An exploration of the role of employment in mental health recovery

By Christopher Barry Flintoft

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Abstract

For people with mental health problems gaining employment is a significant factor in social inclusion and often seen as an indication of mental well-being. Mental health services are dominated by a medical model of illness which focuses on the control of symptoms. In recent decades, service users have written about their experiences of "recovery" from mental illness. Recovery is about the subjective experience of wellness and can exist even if symptoms remain. This research was designed following an observation that employment seemed to be a significant factor in people's recovery.

Research was conducted to explore the relationship between employment and recovery. A grounded theory approach was used to gather and analyse data from nine participants who live in the north of England and have experience of unemployment and mental health problems, but who are now in a process of recovery and are employed. Semi-structured interviews and a workshop were conducted. Data were transcribed and analysed using Nvivo software. Many of the well documented recovery themes were evident in the data. In addition participants talked about factors which make employment either 'toxic' or beneficial to mental health recovery. The research indicated that unemployment and the wrong work at the wrong time are damaging to mental health and result in reduced prospects of gaining employment; the right work at the right time perpetuates a process of wellness and valued employment.

Factors significant in understanding why the right work at the right time is beneficial to recovery are induced from the data. These factors are set out in a matrix and used to consider some implications for practice.

Acknowledgements

I wish to acknowledge and thank all of the staff and fellow students involved in the Professional Doctorate programme for their support and encouragement. In particular my supervisory team.

Dedication

Dedicate to my Dad, Frank Flintoft (1925 - 2005), who taught me the importance of hard work and to my Mum, Ivy Flintoft, who taught always to do my best.

Contents

Introduction

Within this doctoral project report I set out how I conducted grounded theory research to show that, while some employment[1] at the wrong time is harmful to mental health, the right job at the right phase of recovery can be a key component in achieving and maintaining wellness. This study develops a conceptual framework of two spiralling processes. One, a vicious circle of unemployment, 'toxic'[2] employment and deteriorating mental health; the other, a virtuous circle of recovery, meaningful occupation and beneficial employment. These findings are considered in the context of the existing literature. There is an exploration of what the findings mean and their implications for practice.

This doctoral project report is divided into eight chapters. This first chapter provides an introduction and sets out the context and rationale for the research. In chapter two there is an exploration of the chosen research methodology. The next four chapters explore the findings and set out the framework for understanding employment and recovery. The seventh chapter reviews the literature. The last chapter synthesises the work and discusses what the research contributes to knowledge and its implications for practice. The reader is informed when more information is contained in the appendices. It may be helpful to read the vignettes (appendix one) before reading chapter three. Similarly, looking at the codes (appendix two) as part of chapter two may also be prove helpful to understanding the development of the grounded theory.

Within the doctoral project report the generic term mental health problems is used to describe a range of psychiatric conditions (including psychosis, neurosis and personality disorder). Formal diagnosis is only used when a specific condition is being discussed. The term "people with mental health problems" is used rather than the more medical term

[1] Employment and Work are used interchangeably and, unless otherwise stated, refer to an everyday understanding of undertaking paid work for an employer.

[2] The term toxic employment was generated doing the analysis and conceptualisation of the data, it is explored in section 8.1.2

"patients". "Service users" is used when referring more specifically to people with mental health problems who are in receipt of a mental health service. The term 'recovery' will be defined and explored throughout the doctoral project report. Recovery is not about being cured or about returning to a condition that is symptom-free; rather it is a subjective experience of wellness which can exist even if symptoms remain. Some common abbreviations are used, these are explained in full when first used and also detailed in the glossary.

Chapter One: Background to the Research

In this chapter an explanation of why and how the research was developed is explored. It is divided into two main sections. The first describes the context of mental health in the UK today and focuses on employment as part of this. The second section unpicks the reasons for undertaking the study. A small final section acts as a summary and justifies the main research question for the study.

1.1 Context of the Research

This section explores my motivations for undertaking the research, then considers the current context of mental health service and employment in England.

1.1.1 My Motivation in Undertaking the Research

Within the research proposal and the advert to recruit participants I used the following short account to illustrate the type of journey that I intended to study.

Carl's Story

I first met Carl when he was psychotic, sectioned (again), in seclusion and being medicated against his will. The professionals responsible for his care were frustrated that Carl had become so unwell again and pessimistic about his future.

I subsequently knew Carl for a number of years when he took medication. His symptoms were controlled and he stayed well and managed to remain out of hospital for most of the time. The professionals responsible for his care were on the whole happy with his progress; their only ambition for Carl was one of maintaining this state of affairs.

I now know Carl as a Support Time Recovery worker in the mental health team. Carl radiates wellness. He still has an illness and uses medication, but now he has a full-time job. The professionals who were responsible for his care, now have to get used to him as a work colleague.

Every time I think of Carl's story, and others like him, I am struck by the sense that there may be something in the nature of being employed which promotes recovery from mental health problems.

This type of journey is still unusual, but one that I have been increasingly aware of in my work as Mental Health Services Manager. It is the case that, in my role as a senior manager of mental health services, I have employed many staff who a few years ago were 'patients' and whose prognosis was poor. They now exude a wellness and are excellent motivated employees. These journeys fascinate me and led me to wish to explore the relationship between recovery and employment. The research provided an opportunity for people with mental health problems to tell their own stories; it used grounded theory to generate theories from the data and then put these theories to the test.

