 2001) requires that independent ethics review is undertaken of all health and

social care research, at present, there is no national system for review of social care research, comparable to that of the NHS Research Ethics Committees (RECs).

This was considered to be social care research as it was carried out in the community, and the study did not involve patients, service users, care professionals or volunteers within an NHS context. Therefore, it was not considered to be within the remit of NHS Research Ethics Committees. The National Research Ethics Service (NRES) states that the NHS RECs will cover any social care research that involves NHS staff, service users or user-data. However, most will not be appropriate for the NHS RECs if it involves only social care agencies and populations (http://www.nres.npsa.nhs.uk).

The National Research Ethics Service (NRES) acknowledges that a national system for ethics review in social care needs to be developed and in 2004, the Department of Health (DH) issued a consultation document entitled *Ethics review of social care research: Options appraisal and guidelines* (DH, 2004) which sought views on ethics review of social care research. To date, a national system for ethics review in social care has not been developed. However, work is progressing in this area.

Although the research protocol for this research study was not submitted to an NHS Research Ethics Committee, it was subject to a thorough ethical review. The mental health charity's board of directors played a key role in the ethics review for this research. The directors are responsible for all aspects of the organisation, which includes managing staff and projects, developing new services, marketing and public relations, and sourcing funding opportunities. In relation to this research, the board's

role was to ensure that the dignity, rights, safety and well being of the charity's service users were protected. In order to ensure that the research was ethical, valid and reliable, the mental health organisations' board considered the research before it began. The mental health charity's board also closely monitored the research progress throughout. The board, the Chief Executive and the Research Manager within the mental health charity all gave ethical approval for the research prior to its commencement.

3.2. Informed consent

Informed consent is at the heart of ethical research. All studies must have appropriate arrangements for obtaining consent (The National Assembly for Wales, 2001).

The British Psychological Society (www.bps.org.uk) also highlights the importance of consent. Whenever possible, the investigator should inform all participants of the objectives of the investigation. The investigator should inform the participants of all aspects of the research or intervention that might reasonably be expected to influence willingness to participate. The investigator should, normally, explain all other aspects of the research or intervention about which the participants enquire (British Psychological Society).

In relation to medical research, the World Medical Association (2004) also states that in any research on human beings, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, the institutional affiliations of the researcher, the anticipated benefits and potential risks

of the study and the discomfort it may entail. The subject should be informed of the right to abstain from participation in the study or to withdraw consent to participate at any time without reprisal. After ensuring that the subject has understood the information, the physician should then obtain the subject's freely-given informed consent, preferably in writing. If the consent cannot be obtained in writing, the non-written consent must be formally documented and witnessed (World Medical Association, 2004).

3.2.1. Informed consent for this research

The arrangements for obtaining informed consent for this research were considered to be of high importance and great care was taken to ensure that participants were informed about all aspects of the research, prior to giving consent. Participants were given information on the aims and objectives of the research, justification for carrying out the research, methods and process, the institutional affiliations of the investigator, and the anticipated benefits of the research. Participants were also advised that the information would be confidential and anonymous and that taking part would have not have a negative impact on the services they were receiving from the mental health charity. This information was given to participants at two different stages of the research process, namely prior to obtaining informed consent and again, prior to the research commencing. Informed consent was also taken in writing (see chapter 4- Method for the full procedure in obtaining informed consent from participants).

3.3. The appropriate use and protection of data

The National Assembly for Wales (2001) states that the appropriate use and protection of patient data is also paramount. All those involved in research must be aware of their legal and ethical duties in this respect. Particular attention must be given to systems for ensuring confidentiality of personal information and to the security of these systems (The National Assembly for Wales, 2001).

The British Psychological Society (www.bps.org.uk) also asserts that subject to the requirements of legislation, including the Data Protection Act, information obtained about a participant during an investigation is confidential unless otherwise agreed in advance. Participants in psychological research have a right to expect that information they provide will be treated confidentially and, if published, will not be identifiable as theirs. In the event that confidentiality and/or anonymity cannot be guaranteed, the participant must be warned of this in advance of agreeing to participate (British Psychological Society).

In relation to medical research, the World Medical Association (2004) asserts that the right of research subjects to safeguard their integrity must always be respected. Every precaution should be taken to respect the privacy of the subject, the confidentiality of the patient's information and to minimise the impact of the study on the subject's physical and mental integrity and on the personality of the subject (World Medical Association, 2004).

3.3.1. The appropriate use and protection of data in this research

The investigator ensured that the Data Protection Act was adhered to throughout all stages of the research. The appropriate use and protection of data was considered to be paramount during this research study. Prior to the research commencing, participants were advised that the information they give would be confidential and presented in an anonymous way. These principles were adhered to throughout the research and once the research was completed.

For this research study, access to participants' health records or any other personal information was not required at any point. Personal contact information such as participants' names, addresses, and telephone numbers was not recorded. Identifiable data was not shared with anyone as all audio recorded data and transcripts remained anonymous. Transcripts were stored securely and in an anonymous format. Participants were advised that direct quotations would be used but that these would be anonymous and non-identifiable.

3.4. Involving service users in research

The general public and those who use services are key stakeholders in the process of planning the delivery of health and social care services (Welsh Assembly Government, 2002). The Review of Health and Social Care in Wales (Wanless, 2003) also emphasises the importance of public and patients being involved in shaping health and social care services. The strategy for creating world class Health and Social Care for Wales in the 21st century; Designed for Life (2005) outlines three

design principles to improve health and social care, one of which is user-centred services. Indeed, it is the service users and staff who know best the reality of what it feels like to be cared for in Wales (Welsh Assembly Government, 2005). The Welsh Assembly Government requires an equivalent approach in Research and Development (R&D) in Wales.

The National Assembly for Wales (2001) states that participants or their representatives should be involved wherever possible in the design, conduct, analysis and reporting of research.

The Health and Social Care Research and Development Strategic Framework for Wales; a consultation document (Welsh Assembly Government, 2002) endorses the principle of involving stakeholders in research and development. Specifically, this framework outlines that there are four principal areas for service users and the wider public involvement in research and development which can be identified and which will mirror those of professional groups with an interest in research and development namely: setting priorities for research; participants in research; undertaking research; and recipients of the results of research (Welsh Assembly Government, 2002). It also states that the achievement of effective stakeholder involvement requires careful planning to avoid tokenistic approaches and to enable the consumer viewpoint to be fully incorporated into research and development in Wales (Welsh Assembly Government, 2002).

In addition, Trivedi and Wykes (2002) reports that the Department of Health, the National Health Service (NHS) Executive, research charities and funding bodies

have emphasised the importance of user involvement. Numerous documents have been published by the Department of Health NHS Executive which outline the importance of public and patient involvement in research (Consumers in NHS Research, 1999; Department of Health, 1998, 1999; Department of Health, 2000).

A unique group has been commissioned by the Department of Health to provide advice on how best to involve members of the public in the research and development process. INVOLVE plays a key role in promoting public involvement in NHS, public health and social care research. INVOLVE was established to promote public involvement in research, in order to improve the way that research is prioritised, commissioned, undertaken, communicated and used. INVOLVE also has a Support Unit which was established to support the work of INVOLVE and to provide information, advice and support to the public, researchers, and research funders and those working within the NHS and more recently, the Policy Research Programme.

INVOLVE has produced a series of publications on involving consumers in research which are available from the Involve Support Unit such as: *Involving the public in NHS, public health and social care research: Briefing Notes for Researchers* (2004). Guidance has also been produced for consumers who want to be involved in research (*Getting Involved in Research, a Guide for Consumers*, INVOLVE, 2001).

Of particular relevance to this research, a consultation document for *Involving Marginalised and Vulnerable Groups in Research* has been developed for the purpose of stimulating thought and discussion on the issues surrounding the

involvement of vulnerable and frequently excluded groups of people in research and development (INVOLVE, 2004). This document states that involving vulnerable and marginalised people in research requires additional thought, preparation, time and money. However, it is likely to mean that the research project will be more effective because these groups have important expertise to offer (INVOLVE, 2004). This document acts as guidelines for researchers as it provides ideas and recommendations under key areas including reaching vulnerable and marginalised people, consent, accessibility, inclusion and general good practice. A summary document also provides a checklist for researchers to help think of the issues concerned with involving vulnerable or marginalised people as partners in research projects (INVOLVE, 2004).

3.4.1. Involving mental health service users in this research

The mental health charity who hosted the Employment Opportunities Project was very committed to involving mental health service users in this research. Both the mental health charity and the investigator had a thorough understanding of the client group, having had a great deal of experience of working with, and involving people with severe and enduring mental health problems. The charity also ensured that good practice was followed when working with vulnerable adults.

The research involved service users in several different ways. Throughout the research, the investigator worked in close collaboration with the Service User Development Officer within the mental health charity who had personal experience of mental health problems. The investigator utilised the Service User Development

Officer as a 'consultant service user' by asking for advice and ideas on how to involve service users throughout all stages of the research.

The mental health charity employed the Service User Development Officer to co-ordinate the Service User Involvement Group with the specific remit of obtaining user perspectives on the services the mental health charity provided and any further activities in which the organisation was involved. The service user involvement group was based on the ethos that the charity's services were fulfilling service user requirements by being responsive to service users' needs and by addressing the issues that are important to them. Meetings were held regularly and the investigator attended the meetings to discuss the research project with service users, to obtain their input into the design of the research and later on, to recruit participants. Once the research was complete, an event was organised which all the mental health charity's service users were invited to, with the purpose of disseminating the research findings to participants.

3.5. Respecting the diversity of human culture

The National Assembly for Wales states that research and those pursuing it should respect the diversity of human culture and conditions and take full account of ethnicity, gender, disability, age, sexual orientation, religious beliefs, non-beliefs and language preference of participants in the design, undertaking and reporting of research. Researchers should take account of the multi-cultural nature of society (The National Assembly for Wales, 2001).

The British Psychological Society (www.bps.org.uk) also states that investigators should recognise that, in our multi-cultural and multi-ethnic society and where investigations involve individuals of different ages, gender and social background, the investigators may not have sufficient knowledge of the implications of any investigation for the participants. It should be borne in mind that the best judge of whether an investigation will cause offence may be members of the population from which the participants in the research are to be drawn (British Psychological Society).

3.5.1. Respecting the diversity of human culture in this research

The mental health charity and the investigator were committed to respecting the diversity among the participants in this research. As such, the investigator was keen to ensure that the materials developed and methods designed, were appropriate and would not cause offence. The best judges of whether these aims would be achieved were considered to be people with mental health problems themselves. Therefore, two pilot studies were carried out prior to the research commencing with users of mental health services.

The first pilot study was carried out in a local user-led (where mental health service users actually run the service) drop-in centre in Cardiff (South Wales) with four mental health service users. The second pilot study was carried out at a local mental health drop-in centre in Bridgend (South Wales) with three mental health service users. At all stages, the materials and methodology were given to the charity's Service User Development Officer for consultation. Following the pilot studies, the investigator considered that the methodology was appropriate for this research.

However, the materials underwent several amendments as a result of piloting, prior to being considered ready to use.

As well as the piloting of the methodology and the materials, by involving mental health service users at all stages of the research, the investigator had input from service users in terms of respecting individual participant's culture. This was borne in mind by the investigator throughout the research.

3.6. Protection of participants

The National Assembly for Wales (2001) states that some research may involve an element of risk to those participating in it and risk must always be kept to a minimum.

The British Psychological Society (www.bps.org.uk) also states that investigators have a primary responsibility to protect participants from physical and mental harm during the investigation. Normally, the risk of harm must be no greater than in ordinary life, that is participants should not be exposed to risks greater than or additional to those encountered in their normal lifestyles. Participants must be asked about any factors in the procedure that might create a risk, such as pre-existing medical conditions, and must be advised of any special action they should take to avoid risk (British Psychological Society). Where research may involve behaviour or experiences that participants may regard as personal and private, the participants must be protected from stress by all appropriate measures, including the assurance

that answers to personal questions need not be given. There should be no concealment or deception when seeking information that might encroach on privacy.

Furthermore, in relation to medical research, the World Medical Association (2004) states that every medical research project involving human subjects should be preceded by careful assessment of predictable risks and burdens in comparison with foreseeable benefits to the subject or to others. This does not preclude the participation of healthy volunteers in medical research. The design of all studies should be publicly available. Medical research involving human subjects should only be conducted if the importance of the objective outweighs the inherent risks and burdens to the subject. This is especially important when the human subjects are healthy volunteers. Medical research is only justified if there is a reasonable likelihood that the populations in which the research is carried out stand to benefit from the results of the research (World Medical Association, 2004).

3.6.1. Protection of participants in this research

Prior to carrying out this research, the mental health charity's board carried out a risk assessment and considered the risk to be low. Furthermore, because this research was carried out as part of the Employment Opportunities Project, the aim of the latter part of the project was to launch an employment support service developed in accordance with service user need and evidence-based practice. The framework for the employment support service was based on the results of the research findings. As such, an assessment of the risks and burdens in comparison with the benefits to the

participants concluded that participants were extremely likely to benefit from the results of the research.

However, the research topic may have involved talking about experiences that participants would regard as personal, private and potentially distressing. Appropriate measures were taken to protect participants from stress. In particular, the participants' support workers were present whilst the research was being carried out in order to provide emotional support to the participants. Support workers also remained with participants following the research. This meant that if any distressing issues had arisen, of which the investigator was not aware, subsequent support could be given to the participant. Assurance was also given to participants that answers to personal questions need not be given and where participants appeared uncomfortable in discussing previous work experiences, or any other event, they were not encouraged to do so.

The protection of participants in this research was considered to be of great importance. As well as the ways in which the investigator protected participants from stress above, by considering all the ethical issues throughout the research, it was considered that the investigator had put in place the necessary safeguards to ensure that participants were protected throughout the research.

3.7. Research Management and Governance

In addition to research ethics, proper governance of research is also essential to ensure that the public can have confidence in, and benefit from, quality research in

health and social care (The National Assembly for Wales, 2001). The public has a right to expect high scientific, ethical and financial standards, transparent decision making processes, clear allocation of responsibilities and robust monitoring arrangements (The National Assembly for Wales, 2001).

The Research Governance Framework for Health and Social Care in Wales (The National Assembly for Wales, 2001) sets out a framework for the governance of research in health and social care. The Framework seeks to promote improvements in research quality across the board and aims to prevent poor performance, adverse events, research misconduct and fraud, and to ensure that lessons are learned and shared when poor practice is identified. The Framework sets out the responsibilities and standards that must be applied to work managed within the formal research context. Therefore, whilst the Research Governance Framework has a section on ethics, it also outlines other standards in research management and governance which should be adhered to, particularly in relation to science; information; health, safety and employment; and finance and intellectual property.

3.7.1. Research Management and Governance in this research

Wherever possible, appropriate measures were taken to ensure that this research met the standards set out in the Research Governance Framework for Health and Social Care in Wales (The National Assembly for Wales, 2001).

In order to assist with this, a research steering group was established to gain valuable input into the research from representatives with various different perspectives. The research steering group also played a role in closely monitoring the research. The

group was comprised of internal members of staff who were employed by the mental health charity at various levels, and external members. Internal members included the Service User Development Officer, Support Workers, the Services Manager and the Research Manager. External members of the group were representatives from statutory and voluntary sector agencies including representatives from JobCentre Plus, other mental health charities and projects directly involved in providing or enabling service user access to employment, training, education and voluntary work for people with mental health problems. Meetings were held quarterly and the research steering group closely monitored the research progress.

Chapter 4- Method

This research was carried out as part of the Employment Opportunities Project, being undertaken by a registered mental health charity (see chapter 1: Introduction). The Employment Opportunities Project included an 18-months research element carrying out research into mental health and employment in order to explore service users' employment experiences, needs and aspirations. The Employment Opportunities Project also presented a unique opportunity to collect qualitative data from a group of 'under-researched' individuals, namely unemployed men receiving mental health support living in areas of deprivation in the South Wales Valleys.

By using a qualitative research method; a grounded theory approach; this study aimed to explore the employment experiences, needs and aspirations among unemployed men receiving mental health support, living in the South Wales Valleys. The grounded theory approach used for this research was that outlined in Strauss and Corbin (1998). Data were collected from 15 participants for this research through the use of semi-structured interviews.

This research did not use a full grounded theory approach, as theoretical sampling was not included in the design. Rather this research used the *abbreviated version* of grounded theory described by Willig (2001) which works with the original data only (see chapter 2: Qualitative Research and Methodological Issues). The interview transcripts from this study were analysed following the principles of grounded theory

and as suggested by Willig (2001), line-by-line analysis and line-by-line coding was carried out on all data.

4.1. Participants

4.1.1. Inclusion criteria

The research element of the Employment Opportunities Project involved research into mental health and employment with **all** the charity's service users.

Including participants who fitted specific inclusion criteria led to the identification of a sub-group of the participants who were involved in the overall research project. This sub-group of participants are from a group of traditionally under-researched individuals, namely unemployed men receiving mental health support, living in the South Wales Valleys. Possible participants were identified from the total number of service users receiving support from the registered mental health charity and in this way; a form of purposive sampling took place.

In total, 15 participants took part in this research study. Participant eligibility included having experience of severe and enduring mental health problems, being male, unemployed and living in the South Wales Valleys. The full inclusion criteria are outlined below:

- experience of severe and enduring mental health problems
- receiving support from a registered mental health charity
- living in the South Wales Valleys
- male

- unemployed
- have worked in the past

4.1.2. Support from the registered mental health charity

Participants in this study were all service users of a registered mental health charity in South Wales. They were not required to provide a diagnosis to participate in the study but were considered eligible if they were receiving services designed for people with severe and enduring mental health problems, directly from the mental health charity. The vast majority of participants were also receiving services from the community mental health team in their local area.

The types of services participants were receiving from the mental health charity at the time of the research were one of two:

1. floating support; receiving emotional and practical support with everyday living skills within their own homes; and/or
2. supported housing; group homes/ self contained flats for people with severe and enduring mental health problems, this involves emotional and practical support within this home with everyday living skills.

The aim of both of these types of support is to assess service users' needs, support them and carry out progress reviews, with the ultimate aim being to assist them to develop skills in order to live more independently in the future.

4.1.3. Demographic information

Demographic information was collected informally during the data collection, in the context of semi-structured interviews.

Participants' ages ranged from 'below 25 years old' to 'above 55 years old.' The age range within this sample was wide as the mental health charity offers support to people from the ages of 18 years old and upwards.

Participants were asked to specify to which age group they belonged; two participants were below 25 years old; three participants were 25-35 years old; four participants were 36-45 years old; five participants were 46-55 years old and one participant was above 55 years old.

The ethnicity of the participants was that all of the participants within this study were white, which reflects the ethnicity of the registered mental health charity's service user population.

Participants' level of education ranged from no educational qualifications- six participants; qualified up to GCSE level- five participants; qualified up to A level- two participants; to qualified up to degree level- one participant. One participant did not wish to disclose this information.

For further information on participants' demographics, please see table 1.

Table 1: Participant demographics

P't	Gender	Age	Time receiving mental health services	Location	Educational qualifications	Last Job	Time unemployed
1	Male	46-55 yrs	> 15 yrs	RCT	None	Rent collector for local council	20 yrs
2	Male	36-45 yrs	2 yrs to < 4 yrs	MT	Degree	Complementary therapist	2 yrs
3	Male	46-55 yrs	2 yrs to < 4 yrs	MT	None	Manual worker at electronics company	18/20 yrs
4	Male	Below 25 yrs	2 yrs to < 4 yrs	RCT	GCSE level	Manual worker at a factory	2 yrs
5	Male	Above 55 yrs	> 15 yrs	RCT	A levels	Police officer	20 yrs
6	Male	25-35 yrs	10 yrs to < 15 yrs	RCT	None	Manual worker at a factory	9/10 yrs
7	Male	25-35 yrs	6 yrs to < 10 yrs	RCT	GCSE level	Apprentice carpenter	5/6 yrs
8	Male	36-45 yrs	> 15 yrs	RCT	GCSE level	Manual worker at a factory	Unknown
9	Male	36-45 yrs	6 yrs to < 10 yrs	MT	None	"Tea boy" in an office	19/20 yrs
10	Male	36-45 yrs	> 15 yrs	RCT	None	Labourer	Unknown
11	Male	46-55 yrs	> 15 yrs	RCT	None	Painter and decorator	30 yrs
12	Male	46-55 yrs	6 yrs to < 10 yrs	N/ PT	GCSE level	Caretaker	2 yrs
13	Male	25-35 yrs	2 yrs to < 4 yrs	N/ PT	GCSE level	Manual worker at steelworks	3 yrs
14	Male	Below 25 yrs	2 yrs to < 4 yrs	RCT	A level	Planner at a factory	3 yrs
15	Male	46-55 yrs	6 yrs to < 10 yrs	RCT	Unknown	Office clerk in a bank	15 yrs

*Abbreviations:
P't: participant; yrs: years; RCT: Rhondda Cynon Taff; MT: Merthyr Tydfil; N/PT: Neath/ Port Talbot

4.1.4. Location: the South Wales Valleys

Participants in this research lived within the South Wales area and within one of three geographical locations namely: Merthyr Tydfil- three participants; Neath/ Port Talbot- two participants; and Rhondda Cynon Taff- 10 participants.

In order to obtain information on the levels of employment in each area and the culture that exists, information on levels of deprivation and the history of the area was sought.

The Welsh Index of Multiple Deprivation 2005 (WIMD) is the official measure of deprivation for small areas in Wales. It was developed for the Welsh Assembly Government by the Assembly's Statistical Directorate and the Local Government Data Unit (Wales). The WIMD 2005 is made up of seven separate domains (or kinds) of deprivation, namely: income; employment; health; education; housing; access to services; and the environment. England and Wales have been divided into Super Output Areas (SOA) each having roughly the same population. In total, there are 1,896 SOAs in Wales. Deprivation scores have been worked out for each of these areas. An area in itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score (WIMD, 2005).

Merthyr Tydfil (36 per cent), Blaenau Gwent (26 per cent), Rhondda Cynon Taff (19 per cent) and Neath Port Talbot (19 per cent) have the highest percentages of their SOAs in the most deprived ten percent in Wales, for overall deprivation.

The areas in which the participants for this study lived are included in the above namely Merthyr Tydfil, Rhondda Cynon Taff and Neath/ Port Talbot, demonstrating that participants live in some of the most deprived areas in Wales.

Each of these areas also forms part of the South Wales Valleys which are a number of industrialised valleys in South Wales. They stretch from Carmarthenshire in the West to Monmouthshire in the East and located roughly in the centre is the famous Rhondda valley which is in the county borough council area of Rhondda Cynon Taff. The South Wales Valleys are highly populated areas and are important centres of Welsh culture. The South Wales Valleys have a distinct culture which may have implications for inhabitants' attitudes to employment, training and education. Therefore, in the context of this research, the history of the South Wales Valleys is useful in helping to understand the context in which participants live.

During the Industrial Revolution, the South Wales Valleys became important centres for both the coal mining and iron industries. The Valleys became most famous for their coal mines which attracted huge numbers of people from rural areas. As a result of this, Cardiff became among the most important coal ports in the world and Swansea among the most important steel ports (http://www.danceage.com/biography/sdmc_South_Wales_Valleys). At one time, a third of the world's coal was produced in the South Wales Valleys (www.walesinfo.com).

However, the Second World War marked the end of these heavy industries in the Valleys. Steel works and coal mines began to close, despite nationalisation by the UK government. In 1984 and 1985, after the government announced plans to close many mines across the UK, mineworkers went on strike. The ultimate failure of this strike led to the virtual destruction of the UK's coal industry (http://www.danceage.com/biography/sdmc_South_Wales_Valleys). The closure of the heavy industries led to very high unemployment in the Valleys and whilst measured unemployment has fallen considerably since the early 1990s, high levels of economic inactivity remain, particularly in the upper sections of the Valleys (http://www.danceage.com/biography/sdmc_South_Wales_Valleys). The economy remains weak and many parts of the South Wales Valleys are considered to be among the most deprived ten percent in Wales (WMID, 2005).

4.2. Materials

Data were collected for this research through the use of semi-structured interviews. In order to carry out the semi-structured interviews, an information sheet and a consent form were developed to inform participants about the aims of the research and exactly what it would involve. Each participant completed the consent form with the assistance of his or her support worker and in doing so; they gave their written consent to be interviewed. A copy of the information sheet and consent form can be found in Appendix 1.

In addition, an interview schedule was devised which consisted of 27 questions on employment experiences, needs and aspirations. This schedule was used as a guide

for the semi-structured interviews. Participants were asked the questions within the interview schedule but they were also able to determine the interview content by introducing relevant themes. A full copy of the interview schedule can be found in Appendix 2.

This interview schedule was piloted with mental health service users before the interviews began. The interview schedule was piloted using a two-stage process. The first pilot study was carried out in a local user-led (where mental health service users actually run the service) drop-in centre in Cardiff (South Wales) with four mental health service users. The second pilot study was carried out at a local mental health drop-in centre in Bridgend (South Wales) with three mental health service users. At all stages, the materials and methodology were given to the charity's Service User Development Officer for consultation. Significant changes were made before the interview schedule was considered ready to use. Following the pilot studies, the investigator also considered that the methodology was appropriate for this research.

4.3. Procedure

For this research, semi-structured interviews were used to collect data.

Prior to the research commencing, the investigator met all the support workers who were working for the mental health charity to explain the aims of the research and the process. The team of support workers in each of the three geographical locations were asked to approach the service users they support to explain the research to them using the information sheet, to recruit participants and to take written informed

consent, using the consent form. The investigator informed the support workers about how to recruit participants and gave detailed instructions on how to take informed consent.

Support workers had detailed knowledge about individual service users and had developed communication skills to effectively support each client. The participants in this research are considered to be part of a vulnerable population and it was important to ensure that *full* informed consent was obtained from each participant. Because support workers gave emotional support to service users on a day-to-day basis, it was considered appropriate that the information about the research was communicated to service users by their dedicated support worker. It was considered less likely for participants to give *full* informed consent to the investigator as the investigator was unknown to participants and may have been perceived as a being in a position of authority. In addition, as a result of the large numbers involved in the research for the Employment Opportunities Project, this was considered to be the most practical and feasible way of recruiting participants.

The recruitment process was carried out by support workers when they made their scheduled visits to each of the service user's homes to provide emotional and practical support with everyday living skills. At this point, support workers recruited participants into the study.

When recruiting participants to the research study, a participant information sheet was given to every service user. The information sheet was read out to participants and contained information on the aims and objectives of the research, justification for

carrying out the research, methods and process, the institutional affiliations of the investigator, and the anticipated benefits of the research. The participant information sheet also advised participants that the information would be confidential, would be presented in an anonymous way and would not have a negative impact on the services they were receiving from the mental health charity. The information sheet also invited participants to comment upon participation in the research following the interview.

Service users were informed that if they agreed, they would be questioned on their employment experiences, needs and aspirations and that the semi-structured interview would take place in their own home. Participants' homes were considered to be the most suitable venue for the interviews to take place as the environment was considered to be conducive to concentration, private, quiet, comfortable and familiar to participants. If service users agreed to this, they signed the consent form and arranged a date with their support worker when they were both available for the interview to take place. Particular care was taken with the process of obtaining consent by ensuring that clear and comprehensive information was included in the participant information sheet and plain English was used. Informed written consent was obtained from every participant after they had read and understood the participant information sheet.

On this date and arrangement, the support worker liaised with the interviewer and went to the service user's own home for the interview to be carried out. A trained investigator conducted the interviews and the same investigator was used with every interview. The participants' support worker was present at every interview in order to

provide support to the participant. It was considered important for support workers to be present at every interview because of the reasons above, as support workers had detailed knowledge about individual service users and had developed communication skills to effectively support each client. Because support workers gave emotional support to service users on a day-to-day basis, it was considered appropriate for the support workers to be present. The investigator was not familiar with individual service users and it was feared that if the investigator was to carry out the interview alone in service users' homes, it may have been perceived as an intrusion and service users may have felt uncomfortable. In addition, it was also considered important for a support worker to be present at the interview for the security of both the investigator and the participant. As a result, the service user's support worker was present at each interview. It was made clear to participants why support workers were present and the importance of confidentiality was stressed at this point. However, the interview itself was conducted entirely by the investigator and the support worker was present in an observational capacity. The investigator arrived and left the interview independently of the support worker in every interview.

Prior to the interview actually commencing, an introduction was given before every interview reminding participants of the key aims of the research, to ensure that participants understood the information within the information sheet and were happy to proceed. At this stage, participants were informed of the following information; the fact that participants did not have to be interested in work, training or education to take part; that all the information was confidential; and the results would be written up in an anonymous format. Verbal consent was also gained from all participants who did not object to their interview being audio-taped. Participants

were encouraged to ask questions about the research prior to commencing the interviews.

Transcripts were produced from the recorded interviews. Each participant was interviewed using the 27 questions on the interview schedule as a guide. However, participants were also free to discuss any relevant issues, all of which were included in the data analysis. Following the completion of each interview, the participants were thanked. The transcripts of the interviews were then analysed using a grounded theory approach.

4.4. Data analysis

The *abbreviated version of grounded theory* described by Willig (2001) was used for this research which works with the original data only (see chapter 2: Qualitative Research and Methodological Issues).

The data from this research were analysed using the approach outlined in Strauss and Corbin (1998), with a specific aim to generate an emergent theory from research which is 'grounded' in data. The data analysis carried out for this particular research study was also similar to the methods of data analysis used in Kirsch (2000); Honey (2003); and Honey (2004), where grounded theory approaches were used to explore employment issues among people with mental health problems.

Using the transcripts from the semi-structured interviews, data were analysed through the use of coding procedures. The coding process outlined in Strauss and

Corbin (1998) was used and data were analysed by using open, axial and selective coding.

Initial categories were generated by carrying out microanalysis, a detailed line-by-line analysis on the data in the interview transcripts. In particular, each line of text within the transcripts was analysed in-depth and initial categories were identified and noted from this.

Through open coding, concepts were identified within the data and their properties (the characteristics of the category) and dimensions (the range along which properties within the category vary) were described. During this first stage of coding, raw data from the transcripts were examined and broken down into discrete parts, and categories were identified. As more characteristics were identified under each category, the investigator noted the properties and dimensions of each category.

To further develop each category, analytic tools, techniques and procedures were used including asking questions. By asking questions, the investigator was able to consider the ways of interpreting the data and generating ideas. A second analytic tool used was theoretical comparisons which involved looking at the similarities and differences between the properties of the categories in order to help categorise and name them.

Through axial coding, categories were then related to one another and to their subcategories, at the level of properties and dimensions. By looking at the differences and similarities between the categories identified during open coding,

subcategories were identified and named. During this stage of coding, the conditions of a category were identified, along with the actions, interactions (responses of participants) and consequences associated with the category. By carrying out this level of coding, subcategories were related to the overarching categories and relationships between these were noted.

Finally, selective coding took place with the aim of identifying a central category through integrating and refining the theory. At this level of coding, the overarching categories were considered in relation to their relationships with one another and the overarching theory was identified. All of the major categories identified through previous stages of coding were integrated into the emerging theory which was refined throughout this stage of coding. The emerging theory was then considered in the light of all cases in the study.

Theoretical saturation and negative case analysis were implemented within the texts that were being analysed. Saturation of the theory occurred when no new categories were found within the transcripts, and the emergent theory could account for all the data that have been obtained.

The coding process was not carried out in a strictly sequential manner, rather the investigator moved back and forth between types of coding. Coding continued until the categories were meaningfully linked together to provide a comprehensive explanation of the phenomenon, namely the emergent theory.

Throughout the research, the investigator recorded observations by writing memos which recorded the progress, thoughts and feelings the researcher had in relation to the data and emerging theory. The memos written by the investigator informed ideas on the way in which various categories fitted together and interpretations of what these relationships might mean.

Chapter 5- Results

From exploring the employment experiences, needs, and aspirations among unemployed men receiving mental health support, living in the South Wales Valleys, a theoretical model emerged from the results, which contributes to explaining the high unemployment rates among people with mental health problems. The theory resulting from this research is that individuals with mental health problems who become unemployed follow a pathway of experiences which impacts upon the meaning of work to them and their self identity.

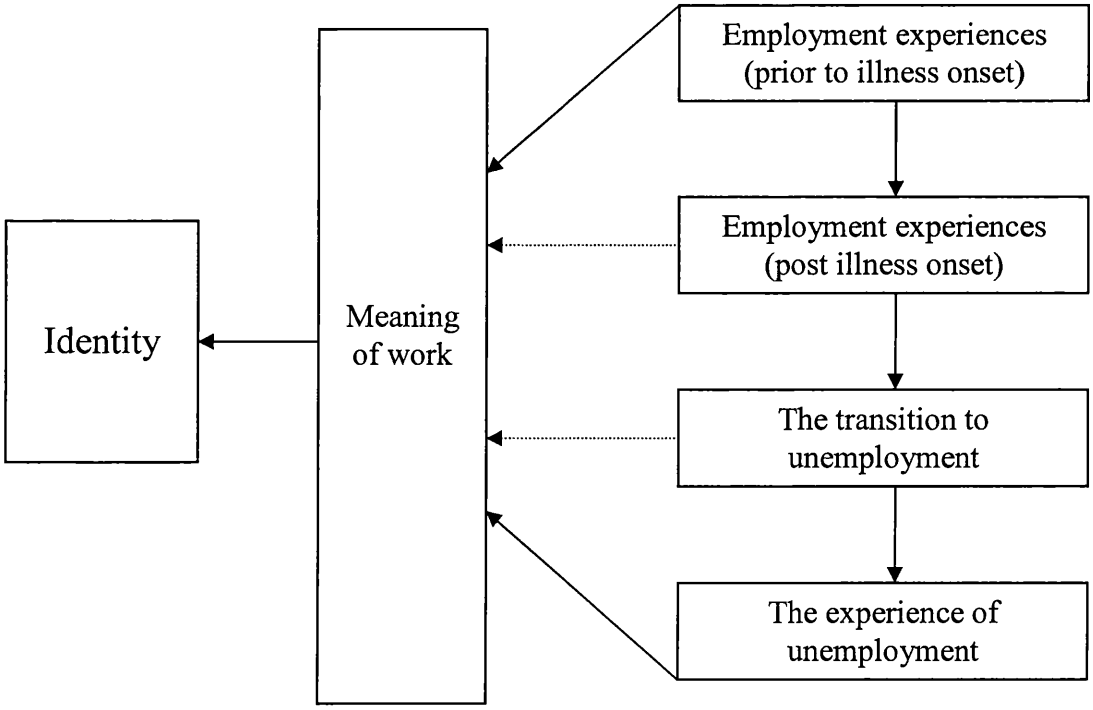
The overall theoretical model developed stems from four lower level, or descriptive, categories, namely employment (prior to illness onset); employment (post illness onset); the transition to unemployment; and the experience of being unemployed. These four descriptive categories describe a pathway to unemployment. In addition, two higher order or analytic categories emerged from the analysis, namely: meaning of work and identity.

In the following chapter, the proposed theoretical model will be presented and categories which emerged from the data will be discussed in turn, along with data extracts, followed by theoretical discussions concerning the relationships between the categories, to support the proposed theoretical model.

5.1. The theoretical model

The proposed theory resulting from this research is that individuals with mental health problems who become unemployed follow a pathway of experiences which impact upon the meaning of work to them and their self concept. Following the onset of mental ill-health, the impact of mental health problems also affects identity. This results in an identity shift between the valued worker and the devalued 'mental patient.' When considering the meaning of work as the devalued 'mental patient,' individuals with mental health problems also experience an identity struggle between the former valued worker and the current devalued 'mental patient' which could also be re-attributed to a struggle between the well self and the ill self.

Figure 1: the proposed theorised model



The proposed model outlined above demonstrates how the two higher order categories: meaning of work and identity; are orthogonal to the four descriptive categories which demonstrate the pathway of experiences to unemployment. The experiences along the pathway to unemployment impact upon the meaning of work to individuals. The employment experiences of people with mental health problems move from being content at work, to experiencing difficulties in the workplace, through to struggling to maintain their employment, to eventually being unemployed and the meaning of work changes at each of these stages. In addition, the meaning of work is central to identity for people with mental health problems. As individuals travel down the pathway to unemployment, the meaning of work changes, which impacts upon individuals' perceptions of themselves and their subsequent identities. Each of the stages through the pathway to unemployment is characterised by identity as individuals with mental health problems take on a new identity as the experiences affect their self concept.

Throughout the research, it is important to note that all of the interviews were carried out with participants at the point when they were unemployed. As a result, the experience of being unemployed is often contrasted with feelings about employment (prior to illness onset); employment (post illness onset); and the transition to unemployment. In addition, the experience of being unemployed also impacts upon the meaning of work and identity and this constant comparison is explicitly evident when participants describe the meaning of work to them.

5.2. Lower level/ descriptive categories

The four descriptive categories which emerged namely: *work experiences (prior to illness onset); work experiences (post illness onset); the transition to unemployment;* and the *experience of being unemployed* illustrate a **pathway to unemployment,** through which participants travelled. Participants' experiences followed a clear temporal line from *work experiences (prior to illness onset)* to the *experience of becoming unemployed.* This pathway is characterised by changes in lifestyle, most notably moving from a lifestyle *full of activity* to a lifestyle which has a distinct *lack of activity.*

5.2.1 Employment experiences (prior to illness onset)

Throughout the interviews, participants recalled strong memories of their work experiences prior to the onset of mental health problems. When describing their previous work experiences before they became unwell, participants were keen to explain that they had a *strong work ethic* throughout their working lives as they *worked hard.* Participants described the ways in which they *worked hard*, including working long hours, over and above what was expected:

> *"I used to like my job in (company), I worked hard for years, I can put my hand to anything"* (Pt 3).
>
> *"(I used to work) 16 hours a day, hard work that was"* (Pt 10).

What emerged from the data is that the participants in this study considered themselves to be good at their jobs or *competent at work* whilst they were in employment:

"While I was working, I was good at what I done" (Pt 1).

"I was a good worker" (Pt 6).

It was very evident from the data that, when participants were working, they enjoyed their work and experienced a level of *work contentment.* The individuals with mental health problems in this study fondly reminisced about their 'working lives:'

"I enjoyed my working life" (Pt 1).

"I used to like my job in (company)... I wish I could work, I used to love my work, I used to enjoy it" (Pt 3).

"I was always happy when I was in work" (Pt 4).

"The first job was brilliant, that's why it (being made redundant) devastated me so much because I really enjoyed it and the money was excellent for my age" (Pt 7).

Whilst recalling their work experiences, it also emerged that participants' lifestyles were *full of activity* whilst they were working as demonstrated below:

"When you're in work, you've got something to occupy you, so when you come home, you don't think about being bored, you just want to have a shower and go to bed" (Pt 7).

In summary, it is clear from the data that prior to the onset of mental health problems, the individuals in this study described their 'working lives' as full, active and content. However, following the onset of mental health ill-health, participants seemed to lose the happiness originally present in their 'working lives' and subsequent negative *employment experiences (post illness onset)* contributed to this loss of happiness.

5.2.2 Employment experiences (post illness onset)

Following the onset of mental health problems, work experiences changed dramatically from being an enjoyable experience to an unpleasant experience. The *employment experiences (post illness onset)* described by participants were characterised by difficulties they experienced in the workplace. The numerous difficulties participants experienced at work were a defining aspect of work experiences, following the onset of mental health problems.

A few participants took on a persona of feeling extremely gracious towards any employers who were willing to employ them as they were simply *being given the chance* to work. For some, this extreme graciousness indicated a negative view of employers attitudes towards employing people with mental health problems, suggesting an assumption that employers consider people with mental health problems as not worthy of being employed. This assumption is illustrated by the participant below who believed that unless employers were familiar with the characteristics of his mental illness, they would not employ him:

> *"Luckily in Ireland I bumped into someone who knew about manic depression otherwise they would of said, 'out,' but this was for a normal job, because she knew about manic depression she said 'ok I'll give you a chance....'. that's what I want, people to realise, I didn't have any problems with that, they knew about my illness....they knew I had manic depression, there was no problem with them, luckily they had experienced, a friend of hers had it, she said 'well I'll give you a chance,' there was no problem. I was delighted"* (Pt 12).

The vast majority of participants in this study found employment a struggle to maintain following the onset of mental health problems, as they started to experience *difficulties at work.* Participants described the feelings of *experiencing work-related*

stress which was generated from the work itself, and for some, this seriously affected their mental well-being:

> *"I just felt I was in a too high pressure job and I was on bad, not very good money either... it was a pretty small factory like, so it was lot of high pressure I think it was the whole atmosphere in the factory that made me bad"* (Pt 14).