This doctoral project report is the substantive part of a professional doctorate undertaken while I also worked in mental health services (initially as a training manager, then service manager, then head of service and finally assistant director). During the doctoral project report I seek to reflect on how these roles influenced my experiences as a researcher in carrying out this study. Qualitative traditions require the researcher to be reflexive - self aware of themselves in the process, and to disclose this as part of the research finding acknowledging the influence it may have had (Creswell 1998). This is discussed in more detail in the final chapter.

1.1.2 Mental health, social exclusion and unemployment

Investment Framework

The last decade has seen a substantial investment in English mental health services to fund a National Service Framework (NSF) (DoH 1999). The NSF made reference to employment and cited one Trust[3] which had had some success; but there was no specific guidance on, or funding for, the development of employment services. Investment in mental health was nearly five billion pounds in 2005/06 and the real average annual growth rate since 2001/02 has been almost six percent (Oxford Economics 2007). The NSF for mental health sought to end a postcode lottery of service provision by setting a range of minimum requirements for commissioners of services. While the NSF resulted in the provision of Assertive Outreach and Crisis Teams there were no requirements for a national approach to employment services. The five year review of the NSF (DoH 2004) had little to say about employment services, reflecting the lack of progress in this area.

Recognising Social Exclusion

More recently increased attention has been paid to the social exclusion of people with mental health problems (Repper and Perkins 2003; ODPM 2004). The focus on exclusion recognises that mental health problems can mean people find it difficult to fit into society - but more significantly the active exclusion by society of people with mental health problems is often far more debilitating and problematic for the individual than their mental health problem. Tew (2005) describes this a "double whammy."

> For many people, living with mental distress may be difficult, but this may be nothing compared with dealing with the 'double whammy' of hostility, vilification, rejection and exclusion that they may face from society at large, and sometimes from friend and family. And it is very easy for negative attitudes and exclusionary classifications to become internalised (p.19).

The Office of the Deputy Prime Minister produced a report on mental health and social exclusion; highlighting the impact that unemployment has on the lives of people with mental health problems (ODPM 2004). The report identified that in addition to the

[3] London St George's NHS Trust

symptoms of mental illness, people also suffer huge social disadvantage. People with mental health problems have poorer physical health, greater unemployment, worse housing, increased social isolation and more debt than people without illness. Inevitably this leads to a vicious cycle of mental health problems and exclusion, with one problem compounded by the other. The report identified five main reasons why mental health problems too often lead to social exclusion:

- Stigma and discrimination
- Low expectations by the professionals of what service users can achieve
- Lack of responsibility within services on promoting social inclusion
- Lack of effective support to enable people to work
- Barriers to engaging in the community

One of the key components of social exclusion is the rising rate of unemployment of people with mental health problems. The rates have risen, despite an overall reduction in unemployment in the general population (Perkins 2002). However, the report also drew on evidence to suggest that the link between mental health problems and unemployment was neither causal nor inevitable. In other words it is not a simple case of the illness itself preventing people securing and retaining employment. The report also highlighted the growing evidence base around employment services within mental health care. In particular, research from North America shows that, with the right support, nearly sixty percent of people with severe and enduring mental health problems are able to work (Drake et al. 1998, Drake et al. 1999). There is emerging evidence that this is also achievable in the UK (Rinaldi et al. 2004; Crowther et al. 2001a, 2001b). The report sets out the following analysis of unemployment and mental health.

> Only twenty-four per cent of adults with long-term mental health problems are in work. With the right support, many more would be able and would like to work. Unemployment is associated with worsening mental health.
>
> GPs can have a crucial role in promoting job retention through suggesting

> work adjustments or referring to a vocational adviser. Occupational health services should support job retention and remove unnecessary barriers to work for people with disabilities or health problems.
>
> Mental Health Trusts spent one-hundred and forty million pounds in 2002-03 on day and employment services. The most effective employment projects focus on helping people with mental health problems find work in mainstream settings as quickly as possible, with ongoing support provided as needed. Such projects need not cost more than other employment projects, but can have better outcomes. (ODPM 2004:51).

My own experience of mental health services in the North of England is that little attention has been paid to employment. It is a requirement of the Care Programme Approach to assess and meet employment needs; typically, this has resulted in a descriptive account of people's employment history with little exploration of future employment hopes and even less effective planning to assist people into employment. Indeed, in my experience, mental health professionals are often fearful that employment may harm mental health and are overly cautious in suggesting that people work. The ODPM report also notes this, identifying that some GPs base the decision to sign sick notes on the grounds of age, attitude and job prospects rather than illness. The report highlights that some mental health professionals' fear that employment might make the mental health condition worse. It is with some discomfort that I think back to my days as a social worker and recognise the times when I contributed to this paternalistic and pessimistic outlook. However, it is also the case that I was aware of many people with mental health problems returning to work and suffering poor mental health as a consequence. Just as there is not a straightforward correlation between mental health problems and an inability to work, neither is there a simple correlation between employment and mental well being. The evidence detailed in the ODPM report helps to substantiate this.