Some participants described experiences of *difficulties thinking* within the workplace as a direct result of their mental health problems. Specifically, the difficulties individuals experienced seemed to be due to impaired cognitive functioning and for some, these difficulties occurred because of hallucinations such as hearing voices in the workplace:

> *"When I was working and I was getting the voices in my head, you had to stick it out all day, you couldn't get up and walk out and it got a bit much"* (Pt 6).

Many of the participants described *difficulties interacting with colleagues* where participants did not 'get on' socially with one or two colleagues at work, at one end of the spectrum; to participants not 'getting on' with anyone in the workplace. Participants indicated that this was a lonely position to be in at work:

> *"You don't get anybody, don't make friends out there, not in the work place..... usually having to deal with people you work with I find, you can choose your friends but you can't choose your family and you can't choose your workmates. That's not that I've got a problem with people, I might come over like that, it's not"* (Pt 13).

A few participants described *difficulties accepting authority* within the workplace in terms of having to 'take orders.' Reactions to the imposed authority within a hierarchical work environment seemed to be based on aggression, violence and anger

which indicates that strained relations may have existed between participants and their line managers/ employers:

> *"I wasn't very good at taking orders from anyone, I've got a sensitive spot that anybody who tells me what to do I react violently that was because of an over-strict father, cruel father who didn't know the meaning of the word discipline"* (Pt 5).
>
> *"(I've got a) short fuse get annoyed very quick, didn't like authority"* (Pt 10).

As well as this, many participants experienced problems in the workplace which resulted from colleagues around them namely *experiencing discrimination; experiencing bullying;* and *experiencing physical abuse;* all of which were common among participants. One participant described his work experiences through *experiencing discrimination* which had a negative impact on his mental health:

> *"Well I had a disastrous time when my mental health was used against me that made me, slightly depressed now, which any normal person would be, but my case it's a bit more difficult"* (Pt 12).

Other participants described work experiences through *experiencing bullying*:

> *"They played a trick on me in work so I left there. They were all staring at me in work so I left and didn't bother going back. It was a bit cheap it was; I didn't get on with them"* (Pt 4).

One participant described the extent to which bullying developed into *experiencing physical abuse:*

> *"I went back to work too early and this horrible person pushed me off a ladder"* (Pt 2).

The discriminatory attitudes and behaviour from colleagues in the workplace ranged from being treated unfairly at work, to the extreme of actually *experiencing physical*

abuse. Some participants concluded that the prejudice directed towards them was because they experienced mental health problems. Individuals in this study described how discrimination experienced towards them in the workplace had a negative impact on their mental well-being and others perceived bullying as the catalyst which forced them to terminate their employment position.

In summary, the data demonstrated that following the onset of mental health problems, the individuals in this study described their 'working lives' as stressful, lonely and fraught with difficulty. Participants described numerous difficulties they experienced at work, some of which were directly related to their mental ill-health, and they also described the prejudice and stigma they faced in the workplace because of their mental health problems. As a result of the difficulties participants experienced at work and in the absence of any notable employment support, it is comprehensible that the individuals with mental health problems in this study found employment a struggle to maintain, following the onset of mental ill-health.

5.2.3 The transition to unemployment

The ongoing struggle participants in this study experienced to try and maintain their employment positions, resulted in a downward spiral from being employed to becoming unemployed. The work experiences described by participants following the onset of mental health problems were characterised by *difficulties at work* and the absence of support from employers and external agencies contributed to the downward spiral to becoming unemployed. The *transition to unemployment* was characterised by extended periods of sickness absence from work, failed attempts to return to employment, followed by periods of hospitalisation.

Whilst participants were struggling to maintain their employment positions and were experiencing *difficulties at work*, they did not receive any emotional or practical support within the workplace. Participants described having *unsupportive employer/ colleagues* and following disclosure about their mental health problems, participants described the reactions of employers and colleagues which included disinterest and disbelief. For some, this lack of support was perceived to be related to misperceptions and prejudice within the workplace, as well as a lack of awareness and misunderstanding about mental health problems. For others, this led to a belief that terminating their employment position was the only option:

> *"He didn't ask me any questions about it, he just told me to get on with it"* (Pt 7).

> *"I think they thought I was (lying) to be honest with you, that's the impression I got, you know when I bumped into people from time to time. that's how people are, they think the worst.....that made it quite hard, behind my back, you know they didn't believe it at all, so that made it difficult going back because you know, you know what people are like. To be honest with you, I haven't had a great deal of time for people like this"* (Pt 13).

> *"(He) just told me to go back to work, well he didn't understand.... I wish I didn't quit it now, looking back and talked my boss round to giving me time off but, he wasn't having any of it, it was the only option really. I regret quitting in the end"* (Pt 14).

Several participants also described a *lack of external employment support* from outside agencies, beyond the workplace. All the participants in this study were receiving mental health support from at least one organisation, yet they were not receiving employment or vocational support from health professionals, mental health organisations or job centres as demonstrated below:

> *"I was seeing my local doctor and he was giving me sick notes all the time"* (Pt 14).

> *"I just soldiered on that's all. People get breakdowns today; they don't get help from anybody. They are just left in the corner they are. I have seen it so many times before. They didn't know how to help me so they didn't, psychiatrists, nobody"* (Pt 15).

The lack of support from health professionals in particular, demonstrates low expectations of people with mental health problems in terms of their employment potential. Participants with mental health problems in this study indicated feelings of hopelessness in relation to the support they received from health professionals, reinforcing the belief that they are not worthy of being employed:

> *"It's just when I was living up the Rhondda, (a mental health professional) helped me with finding my college place and then he decided that work would be too much pressure for me again"* (Pt 14).

The downward spiral resulting in unemployment often meant that the point of actually *becoming unemployed* was an end result of a cyclical pattern of sickness absence from work, unsuccessful attempts to return to work, followed by a period of hospitalisation. An unsuccessful attempt to return to work described by one participant below was hampered from the outset, as following a period of hospitalisation due to mental ill-health, the participant's employer lost trust in him and doubted his ability to return to his previous job because of health and safety issues. Experiences such as these may have reinforced the belief in participants that they are not worthy or capable of being employed. This exasperating cyclical pattern of experiences often meant that the actual point of *becoming unemployed* was a particularly low point for participants:

> *"I worked in noisy places and when I finished; I had a lot of noise in my head"* (Pt 3).

"Uh, well from what I can remember of it, I wasn't the same worker, I was on injections for a year when I was working, I was depressed and fed up and when they gave me redundancy, I was happy like....I had a breakdown, went to hospital and then went back to work for a year... The first time, I was only in hospital for 6 weeks. I had another breakdown and I was in hospital for 6 months....they couldn't pay me sick pay anymore, so they gave me £1000 redundancy..." (Pt 6).

"I got laid off again (because of my) mental ill-health and the reason I didn't go back after is because I became ill. I got laid off again in (month) and became ill in (year)" (Pt 8).

"I was on the sick for about 12 months, they seen the doctors papers you know, obviously it was on my record. I tried to go back but it didn't pan out. I tried to go back after 12 months. (I was) stuck in an office then, you know health and safety, they were afraid because my job was working nights, working inside gas mains and they, from their point of view, insurance, they couldn't trust me, you know what I mean. If you've got somebody in there and I'm on a safety board, they are not going to do it are they. I was going in for a couple of days a week for a while" (Pt 13).

The reason for actually *becoming unemployed* differed among participants with the majority *becoming unemployed* as a result of their *mental ill-health*, although others did become unemployed as a result of *physical ill-health, end of employment contract, discrimination at work* and through *redundancy*. However, what was also clear from the data was that some participants were unsure about actually *becoming unemployed* and could not give a reason for their unemployment, because of the amount of time which had passed since then. The participant below demonstrates this, as he states that he is unable to remember how he became unemployed:

"I dunno, I was a lot younger then, can't remember...." (Pt 11).

Some participants explicitly stated that they had become unemployed as a result of their *mental ill-health* as described below:

"Bottom line, I was cracked, you know, pressure at home, I don't know what it was, pressure of work, everything, they just took me home one day...." (Pt 13).

"Because of my mental health, I resigned, ***stress*** *the doctor said it was originally, (which) lead to depression"* (Pt 14).

"I had a nervous breakdown" (Pt 15).

There were however, some participants who became unemployed under other circumstances, including *physical ill-health*, *end of employment contract*, *discrimination at work* and through *redundancy.* One participant described the experience of *becoming unemployed* as a result of *redundancy*:

"He took us into the yard one day and said I can't afford to pay you this week and the work is finished, I was like devastated, (it) took away my whole identity" (Pt 7).

Additionally, many participants became unemployed because of a combination of reasons which is demonstrated in the quote below as *mental ill-health* was often the catalyst which resulted in early retirement and *redundancy*:

"(I) retired through mental ill-health" (Pt 1).

Some of the reasons given by participants for *becoming unemployed* appeared initially to be unrelated to their *mental ill-health* however; it became clear that this may not be the case. In particular, one participant gave the reason for *becoming unemployed* as *discrimination at work*; however, it may be that the individual was being discriminated against as a result of his *mental ill-health*:

"Because they played a trick on me in work so I left there...." (Pt 4).

Another participant described how he became unemployed through *redundancy*; however, this was also related to his *mental ill-health* as described below:

> *"I had a mental breakdown..... I went into hospital, they couldn't pay me sick pay anymore so they gave me £1000 redundancy"* (Pt 6).

Cleary, the reasons for *becoming unemployed* may make a difference to the experiences participants had in relation to the *transition to unemployment.*

At the actual point of *becoming unemployed*, participants also described having an *unsupportive employer.* The participant below described the lack of support from his employer at the point when his employment position was terminated, which he felt was deserved, once again demonstrating the belief that he is unemployable:

> *"They just wanted me to go with minimum fuss and minimum of money obviously; you can't blame them for that, if you're not doing anything"* (Pt 13).

The experience of *becoming unemployed* generated a number of *feelings about becoming unemployed* among participants which were very mixed. At one end of the spectrum, participants described feelings of relief of not having to work any more. At the other end of the spectrum, participants described feelings of sadness, and even described a sense of loss, believing that they would never work again. These mixed feelings are described by one participant in the sample extract below:

> *"Half of me was happy and then half of me was thinking I'd never get another job"* (Pt 6).

In summary, the *transition to unemployment* experienced by participants in this study was characterised by a downward spiral to *becoming unemployed*, with

unemployment being the end result of an exasperating pattern of sickness absence from work, unsuccessful attempts to return to work, followed by a period of hospitalisation. This downward spiral to unemployment, along with a lack of emotional and practical support and low expectations from health professionals meant that the point of actually *becoming unemployed* was a particularly low point in terms of participants' mental well-being. Participants at this time expressed feelings of hopelessness and they harboured a belief that they were not worthy or capable of employment. It is with these feelings that participants entered a period of unemployment, and for some, long-term unemployment.

5.2.4 The experience of being unemployed

At the point which participants became unemployed, they were experiencing a particularly low period in their lives in terms of their mental well-being and felt hopeless and in despair. Having entered an extended period of unemployment and for some, long-term unemployment, participants' lives became characterised by *lack of activity*, a *fear of leaving the house,* a *fear of groups,* a *fear of change* and *social isolation.*

Participants described a distinct *lack of activity* in their lives. They spent a great deal of time alone, doing very little, other than in some cases, just smoking cigarettes. This indicates a lack of enthusiasm for life and participants seemed to lack abundance for life. Participants recognised that this lifestyle had a negative impact upon their mental well-being and is an unhealthy way to live:

> *"I think too much time spent on your own is bad for you, and you feel if you go out and do something it is beneficial"* (Pt 1).

> *"For ten years, I didn't do anything... (Now) I just sit here and smoke, it's ridiculous maybe a part time job would do me better, through the fact that I wouldn't be smoking all the time"* (Pt 6).

When participants were describing their lifestyles, it was also apparent that they had an overwhelming *fear of leaving the house* which would undoubtedly affect participants' ability to work and participate in normal day-to-day activities. Participants described the huge impact this fear had on their lives, to the point where their lifestyles were severely restricted. For some, leaving the house was something they wanted to do, but they felt constrained because of an intense fear, which led to frustration and despair:

> *"I very rarely go out apart from taking the dog for walks"* (Pt 5).
>
> *"I'm so paranoid, I can't even go to (the next town)"* (Pt 10).
>
> *"That's why I really want to get out (of the house), because if you don't do that, you just lie there going into decay"* (Pt 12).

Related to the *fear of leaving the house,* participants also described an intense *fear of groups* of people and crowds:

> *"I pass the college occasionally, I try to avoid it. I try to avoid it any how when there's a lot of people to be honest with you. The thought of going down there, walking into all that crowd would just freak me out totally. I know it's irrational but it's just the way it is. It's not the case of not wanting to, it's just the case of I just couldn't do it, I just couldn't walk you know, I just couldn't walk into all them people, just couldn't do it"* (Pt 13).

Participants also described a *fear of change* as they have become so used to the way in which they are living that a change in lifestyle is a daunting consideration:

> *"I'm so used to the way I'm living; I've been like it for years"* (Pt 8).

Not only do participants have a *lack of activity* in their lives and feel confined to the home, they also described feelings of *social isolation* where contact with others has been severely limited because of a confinement to the home:

> *"I've been here so long, I've lost my concentration, lost contact with people"* (Pt 9).

The *fear of leaving the house* led to *social isolation* and participants subsequently described a *need for social interaction* and a desire to get out of the house, meet new people and socialise.

In summary, the *experience of being unemployed* is characterised by a distinct *lack of activity* in participants' lives, a lack of enthusiasm and abundance for life, all of which have a negative impact on mental well-being. As a direct result of intense fears of leaving the house, groups of people and change, the lifestyles of the participants in this study were severely restricted, leading to frustration and despair. These factors have led to the individuals with mental health problems in this study to become socially isolated because of reduced social contact and spending so much time alone. This may have led to feelings of loneliness and reduced quality of life. All the participants in this study were at the end of the **pathway to unemployment**, namely they were subsumed by the *experience of being unemployed* and reminisced about the journey to unemployment from this position.

5.3. Higher order categories

The two higher order categories which emerged from the data namely: *meaning of work* and *identity* are directly related to each other as it became evident that for the individuals with mental health problems in this study, *identity* is central to the *meaning of work.* The *meaning of work* and *identity* are also directly related to the lower level or descriptive categories as the identities taken on by participants namely *the valued employee* and *the devalued 'mental patient'* were adopted at different stages of the **pathway to unemployment.**

5.3.1 The meaning of work

Although all participants within this research study were unemployed men, who had been unemployed for varying amounts of time, *the meaning of work* to participants emerged from the data. When describing their attitudes towards work, it became evident that despite being unemployed, work still had significant meaning to participants. The people with mental health problems in this study described the *meaning of work* to them as unemployed individuals, reflecting on previous work experiences, as well as using their unemployed status as a comparison to their previous work experiences. When reflecting on previous work experiences, several subcategories emerged from the data which describe *the meaning of work* to participants.

The subcategories which emerged from the data in relation to the *meaning of work* run through all four descriptive categories. However, it was also clear from the data

that the *meaning of work* is central to *identity* and as participants' *identity* altered throughout the **pathway to unemployment**, so did the *meaning of work* to participants.

Despite the fact that the majority of participants could freely describe the difficulties they experienced at work, participants also described several positive features of work which emerged from the data. A subcategory which emerged and was highlighted by the majority of participants was that work *improves self concept* in terms of giving individuals pride, self respect, gaining respect from others, improving self-esteem and confidence, and making individuals feel useful and valued:

> *"(Work improves your) self-esteem, and self confidence and it makes you feel useful"* (Pt 5).
>
> *"People respect you more if you have a job, I think it is important"* (Pt 6).
>
> *"It makes you feel a better person inside, it makes you feel like you're doing something with your life, it's hard work doing nothing, you might not believe it, you get really bored* (Pt 7).
>
> *"It gives you a bit of pride...."* (Pt 13).

A further subcategory which emerged from the data was that work *benefits mental health* as work *occupies the mind, forces activity* and *relieves boredom.*

Participants described how work *occupies the mind* which was considered to be particularly important for individuals who have mental health problems. For some, work, or the absence of work, took on a greater importance when they became unwell and participants seemed to perceive work as being potentially beneficial to

mental well-being at this point in time. Others described work as a distraction from their mental ill-health and therefore potentially beneficial to their mental well-being:

> *"It takes your mind off things.... when I'm at the brink of being unwell, that's when I should be in work to keep my mind off things"* (Pt 8).

> *"It gives you less time to think about it (mental ill-health) if you are working"* (Pt 13).

Work also *forces activity* and *relieves boredom* with the consequence of *benefits mental health*. From participants' perspectives, these subcategories were not restricted to paid work per se, but on occasions, included participation in training, education and other work related activities. Participants gave many reasons through which the forced activity and relief of boredom *benefits mental health* as work forces social interaction, forces people to leave the house, provides routine, provides a focus and a distraction from thinking about their mental ill-health.

> *"I think too much time spent on your own is bad for you and you feel if you go out and do something it is beneficial. Some kind of activity is important for mental health"* (Pt 1).

> *"It breaks up the day, it's not doing me any good sitting here smoking all day, like I say, you get satisfaction out of working"* (Pt 6).

> *"I think it would help me if I had another job, something to do, cos it gets boring, get down in the dumps being here on my own"* (Pt 9).

> *"I think it's necessary to, for somebody to be doing something that they are interested in, they must like what they are doing and must be interested. Well if they like... there's an interest but if you're not doing that you can then only go on to bad mental health.... at least it's doing something, it's getting out of here for an hour getting up there to the library....that's why I really want to get out, because if you don't do that you just lie there going into decay....that stops that (being in work). You're mind is concentrating on one thing, at least if you like what you're doing, its no use having something to do that you don't like because you're not going to do a good job of it. You've got to like doing it... It's very important to me, well doing a course or some type of work"* (Pt 12).

One participant also highlighted how he tries to dissociate himself from the *identity* of someone who is unemployed with no activity in his life:

> *"It's (work is) better than sitting (down) all day, in it, obviously, you know, got too much time to think, haven't you? You know I'm not one of these people that are happy to sit round all day, you know, I try not to think of myself like that"* (Pt 13).

Participants also considered s*ocial interaction* to be a meaningful aspect of work in itself. The *social interaction* gained from working was considered to be a way of reducing the *social isolation* and loneliness felt by participants:

> *"The companionship of your fellow workers"* (Pt 1)
>
> *"Atmosphere, talk about football, social things"* (Pt 4)
>
> *"I thought I'd go out and kill two birds with one stone, I'd have company, make new friends, I'd be helping myself as well"* (Pt 5).

Providing financial incentives was also identified by participants as a meaningful aspect of work. However, this was somewhat contingent on employment being well paid and extremely well paid in some cases, as described below:

> *"If you are earning £1000 a week it's ok, if not it's a waste of time. You can't pay all your ... bills and everything. It's £170 a week in this place"* (Pt 15).

Whilst *providing financial incentives* emerged as a positive feature of work, *financial disincentives* also emerged as a negative feature of work; in particular, participants considered a loss of benefits to be negative:

> *"Well I'd have to have pretty good money to pay for this place, pay the bills*" (Pt 3).
>
> *"I wouldn't mind paid employment as long as it didn't interfere with what I'm on at the moment, my benefits*" (Pt 5).

> *"I don't want to jeopardise anything now ..... but benefits. If I was to go to work I'd lose all my benefits, housing, I would have to earn about £300-00 per week to come out on top. Where am I going to find a job like that?"* (Pt 8)

> *"I couldn't afford, even if I managed to get a job, who the hell is going to give me a job at the moment, I couldn't work for £4 an hour I couldn't afford it, I'd lose this flat, you know so at the moment I'm just thinking me and the dog at the moment, I know it sounds stupid but that's just the way it is"* (Pt 13).

This suggests that participants in this study considered themselves to be stuck in the benefits trap whereby they believed that they would be no better or worse-off financially if they became employed. This is particularly important for people with mental health problems who have to pay for *supported* housing.