Economics

Another key national driver around employment and mental health has been the desire to get more of the population back into employment. Over the last decade there has been a fall in the rate of male unemployment, but this has coincided in a rise in the number of people who are "economically inactive" due to sickness (Oxford Economics 2007). There are now more adults in England who claim sickness and disability benefit for mental health conditions than claim job seekers allowance (ODPM 2004:59). Forty percent of new claimants of incapacity benefit have a mental health problems (Oxford Economics 2007). One of the most influential reports on this was conducted by Layard, which provided a compelling economic motivation for the Government to return people with mental health problems to work. The report estimated that the cost of mental illness to the economy is some two percent of the GDP. Specifically, there is a 'lost' fifteen billion pounds of output due to people with mental health problems being economically inactive (Layard 2004). Recent announcements from central Government relating to the rules for claiming incapacity benefit are part of its resolve to tackle this issue. The aim is for one million people who claim incapacity benefit to gain paid employment within the next ten years (DWP 2006).

Research

The growing quantity of research in this area is helping to dispel some of the prevailing myths about mental health and employment:

"People with mental health problems don't want to work"

Studies have shown that the desire to work is held by between half and two thirds of people with long term mental health problems. (Bates 1996, Pozner et al. 1996, Rinaldi and Hill (2000) but less than a quarter are actually employed (ODPM 2004).

"People with mental health problems are too ill to work"

Very few studies have found a link between either diagnosis or severity of impairment and employment retention, a conclusion confirmed by an extensive review carried out by

Anthony (1994). Open employment was most frequently identified as a long term goal by mental health service users (Secker, Grove and Seebohm 2001). Social recovery models hold more promise than clinical models of recovery in achieving supported employment (Secker et al. 2002).

"Work may be harmful"

Meaningful occupation is a critical factor in clinical improvement, improved social functioning and reduction in symptoms (Schneider 1998). There is also evidence that unemployment is harmful to both physical and mental health (Waddell and Burton 2006; Platt 1984; Bolton and Oatley 1987; Lewis and Sloggett 1998).

"Most people with mental health problems are not ready for open employment (and some never will be)."

Research in the USA demonstrated mental health service users preferred open employment to sheltered work (Bell et al. 1993). A systematic review found that people who receive supported employment were significantly more likely to be in competitive employment than those who received pre-vocational training (Crowther, Marshall, Bond and Huxley 2001b).

What works in getting people into employment?

The ODPM report detailed a number of approaches to helping people with mental health problems into employment. Schneider, Heyman and Turton (2002) concluded that Individual Placement Support (IPS) has strong evidence in its favour. IPS was developed in the US and has been replicated in England (Bond et al. 2001). Traditional day services have sought to occupy service users' time, typically in mental health settings exclusively for people with mental health problems. These services are not without value but do tend to compound the social exclusion of living with mental health. Other services have engaged users to undertake tasks aimed at preparing them for work or provided sheltered work environments. A criticism of these approaches is that they reinforce segregation and are paternalistic - with few people being deemed ready for real work (Torrey & Becker

(1995); Baily et al. (1998); Becker et al. (2001)).

In contrast, IPS is offered to anyone who expresses a desire to work and is based on their preferences. The IPS approach uses vocational specialists to undertake a relatively quick assessment of vocational skills and preferences, and places people in real employment settings consistent with their abilities and interests. There follows time unlimited support to the employee and employer to maintain the placement. In order for this to work, vocational programmes are integrated into mental health teams and the focus is on securing paid employment in real work settings.

Benefits of employment

Returning to employment is often seen as a rare success story, often only considered at the point of discharge once the mental health problems have abated or are well under control. Few doubt that retaining full time employment is a good thing. It is what many service users want, it reduces social exclusion, it has financial benefits and is related to self esteem and validation of social role (ODPM 2004). Although there are some claims that employment improves mental health, the presence of employment is more commonly identified as an indication that the mental health problem is in remission, rather than identifying employment as a contributing factor to wellness. In contrast, it is well established that unemployment is bad for mental health. Prolonged unemployment is linked to worsening mental health (Singleton et al. 2001). There are strong links between unemployment and poor mental health (Warr 1987) and between unemployment and suicide (Platt 1984; Bolton and Oatley 1987; Lewis & Sloggett 1998).

There is less research on the positive impact that employment has on mental health. Employment increases self-esteem, alleviates psychiatric symptoms, and reduces dependency and relapse (Lehman 1995; Crowther et al. 2001b; Dewa & Lin 2000; Royal College of Psychiatrists 2002). However, this is from the perspective of the mental health professionals measuring aspects such as a reduction in symptoms (Bell et al. 1993; Cook and Razzano 2000), fewer hospital admissions (Warner 1994) and reduced service use

(Drake et al. 1999). There is as yet very little research on the person's subjective experience of recovery - i.e. service users' own determination of what constitutes wellness.

1.2 Rationale for my Study

The initial motivation for this research is from observing people with mental health problems gain work and experience recovery. The observation was on the relationship between the two; it was not just that people are in work when they are well and out of work when they are not. What I seemed to be observing was a journey involving a recovery process and employment that were mutually beneficial. Concurrent with this I was working in a job where I had responsibility for delivering services that promoted social inclusion. The creation of the post coincided with the publication of the social exclusion report (ODPM 2004) which contained evidence that employment was a realistic prospect for nearly two thirds of people with mental health problems. In addition there was a focus on the economic argument. Tthis continues and is likely to grow in future years.

Reflexivity

The areas of employment, recovery and mental health were issues of particular interest to me. Theoretical perspectives have influenced my motivations and the assumptions underlying the main research question and proposal; throughout the research I have tried to ensure that influences bearing upon me are recognised and acknowledged. At the outset of the research proposal I identified two broad theoretical perspectives: the social care model of mental health and the disability inclusion model.