In all of the interviews, participants described numerous positive features of work and related work directly to positive effects on mental health. The beneficial effect work has on mental health was also contrasted with feelings about their current *experience of being unemployed.* The negative aspects of being unemployed were often described as a contrasting position to the positive features of work and the *meaning of work* to participants. Participants described the *meaning of work* to them by considering their current situation of being unemployed where their lifestyles were characterised by *a lack of activity*, a lack of enthusiasm and abundance for life, *social isolation* and loneliness, all having a negative impact on their mental well-being. Participants considered the *meaning of work* to them within this context and by explaining that their current situation is not healthy or beneficial to their mental health, thereby indicating a perception that work could only improve the situation:

> *"It breaks up the day, it's not doing me any good sitting here smoking all day, like I say, you get satisfaction out of working"* (Pt 6).

"I think it would help me if I had another job, something to do, cos it gets boring, get down in the dumps being here on my own" (Pt 9).

Throughout this research, participants made hugely uplifting statements about the *meaning of work* to them. In particular, participants believed that work *benefits mental health* in numerous different ways such as improving their self concept and reducing *social isolation.* The participants in this study also perceived work as an activity which would give them something to occupy their minds, and something to focus on which provides a distraction from thinking about their mental ill-health. Work was also considered to force activity and relieve the boredom which the individuals with mental health problems in this study experienced in their day-to-day lives. Participants consistently described the *meaning of work* to them in the context of their current unemployed position, characterised by a *lack of activity* and *social isolation.* This suggests the recollection of the positive aspects of work from their past work experiences, in contrast to their current lifestyles. It could also suggest a perception of work which has become romanticised over a period of time when considering the unhappiness and despair in their lives at present. As participants held a belief that they are not worthy or capable of employment, this could also reflect the experience of wishing for something which is perceived to be beyond their reach.

Whilst participants' considered the *meaning of work* to them, references were continually made to *identity.* What became clear throughout the analysis is that *meaning of work* is central to *identity* and that as participants' experiences changed as they travelled through the **pathway to unemployment**, their identities also changed.

5.3.2 Identity

Two distinct identities emerged from the data namely: *the valued employee*; and *the devalued 'mental patient.'* Whilst these two identities emerged strongly from the data, there were indications of stages in the transition between being *the valued employee* to becoming *the devalued 'mental patient'* as feelings of distress, frustration, desperation and hopelessness emerged in between.

The subcategories which emerged from the data in relation to *identity* run through all four descriptive categories. However, *the valued employee* was clearly evident at the beginning of the **pathway to unemployment** and *the devalued 'mental patient'* was clearly evident at the end of the **pathway to unemployment**. In addition, it emerged from the data that the *meaning of work* is central to *identity* and participants' *identity* was heavily influenced by work and it's meaning to them.

The valued employee

The identity of the *valued employee* was observed at the top of the **pathway to unemployment**, at the point where participants were working, prior to the onset of mental health problems. Whilst participants were employed (prior to illness onset), participants had a *strong work ethic* and *worked hard*. They experienced a strong level of *work contentment* and so were content with their working lives. Their lifestyles were meaningful and *full of activity*.

As well as feeling content, participants also considered themselves to be *competent at work*, and as a result, felt *confident* in the work they were doing:

"(work) can be a pain on times, (but) you get great joy out of climbing the hurdles and your confidence can slowly but surely (grow)" (Pt 5).

As a result of these factors, participants took on a valued social identity as whilst describing the *meaning of work* to them, it was clear that participants felt *valued* whilst in employment as they felt worthwhile, useful and employable.

"(Work gives you a) feeling of value" (Pt 2).

"It gives you self respect, makes you feel useful, builds up your self-esteem" (Pt 5).

The devalued 'mental patient'

The identity of the *devalued 'mental patient'* was observed at the bottom of the **pathway to unemployment**, at the point where participants were experiencing unemployment, following the onset of mental health problems.

When participants became unemployed, their lifestyles became less meaningful to them and were characterised by a *lack of activity*, a *fear of leaving the house*, a *fear of groups* and a *fear of change*. All of these lifestyle characteristics led to feelings of *social isolation.*

As a result of these factors, participants took on a devalued social identity as whilst describing the *meaning of work* to them, it was clear that participants felt totally *devalued* as an unemployed individual with mental health problems, as they felt useless:

"At the moment, I feel useless, I'm not doing anything to occupy my mind" (Pt 5).

Participants had a strongly perceived *identity* of themselves as someone who is worthless and who does not contribute to society due to inactivity. Participants appeared to actively dissociate themselves from this *identity* as one participant described how he dissociates himself from the perceived *identity* of someone who is unemployed with no activity in his life:

> *"It's (work is) better than sitting (down) all day, in it, obviously, you know, got too much time to think, haven't you? You know I'm not one of these people that are happy to sit round all day, you know, I try not to think of myself like that"* (Pt 13).

The impact of mental health problems on identity

Following the onset of mental ill-health, the *impact of mental health problems* on each of the individuals involved in the study also affected them to the extent that they had adopted the *identity* of the '*mental patient.*'

When describing their experience of mental health problems, it emerged from the data that participants' *identity* as a *'mental patient'* were based on *externally generated perceptions of their mental health problems* and participants used 'labels' by which their illness is defined. Specifically, participants in this study described their experiences of mental health problems by using *externally generated perceptions of mental health problems* through definitions such as *defined by diagnosis; defined by treatment*; or *defined by health professionals.* One of the individuals in this study clearly defined his experience of mental health problems through being *defined by diagnosis:*

> *"Very awful, I have got schizophrenia...and anxiety"* (Pt 15).

This could be representative of being given a diagnosis of an illness, *defined by health professionals,* which labels an individual but which does not necessarily reflect the individual's true experience as is certainly the case with this participant:

> *"I keep saying I don't have a mental health problem, so it's up to the doctor to tell me if I've got a mental health problem"* (Pt 4).

The fact that participants considered their illness based on imposed definitions such as *defined by diagnosis; defined by treatment*; or *defined by health professionals,* also demonstrates a sense of their own opinions and experiences being *devalued.* The participant above described how a diagnosis had been imposed upon him, seemingly without input from him. As well as this, participants who had been given a diagnosis and labelled by this had almost *become* the mental illness itself and participants described their experience of mental health problems by using medical terms. This indicates that participants' illnesses have almost subsumed them to the extent that their diagnosis is what identifies them. Participants appeared to identify themselves as a '*mental patient*' suggesting that they are not human beings in their own right, as opposed to the *identity* of a person who **also** has mental health problems.

Participants in this study had a degree of *insight into their mental health problems*, with some individuals describing their mental health problems in terms of being *under control.* This suggests that their experience of mental health problems fluctuated but can be kept *under control*; presumably by the appropriate treatment such as pharmacological (medication) treatment and/or psychological (therapy) treatment. Other participants considered their mental health problems to be

fluctuating suggesting a *cyclical nature of mental ill-health* which indicated that participants seem to experience cycles of ill-health where for a period of time, their mental health is *under control* which is then followed by a period of ill-health.

> *"I've been diagnosed with schizophrenia now since the beginning of February, but I feel it's under control now, where as when I was in hospital, it wasn't under control and I needed people watching me all the time"* (Pt 14).

> *"Sometimes up, sometimes down but when I do get depressing bouts, they are very severe. What I normally do is go along with it until I come out the other end. I just lie on the couch or go for a walk, it fluctuates, highs and lows"* (Pt 5).

> *"At the moment, good days and bad days.... You never know how it is going to be.... Not too bad today"* (Pt 13).

It also became clear that participants viewed their mental health problems from a *medical perspective* as if the experience of mental health problems is an illness with a limited lifespan and a cure, rather than a long-term disability. Participants in this study used medical language to describe their experience of mental health problems such as the word 'suffer' and described strategies they have used to 'get better.' Clearly this has an impact on the *meaning of work* for participants as they describe the need to 'get better' before considering employment:

> *"If I get better I would (work again), same job if my mental health was better"* (Pt 3).

> *"I would (return to previous type of work) but I can't on medical grounds..... I'd love to go back to work if I was well enough... I've used my own money to try and get better.... If I had my health, I'd love to go back to work"* (Pt 10).

Participant 10 quoted above clearly considered his mental health problems from a *medical perspective* as he sees mental illness as an illness with a specific cure, as opposed to a disability which can be managed effectively. The fact that he referred to

using his own money to "get better" suggests that he has pursued some form of treatment beyond the NHS, which he considered to be a cure for mental illness.

Both the impact of unemployment and the *impact of mental health problems* have led participants to take on an *identity* of the *devalued 'mental patient'*. This has had a major impact upon participants' self concept as participants described a *lack of confidence* and a *lack of motivation* for life:

> *"I can't be bothered to do anything"* (Pt 8).
>
> *"Confidence is a big thing with me, I know I can do it, it's just a matter of getting myself up to it and going through it"* (Pt 14).

5.4. Relationship between the higher order categories

5.4.1 The meaning of work and identity

Identity is central to the *meaning of work* for participants. Both the *valued worker* and the *devalued 'mental patient'* considered work to have a positive impact upon self concept and mental health. The loss of work to the *valued worker* following unemployment clearly had a profound impact upon *identity* as described below:

> *"He took us into the yard one day and said I can't afford to pay you this week and the work is finished, I was like devastated, (it) took away my whole identity"* (Pt 7).

Participants had goals for *future work related activities* as they had *educational/ training aspirations,* they *want to work* and had *work aspirations:*

"I wouldn't mind doing a degree in English; I'd like to return to studying full-time" (Pt 5).

"Well I wouldn't mind going on an upholstery course, learn to make settees because I never done settees..... Upholstery, I wouldn't mind going on a course to get back into it" (Pt 6).

"I should sit exams, get qualifications, I want a certificate, do you know what I mean, to achieve.... It's really for employment situations, I want it" (Pt 12).

"I don't mind working as a caretaker, data entry, computer, working with pottery anything really....like I was doing, where I can be helpful to someone even if it was only a security.....Well, I'm going to (look for work) yeah, I want to, I want to do that" (Pt 12).

"I want a grant to start my own business" (Pt 4).

"I wouldn't mind working in the hospital because I'm interested in people's good health and welfare. I wouldn't mind being a psychiatric nurse or a general nurse" (Pt 5).

"I like using computers that's what I eventually want to get back into and get a job in computing.... very conscientious, very diligent" (Pt 14).

However, it is clear that *identity* does have a huge impact upon the *meaning of work* as the *devalued 'mental patient'* is fraught with *fears about work:*

In particular, participants with their current *identity* (the *devalued 'mental patient'*) had an overwhelming *fear of becoming unwell* if they were ever to go back to work, which acted as a barrier to seriously considering future vocational activities:

"I had a mental breakdown, it worries me a bit about working that it can come on at anytime, you can't feel it coming on, you start tremoring and then you get voices in your head, they surround you and you won't go out, I suffer with schizophrenia see...half of me is worried about working if I have a breakdown again" (Pt 6).

One participant described how this overwhelming *fear of becoming unwell* was reinforced by the low expectations of people with mental health problems, in terms of their employment potential, which are held by mental health professionals:

> *"It's just when I was living up the Rhondda, (a mental health professional) helped me with finding my college place and then he decided that work would be too much pressure for me again and I'd end up bad again and back in hospital"* (Pt 14).

The *devalued 'mental patient'* also had a *fear of stress* which could lead to the *fear of becoming unwell* and so participants actively avoided stressful situations, opting for work related activities which were not likely to cause any distress:

> *"I'm quite happy just doing a bit of carpentry, there's no pressure involved if you don't feel up to doing anything you can just talk to the other workers and have a cup of tea and come and go as you please, no pressure"* (Pt 1).

> *"(I would like to return to this type of work).... office job definitely, but not in a factory when there's pressure on production and stuff, it's too high pressure for me in the end"* (Pt 14).

The *devalued 'mental patient'* also has an overwhelming *fear of discrimination* in the workplace:

> *"All I know is to go to the labour exchange (job centre), and I mean I don't know what they are going to say or turn round, and say to me, no, we don't plug people with mental illness or what....I have to have obviously someone to be able to say look this is what he can do and this is his record and he is stable, you mean someone taking on doesn't want to think is this fellow going to go off his head, or he is going to be torn up, or is he (on the) smoke or is he on the drink. You know all those, they don't want their problems so you need someone to say this is the situation"* (Pt 12).

Furthermore, the *devalued 'mental patient'* is also fraught with concern about their *capability to work* as all the participants in this study made references to their *capability to work*, and this extended to capability to participate in training/

educational courses. The majority referred to themselves as *incapable of work* and the *identity* of the *devalued 'mental patient'* had a major impact upon the way in which participants considered the *meaning of work* to them:

> *"I would (work) but I can't on medical grounds"* (Pt 10)
>
> *"I would like to (work) but I can't. It is physically impossible and mentally really... work isn't important to me anymore because I can't work, therefore it isn't important"* (pt 15).

The fact that participants saw their mental ill-health from a *medical perspective* also impacted upon this as participants described the need to 'get better' before considering employment:

> *"If I get better I would (work in the future), same job if my mental health was better"* (Pt 3).

The *impact of mental health problems* and past work experiences on the *devalued 'mental patient'* have impacted upon the *meaning of work* to participants and defeated the positive spirit held by the *valued worker*. The experiences whilst on the **pathway to unemployment** also impacted upon the *meaning of work* as *experiencing discrimination*, *experiencing bullying*, *experiencing physical abuse*, having *unsupportive employers/ colleagues*; and a *lack of external employment support* have lead to the *fears about work* and undoubtedly impacted upon self concept, leading to feelings of being *incapable of work.*

5.4.2 An identity shift

The employment experiences which participants had at each of the stages on the **pathway to unemployment**, clearly modified participants' self identity.

The identity of the *valued employee* was observed at the top of the **pathway to unemployment**, where participants were working, and prior to the onset of mental health problems. At this point, participants had *strong work ethic*, *worked hard*, experienced *work contentment* and their lifestyles were *full of activity*. In terms of their self identity, participants were *confident* in their work and felt *valued*.

However, as participants' experiences followed the clear temporal continuum down the **pathway to unemployment**, their experiences impacted upon their feelings, emotions and perceptions of their environment to the extent that they experienced a change in their self concept.

At the bottom of the **pathway to unemployment**, where participants were experiencing unemployment, the identity of the *devalued 'mental patient'* was observed. At this point, participants' lifestyles were characterised by a *lack of activity*, a *fear of leaving the house*, a fear *of groups*, a *fear of change* and *social isolation*. In terms of their self identity, participants had adopted the *identity* of the '*mental patient*,' and described a *lack of confidence*, a *lack of motivation* and felt *devalued*.

Work is central to *identity* and as participants travelled down the pathway from *employment experiences* (prior to illness onset) to the *experience of being unemployed*, their self identity changed. This resulted in an *identity shift* as unemployment progressively became a larger part of their lives.

One participant demonstrated this shift in *identity* from a *valued worker* to a *devalued 'mental patient*:'

> *"It (work) gives you self respect, makes you feel useful, builds up your self-esteem, builds up your confidence, it can be a pain on times, you get great joy out of climbing the hurdles and your confidence can slowly but surely (grow), it makes you feel useful, at the moment I feel useless, I'm not doing anything to occupy my mind, I got fed up of crosswords"* (Pt 5).

5.4.3 An identity struggle

What also emerged from the data is that participants experienced an overwhelming *identity struggle* between the *valued worker* and the *devalued 'mental patient'*.

Whilst the *devalued 'mental patient'* initially considered himself to be *incapable of work*, as the interviews progressed, participants began to demonstrate that they are actually *uncertain about capability* by using phrases such as *I don't think I'd be able to.....:*

> *"I don't think I'd be able to.....I don't think I'd be able to return to full-time employment because I'm on quite a lot of medication and I don't think I could get up in the mornings and do a proper job like.... I don't think I could cope with it..... I don't think I'm capable of going back into full time employment"* (Pt 1).
>
> *"I don't think I'd be able to get a full time job.... I don't know if I'd be able to do it or not..... I don't think I'd be able to do it love"* (Pt 3).
>
> *"I'd like to return to studying full-time, that's if I could cope with it but that's debatable in view of my illness. I could imagine me in a state of depression and not feeling like doing any work, that's the big hiccup but all being well I wouldn't hesitate"* (Pt 5).

Some participants were aware of their fluctuating perceptions in relation to their capability to work as described below:

> *"My mind changes (in relation to capability to work), one minute I feel like allright and then other days I feel sluggish"* (Pt 6).

For the majority of participants who were *uncertain about capability*, *future work is contingent on capability,* therefore despite the fact that many participants *want to work,* some considered this to be an unrealistic option, or more specifically, they would like to work in the future, provided they felt capable of doing so. This feeling of future work being contingent on capability is demonstrated by the quotes below:

> *"Yeah (I would like to be in paid work sometime in the future), if I was capable of holding a job down"* (Pt 6).
>
> *"(I) don't feel I'm up to it yet, getting another job, in the future definitely"* (Pt 14).
>
> *"If I had my health, I would love to go back to work...I'd love to go back to work if I was well enough"* (Pt 10).

This perception that *future work is contingent on capability* is also synonymous with the view of participants' mental health problems from a *medical perspective* as it suggests that once their mental health problems 'get better,' then participants would become capable of work.

The fact that participants were *uncertain about capability* is extremely clear when looking at the emerging data **within** interviews. Whilst some participants were certain that they consider themselves to be absolutely *incapable* of work, others were *uncertain about capability.* These participants stated that they do *want to work* but are *uncertain about their capability* to do so. In particular, individual participants contradicted themselves throughout their interview demonstrating their *uncertainty about capability* and their confused state of mind.

One participant (Pt 2) initially stated that he is incapable of completing a training/ educational course to help find work. However, he also stated that he would like to attend a training course to help find work and listed the training courses he would like to attend. As the interview progressed, participant 2 became increasingly enthusiastic about the prospect of going back to work. When asked whether he would like any particular support to help find work, he warily said yes adding a contingency that if he felt able to do a job. Yet he also asked for help and advice to find a job and towards the end of the interview, it emerged that he had recently engaged in job-seeking behaviour by asking an acquaintance for work, but to no avail.

Another participant (Pt 11) stated that he would not like to return to the type of work he was doing in the past and stated that there is no work that he would like to do. However, as the interview progressed, participant 11 became more positive about the prospect of going back to work. When asked whether he would like to be in paid work in the future, he said yes immediately. He also said that he would have to think about it but continued to say yes. However, towards the end of the interview, he suggested that he is unsure again as he hasn't had a job for so many years that it is difficult.

A third participant (Pt 14) stated almost immediately that he was told by a health professional that work is too much pressure for him and he therefore, doesn't want to go back to work. However, as the interview progressed, participant 14 became increasingly enthusiastic about the prospect of going back to work. When asked if he

would like to return to his previous type of work, he said yes. He also had employment aspirations for work he would like to do in the future.

Whilst describing the *uncertainty about capability* to work, participants used language and phrases to demonstrate uncertainty which were used repeatedly throughout individual interviews, almost inviting the investigator to contradict the statements. Throughout the interviews, participants appeared to be seeking reassurance that they **are** capable of working and this was evident in several interviews.

Participants in this study experienced a tension between wanting to work and being uncertain about their capability to work which demonstrated an *identity struggle* between the *valued worker* and the *devalued 'mental patient.'* On the one hand, participants strived to be employed, to be *competent at work*, to be *confident* and content with their working lives, just like the *valued worker.* Whilst on the other hand, the overwhelming fears of the *devalued 'mental patient'* prevented them from seriously considering this as a realistic option.

Despite the fact that all participants were interviewed whilst at the bottom of the **pathway to unemployment,** when their identities were firmly rooted as the *devalued 'mental patient,'* the positive spirit of the *valued worker* emerged at times during the interviews. The *identity* of the *valued worker* was naturally evident when participants were talking about their *employment experiences (prior to illness onset).* However, the *valued worker* also emerged when participants were talking about the *meaning of work* to them, particularly when they were outlining the positive features of work

such as *improves self concept* and *social interaction*. The positive spirit of the *valued worker* was also evident when participants were talking about the desire to work in the future.