Social model of mental health

In the second half of the twentieth century the development of more effective psychotropic medication has led to a medicalization of mental health services. Despite all the advances in medication and evidence based interventions, recovery rates of

schizophrenia are higher in 'developing' nations than in 'developed' nations (Warner 1994). There is no clear explanation for this. However it is not difficult to imagine that social factors, particularly the support networks provided by extended families and a normalization of disability, may be significant components.

Policy and legal frameworks like the NSF for mental health, the Care Programme Approach, and NHS and Community Care Act have all encouraged an integration of health and social care for people with mental health problems. Traditionally British mental health services were dominated by the "medical model" - with resources and power residing in the control of health professionals. This resulted in an emphasis on diagnosis, medical intervention (usually medication), and an ethos of promoting compliance with treatment and clinical assessment of symptoms.

Science has produced some very effective medications, but none has been the magic bullet which remove mental health problems for all sufferers and without side effects. The limitations of the medication based approach to mental health are more than pharmacological. Even the perfect medication would not be able to impact on the social factors which are crucial in enabling people with mental health problems to have full and meaningful lives. In fact, it is unhelpful to consider the 'medical' and 'social' models in dualistic terms and few mental health professionals would argue against a combination of approaches. This theoretical perspective is about shifting the balance towards the social model and, in some cases, the need to redress medically dominated thinking about mental health care. Tew (2005), quoting Bracken and Thomas (2000), makes similar points about medication, claiming that psychiatry has fanned the flames of public hope and expectation, but that these promises have failed to materialise.

Bracken and Thomas believe "that psychiatry should start a 'decolonisation', a phased withdrawal from the domains that it has laid claim to, including psychosis, depression and PTSD, by admitting the limited nature of its knowledge" (Bracken and Thomas 2000:20 quoted in Tew 2005:15). Tew points out that a 'decolonisation' does not imply

an abandonment of what medicine may have to offer but is more "a process of reclaiming the whole person as a social being from the partiality of a purely medical definition" (2005:15).

Within Britain, the history of mental health services has been one of segregation, control and incarceration. In his seminal writing, Foucault's (1965) account of 'unreason' gives an insight into the links between madness and exclusion. These actions were sometimes well intentioned and the ambition to provide humane services to the "mad" were thwarted by institutions that incarcerated long stay patients, became overcrowded and generated conditions that led to neglect and abuse (Murphy 1991). The advent of effective treatments, especially medication and the establishment of psychiatry as a medical profession, enabled a move away from institutions towards local hospital and community based care. The NHS and Community Care Act 1990 shifted services towards being needs-led, premised on promoting and maintaining independence. By the final quarter of the last century most large long stay institutions were closed; individual, needs-led, packages of care were being developed to enable people to live in the community. Community care was seen as being not only cheaper but more libertarian (Repper 2000).

As the institutions closed, the balance of care transferred to the community. However, this 'community' is a less than perfect place for providing care and protection for vulnerable citizens. Moving someone out of a hospital into a 'community home' does not make them part of that community; it does not integrate them into society. The unkind jokes about people being taken away by men in white coats were replaced by comments about someone being a "care in the community case". Repper notes that "For all the promise held in this utopian term, 'community care' has excluded people with mental illness just as effectively as the asylums did before" (Repper 2000:342).

For some individuals, medication and community services are able to provide a level of treatment, care and support that enables them to have greater choice and independence. However, the question of how to have 'a life' rather than a service has sometimes been

eclipsed (Sayce 2000a:1). Not only have people fallen through the safety net of community care in terms of treatment, care and support; a majority of people with mental health problems remain socially excluded and subject to abuse. Read and Baker (1996) found that, of the 778 users who responded to their survey:

- 47% had been verbally or even physically attacked (for example, having eggs thrown at them while being called a 'nutter', or dog faeces or lit paper pushed through their letter boxes).
- 62% said that they had been treated unfairly by family or friends and 50% by general health care services.
- 25% had been turned down by insurance or finance companies because of their psychiatric record.

Foucault (1965) suggested that segregation was about exorcism and purification of those who were 'less than human'. This may still be a factor in the social exclusion of people with mental health problems in contemporary society. This notion of 'less than human' has been used by popular culture and the mass media to create a false but powerful stereotype of mental illness as synonymous with violence - especially unprovoked, unpredictable homicide. In Britain, Philo et al. (1993) found that two-thirds of media coverage of mental illness made a link with violence. 'Madness' is therefore rejected not only on the grounds of 'difference', lack of contribution to society, or 'imperfection', but also on the grounds of fear (Repper 2000:344).

Tew identifies the core values which he sees as fundamental in any development of social perspectives:

- An end to 'them' and 'us' thinking that imposes (or reinforces) splits between 'normal' people and those suffering distress.
- A commitment to a holistic approach - always seeking an integrated understanding of people in their social context.
- A commitment to hear, and take seriously, what people may have to say about their mental distress: the content of their experiences, and the meanings, histories and

aspirations that *they* attach to them.

- A social perspective should be informed by principles of anti-oppressive and empowering practice. This involves an awareness of power differentials and maintains a concern with those factors which may diminish people's sense of self esteem or value or constrain their personal, social or economic opportunities. (2005: 16 & 17).