However, the identity struggle between the *valued worker* and the *devalued 'mental patient'* was also clear throughout the interviews as whilst the positive spirit of the *valued worker* emerged at times, this was overshadowed by the contrasting *identity* of the *devalued 'mental patient.'* Whilst participants strived for the characteristics of their former lifestyles which were full, active and content, the overwhelming fears which characterised the identity of the *devalued 'mental patient'* such as a *fear of leaving the house* and a *fear of change* dominated participants' thoughts which resulted in the *identity struggle.*

This *identity struggle* between the *valued worker* and the *devalued 'mental patient'* had the effect of causing confusion for participants and also led to participants experiencing a *detachment from work* which acted as a barrier to considering future work in any serious way. When discussing the importance of work to them, participants made comments such as:

> *"Well, at the moment I don't think anything, not with my mental health"* (Pt 3).
>
> *"I dunno (whether I'd like to return to this type of work, I don't think about it"* (Pt 8).
>
> *"I haven't really thought about it, I dunno really.....I would have to think about it, yeah yeah, wouldn't mind doing painting and decorating.... I haven't had a job for so many years, that it's difficult. Well I'm not sure really give me something to occupy my time, if I did work... even if I wasn't paid you know, yes"* (Pt 11).
>
> *"It's (work's) important to most people, suppose it's important to me, yeah. I can't really think about it at the moment*" (Pt 13).

Participants also referred to a former working life that was no longer relevant to their own:

> *"I enjoyed my working life"* (Pt 1).

Participants clearly considered employment as something they did when they were well; as if work is something they associated with their former life as the *valued worker*, in a previous lifetime. Now that participants had become unwell and had adopted the identity of the *devalued 'mental patient,'* work was almost considered to be an unrealistic aspiration. Participant 1 referred to his 'working life' in a disconnected manner as if he was talking about another person. It was almost as if the *identity* of himself as a *devalued 'mental patient'* was far removed from that former *identity* of himself as a *valued worker.* This *detachment from work* was common among participants.

Many of the participants in this study had been unemployed for a number of years and the *experience of being unemployed*, along with the adoption of the devalued *identity* as a *'mental patient'* had led them to doubt their former self as a *valued worker.* As a consequence, when describing the *meaning of work*, participants experienced a subconscious struggle between the two identities of the *valued worker* and the *devalued 'mental patient'*. This struggle also manifests itself as a struggle between the well self and the ill self as the adoption of these two identities span the period of time prior to, and following illness onset. The struggle between the well self and the ill self also demonstrates an *identity struggle* between the former self and the current self; the strong self and the vulnerable self; and the confident self and the under-confident self. The *impact of mental health problems* has meant that the

participants in this study have located themselves within two identities, namely in the past and in the present.

Chapter 6- Discussion

By using a qualitative research method; a grounded theory approach; this study aimed to explore the employment experiences, needs and aspirations among unemployed men receiving mental health support in the South Wales Valleys.

This study found four lower level, or descriptive, categories, namely employment (prior to illness onset); employment (post illness onset); the transition to unemployment; and the experience of being unemployed. The characteristics of each of these categories were also identified including that the individuals with mental health problems in this research have a strong work ethic, worked hard and were competent at work. The people with mental health problems in this study experienced difficulties at work, work-related stress and discrimination in the workplace. They also had unsupportive employers/ colleagues and a lack of external employment support. The experience of being unemployed was found to be characterised by a lack of activity, a fear of leaving the house and social isolation. This research also found that the individuals with mental health problems in this study who became unemployed followed a pathway of experiences which impacted upon the meaning of work to them and their self concept.

In addition, when looking at the employment experiences, needs and aspirations of the unemployed men with mental health problems in this study, this research also identified two higher order or analytic categories namely: meaning of work and identity. This research found that work still has significant meaning for the participants with mental health problems in this research as it improves self concept

and benefits mental health. A further finding is that the meaning of work is central to idenity and two distinct identities emerged namely the valued employee and the devalued 'mental patient.' The impact of mental health problems was also found to affect identity. This research found that the participants with mental health problems had insight into their mental health problems, which they viewed from a medical perspective. The people with mental health problems in this research also had educational/ training aspirations; they want to work and had work aspirations but also had fears about work such as fear of becoming unwell and fear of discrimination. An identity shift was also identified in this research between the valued worker and the devalued 'mental patient' and participants experienced an identity struggle between the two identities. In particular, the devalued 'mental patient' considers him/herself to be incapable of work, uncertain about capability to work and has a detachment from work.

Whilst this research was carried out with unemployed men receiving mental health support living in the South Wales Valleys, it may be that these results are generalisable to unemployed individuals with mental health problems in general, as well as to unemployed individuals in other populations. The results from this research have led to the generation of a substantive theory which is outlined below and is specific to the situation in this research. However, this theory may also be relevant to unemployed individuals with mental health problems in general, as well as to unemployed individuals in other populations. Further research is needed to confirm whether the theory fits and works with unemployed people with mental health problems in general. However, this research proposes that these findings and the resulting theory are generalisable beyond the scope of this research and that the

findings have wider implications for unemployed people with mental health problems.

The proposed theory resulting from this research is that individuals with mental health problems who become unemployed follow a pathway of experiences which impact upon the meaning of work to them and their self concept. Following the onset of mental ill-health, the impact of mental health problems also affects identity. This results in an identity shift between the valued worker and the devalued 'mental patient.' When considering the meaning of work as the devalued 'mental patient,' individuals with mental health problems also experience an identity struggle between the former valued worker and the current devalued 'mental patient' which could also be re-attributed to a struggle between the well self and the ill self.

The findings from this study support and expand upon previous research in this field, contribute new knowledge to this area and have implications for future research. In addition, the findings have a number of major implications for policy and practice and in particular for mental health professionals, mental health services, vocational rehabilitation services and employers.

6.1. Pathway to unemployment

This research clearly demonstrated that people with mental health problems follow a pathway to unemployment from employment experiences prior to the onset of mental ill-health, through to the experience of being unemployed. This pathway is characterised by changes in lifestyle, most notably moving from an active and

content lifestyle which is full of activity to a lifestyle which has a distinct lack of activity, characterised by social isolation.

A distinct pathway to unemployment has not been described in previous research in this way before. Other researchers have described *models of unemployment* in terms of stages, whereby people with mental health problems' state of minds alter at different stages in time, depending on their unemployment status (Eisenberg & Lazarsfeld, 1938; Hill, 1973; *in* Ezzy, 1993). However, these models focus entirely on *unemployment* and do not include experiences where people with mental health problems are actually employed or indeed the transition to unemployment.

In addition, they consider individuals' *responses* to unemployment only and not the environmental features that inevitably play a part. Whilst there is a model of unemployment which describes the jobless environment, namely Warr's vitamin model (1987), this again focuses on unemployment.

The way in which this model expands upon models of unemployment, and contributes new knowledge to this field of research is that it includes employment experiences (prior to and post illness onset), the transition to employment and the experience of being unemployed. It also highlights the interaction between individuals' environment, the meaning it has for them and the subsequent impact of this on their mental health. Whilst the pathway to unemployment described through this research is not strong on individuals' responses to becoming unemployed, this is something that could be worked into the model through future research.

Alternatively, this model could complement those which describe people with mental health problems' responses to unemployment in great detail.

In addition, whilst a distinct pathway to unemployment has not been described in previous research, the characteristics at different stages of the pathway to unemployment through which people with mental health problems in this research travelled down, support and expand upon previous research in this field.

This research found that individuals with mental health problems experience a number of difficulties in the workplace as participants in this study experienced work-related stress, difficulties at work, difficulties retaining their employment position, as well as discrimination within the workplace. A number of barriers to employment were also identified namely a lack of vocational support and low expectations. Furthermore, the characteristics of becoming unemployed were identified by this research, particularly in terms of actually becoming unemployed and the subsequent unemployed lifestyle.

6.1.1. Difficulties in the workplace

The unemployed men experiencing mental health problems in this research described the work-related stress they experienced whilst in employment. This supports previous research which found that in the UK, stress in the workplace appears to be a common problem (Warr, 1987). More recent research by Mino *et al.* (2006) shows that stress; mental health and depression in the workplace have emerged as common and significant problems.

The people with mental health problems in this study also described the many problems they experienced at work such as difficulties thinking; difficulties interacting with colleagues; and difficulties accepting authority in terms of having to take orders from managers and employers. Some of these problems may reflect the sorts of difficulties which anybody may experience at work for example difficulties interacting with colleagues. However, previous research suggests that the likelihood of a person with mental health problems experiencing these difficulties is high.

Findings from this study support previous research demonstrating that people with mental health problems have difficulties interacting in the workplace as Scheid (1999) found that difficulties dealing with co-workers and customers are major handicaps in people with mental health problems' ability to manage a full-time job. Other qualitative research in this field found that when examining the impact of mental illness on employment, *difficulties with work performance* was one of three themes where mental illness affected consumers' experiences and outcomes; with a reduced ability to think clearly, lack of energy and difficulty interacting with other people in the work environment directly affecting participants' ability to perform well in a job (Honey, 2003).

Certainly, some of the difficulties identified in this research appear to be cognitive and illness-related difficulties people which mental health problems experience at work such as difficulties thinking. Cognitive difficulties could potentially be reduced by the use of psychiatric medication and psychological therapies such as cognitive behavioural therapy. Research has shown that second-generation antipsychotics

might favourably affect the capacity, seriously impaired in schizophrenia, of finding and keeping paid employment (Percudani *et al.*, 2004).

However, Honey (2003) reported that difficulties with work performance could also be a side effect of medications that people with mental health problems use to control their illness. Indeed, medication can interfere with capacity to work (Scheid & Anderson, 1995). Researchers have suggested that future research on the effects of medication compliance and side effects on work performance should be carried out (Scheid & Anderson, 1995).

The participants in this study found employment a struggle to maintain following the onset of mental health problems, due to the difficulties they experienced at work. This supports findings from previous research which found that job retention is increasingly becoming recognised as a major difficulty in the employment of people with mental health problems. A study carried out by Secker *et al.* (2001) demonstrated that retaining a job was more problematic for clients than finding it in the first place. Several other research studies have also found that job retention is a problem for people with mental health problems (Bond *et al.,* 1997; Xie *et al.*, 1997).

Thomas *et al.* (2002) carried out a literature review on job retention among people with mental health problems and outlined the factors which create barriers to job retention such as the stigmatisation of mental illness and its implications for employers' attitudes and take up of support; lack of awareness of employment rights; problems on the job; and low expectations amongst both mental health professionals

and those experiencing mental health problems. The review by Thomas *et al.* (2002) also highlights factors which promote or predict job retention.

In addition, many of the participants in this research experienced discriminatory attitudes and behaviour from colleagues/ employers in the workplace which ranged from being treated unfairly at work, to the extreme of actually experiencing physical abuse. This prejudice was perceived to be directed towards them as a direct result of their mental health problems.

These findings support previous research demonstrating that people with mental health problems experience bullying and discrimination, when trying to obtain an employment position or within the workplace itself (Blackwell *et al.*, 2001; Focus, 2001; Gray, 1999, 2000; Warner, 2002). Other research has found that discrimination is often manifested as a barrier to employment for people with mental health problems (Marwaha & Johnson, 2005; Secker *et al.*, 2001).

There is undoubtedly a great deal of evidence to demonstrate that discrimination exists towards people with mental health problems, including the evidence from this research. The majority of the evidence available is self-reported and based on mental health service users' perceptions. However, the amount of this self-reported discrimination is overwhelming and reported in numerous studies. As well as this, research amongst employers confirm the prevalence of discrimination as a barrier to employment as fewer than four in ten employers would consider employing someone with a history of mental health problems, compared to more than six in ten for physical disability (Manning & White, 1995).

6.1.2. Barriers to employment

What emerged strongly from this research is that people with mental health problems receive very little vocational support whilst trying to retain or obtain an employment position, which can act as a barrier to employment. Whilst participants in this research were finding it difficult to retain their employment positions, they received very little support, vocational or otherwise, from colleagues, employers, health professionals, and external agencies such as job centres or mental health organisations. This lack of support contributed to the resulting downward spiral from being employed to becoming unemployed, with a transition to unemployment characterised by extended periods of sickness absence from work, unsuccessful attempts to return to employment, followed by a period of hospitalisation.

This research supports previous findings demonstrating that employers are unsupportive towards people with mental health problems. In fact, previous research has found that employers discriminate towards people with mental health problems either at the recruitment stage, or at work itself (Manning & White, 1995; Office of the Deputy Prime Minister, 2004; Rice, 2001).

However, other research has found that employers would like help on mental health issues as external sources of help would be welcomed and used, but there is low awareness of what they are (Blackwell *et al.*, 2001). Although there is a current lack of support and information on how to manage people with mental health problems in the workplace, the situation is improving as Mindout (2003) published 'A Line Managers' Resource: a practical guide to managing mental health in the workplace'

covering retirement, early intervention, keeping in touch during sickness absence and managing the return to work.

In addition, the British Occupational Health Research Foundation has funded an evidence review on managing mental health problems in the workplace (Office of the Deputy Prime Minister, 2004). This systematic review was designed to provide evidence-based answers on key questions related to mental ill-health in the workplace. It has been carried out to assist managers, occupational health professionals and other interested parties in making management decisions and offering advice in the confidence that they are based on the most robust evidence available (British Occupational Health Research Foundation, 2005). The review itself focused broadly on prevention, retention and rehabilitation. In relation to prevention, a key finding from this review was that amongst employees who have not manifested with common mental health problems or who are not at high risk, there is moderate evidence to suggest that a range of stress management interventions can have a beneficial and practical impact, although the extent to which any of these interventions prevent common mental health problems remains unclear. When looking at retention at work, this review found that amongst employees deemed to be at risk, either through their job role or who have been assessed as at risk, there was strong evidence from eight studies demonstrating that individual rather than organisational approaches to managing common mental health problems are most likely to be effective. The most effective programmes focused on personal support, individual social skills and coping skills training (British Occupational Health Research Foundation, 2005). Finally, this review also focused on rehabilitation and found that for people already experiencing common mental health problems at work,

there was strong evidence from four studies demonstrating that the most effective approach is brief (up to 8 weeks) individual therapy, especially cognitive behavioural in nature (CBT) (British Occupational Health Research Foundation, 2005). The findings from this gold standard evidence review were published in 2005, along with summaries for health professionals and for employers and employees.

In terms of the lack of support from external agencies, this research expands upon findings from a Welsh study demonstrating that there is a lack of appropriate support services which acts as a barrier, preventing people with mental health problems from re-entering supported or open employment and in taking up educational and vocational opportunities (Ng *et al.*, 2001). Whilst previous research has demonstrated the importance of employment support for people with mental health problems in successful vocational outcomes (e.g. Bond *et al.*, 1997; Curran *et al.*, 2003), studies have shown that many users receive no help or advice about work at all (Secker *et al.*, 2001). This lack of impartial advice is a major barrier to employment (Secker *et al.*, 2001).

Furthermore, participants in this research described the low expectations that health professionals had in terms of their vocational potential. Previous research has found that both mental health professionals and those experiencing mental health problems have low expectations in terms of vocational and employment outcomes (Thomas *et al.*, 2002). The Office of the Deputy Prime Minister (2004) identified seven barriers to employment for people with mental health problems, one of which was low expectations of staff, for example health and social care staff.

Low expectations from others may have a detrimental effect on mental health service users' motivation to re-enter the workplace. Rogers (1995) illustrates this by arguing that this kind of self-fulfilling prophecy does great damage: when people are told they are worthless, they believe it, yet by the same token, tell people that they are valuable members of society -at least potentially- and this is what they will believe. Grove (1999) also argues that low expectations are a significant barrier because studies have shown that positive expectations in the social environment are one of the most important indicators of successful employment outcomes. Grove (1999) argues that in order for people with mental health problems to achieve their vocational goals, service users should not have low expectations and neither should mental health professionals.

6.1.3. Characteristics of becoming unemployed

This research showed that the experience of actually becoming unemployed generated a number of feelings about unemployment among participants, some of which were very mixed. People with mental health problems described feelings of sadness, and even described a sense of loss with a feeling that they would never work again. This supports the overwhelming amount of previous literature which demonstrates that unemployment has a negative impact on mental health (Fryer, 1999; McKee-Ryan *et al.*, 2005; Owen & Watson, 1995; Proudfoot *et al.*, 1999; Warr, 1987).

However, this research also found that participants described feelings of relief of not having to work any more. The mixed feelings about unemployment found in this research could be explained through Warr's vitamin model. When examining

previous research into unemployment and mental health, Warr (1987) cites studies which found a small number of unemployed men reporting improved psychological health as a result of becoming unemployed, usually because they were free from the negative aspects of their job.

As a consequence of his research, Warr (1987) developed a vitamin model with nine environmental features or 'vitamins' which are assumed to be of importance when determining mental health. The nine vitamins are: opportunity for control; opportunity for skill use; externally generated goals; variety; environmental clarity; availability of money; physical security; opportunity for interpersonal contact; and valued social position. The central contention of this model is that when levels of environmental 'vitamins' are low, this will result in lowered levels of mental health. Low values of the nine principal environmental features within an unemployed person's environment are responsible for the typically negative impact of unemployment (Ezzy, 1993).

There are several models of unemployment which have been outlined by previous researchers including Jahoda's functional model. The central connotation of Jahoda's functional model is that unemployment deprives an individual of various beneficial by-products typically gained from employment (Ezzy, 1993). Jahoda differentiates between manifest and latent functions of employment whereby the manifest function is financial remuneration allowing an individual to 'earn a living.' However, there are some limitations to this model as "Jahoda appears to romanticise employment and fails to appreciate that paid employment is for some people, isolating and unpleasant" (Ezzy, 1993). In addition, this theory fails to take into account either the

differences in the experiences at work or the variations in the meaning unemployment may have depending on an individual's social location.

In contrast, Warr's vitamin model, can account for the observed positive effects of leaving oppressive work, as an oppressive work environment may contain less 'vitamins' than the unemployed environment. The movement into the relatively more 'healthy' environment would therefore be expected to result in improved psychological well-being (Ezzy, 1993). Furthermore, the findings from this research support many of the underlying principles of this model, particularly in relation to the individuals with mental health problems in this study having mixed feelings towards unemployment and difficulty filling their days. This model also explains that fact that a characteristic of employment could be either a positive or negative feature. Consequently, this model provides an explanation to some of the findings in this research, over and above the central connotations outlined by other models of unemployment.

The people with mental health problems in this study were all unemployed for varying amounts of time, yet their lifestyles resonated certain similarities in that they described the experience of being unemployed as being characterised by a distinct lack of activity. They also described fears of leaving the house, a fear of groups, a fear of change and of experiencing social isolation. Participants in this study spent a great deal of time alone, doing very little, other than in some cases, just smoking cigarettes. Participants also recognised that this lifestyle had a negative impact upon their mental well-being and is an unhealthy way to live.

Previous research supports this finding to some extent as a study carried out in the UK has shown that many people with mental health problems do not engage in any kind of activity, voluntary or otherwise. Butterworth and Dean (2000) found in their survey that less than 50 per cent of mental health service users were engaging in any kind of meaningful activity.

This research also suggests that people with severe and enduring mental health problems are 'bored' with their day-to-day lives due to lack of meaningful activity. Warr (1987) highlights the importance of this when describing his 'vitamin model' where 'vitamin' three is externally generated goals. This 'vitamin' is based on research finding that many unemployed people have difficulty filling their days. Reported difficulties filling time are significantly correlated with general distress, depression and negative self-esteem (Warr, 1987). Clearly this has major implications for the services which are required to address the recreational needs of people with mental health problems.

Whilst this research supports findings from previous studies in this field, it also contributes new knowledge to this area of work. This research identified a distinct pathway to unemployment through which people with mental health problems travelled. Participants' experiences in this study followed a clear temporal line from employment experiences (prior to illness onset), employment experiences (post illness onset), the transition to unemployment, through to the ultimate experience of unemployment. This is an extremely important finding as describing an identifiable process where the onset of mental ill-health leads to difficulties at work and

subsequent job loss, characterised by changes in self perception, significantly contributes to the evidence base on mental health, employment and unemployment.

6.2. The meaning of work

What is very clear from this research is that despite being unemployed, work still has significant meaning to people with mental health problems. The individuals with mental health problems in this research described numerous positive features of work in terms of the way in which work improves self concept and individuals' mental health. However, the participants in this study were also able to identify a negative feature of work namely financial disincentives. The individuals in this study therefore considered both the benefits and drawbacks of employment.

6.2.1. Positive features of work

Participants freely described several positive features of work such as that work improves self concept in terms of giving individuals pride, self respect, gaining respect from others, improving self-esteem and confidence, and making individuals feel useful and valued. A further positive feature of work identified through this research is that work provides individuals with financial incentives.

Many positive features of work were identified which is consistent with findings from previous research (Evans & Repper, 2000; Harnois & Gabriel, 2000; Perkins & Repper, 1996). In particular, previous research has shown that employment can improve life satisfaction as well as increase self-esteem levels among people with mental health problems (Evans & Repper, 2000). Kirsch (2000) also found that work

provides a set of opportunities to seek out and meet new challenges and to experience a sense of accomplishment, thereby validating and developing self-esteem and a sense of self-worth.

The findings from this research also demonstrates that employment benefits mental health as work occupies the mind, forces activity and relieves boredom, provides social interaction and reduces social isolation. This confirms the findings from previous research which provides evidence for the beneficial effect work has on mental health (Evans & Repper, 2000; Kirsch, 2000; Perkins & Repper, 1996). Research also demonstrates that this is particularly true for people with mental health problems as several studies have shown that in the majority of cases, employment has a positive effect on mental health. For people with severe mental health problems, having a job can result in a reduction in symptoms (Bell *et al.*, 1993; 1996), fewer hospital admissions (Drake *et al.*, 1994; 1996), reduced service use (Rogers *et al.*, 1995), improved social skills (Lysaker & Bell, 1995), and compliance with medication (Freeman, 1993; Turton, 2001).

This research also identified recurring themes which were considered to be positive features of work for people with mental health problems namely that work occupies the mind; forces activity; and relieves boredom. Previous researchers have indicated the benefits of work in terms of relieving boredom (Harnois & Gabriel, 2000; Jahoda's functional model *in* Ezzy, 1993; Perkins & Repper, 1996). The importance of this theme amongst people with mental health problems in this study emerged very clearly as many of the categories identified revolved around this such as: work

occupies the mind; forces activity; and relieves boredom with the consequence of benefits mental health.

6.2.2. Negative features of work

Whilst providing financial incentives emerged as a positive feature of work, financial disincentives also emerged as a negative feature of work; in particular, participants considered a loss of benefits to be negative. This suggests that participants in this study considered themselves to be stuck in the benefits trap whereby they believed that they would be no better or worse off financially if they became employed.

Several previous research studies have found that financial disincentives are a major barrier to employment for people with mental health problems (Turton, 2001). Previous qualitative studies have also found that the fear of losing benefits is a barrier to employment for people with mental health problems (Secker *et al.*, 2001), as are monetary disincentives (Marwaha & Johnson, 2005). This situation may be exacerbated for mental health service users as good quality housing and/or supported housing is essential for people with mental health problems to manage their lives in the community. Turton (2001) argues that accommodation costs and supported care charges are too high to be covered by low and average incomes from work. The removal of someone's benefits has further implications for their financial status. Evans and Repper (2000) state that starting paid work is not just a case of replacing unemployment or sickness benefit with a wage; it often means the instant removal of wide ranging subsidies such as exemption from housing and prescription charges, which low incomes are unlikely to replace.

6.2.3. The benefits and drawbacks of employment

The fact that a positive benefit of work can also be highlighted by people with mental health problems as a negative benefit of work has also been found in previous research. Honey (2004) carried out qualitative research into the benefits and drawbacks of employment from the perspectives of people with mental illness and found that participants experienced the benefits and drawbacks of employment in six domains namely: money, purposeful and meaningful activity, growth and development, social participation and belonging, self-esteem and mental health. Within each of the six domains, experiences and beliefs exist along a continuum from very negative to very positive.

As a result of her findings, Honey (2004) proposed the theory that people with mental illness engage in an active process of weighing up the perceived benefits of employment against the perceived drawbacks of employment. In the process of weighing up, people with mental illness take into account, and are influenced by their broader social context. Honey (2004) also argues that the outcome of the weighing-up process influences the decisions that people with mental illness make about what actions to take with regard to employment and their satisfaction with their employment situations.

This finding also supports Warr's vitamin model which postulates that when levels of environmental 'vitamins' are low, this will result in lowered levels of mental health. This model would allow for the same 'vitamin' to be either positive or negative, depending on the individual's experiences.

This explains why individuals in this research reported providing financial incentives as a positive feature of work, and financial disincentives as a negative feature of work. When levels of financial remuneration are low and workers receive a low salary, individuals are not likely to cite financial incentives as a positive feature of work. In particular, one of the 'vitamins' in Warr's (1987) model is the availability of money. Therefore, Warr (1987) asserts that when the availability of money is low, and people are experiencing low levels of the other eight 'vitamins,' this will result in lowered levels of mental health.

6.3. Identity

This research found that both work and unemployment has an impact upon identity. The people with mental health problems in this study described how work impacted on their identity to the extent that whilst they were in employment, they took on the identity of the valued employee. The participants in this study also described how unemployment impacts upon identity as once the people with mental health problems in this study became unemployed; they took on the identity of the devalued 'mental patient.' The impact of mental health problems also affected individuals' identity as following the onset of mental ill-health; the participants with mental health problems in this study adopted the identity of the 'mental patient.' Participants in this study also had a degree of insight into their mental health problems and viewed their mental health problems from a medical perspective.

6.3.1. The impact of work and unemployment on identity

The results from this research found that two distinct identities emerged from the data namely: the valued employee; and the devalued 'mental patient.' The valued employee had a strong work ethic, worked hard, was competent and confident at work, felt valued and had a life full of activity. In stark contrast, the devalued 'mental patient' has a fear of leaving the house, a fear of groups, a fear of change, feels devalued and has a lack of activity in his/her life.

This finding contributes new knowledge to this field of research as it expands upon the results of previous research which suggests links between the meaning of work and identity. However, these findings also support previous research to some extent as some of the characteristics of the valued employee and the devalued 'mental patient' have been identified in previous studies. In fact, the characteristics of the devalued 'mental patient' have been described in previous research, but have not been brought together within one identity before.

The devalued 'mental patient' feels devalued and socially isolated, which impacts upon self-esteem. It is well known that unemployed people develop negative thoughts about themselves and that these thoughts lead to a reduction in confidence, self-esteem and motivation, resulting in reduced effort and giving up (Proudfoot *et al.*, 1999).

This research also found that people with mental health problems' identity changes as they move down the pathway to unemployment. The valued employee was clearly evident at the beginning of the pathway to unemployment, at the point where

participants were working, and the devalued 'mental patient' was clearly evident at the end of the pathway to unemployment when they had become unemployed.

Previous research has described *models of unemployment* in stages, whereby people with mental health problems' state of minds alter at different stages in time. Researchers Eisenberg and Lazarsfeld (1938) suggested a three-stage model of unemployment, whereby "first there is shock, which is followed by an active hunt for a job, during which the individual is still optimistic and unresigned; he [sic.] still maintains an unbroken attitude. Second, when all efforts fail, the individual becomes pessimistic, anxious, and suffers active distress; this is the most crucial state of all. And third, the individual becomes fatalistic and adapts himself to his new state but with a narrower scope. He now has a broken attitude" (Ezzy, 1993).

More recently there have been reports of studies which support various versions of the stages model of unemployment such as research carried out by Hill (1978) which identified a three-stage model of the responses to unemployment; a period of optimism is followed by increasing stress which leads into a state of toleration and depression (Ezzy, 1993).

6.3.2. The impact of mental health problems on identity

The impact of mental health problems on identity was clearly demonstrated in this research. Following the onset of mental ill-health, the impact of mental health problems on each of the participants affected them to the extent that they adopted the identity of the 'mental patient.' The identity of the 'mental patient' was based on externally generated perceptions of individuals' mental health problems as their

experiences were defined by diagnosis, defined by treatment or defined by health professionals.

The people with mental health problems in this study who had been given a diagnosis and had been labelled by this had almost become the mental illness itself, to the extent that their diagnosis had almost subsumed them and that their diagnosis is how they identified themselves. This finding supports previous research by Mitchell (1998) which describes the concept of 'engulfment,' whereby individuals begin to see themselves totally in terms of their illness.

The fact that the mental illness experienced by the people in this study is defined by health professionals and by medical terminology suggests the possibility of the individuals having become institutionalised and reliant on doctors for information about their own experiences. The people with mental health problem in this research referred to periods of institutionalisation in psychiatric hospitals, although this was not explored in any great detail. This institutionalisation is also another example of where mental illness appears to have subsumed the individuals in this study.

Research has shown that institutionalisation is common among people with mental health problems who have experienced long periods of hospitalisation. Machado *et al.* (2005) carried out a qualitative research study which found that despite proposals for de-hospitalisation, patients who were institutionalised in a psychiatric hospital with a diagnosis of schizophrenia were not in favour of de-hospitalisation. Previous research also shows that institutionalisation can have a detrimental effect on the social functioning of individuals with mental health problems, with significantly

impaired social functioning, autonomy, and quality of life being common problems among the institutionalised population (Fleck *et al.,* 2007)

A process of deinstitutionalisation and a series of mental health care reforms targeting severely mentally-ill people have taken place worldwide, including within mental health services in Wales, all of which are moving away from institutionalisation. This reform of mental health services in Wales is based on evidence-based practice as research demonstrates that de-institutionalisation is beneficial for people with mental health problems as patients' psychopathology stabilises and their quality of life improves (Jahnel *et al.*, 2007)

6.3.3. Insight into mental health problems

This research found that the people with mental health problems in this study had a degree of insight into their mental health problems, with some individuals describing their mental health problems in terms of being under control. Others considered their mental health to be fluctuating, being of a cyclical nature and viewed from a medical perspective as if the experience of mental health problems is an illness with a limited lifespan and a cure, rather than a long-term disability.

The fact that the individuals in this study had a degree of insight into their mental ill-health is a very positive finding as the way in which people with mental health problems understand their illness has shown to be important when considering employment. Previous research has demonstrated that insight into mental health can have an impact on employment outcomes. Cunningham *et al.* (2000) carried out a qualitative study which found that individuals with mental health problems who were

most successful at gaining and maintaining employment tended to have a clear perspective on their illness and the place of the illness in their lives more generally.

The fact that the unemployed men in this research considered their mental health problems from a *medical perspective* is a very interesting finding. This suggests that the people with mental health problems in this research view their illness from the medical or illness model of disability. Previous research has found that a factor which appears to mediate the success of an employment model is the question of whether the model operates on the basis of a 'social model of disability' or a 'medical/ illness model' (Secker *et al.*, 2001). The disability model/ or the social model of disability appears to offer greater opportunities to achieve social inclusion in general, and labour market participation in particular, than the illness model (Secker *et al.*, 2001).

Grove (1999) describes that a social model of disability asserts that people are disabled by economic, social and environmental barriers and by the (often unintentional) discriminatory practices and attitudes which are still a feature of our society. Further, a person may have functional impairments but these need not result in disability- providing society accommodates and does not erect barriers to participation by stigmatising or discriminating against that person. Grove's paper (1999) on mental health and employment assumes a social model of disability for describing the consequences of mental ill-health in preference to the so-called 'medical model.'

6.4. The meaning of work and identity

This research found that the meaning of work has a positive impact upon identity as work was considered to have a positive effect upon self concept and mental health. Participants in this study also had clear vocational aspirations. Conversely, unemployment was considered to have a negative impact upon identity as the unemployed individuals with mental health problems in this study had perceived fears about work as well as doubts about their capability to work. The impact of the meaning of work resulted in an identity shift from the distinct identity of the valued worker to the devalued 'mental patient.' The participants in this study also described an identity struggle between these two distinct identities.

6.4.1. The positive impact of the meaning of work on identity

This research found that identity is central to the meaning of work for people with mental health problems. At all stages, the people with mental health problems in this study considered work to have a positive impact upon self concept and mental health and this was considered to be the case by both the valued worker and the devalued 'mental patient.'

This finding supports previous research which demonstrates the importance of work on identity as work affords us a social identity and status, a role and a meaning in life (Perkins & Repper, 1996). Work provides a sense of purpose and belonging; an opportunity to contribute to shared goals; a social forum; status and recognition for our efforts and achievements (Evans & Repper, 2000). Research for the World Health Organisation/ International Labour organisation, outlined five categories of

psychological experience that promote well-being, which employment is able to provide, one of which is social identity as employment is an important element in defining oneself (Harnois & Gabriel, 2000).

As a direct result of the advantages work provides us with, Perkins and Repper (1996) believe that for people who experience serious and ongoing mental health problems, work takes on an even greater importance. The benefits of employment described above are even more important for those who have experienced mental health problems as mental illness can have catastrophic effects on a person's self concept (Mitchell, 1998).

What is also clear from this research is that people with mental health problems want to work, and have goals for future work related activities such as educational/ training aspirations and work aspirations. This research is consistent with previous research finding that despite the barriers and disappointments people with mental health problems face; paid employment is still something to which they aspire (Butterworth & Dean, 2000; Secker *et al.*, 2001; Turton, 2001). Research using a purely Welsh sample of mental health service users also found that that people with mental health problems would like to gain paid employment (Ng *et al.*, 2001).

6.4.2. The negative impact of unemployment on identity

Results from previous research demonstrate that work has a positive impact on identity therefore; it is not surprising that lack of work can have a negative effect on self concept. The negative psychological effects of unemployment are well documented: lowered self-esteem and confidence; social isolation; anxiety;

depression; reduced life satisfaction; and hopelessness about the future (Proudfoot *et al.*, 1999).

This research also found that the loss of work to the valued worker following unemployment clearly had a profound impact upon identity. Furthermore, it is clear that identity does have a huge impact upon the meaning of work as the devalued 'mental patient' is fraught with perceived fears about work. In particular, the devalued 'mental patient' has an overwhelming fear of becoming unwell if they were ever to go back to work, a fear of stress and discrimination in the workplace.

These findings also support previous qualitative research by Marwaha and Johnson (2005) who found that people's attitudes and beliefs were barriers to employment, which are likely to be reflections of low self-esteem, a loss of motivation and acceptance of unemployment, worries and past experience.

Furthermore, although the people with mental health problems in this study are unemployed, other research has found that these fears actually extend into the workplace itself. Qualitative research carried out by Honey (2003) found that one of the three themes where mental illness affected consumers' work experiences and outcomes was *the need to maintain mental health.* This research found that stress, fear of illness, getting sick and stress avoidance were major ways in which mental illness affected employment experiences, with an overall goal of staying mentally healthy (Honey, 2003).

Furthermore, whilst previous research has shown that discrimination does exist towards people with mental health problems in the employment context (Blackwell *et al.*, 2001; Focus, 2001; Gray, 1999, 2000; Kirsch, 2000; Warner, 2002), the fear of discrimination among people with mental health problems can be just as disabling. Previous research from Wales has also demonstrated that people with mental health problems have a fear of discrimination which can act as a barrier to work (Ng *et al.*, 2001).

What is also very interesting about these results is that the devalued 'mental patient' is fraught with concern about his/her capability to work, as the people with mental health problems in this study referred to themselves as incapable of work. This also supports previous research by Honey (2003) which found that when examining the impact of mental illness on employment, *work confidence and work goals* was one of three themes where mental illness affected consumers' experiences and outcomes. In this study, participants lacked confidence in their work abilities and prospects due to their mental illness, and this lack of confidence was often due to the other effects of mental illness such as reduced work performance, fear of stress and the threat of discrimination (Honey, 2003). Results from this study found that people who were not in the job market simply believed that they were unable to work. Honey (2003) concluded that when people become mentally-ill, they often undergo a complete reassessment of their work capacity and potential.

Previous qualitative research has also found that people with mental health problems have an ongoing struggle with illness which results in ongoing disruptions to aspects of their lives and sense-of-self as workers (Kennedy-Jones *et al.*, 2005)

This view also resonates with a general public perception that people with mental health problems are unable to work. Scheid (1999) argues that the stereotypical view is that those with mental illnesses are unpredictable, irrational, slow, stupid, and unreliable, that mental illness is also associated with violence or dangerousness and such labels are not generally associated with that of a desirable employee.

Despite this, Hammond *et al.* (1998) clearly state that many people with mental health problems can work given the right opportunities and support. A study carried out by Scheid (1999) found that in general, employers had very positive experiences with their employees with mental disabilities.

6.4.3. An identity shift/ struggle

The characteristics of the identities of the valued employee and the devalued 'mental patient' have been described in previous research. However, the explicit distinction between the two identities and the detailed description of the devalued 'mental patient,' as well as his/her attitude towards employment, has not been outlined in this way before. Therefore, this research contributes new knowledge to this field of work.

What is also significant about the two identities that have been highlighted through this research, namely the valued employee and the devalued 'mental patient,' is that they are inextricably linked to the meaning of work to individuals; as people with mental health problems travelled down the pathway to unemployment, their self identities changed. The identity of the valued employee was observed at the top of the pathway to unemployment, and the identity of the devalued 'mental patient' was

observed at the bottom of the pathway to unemployment. The impact of the meaning of work on identity resulted in an identity shift as unemployment progressively became a larger part of individuals' lives.

These results also found that the people with mental health problems in this study experienced an overwhelming identity struggle between the valued worker and the devalued 'mental patient.' This struggle is characterised by a tension between wanting to work and being uncertain about their capability to work which demonstrated an identity struggle between the valued worker and the devalued 'mental patient.' This identity struggle acted as a barrier to employment as it prevented the people with mental health problems in this study from seriously considering vocational activities as a realistic option.

This identity struggle between the valued worker and the devalued 'mental patient' also caused confusion for the people with mental health problems in this study and led to a detachment from work which can act as a barrier to considering future work in any serious way.

Whilst previous research has not identified an identity shift or an identity struggle, a detachment from work has been identified to some extent in other qualitative research studies involving people with severe and enduring mental health problems.

Marwaha and Johnson (2005) found that when asking people with severe and enduring mental health problems for a yes or no response, nearly everyone said they wanted to work. However, this was frequently followed by the expression of

substantial doubts and these initial assurances may to some extent, reflect the social desirability of work. Marwaha and Johnson (2005) found that these initial statements about wanting to work could be described as public accounts, behind which a set of rather more complex and contradictory private accounts emerged on more detailed exploration. Marwaha and Johnson (2005) also argue that doubts about working and perceived barriers are important and seems to be confirmed by the observation that there was very little evidence of current active job-seeking among the participants.

6.5. Implications for policy and practice

The results from this study have a number of major implications for policy and practice and in particular for mental health professionals, mental health services, vocational rehabilitation services and employers.

Prior to considering any implications for policy and practice from this research, it would be useful to understand the current practice in terms of mental health support and vocational support for people with mental health problems in Wales.

The strategy document *"Adult mental health services for Wales: equity, empowerment, effectiveness, efficiency"* (The National Assembly for Wales, 2001) outlines the mental health services currently existing in Wales. Mental health services in Wales have been developed in recent years. Currently service provision consists of community-orientated and locally-based services which have been developed, including the establishment of multidisciplinary Community Mental Health Teams (CMHTs) throughout Wales. A wealth of voluntary sector facilities

have been developed including drop-in facilities, self-help groups and employment training (The National Assembly for Wales, 2001). There has also been an important impact on primary health care which now has to provide services for a group who were previously cared for entirely within secondary care. These changes have enabled some of the large older institutions to be closed including several psychiatric hospitals across Wales. Some other services have moved in-patient units to more local facilities (The National Assembly for Wales, 2001). Day hospitals and day services are also available for people with mental health problems, and provided by the CMHT and in-patient units. Traditionally, day care has been provided in either day hospitals or day centres. However, this pattern of service delivery has been changing to provide people with more flexible support which includes social rehabilitation within settings which are available to the public as a whole (The National Assembly for Wales, 2001). Many of the findings from this research have implications for the way in which mental health support and vocational support is currently provided in Wales.

6.5.1. The pathway to unemployment

A major finding from this research is that people with mental health problems who become unemployed follow a pathway to unemployment which impacts upon the meaning of work to them and their self concept. What is significant about this pathway to unemployment is that each of the participants in this research traveled down this pathway and became unemployed. This suggests that following the onset of mental health problems in the current environment, individuals will almost certainly travel down the same route to unemployment and that unemployment among this group is almost inevitable.

Previous research has also indicated that unemployment is a highly likely outcome for mental health service users as Gates (2000) found that many people with mental health problems who are in a period of sickness absence from their employment may be at risk of losing their jobs. Figures from the Labour Force Survey in 2003 suggest that people with mental health problems are at more than double the risk of losing their job than those without (Office of the Deputy Prime Minister, 2004). The unemployment rates among people with mental health problems also suggest an inevitability of people with mental health problems becoming unemployed as unemployment rates amongst people with mental health problems remain surprisingly high (Grove, 1999; Office of the Deputy Prime Minister, 2004; Turton, 2001).