The theoretical perspective of a social care model of mental health seeks to address a holistic range of social need. In this context holistic means individual, relational and environmental factors shaping social need. It could be thought of as all the other factors, apart from the symptoms of illness, which are a result of living with the illness. The social care model recognizes that medication alone will not enable people to enjoy meaningful lives and that "society" continues to fear and reject people who have mental health problems. Social care is about seeing the whole person and planning support and care to meet al.l their needs. Social care is not just about wellness, it is about having a life worth living and citizenship. The social care model is essential in tackling the social inclusion agenda. Issues of employment, housing, social life, spirituality, education, leisure, arts and finances need to be seen as central to plans of care - not "add ons" or by-products of effective treatments.

Underpinning this research is the theoretical perspective of, and my personal commitment to, the centrality of the social model in mental health care. It is a belief that care in the community can only work if people are supported to be full citizens of that community, the fear and prejudice of the community is challenged and care is person-centred, user-led, empowering and holistic. In this model, satisfying the ambition of a service user to have the right to experience paid employment ranks in importance with the treatment of their mental illness.

Disability inclusion model

A greater emphasis on a social model within mental health leads to further consideration

of how society conceptualises the nature of mental health problems. People with mental health problems are raising consciousness and have begun to articulate ideas that go against the grain of popular prejudice (Sayce 2000a:27). Sayce explores various models for thinking about mental health:

- The social model of disability.
- Brain disease model.
- The individual growth model.
- Libertarian model.
- The disability inclusion model.

She argues that the brain disease model, while removing the moral taint of mental illness, also removes responsibilities - including those necessary for citizenship. The individual growth model emphasizes common humanity, suggesting that we are all on a continuum of emotional well-being. It gives back the responsibility of health to the individual, but also implicitly blames people when they do not get better. In the libertarian model, incarceration and forced treatment are at the very heart of oppression, but it leads to a conclusion that, to claim any rights, the individual has to fit in with society with no reciprocal responsibility on society to make accommodation.

> This [disability inclusion model] is a civil right, as opposed to a civil libertarian, agenda. It is about positive rights - to have fair opportunities and, for some, adjustments / supports to make them viable - as well as negative rights, to be free of unfair coercion. The social model of disability - which says that people are disabled not, or not only, by their so-called 'impairment' (that is, physical, mental or emotional difference from the norm), but instead by the barriers and prejudices that society place in their way - becomes a banner under which user/survivors and other disabled people can rally (Sayce 2000a:129).

The disability inclusion model has many parallels and a co-dependency with the recovery model. Recovery is owned and led by the individual service user. It is not about 'cure' but about leading a fulfilling life with mental health problems. Recovery is totally dependent on civil rights and opportunities for inclusion (Sayce 2000a:132).

Recovery

Recovery can exist even if the mental illness remains. Recovery in this context is about the subjective experience of illness, a movement from a personal narrative which is "problem saturated" which emphasizes pathology and victimization to one which accentuates latent strengths (Ridgway 2001). Recovery is also a proactive process of education, defining wellness, planning and self advocacy. Within the recovery model there is a transfer of ownership and responsibility from professionals to the individual.

The recovery model has grown out of self-help groups, particularly in the US. Influential figures in the US model are Copeland (2000) and Deegan (1996). It is the expertise of the experience of living with mental health problems (Repper and Perkins 2003). The main elements of the model are a reawakening of hope which is often associated with the person gaining an understanding and acceptance about their mental health problems. There is an active participation in life and an active coping rather than passive adjustment. There is a process of advocacy for self and others. The journey to recovery is complex and non linear. It involves gaining support and working in partnership.

Some see recovery as an exciting new framework for organizing the mental health field (Anthony 1993). In the US, the Surgeon General's (1999) landmark report on mental health called for every mental health system to assume a recovery orientation.

There are strong links between the disability inclusion model, employment and recovery.

> The positive benefits of work can not fully be captured by objective observers, employment can represent a valued social role that is indicative

of recovery (Torrey and Wyzik 2000).

> It is the capacity of work to create the opportunity for control, skill use, externally generated goals, variety, interpersonal contact and valued social position that promotes recovery (Warr 1987).

The theoretical perspective of the social disability model is a key to this research. It asserts that people with mental health problems have the right to employment and the right to be free from coercion and from those societal barriers that create and sustain disability, preventing people from claiming their full right to citizenship. This civil rights model is wholly consistent with recovery in its promotion of self advocacy and empowerment.

1.3 Defining the Research Question and Summary

I have observed the amazing journeys that some people with mental health problems have made and wondered about the role of employment in that journey. There has been much greater government focus and investment in mental health services over the last decade, with increased attention to the impact that social exclusion has on the lives of people with mental health problems. Unemployment has been identified as a key component in this. However, many people want employment, and with the right support, can achieve this. As noted earlier there is evidence that unemployment is harmful and there are some studies about the benefits of employment on mental health.

I approach this research from a social model of mental health care and favour conceptualising mental health within a disability inclusion paradigm. This is consistent with the growing recovery framework, which is led by service users defining, planning to achieve and maintaining their own wellness.