This research has also described the low expectations that individuals with mental health problems and health professionals have in terms of their vocational potential, which supports previous research showing that both mental health professionals and those experiencing mental health problems have low expectations in terms of vocational and employment outcomes (Grove, 1999; Office of the Deputy Prime Minister, 2004; Thomas *et al.*, 2002). This indicates that the participants in this study, and their mental health professionals who provided support to them, appeared to believe that the downwards spiral towards unemployment was inevitable. However, this may not necessarily have been the case and with the right support and interventions, the position in which the participants in this study found themselves may have been avoided.

Subsequently, the main implication from this research is that understanding more about the pathway to unemployment which people with mental health problems can travel down, should help to inform ways in which to reduce the chances of individuals traveling down this pathway. The key challenge for practitioners and policy makers is to develop ways in which to break this trajectory and the negative self concept attached to it.

The first stage of the pathway to unemployment is the point at which participants were working prior to the onset of mental ill-health. At this point in time, participants had a strong work ethic; they worked hard, and were competent and content at work. The identity of the valued employee was observed at the top of this pathway to unemployment. Whilst this initial stage appeared to be without difficulty, it is when the participants moved onto the next stage in the pathway that problems began to arise.

The initial problems which began to lead to unemployment for the people with mental health problems in this study were identified when participants were employed following the onset of mental ill-health. These difficulties were described through participants' employment experiences (post illness onset) during the second stage on the pathway to unemployment. It was at this stage that participants described the difficulties they experienced in the workplace which included work-related stress, difficulties thinking, difficulties interacting with colleagues, and discrimination.

Immediately following the onset of mental ill-health, vocational support should be offered to individuals with mental health problems to try and prevent them moving towards the next stage which is the transition to unemployment. As a result of the difficulties participants experienced at work, this research has identified some of the specific features of vocational support that people with mental health problems might need such as stress-management programmes, support to overcome the difficulties they experience at work, as well as assistance with obtaining and retaining employment. Employment models should also try to address the fears people with mental health problems hold about work and should be based on the social model of disability, to encourage social inclusion.

Findings from this research demonstrate that people with mental health problems struggle to maintain their employment positions due to a number of factors such as the difficulties they experience at work and a lack of vocational support. This clearly has implications for policy and practice as if employees were to retain their jobs in the first place, through early intervention; the negative psychological effects of unemployment would theoretically be avoided or at least reduced. Therefore, helping someone to retain their job avoids all the negative consequences of unemployment in health, social and economic terms (Hammond *et al.*, 1998).

A literature review carried out by Thomas *et al.* (2002) outlines the factors which create barriers to job retention, as well as those which promote or predict job retention. Thomas *et al.* (2002) also described the case management model adopted for the Commonwealth Rehabilitation Service in Australia, which appears to be the ideal job retention model. The case management approach involves a central worker,

the case manager, who facilitates and maximises communication between health services, employment services, employers and other relevant individuals and agencies. Return to work strategies and necessary adjustments are identified and ongoing support is provided by the case manager to ensure a successful return to work (Thomas *et al.*, 2002). This could be a model which is adopted into vocational services in Britain which would potentially reduce the enormous cost of unemployment for both the individual and for society as a whole. This has major implications for practice as the case management approach could be piloted in the UK to determine whether it has the potential to improve the model on which existing vocational services are currently based.

As well as the vocational support needs of people with mental health problems, research has also shown that employers would like help on managing mental health issues within the workplace (Blackwell *et al.*, 2001). Therefore, employers should routinely be offered advice and assistance with managing people with mental health problems in the workplace, as part of employment support services.

As well as offering access to vocational support at the earliest opportunity, another way to reduce the likelihood of people with mental health problems traveling down the pathway towards unemployment would be to introduce interventions which have been found to reduce the impact and prevalence of work-related stress, and this could be a key element of vocational services. Whilst this research and other research in this field has found that stress can be a significant problem for people with mental health problems in the workplace, other researchers have examined ways in which to reduce the impact of stress. Research has shown that a stress-management

programme, based on a cognitive behavioural approach, may have potential for the prevention of depression (Mino *et al.*, 2006). Similar results were found by Rose and Perz (2005) where participants on a vocationally-oriented cognitive behavioral therapy training programme for people receiving public mental health services, reported significant improvements in general mental health, optimism and attitudes to work following training. The fact that stress- management programmes and adaptations of cognitive behavioural therapy may have the potential to reduce stress and symptoms of mental ill-health in the workplace, has major implications for policy makers and practitioners in this field. These findings have major implications for both policy and practice as if a stress-management programme is built into existing vocational services; the severity of the symptoms of poor mental health could be significantly reduced.

Another way in which to try and prevent people with mental health problems going through the identified process towards unemployment is to tackle discrimination in the workplace. This research found that unemployed men receiving mental health support in the South Wales Valleys, experience discrimination in the employment arena. Despite Government campaigns such as 'mind out for mental health' (Department of Health), and the introduction of the Disability Discrimination Act (1995), discrimination towards mental health service users still exists. Welsh policy documents have highlighted this problem as the Adult Mental Health Services Strategy Document (2001) written by The National Assembly for Wales states that "people suffering from mental illness are at risk of being stigmatised." Much of this is based upon public misperception of mental illness, which in turn is often due to misunderstanding, and lack of knowledge. Sensationalised media coverage can create

additional difficulties and contribute to stigma and discrimination (The National Assembly for Wales, 2001). However, the fact that discrimination still exists towards people with mental health problems clearly has implications for future policy making.

It is important that a serious attempt is made at tackling this issue as Grove (1999) asserts that there must be an explicit commitment to combat discrimination. Harnois and Gabriel (2000) state that the best way to fight stigma is through appropriate education and information, which may include a public information campaign, courses and conferences. Devising strategies that present positive images of people with mental health problems as workers, colleagues and managers successfully coping with their difficulties is just as important (Grove, 1999). The Welsh strategy document (The National Assembly for Wales, 2001) also states that "improved public understanding should help to reduce stigma and social exclusion." Policy makers should therefore continue to focus on these methods of combating discrimination in Wales.

When participants moved onto the next/ third stage on the pathway to unemployment, they were in the transition to unemployment. During this stage participants described having unsupportive employers/ colleagues, a lack of external employment support from outside agencies, beyond the workplace and low expectations from health professionals, all of which contributed to them subsequently becoming unemployed.

This research found that unemployed men receiving mental health support in the South Wales Valleys do not receive support with employment issues such as support from mental health professionals, mental health organisations, and job centres in terms of obtainng and maintaining employment. The UK government has demonstrated increased interest in enabling people with mental health problems to gain employment with the development of several initiatives and programmes (such as Workstep) in order to achieve this goal. This suggests that employment policy and practice in the UK has so far failed to make an impact on the employment status of this group of individuals, which indicates that more needs to be done in terms of providing support for people with mental health problems to gain and obtain meaningful occupation.

This lack of support provides a strong argument for the need to develop employment support services for people with mental health problems in Wales. These results indicate a gap in mental health services at present, and clearly demonstrate the need for further service provision. It would be extremely beneficial to further develop services to support mental health service users to find and retain training/ educational opportunities and employment positions across Wales and the UK.

The need for employment support services is reinforced by the fact that work still has significant meaning to people with mental health problems and that many actually want to work but are currently unemployed. Indeed, people with mental health problems have training, educational and work aspirations and this strongly reinforces the need for the services available to help them achieve these goals.

As well as this, work has a positive impact on mental well-being, particularly for people with mental health problems, to the extent that it can actually reduce symptoms. In contrast, unemployment has been shown to have a negative impact on mental health. All of these factors demonstrate a very strong business case for the development of adequate vocational services in Wales and across the UK, which should be accessible for people with mental health problems who would like vocational support. Given all of the arguments put forward, the development of vocational services for people with mental health problems should be a high priority for policy makers.

The final/ fourth stage of unemployment on this pathway is the experience of being unemployed whereby participants' lives were characterised by lack of activity, a fear of leaving the house, a fear of groups, a fear of change and social isolation. The identity of the devalued 'mental patient' was observed at the bottom of the pathway to unemployment.

A major finding from this research is that once participants had become unemployed, they had a distinct lack of activity in their lives, whereby they sat at home alone with nothing to do. This lifestyle also has a negative impact upon mental well-being and seems to exasperate mental health problems at a severe cost to the individual. With the range of psychiatric services available in Wales, and the existence of day centres and services, it is an unexpected finding that people with severe and enduring mental health problems have *nothing* to do. It may be that existing services available for people with mental health problems (such as day centres) is not an attractive option and therefore, people would rather 'do nothing.'

This is an important finding as it suggests that existing vocational service provision provided by statutory services are not necessarily attracting the people they are designed to serve, namely people with mental health problems. This has serious implications for mental health services in the Wales.

6.5.2 The meaning of work and identity

The fact that two separate identities were identified in this research also has major implications for policy and practice as if researchers can further understand the characteristics of both identities, as well as the ways in which to avoid the possibility of becoming the devalued 'mental patient,' it may be that negative self identity can be avoided, or at least reduced. Similarly, the meaning of work to participants in this study was also identified through this research which has implications for the provision of vocational services in the future.

Specifically, the identification of the valued worker and the devalued 'mental patient' has implications for the provision of vocational services, particularly emerging from the characteristics of these identities. It is clear from the findings of this research that in order for the devalued 'mental patient' to meaningfully consider vocational activities in the future, individuals with mental health problems would require significant changes in the way in which they, and those around them, perceive themselves and their vocational ability.

Due to the fact that the people with mental health problems in this study have the identity of the devalued 'mental patient,' and are uncertain about their capability to

work, vocational services should take this into account and offer ways in which to combat negative self concept and improve self confidence in the employment arena. Similarly, vocational services could include elements of confidence building into supported employment models. Practitioners should uncover the cause of the perception that people with mental health problems consider themselves to be incapable of working and should address any barriers to employment that this may include. The negative assumptions which may have been adopted through low expectations and stigma towards people with mental health problems should also be addressed appropriately.

Although the participants in this study want to work, research suggests that people with mental illness engage in an active process of weighing up the perceived benefits of employment against the perceived drawbacks of employment, which influences the decisions that people with mental illness make about what actions to take with regard to employment (Honey, 2004). This suggests that when practitioners and people with mental health problems are considering the employment options available, a careful process of weighing up the positive and negative aspects of the employment position should take place, as unsuitable employment positions may make it more difficult for the individual to retain their job. This is particularly important when it comes to the financial aspects of becoming employed as people with mental health problems may find themselves no better, or worse-off than they were when they were unemployed. This is also important as according to Warr's vitamin model, if any of the nine environmental features of the position are low, this may result in lowered levels of mental health (Warr, 1987). These factors should all

be taken in account when considering the features of effective vocational support services for people with mental health problems.

As well as this, insight into mental health problems has also shown to have a positive impact on vocational outcomes, therefore psychiatric services should pay attention to considering how individuals with mental health problems view their illness. This has major implications for practice in this field as practitioners should ensure that as part of their treatment, people with mental health problems should be encouraged to understand their mental illness and the place of illness in their lives. In terms of employment, individuals should learn to understand their mental ill-health and its impact upon identity and employment. This should help to reduce the likelihood of mental illness subsuming people's lives so that they are 'engulfed' and see themselves totally in terms of their illness.

People with mental health problems should be encouraged to view their illness from the social model of disability and not from a medical perspective as this can act as a barrier to employment, particularly as it often means that individuals do not want to consider vocational activities until they are medically 'cured.' Better advice and training on the nature of mental ill-health from a social framework should be made available to people with mental health problems, mental health professionals, support workers and employers to try and move away from the assumption that individuals need to be entirely symptom free before being able to work.

Furthermore, where individuals with mental health problems have become institutionalised as a result of long periods of hospitalisation, practitioners should provide support to help reverse this phenomenon.

6.6. Implications for future research

Findings from this research have shown that stress can be a significant problem for people with mental health problems in the workplace. The fact that other researchers have found successful ways in which to reduce the impact of stress, such as through stress-management programmes (Mino *et al.*, 2006; Rose & Perz, 2005) could have enormous benefits for people with mental health problems in the UK. It would be useful to carry out further research in this area, particularly with people with mental health problems in the UK as the potential benefits and impact this could have is immense. If a successful programme for managing stress in the workplace is found for people with mental health problems, this could be generalisable for anyone who experiences work-related stress.

Findings from this research have shown that people with mental health problems experience difficulties at work, some of which appear to be cognitive and illness-related difficulties people such as difficulties thinking. Previous research has suggested that cognitive difficulties could potentially be reduced by the use of psychiatric medication and psychological therapies (Percudani *et al.*, 2004). However, other researchers argue that difficulties with work performance could also be a side effect of medications itself (Honey, 2003). Subsequently, further research in this field is required to determine whether the use of psychiatric medication helps or

hinders the cognitive and illness-related difficulties that people with mental health problems experience at work. Other researchers have also suggested that future research on the effects of medication compliance and side effects on work performance should be carried out (Scheid & Anderson, 1995).

This research also demonstrated that individuals with mental health problems have difficulties maintaining their employment positions following the onset of mental ill-health. Whilst there has been some research carried out in this area, researchers assert that there is a large gap in research and practice on mental health and job retention (Thomas *et al.*, 2002). However, the system cannot be effective for people with mental health problems unless there is support in both maintaining, as well as gaining employment (Thomas *et al.*, 2002). This demonstrates a need for further research in this area.

As this research has found that the lifestyles of unemployed men in the South Wales Valleys is characterised by a distinct lack of activity, this suggests that existing vocational service provision provided by statutory services (for example day centres) are not necessarily attracting the people they are designed to serve, namely people with mental health problems. A review of mental health services would determine whether this is the case, particularly in the areas in which this research was carried out.

Similarly this research has also found that there is a lack of vocational support for people with mental health problems in Wales. It has also identified the features of an effective model on which to base effective vocational support services. A review of

vocational support services for people with mental health problems in Wales would determine the number of services currently in existence, accessibility to these services and the models on which they are currently based. This would help to map service development needs to ensure the provision of adequate vocational services for people with mental health problems in the future.

The strategy document *Adult mental health services for Wales: equity, empowerment, effectiveness, efficiency* (The National Assembly for Wales, 2001) is a ten-year plan to improve, modernise and develop mental health services in Wales to a position where they provide the best possible care for those with mental health problems. This document sets out the requirements for mental health services in Wales including that they must be organised in a way that is flexible and responsive to the needs, preferences and interests of the client groups; and a comprehensive range of employment and occupational opportunities should be provided which should range from specialist employment and training for mental health service users to schemes that support users in general employment and training (The National Assembly for Wales, 2001). In addition, the National Service Framework (NSF) for Mental Health in Wales was developed and made available in April 2002 and it establishes the practical guidelines that will ensure consistent and comprehensive implementation of the Strategy's vision across Wales (Welsh Assembly Government, 2002).

It would be useful to carry out a review of mental health and vocational services across Wales in the context of the strategy and the National Service Framework for Wales, in order to evaluate progress made and to determine whether any gaps still

exist. A review could also look at a comparison between local experiences of mental health and vocational services such as the experiences outlined by this research, as well as national experiences both within Wales and across the UK. This would help to consider whether service provision is available to a consistent standard across the UK, regardless of environmental factors such as levels of deprivation.

This research also found that financial disincentives is a major barrier to employment for people with mental health problems as they find themselves in the benefit trap whereby they would be no better or worse-off financially if they became employed. This suggests that any benefits reforms which have been introduced as part of the UK government's welfare to work policy have so far failed to facilitate the transition from incapacity benefits to employment and the benefits rules still remain as a barrier to employment. Policy makers should therefore re-consider the benefits rules as they stand to make it easier for individuals to go back into employment without being financially disadvantaged. A review of the current benefits system would contribute to knowledge in this area and could make recommendations on the way forward.

This research has identified a number of barriers to employment for people with mental health problems. However, future research is required in order to fully understand these barriers to employment, including the causation and the impact upon people with mental health problems. If these barriers to unemployment were fully understood, policy makers could develop strategies to overcome these barriers, thereby making access to employment for people with mental health problems easier.

As this is the first study to identify this pathway to unemployment, further research is necessary to discover the characteristics of each stage of the journey in more detail and to identify the needs of people with mental health problems at each stage. For example, if further research was carried out on the needs of people with mental health problems during their employment experiences, following the onset of mental ill-health, vocational services and mental health professionals may be able to provide the support necessary to prevent, or at least reduce the number of people with mental health problems moving onto the next stage namely the transition to unemployment and eventually, the experience of unemployment.

In addition, new knowledge has been identified from this research in the form of the identification of two identities evident on the pathway to unemployment, namely the valued employee and the devalued 'mental patient.' Whilst there was a great deal of evidence for the devalued 'mental patient,' more research needs to be carried to discover the detailed characteristics of the valued employee. Furthermore, whilst these two identities emerged strongly from the data, there were indications of stages in the transition between the valued employee and the devalued 'mental patient' as feelings of distress, frustration, desperation and hopelessness emerged in between. It was not within the scope of this research to explore this further, subsequently future research on the meaning of work and identity, and the pathway to unemployment and identity, would greatly contribute to this field of work.

As this research supports and expands upon a great deal of previous research in this field, this indicates that socio-economic class does not confound the relationships between employment and mental health, unemployment and mental health and does

not have an impact on the barriers to employment experienced by people with mental health problems. However, further research is needed to confirm whether this is the case.

The fact that the people with mental health problems in this study did not receive any vocational support at all could be related to the areas in which they live as suggested by Crowther and Marshall (2001), who found that vocational service provision for people with mental health problems in England, was the highest in areas with the lowest deprivation levels. However, this research did not explore this issue in enough depth to determine whether this is the case. A review of mental health and vocational services across Wales would undoubtedly contribute to this. It would also be useful for further research to be carried out into the impact of socio-economic class on vocational issues for people with mental health problems.

Finally, this research was carried out with a group of 'under-researched' individuals, namely unemployed men receiving mental health support living in areas of deprivation in the South Wales Valleys. Further research should be carried out to determine whether the findings are generalisable to all populations of people who experience severe and enduring mental health problems. The potential relevance of the overall theory to other populations is an area for further study as it may be that people with other disabilities may follow the same pathway to unemployment and that the experiences impact upon the meaning of work to them and their self identity. Indeed, this theory also may be generalisable to unemployed men and women in the general population. Research looking at the generalisability of the findings from this research would therefore be of great value.

6.7. Methodological limitations

There are a number of methodological limitations within this research.

6.7.1. Organisational constraints

Firstly, this research was carried out within the constraints of an Employment Opportunities Project for a mental health charity, whereby the method, and the type of information the charity wanted to gather was very much based on a practical framework including policy related factors, factors relating to service development and also some organisational-specific characteristics (see chapter 1: Introduction). This meant that the research design had to satisfy both the requirements of an academic qualitative research study and research which aimed to identify service users' employment experiences, needs and aspirations, with an ultimate aim of evidence-based service development. Whilst the research design for this study successfully achieved this, there were tensions in relation to the need to satisfy both requirements. An example of this tension was in designing the interview schedule, as it needed to include both open-ended questions to collect the qualitative data needed for this research, as well as closed questions to collect some essential data for the Employment Opportunities Project.

Having said this, if the current study was not set within the context of the Employment Opportunities Project, the opportunity to carry out this research with the under-researched sample of unemployed men with severe and enduring mental health problems, living in areas of deprivation in the South Wales Valleys, may not have arisen. In addition, by carrying out this research within the context of the

Employment Opportunities Project, it gave the investigator the opportunity to carry out research in a secure environment, where both the investigator and the participants had the organisational support of the mental health charity.

6.7.2. The interview schedule

When designing the interview schedule, it was important to ensure that it included both open-ended questions to collect the qualitative data needed for this research, as well as closed questions to collect some essential data for the Employment Opportunities Project. Subsequently, the interview schedule used for this research is a combination of open and closed questions which is not typical for a semi-structured interview using a qualitative research method.

However, the investigator was aware of this limitation and used the open questions within the interview schedule to best effect, using supplementary questions where appropriate. Whilst the participants were asked the questions within the interview schedule, the investigator was also careful to ensure that participants could also determine the interview content by introducing relevant themes. In addition, the interview schedule was piloted with mental health service users before the interviews began to ensure that the open-ended questions within the interview schedule were suitable (see chapter 4: Method).