The aim of this research is to explore the benefits of employment on mental health in terms of the experience of recovery. It does not attempt to compare employment with other interventions (medication, treatments, etc,) or, indeed, with an absence of employment. Using a small sample, it attempts to uncover if there is a relationship between employment and recovery for those participants; and explore the nature of any such relationship. It is about the participants' subjective experience of being in paid work. This distinguishes the doctoral project report from other research about increased social contact or meaningful occupation of time (day centre attendance, voluntary work, etc.). Given the small sample size, and the resulting limited demographics it is not possible to generalise these subjective experiences to a wider population. Nevertheless, it is hoped that some important findings can be uncovered to generate further work on the role of employment in mental health recovery.

The main research question is therefore: "What is the relationship, if any, between employment and recovery in mental well-being?"

Central to the framing of the question is a focus on the importance of employment and recovery from the perspective of people with mental health problems. The aim is to provide a rich description of how it feels to experience work and recovery.

This chapter has detailed the motivation, context and the theoretical paradigm, which generated the research question. The next chapter establishes the methodology for answering this research question.

Chapter Two: Methodology

This chapter moves from the rationale and context which generated the research question to explore how the question was addressed and answers found. Section One presents a concise account of my decision making in choosing a qualitative approach and then in selecting grounded theory (section one). In section two I provide a more detailed account of how I used grounded theory in practice and finally in section three issues of rigour, trustworthiness and ethics are addressed.

2.1 Choice of Methodology

2.1.1 How Best to Answer the Research Question

The research concerns the relationship between employment and recovery. Although employment is a relatively quantifiable term, recovery and social inclusion are far from easy to define. In fact, it is in the nature of what is meant by recovery that means it can best be defined by the person experiencing it. They are not terms which lend themselves to easy measurement. Moreover there is no hypothesis to be tested, the nearest thing to a hypothesis would be: that employment is beneficial to mental health; however there is sufficient evidence to suggest that some employment is harmful to mental health. The question, therefore, is a more subtle one that cannot easily be answered by quantitative methodology. My research question is: what is the nature of the relationship between employment and mental health in the cases where employment is defined by the person as being important to their recovery?

2.1.2 The Nature of Truth

The advantages to use qualitative methodology to explore subjective experience are somewhat obvious. Becker (1993) highlights this by stating that qualitative research differs from quantitative research in five significant ways:

- Quantitative research's use of positivism. Post-positivists argue that reality can only ever be approximated; qualitative researchers are attached to post-modern, post-structural sensibilities.
- Capturing the individual's point of view through detailed interview and observation.
- Examining the constraints of everyday life.
- Securing rich descriptions.
- The gendered, multi-culturally situated researcher approaches the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology) that are then examined (methodology, analysis) in specific ways.

The decision to use qualitative methodology brings with it a range of philosophical assumptions about the nature of knowledge:

> Knowledge is within the meaning that people make of it; knowledge is gained through people talking about their meanings; knowledge is laced with personal biases and values; knowledge is written in a personal, up-close way; and knowledge evolves, emerges, and is inextricably tied to the context in which it is studied (Creswell 1998:19).

Creswell's comments about knowledge encapsulate the rationale for going and talking to service users about their lived experience of mental health and employment. The knowledge that I wanted to uncover in this study was the meaning that the participants attached to employment within their recovery journey. Therefore the decision to use qualitative research brings with it more than a utility in addressing a particular research question. It is also a philosophical question on the nature of knowledge. Bryman terms this as a "a question of epistemology or technique" (1988:04).

Epistemology

In relation to epistemology Gordon goes on to provide three responses:

- Firstly that the possibility of an objective, value-free account of the social world is questionable.

- Secondly, the validity, defined as how truly empirical evidence represents reality, is important to both quantitative and qualitative research. It must be made clear what or whose 'reality' is being represented.
- Thirdly the answer is to find criteria to satisfy the reader that the reality being represented is a faithful interpretation of the evidence (Gordon 2000).

Truth in terms of quantitative methodology is reductionist and often deductive. It involves a process which objectively treats data establishing correlation and probability in order to find the irrefutable truth (internally / externally valid). This "truth" is pure and stable in its composition, and is therefore able to be utilised in other contexts (generalizerable) and enduring over time (reproducible).

In contrast qualitative research is inductive, explorative, and narrative in style. It holds that there are multiple truths and seeks to provide a rich (dependable and confirmable) description of the data - allowing it to tell its own (credible) story, noticing patterns and its distinctive nature. By understanding the story we understand the nature of the thing discussed. We gain knowledge about it which allows us to connect with it and with other things (transferability) Lincoln and Guba (1985) .

In the previous section some statistical and quantitative information provided evidence of the degree to which people with mental health problems experience unemployment and the resulting social exclusion. This quantitative information has acted as a springboard for me to undertake this research to explore the nature of the problem, or more accurately the nature of employment and recovery. In private discussion with Miles Rinaldi[4] he articulated the opposite view; that for him qualitative research has often acted as a springboard to undertake quantitative research. Quantitative research is often seen as more provable and scientific, whereas qualitative research provides a much richer description that allows us to connect with the lived experience of recovery and

[4] Rinaldi works within mental health employment service for St George's London and has written about the introduction of IPS into the UK - see references

employment. The differing approaches of Rinaldi and myself could be used to suggest that there is a healthy relationship between the two traditions and nature of truth, with one set of answers generating a new a different set of questions, each building on the other. In my own experience it has been useful to be able to present hard facts about the success rates of employment schemes when arguing the case for new investment. Similarly understanding the experience of work and unemployment has helped me develop a compelling argument when trying to win 'hearts and minds'.

2.1.3 Technique

Creswell (1998:17-18) sets out the reasons for choosing qualitative research:

- The nature of the research question (how or what as opposed to why)
- The topic needs to be explored - difficult to identify variables, lack of theories
- Need for a detailed view of the topic
- In order to study individuals in their natural setting
- An interest in writing in a literary style
- Sufficient time and resources to spend in data collection
- Audience is receptive to qualitative research
- To emphasis researcher role as active learner, rather than an expert.

Some of these reasons are explored in the context of mental health and social inclusion:

The nature of the question. This has been addressed above. The phenomena of social inclusion and recovery are somewhat slippery, and recovery is defined by the person experiencing it. This is best approached through qualitative research methods.

Audience receptive to qualitative research. One ambition of this research is to explore the experience of the difficulties faced by people with mental health problems moving into or towards work. There is evidence (ODPM 2004:43) to suggest that mental health professionals are often those with the least optimism about service users returning to real

work. In disseminating the results of this research it is hoped that it will promote services to engender hope. It is proposed that the narrative style of qualitative research is more likely to create a inspirational climate, by telling accessible 'real' stories of success and achievement.

Active Learner The past few decades have witnessed an increase in partnership working between mental health services and service users. This is consistent with qualitative research's objective to minimising the distance or 'objective separateness' between the researcher and the those being researched (Guba and Lincoln 1988).

All research starts with a question or problem, or more accurately with an individual's curiosity about something which is posed as a question. I am aware that the elements of the unknown which stimulate my curiosity are those which relate to the human interaction within any dynamic: "how is it being you, in this context?"

In addition to Creswell's list I would also add personal preference and story telling as reasons why I chose qualitative research.

Personal Preference

> You need to think through exactly what you are trying to achieve rather than be guided by some fashion or trivial preference - perhaps you are not comfortable doing statistical calculations (Silverman:2005:7).

Silverman is undoubtedly right in this. However it is also the case that the researcher has to survive the process. This study was undertaken while I was working full-time and required me to sacrifice huge amounts of time and energy to its completion. The choice to adopt a qualitative rather than a quantitative approach was not a trivial preference. I had to pick an area and method of study that would keep me motivated throughout the research process. It is no accident that the choice of the research question is based in an area which lends itself to a preferred style of research - and Silverman is absolutely right:

I hate statistics!

Story Telling

The study seeks to explore lived experience which is more likely to be made accessible through the study of language and dialogue, to provide a rich description. Thornhill et al. (2004) argue that work is needed to redress the over emphasis on positivism and the use of positivist methodology in relation to recovery from psychosis. It is important that people tell their own story of recovery and employment. Ridgway (2001) describes first person recovery narratives as having the power to help us refocus our thinking. Within a traditional medical model the doctor will typically sift through an account (not always the patient's own account) of a behaviour, beliefs and presentation and present it in medical language and meaning. People are given a diagnosis which often becomes a label applied at the level of identity "you are a schizophrenic / manic depressive etc". Behaviours and thoughts are described in terms of symptoms: "paranoid thought", "flight of ideas", "elated mood" etc. Within this exchange there is little expectation or opportunity for the person to tell their own story, in their own language and finding their own meaning.

Ridgway (2001) also argues that narratives help practitioners understand and respect diversity. Giving voice to the previously marginalized enables issues of justice, power and abuse to emerge. A revision of discourse may then occur that serves to empower the oppressed group. Somers (1994) argues that stories guide action, that by telling stories people construct identities and that experience is constituted through narratives. Therefore in answering the research question a mechanism that starts with and is centred on people's own stories is essential. The research question is asking more than "what has work done for you?" It seeks to reveal a rich description which is likely to involve issues around identity, relationship with illness and wellness, and social inclusion.

Choosing between the five traditions

The research question could be answered using a variety of qualitative methods which involve asking people about their subjective experience of work and recovery. Creswell

(1998) discusses how the same event could be explored using one of five traditions of qualitative research. The distinctive nature of the traditions means that some lend themselves better to some research questions; in addition the researcher also needs to consider the audience and method of dissemination as this may also influence the decision about which traditions to use. Creswell proposes five traditions of qualitative research:

- A Biographical Life Story - a form of narrative, one which often focuses on epiphanies and sets them in a social context; generally it relates to only one individual

- Phenomenology - reports the meaning of the lived experience for several individuals about a concept or phenomenon

- An Ethnography - a description and interpretation of a cultural or social group system

- A Case Study - is the study of a "bounded system" (an event set in a time and place)

- Grounded Theory - general methodology for developing theory that is grounded in data systematically gathered and analysed

Grounded theory was not the only method of answering the research question. Ethnography and case study were discounted as the experience under observation is not bound in a time or place; and not really a cultural or social group in its own right. A phenomenological or narrative approach were both considered as alternatives. Within the research there are elements of studying a phenomena and doing this through the telling of life stories. However it is hoped that this research would be a creative process and grounded theory is appropriate to use where there is a lack of knowledge or theory of a topic, where existing theory offers no solution to problems or for modifying existing theory (Bluff 2005:147). In Grounded Theory there is a continuous interplay between analysis and data collection during which new theory evolves (Strauss & Corbin

1998:158). Grounded theory methodology explicitly involves "generating theory and doing social research [as] two parts of the same process" (Glaser, 1978, 2).