6.7.3. The use of semi-structured interviews

In the context of these constraints, the use of semi-structured interviews was chosen for this research. Semi-structured interviews involve the implementation of a number of predetermined questions and/or special topics which are typically asked of each

interviewee in a systematic and consistent order, but the interviewers are allowed freedom to digress that is, the interviewers are permitted (in fact expected) to probe beyond the answers to their prepared and standardised questions (Berg, 2001).

There are a number of different theoretical perspectives on in-depth interviewing, and different types of interview. But the features which are broadly consistent are their flexible and interactive nature, their ability to achieve depth, the generative nature of the data and the fact that it is captured in a natural form (Legard *et al.*, 2003).

Semi-structured interviews were used as the method of data collection for this research for a number of reasons. Interviews can permit exploration of issues that may be too complex to investigate through quantitative means (Banister *et al.*, 1994). The topic of this research was considered to be more effectively explored through qualitative data collection and the use of semi-structured interviews.

The use of semi-structured interviews is an efficient and practical way of collecting data about emotions and feelings that cannot be observed. In this way, the semi-structured interview is a valid method of data collection as participants are able to talk in detail and in depth. In addition, complex questions and issues can be discussed and clarified as the interviewer can probe areas suggested by the respondent's answers.

Semi-structured interviews were also selected because interview data can be analysed in a variety of ways. Therefore, semi-structured interviewing is a method of

data collection that is compatible with several methods of data analysis, including grounded theory (Willig, 2001). For all of these reasons, semi-structured interviewing is the most widely used method of data collection in qualitative research (Willig, 2001).

However, the use of semi-structured interviews does have some disadvantages. It is possible that interviewer bias may affect the data collected as the interviewers' social identity, gender, social class, ethnicity, nationality and age may affect the responses given by participants.

Other disadvantages of using interviews include the possibility of recall bias (problems of remembering accurately), social desirability (the wish to appear as a morally worthy person to the interviewer) and interviews only provide access to what people *say*, not what they *do* (Green & Thorogood, 2004).

The use of semi-structured interviews can also be time consuming, in the data collection stage, when transcribing the audio recordings and when analysing the data. For this reason, the use of semi-structured interviews is suited to a study with a restricted number of interviews, and to do justice to the material generated (Banister *et al.*, 1994).

Whilst these disadvantages could be viewed as methodological limitations, care was taken in order to minimise the risks of these occurring. The limitations of the use of semi-structured interviews have been noted by many researchers. However, Green and Thorogood (2004) argue that their strengths lie in appropriate use: when the

research question requires analysis of accounts, and when the researcher is reflexive about how the research context impacts on the data collected.

Green and Thorogood (2004) argue that social, cultural and personal characteristics will inevitably shape the kind of relationship established between the researcher and the participant during an interview. Characteristics such as age, gender and ethnicity cannot be eliminated, nor is it desirable that they are (Green & Thorogood, 2004). However in qualitative research, there is more typically an acceptance that any interview account is situated and contextual, and that we therefore have to account explicitly for the ways in which social and cultural characteristics have an impact on the kind of data collected (Green & Thorogood, 2004).

Additionally, there are ways of minimising the risk of these potential limitations. In particular, the investigator for this study received training on interviewing skills and care was taken to prepare for the semi-structured interviews. The semi-structured interviews for this study were carefully planned in terms of the recruitment of participants, the recording and transcribing of interviews, as well as the development of the interview schedule itself. By piloting the interviews (see chapter 4: Method); the investigator took steps to ensure that the questions were clearly communicated to participants in understandable language.

There are debates about how far knowledge is constructed in the interview or is a pre-existing phenomenon, and about how active or passive the role of the interviewer should be (Legard *et al.*, 2003). However, the investigator for this research was careful to ensure the right balance was achieved between maintaining control of the

interview and allowing the interviewee the space to re-define the topic under investigation and thus to generate novel insights (as described in Willig, 2001).

6.7.4. The use of a grounded theory approach

A grounded theory approach was used in this research, with a specific aim to generate an emergent theory from research which is 'grounded' in data. Using the transcripts from the semi-structured interviews, data was analysed through the use of the coding process outlined in Strauss and Corbin (1998). However, this research did not use some of the techniques which are central to using a grounded theory approach; in particular, this research did not include theoretical sampling.

Theoretical sampling is data gathering which is driven by concepts derived from the evolving theory (Strauss & Corbin, 1998). It involves sampling, which evolves during the process of research. It is based on concepts that emerge from analysis and that appear to have relevance to the evolving theory (Strauss & Corbin, 1998). The aim of theoretical sampling is to maximise opportunities to compare events, incidents, or happenings to determine how a category varies in terms of its properties and dimensions (Strauss & Corbin, 1998). Strauss and Corbin (1998) maintain that theoretical sampling is a key technique used in grounded theory where sampling takes place on the basis of emerging concepts.

As this research did not use theoretical sampling, it could be argued that this research did not use a true grounded theory approach. Rather it is an exploratory study as the true grounded theory approach only features in the analytic techniques used to analyse the data.

The grounded theory approach used for this research is similar to that described by Willig (2001) namely, the *abbreviated version* of grounded theory which works with the original data only. Here, interview transcripts or other documents are analysed following the principles of grounded theory; however, *theoretical sensitivity*, *theoretical saturation* and *negative case analysis* can only be implemented within the texts that are being analysed. The abbreviated version of grounded theory should only be used when time or resource constraints prevent the implementation of the full version of grounded theory (Willig, 2001). As this study was carried out as part of the Employment Opportunities Project (see chapter 1: Introduction), time constraints were imposed on data collection. Subsequently, the abbreviated version of grounded theory was used for this research.

This study collected data in a novel area of research in order to identify preliminary themes and to allow a tentative overarching theory to emerge. This study did not use the full grounded theory approach as the research involved the one-off collection of data and theoretical sampling was not used, which makes it an exploratory study at this stage. It would therefore be useful for further studies in this field of research to be carried out using the full grounded theory approach.

6.7.5. Participant selection

This study was carried out with unemployed men receiving mental health support, living in the South Wales Valleys.

The participants in this research study were considered to experience severe and enduring mental health problems by virtue of being service users of a mental health charity which offers a range of community based services for people experiencing severe and enduring mental health problems. Although the mental health charity does not carry out any clinical work, the charity's support workers work alongside the local Community Mental Health Teams who would provide any clinical support required. When registering as a service user of this charity, individuals take part in a comprehensive assessment of their support needs. As part of this assessment, individuals' diagnoses are recorded. However, the diagnoses of participants' specific mental health problems were unknown to the investigator in this research.

Both the assumption that the individuals in this research experience severe and enduring mental health problems by virtue of the mental health support they receive, and the absence of recording participants' diagnoses could be considered to be methodological limitations of this research.

However, this research did not aim to consider mental ill-health from a medical perspective, in relation to employment issues. Rather this research aimed to explore the employment experiences, needs and aspirations among individuals who have been diagnosed as having a mental illness, who receive mental health and vocational support from services in Wales and who have been through the 'mental health system.' In particular, this study wanted to explore participants' perceptions of their health, whether they consider themselves to have a mental health problem, what this means to them and whether this impacts upon their employment experiences, needs and aspirations.

In addition, all the participants in this study were unemployed at the time of the interviews and were therefore required to recall their employment situations from the past, in some cases up to 30 years prior to the study. Throughout the research, participants described the meaning of work to them as unemployed individuals, reflecting on previous work experiences, as well as using their unemployed status as a comparison to their previous work experiences. As a result, it is possible that the participants in this study had romanticised ideas about employment and were out of touch with reality. In addition, it is also possible that the participants' could not remember their experiences accurately. Having said this, there was no indication that participants were having difficulty recalling their previous work experiences. In addition, other studies (Honey, 2003) have also carried out qualitative research with *unemployed* individuals looking at the benefits and drawbacks of employment. However, these factors must be borne in mind when considering the applicability of the results.

6.7.6. Generalisability

Finally, this research was carried out with unemployed men receiving mental health support living in areas of deprivation in the South Wales Valleys which may limit the generalisability of these findings to this group of individuals. Therefore, the findings of this research are not necessarily representative of the entire population of people with severe and enduring mental health problems.

According to The Welsh Index of Multiple Deprivation 2005 (WIMD) the areas in which the participants for this study lived namely Merthyr Tydfil, Rhondda Cynon

Taff and Neath/ Port Talbot, are some of the most deprived areas in Wales. In addition, the South Wales Valleys have a distinct culture which may have implications for inhabitants' attitudes to employment, training and education. Subsequently, the individuals in this study represent a specific group of people with mental health problems, which may limit the generalisability of these findings.

Whilst this research proposes that these findings and the resulting theory are generalisable beyond the scope of this research and that the findings have wider implications for unemployed people with mental health problems, further research is needed to confirm whether the theory fits and works with unemployed people with mental health problems in general. In particular, it would be useful to test the substantive theory with people with mental health problems living in more affluent areas of Wales, and indeed across the UK.

In addition, these results may not apply to individuals with mental health problems living in areas with low unemployment levels. Indeed, there is some evidence to suggest that the negative psychological effects of unemployment may be dependent on the local rates of unemployment for the general population. Jackson & Warr (1987) stipulate that very high local unemployment might be associated with either impoverishment or resilience within the community, which would affect health in opposite ways. Further research in this area would help to determine whether these findings are generalisable to other individuals with mental health problems across Wales and beyond, as well as among other populations.

Whether these results are generalisable to other individuals with mental health problems across Wales and beyond requires future research. It may be that these findings are situation specific in the sense that individuals with mental health problems who become unemployed and who are living in comparable demographic situations (such as in areas of high deprivation) may also follow a pathway of experiences which impact upon the meaning of work to them and their self concept. It could also be the case that the likelihood of individuals with mental health problems following this pathway is reinforced by living in a comparable environment where many individuals have travelled down the same pathway to unemployment before. In this sense, the relevance of the findings from this research to a specific situation may not be viewed as a methodological limitation, but as a potential insight into the pathway to unemployment which unemployed people with mental health problems travel down when living in areas of deprivation.

6.8 Conclusion

This research supports and expands upon many of the findings from previous research, particularly the fact that people with mental health problems lack confidence in terms of employment (Honey, 2003; Mitchell, 1998), that people with mental health problems experience discrimination and bullying (Focus, 2001; Gray, 1999, 2000; Warner, 2002), difficulties at work (Honey, 2003; Schied, 1999) and difficulties retaining their employment positions (Bond *et al.*, 1997; Secker *et al.*, 2001; Thomas *et al.*, 2002; Xie *et al.*, 1997). This research also supports previous research finding that employers are unsupportive of people with mental health

problems (Manning & White, 1995; Office of the Deputy Prime Minister, 2004; Rice, 2001).

Previous research also supports the lack of external employment support (Ng *et al.*, 2001; Secker *et al.*, 2001), that work creates pressure and results in stress (Harnois & Gabriel, 2000; Mind, 2002; Warr, 1987), as well as the fears people with mental health problems have about work such as fear of discrimination (Ng *et al.*, 2001), fear of becoming unwell and fear of stress (Honey, 2003). The findings from this research also support previous research finding that employment improves self concept (Evans & Repper, 2000; Kirsch, 2000) and mental health (Evans & Repper, 2000; Kirsch, 2000; Perkins & Repper, 1996).

This research proposes a theory which is a consequence of all of these factors. The proposed theory resulting from this research is that individuals with mental health problems who become unemployed follow a pathway of experiences which impact upon the meaning of work to them and their self concept. Following the onset of mental ill-health, the impact of mental health problems also affects identity. This results in an identity shift between the valued worker and the devalued 'mental patient.' When considering the meaning of work as the devalued 'mental patient,' individuals with mental health problems also experience an identity struggle between the former valued worker and the current devalued 'mental patient' which could also be re-attributed to a struggle between the well self and the ill self.

This research is not representative of people with mental health problems therefore this theory applies only to the unemployed men in this study receiving mental health

support, living in the South Wales Valleys. However, it is possible that the same theory could potentially apply to people with severe and enduring mental health problems across Wales and beyond, as well as among other populations. Further research would be required to determine whether this grounded theory is transferable to other individuals with mental health problems, people with a physical disability, and indeed people from other populations.

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Appendices

Appendix 1: Information sheet and consent form

Appendix 2: Interview schedule

Appendix 1: Information sheet and consent form:

Date:
Dear.....

EMPLOYMENT OPPORTUNITIES PROJECT:

What are we doing?

(The mental health charity) is carrying out a project to:

- Discover what other researchers have found out about **employment and mental health.**
- Find out what employment, training and education services are available for people with mental health problems in **your area.**
- Find out what **your** employment experiences and needs are.
- Help our service users to get training, education and work.
- Help those who are working **to stay in work**.
- Give the results to others working in the same field so we can reduce discrimination towards people with mental health problems amongst employers, and others in Wales.

Why are we doing it?

➔ We noticed that people with mental health problems are four times less likely to have access to jobs than the rest of the population (Outset Report 1999/Schneider 1998).

➔ A recent survey into the needs of our service users has shown that employment is important to them.

Why do we need your help?

We want to arrange short interviews with yourselves and with one of your support workers, to ask you some questions on:

- ✶ What type of work/ training you have done
- ✶ What problems, if any, you have had in finding and/or keeping work
- ✶ What type of work/training you would like to do, if any
- ✶ What help/support you would like
- ✶ What you think are the best ways to help you to return to work, training and/or education, if you want to do so

✪ **Remember- This survey is designed to improve the services available to you so your needs, ideas and suggestions are very important.**

Please Note:

- ❖ Any information you tell us will be completely confidential
- ❖ Your name would not be mentioned in any report or follow-up
- ❖ You do not have to be working or interested in work/training to take part in this survey
- ❖ Whether or not you take part in this survey will make no difference to the services you are getting now or in the future

- ❖ Any comments you have regarding the survey will be gratefully accepted

YOUR CONSENT:

I have read and understood the information regarding the Employment Opportunities Project being carried out by (the mental health charity).

I agree/do not agree to take part in this Survey:
(please delete as appropriate)

Name (Please Print)…….
Signed……..
Date……..

If you do agree to take part in this study:

→please could you suggest a date, sometime in ……. (date) when you and your support worker from (the mental health charity) would be able to answer a few questions;

Date……. Time…….

Your support worker's name……
Your contact telephone number……

Many Thanks

Investigator
Organisational affiliation

Appendix 2: Interview schedule:

FRAMEWORK FOR SERVICE USERS INTERVIEWS

INTRODUCTION:

- **An introduction to service users with all main points:**
- **Aims of the project= to improve the services available to you & to be able to offer job opportunities in the future, to those who want it.**
- **N.B. You do not have to be interested in work, training &/or education to take part in this interview.**
- **CONFIDENTIALITY**
- No-one is going to know what you have said
- Whatever you say will not change the services you receive
- A report will be written up with your comments being anonymous i.e. your name would not be mentioned in any report or follow up
- We will contact you when the report has been produced & ask you if you would like a copy
- Also, we will organise a day which we would like to have a great deal of service user involvement, in an informal place of your choice, where feedback would be given
- If you agree to be recorded, the tapes would be destroyed after the results have been gathered.

Collectable Data:

- Gender:
- Ethnic origin:
- Location (area in which the participant lives):
- Time Taken:

1. How long have you been receiving services from [the mental health charity]?
   (If not a continuous period, then since you began using [the charity's] services)

   Less than 12 months ☐
   12 months to less than 2 years ☐
   2 years to less than 4 years ☐
   4 years to less than 6 years ☐
   6 years to less than 10 years ☐
   10 years to less than 15 years ☐

More than 15 years ☐

2. Have you been offered any opportunities to find paid work by [the mental health charity]? If yes, details.

3. Have you been offered any opportunities to find education or training by [the mental health charity]? If yes, details.

4. How long have you been receiving mental health support from other organisations? (If not a continuous period, then since you began receiving support)

Less than 12 months	☐
12 months to less than 2 years	☐
2 years to less than 4 years	☐
4 years to less than 6 years	☐
6 years to less than 10 years	☐
10 years to less than 15 years	☐
More than 15 years	☐

5. Have you been offered any opportunities to find paid work by other organisations? If yes, details.

6. Have you been offered any opportunities to find education or training by other organisations? If yes, details.

7. How would you describe your mental health at the moment?

8. How would you describe your general health at the moment?

9. Do you have any educational qualifications? If yes, details.

10. Have you done any training courses? If yes, details.

11. Are you doing any training or educational courses at the moment? If yes, details.

12. Would you like to go on any training/ educational courses to help you find work?

IF YES:
What sort of courses do you think would be helpful?

13. What do you think you are good at?

14. Have you ever been part of a user's forum/ group?

Yes ☐
No ☐

IF YES:
i) Has this helped you in any way? If yes, how?

15. Have you ever attended a drop in centre/ day centre?

Yes ☐

No ☐

IF YES:

i) Has this helped you in any way? If yes, how?

16. Are you working at the moment?

Yes ☐

No ☐

IF YES PLEASE ANSWER i-ix, IF NO GO TO QUESTION 17.

i. What type of work do you do?

ii. How long have you been doing this work?

iii. Would you like to stay in this type of work?

Yes ☐

No ☐

IF NO:

a) Why not?

b) What type of work would you like?

iv. Thinking about your work experiences, do you feel that work causes you any problems?

v. Does your employer know that you experience mental health problems?

Yes ☐ What was your employer's reaction?

No ☐

vi. Do your colleagues know that you experience mental health problems?

Yes ☐ What was their reaction?

No ☐

vii. Do you get any support or help from:

a) Your employer?

Yes ☐ Details?

No ☐

b) Other staff?

Yes ☐ Details?

No ☐

c) Other organisations?

Yes ☐ Details?

No ☐

viii. Are you happy with the pay you are getting?

Yes ☐ Is it the same rate as other people doing the same job in your company?

No ☐ Why not?

ix. Do you have any (other) problems at work?
n.b. (other) depends on answers to previous questions

PLEASE GO TO QUESTION 22.

17. Have you worked in the past?

Yes ☐

No ☐

IF YES PLEASE ANSWER i-x, IF NO GO TO QUESTION 18.

i. What type of work have you done?
(Maximum of last 3 jobs)

ii. How long were you doing this work?
(Maximum of last 3 jobs)

iii. Would you like to return to this type of work?

Yes ☐

No ☐

IF NO:

a. Why not?

b. Is there any work that you would like to do?

Yes ☐

No ☐

If Yes to b (above)

c. What type of work would you like?

iv. Would you like any particular support to help you find work? If yes, details.

v. Why did you stop working?
(Maximum of last 3 jobs)

vi. Thinking about any past work experiences, do you feel that work caused you any problems?

vii. Did your employer know that you experience mental health problems? (Maximum of last 3 jobs)

Yes ☐ What was your employer's reaction?

No ☐

Didn't know yourself at that time ☐

viii. Did your colleagues know that you experience mental health problems? (Maximum of last 3 jobs)

Yes ☐ What was their reaction?

No ☐

Didn't know yourself at that time ☐

ix. Did you get any support or help from:
(Maximum of last 3 jobs)

a) Your employer?

Yes ☐ Details?

No ☐

b) Other staff?

Yes ☐ Details?

No ☐

c) Other organisations?

Yes ☐ Details?

No ☐

x. Were you happy with the pay you were getting? (Maximum of last 3 jobs)

Yes ☐ Was it the same rate as other people doing the same job in your company?

No ☐ Why not?

xi. Did you have any (other) problems at work? (Maximum of last 3 jobs)

n.b. (other) depends on answers to previous questions

xii. How long is it since you had a paid job?

PLEASE GO TO QUESTION 19.

For those who answered NO to Question 17 only:

18. Would you like to be in paid work some time in the future?

Yes ☐ What type?

No ☐ Why not?

19. Do you do any voluntary work at the moment?

Yes ☐ Details?

No ☐

20. Have you done any voluntary work in the past?

Yes ☐ Details?

No ☐

IF YES TO Q. 19 &/OR Q. 20:

i. Has this helped you in any way? If yes, how?

21. Are you looking for work at the moment?

Yes ☐ How?

No ☐

Any comments?

22. Is there anything you think is good about being in work?

Yes ☐ What?

No ☐

23. Is there anything about working that's not so good?

Yes ☐ What?

No ☐

24. Thinking about your mental health, how important do you think work is to you?

25. What benefits are you on at the moment?

26.What age group are you in?

a) Below 25 years old ☐
b) 25-35 years old ☐
c) 36-45 years old ☐
d) 46-55 years old ☐
e) Above 55 years old ☐

27.Any other comments?

Thank you for your time