2.2 Using Grounded Theory

This section is in two parts: an overview of what grounded theory is, and then a more detailed account of how I used it in practice.

2.2.1 What is Grounded Theory

> Grounded theory is a *general methodology* for developing theory that is grounded in data systematically gathered and analysed. Theory evolves during actual research, and it does this through continuous interplay between analysis and data collection. (Strauss & Corbin 1998:158).

In *The Discovery of Grounded Theory*, Glaser and Strauss challenged the prevailing methodological assumptions. What came to be known as Grounded Theory provided a systematic strategy for qualitative research. Glaser and Strauss joined epistemological critique with practical guidelines for action; producing a systemic approach to analysis that could generate theory (Charmaz 2006:5).

For Glaser and Strauss (1967; Glaser, 1978), the defining components of grounded theory practice include:

- Simultaneous involvement in data collection and analysis
- Constructing analytical code and categories from data, not from preconceived logically deduced hypotheses
- Using the constant comparative method, which involves making comparisons during each stage of the analysis
- Advancing theory development during each step of data collection and analysis
- Memo writing to elaborate categories, specify their properties, define relationships

between categories, and identify gaps

- Sampling aimed toward theory construction, not for population representativeness
- Conducting the literature review *after* developing an independent analysis.

(Charmaz 2006:5)

Glaser and Strauss, in an attempt to defend qualitative research, developed Grounded Theory (1967). However in subsequent years the writers and theory went in separate directions. Glaser's work became closer to a more traditional positivist approach, with assumptions of an objective, external reality, and a neutral observer who discovers data. Whereas Strauss, writing with Corbin, favoured using data coding and analysis to generate questions and seek answers in the data (Charmaz 2003). These questions generate a working hypotheses or propositions that can be validated in subsequent data collection. Grounded Theory is therefore an inductive and deductive process (Bluff 2005:153). For Glazer this amounted to forcing theory by asking specific questions - rather than allowing the data to speak for itself.

The main distinction between grounded theory and other qualitative approaches is the focus on the development of theory. There are interrelated processes of data collection and theoretical analysis; built into this is an explicit mandate to strive toward verification of its resulting hypotheses.

Essentially, grounded theory methods consist of systematic inductive guidelines for collecting and analysing data to build middle-range theoretical frameworks that explain the collected data. Throughout the research process, grounded theorists develop analytic interpretations of their data to focus further data collection, which they use in turn to inform and refine their developing theoretical analyses (Charmaz 2003a:249).

2.2.2 Using Grounded Theory In Practice

Participants

The sample was generated by advertising in the local area for people who: (i) had been unemployed (for a period of more than 3 months) during their mental health problems and were (ii) now employed (for a period of more than three months[5]) and (iii) described themselves as being in a process of recovery. Research governance and ethics approval was gained from the Local Research Ethics Committee. Adverts were distributed via mental health services and service user groups. It was hoped that this would generate enough interest in the project to ensure a small but diverse sample. In the end the sample was not forthcoming and the research plan was delayed due to a lack of participants. I did not intend to interview people who were known to me or who were employed within the same organisation as me. In order to complete the research in a timely fashion I had to put aside this intention and interview the nine people who came forward and met the main criteria as outlined above.

The sample comprised of eight men and one woman, all of whom described themselves as white British. Four of the participants were employed as Support Time Recovery (STR) workers in mental health services; three were chefs and one was an office worker and an NHS employee[6]. Their diagnosis was the most current given diagnosis - whether they felt it accurate or meaningful. I had met four of the participants before, they were now all employed within the same organisation as myself. I had also known three of the participants as service users, though none had been on my caseload. Participants were invited to chose their own pseudonyms.

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5 The Government usually use employment for over 16 hours a week sustained for 13 weeks to measure that someone has gained employment.

6 The nature of Andrew's post is so unique that to be any more specific about his role would compromise his confidentiality.

Table One: Demographics of Participants

Chosen pseudonym	Gender	Age	Current Job	Diagnosis
Mark	Male	35	STR	Bi-polar
David	Male	55	STR	Bi-polar
Andrew	Male	29	NHS	Schizo affective
Pete	Male	54	Chef	Depression
Fiona	Female	29	Office Work	Depression
Leonard	Male	46	Chef	Bi-polar
Boris	Male	56	Retired Chef	Schizophrenia
Noel	Male	34	STR	Schizophrenia
Wilbur	Male	37	STR	Schizophrenia

A brief vignette has been written about all of the participants (Appendix One). In chapters three, four and five there are more detailed accounts of Boris, Andrew and David.

Four of the participants were STR workers. In introducing the role the Department of Health (DoH 2003) defined an STR worker as someone who works as part of a team which provides mental health services and focuses directly on the needs of service users, working across boundaries of care, organisation and role. STRs provide **S**upport, give **T**ime to the service user and thus promote their **R**ecovery. STR workers do not have to have experienced mental health problems themselves - but the role is ideally suited for someone who has first hand experience of recovery

The guidance set out what STRs should do:

- STR workers, who must be linked into the care co-ordination process, will
- promote independent living;
- provide companionship and friendship but within appropriate, transparent boundaries;
- provide regular and practical support;
- provide support with daily living;
- facilitate people living "ordinary lives";

- help the service user to gain access to resources;
- provide information on health promotion;
- help to identify early signs of relapse; and
- support service users with involvement/participation with their treatment.

Sample composition and masculinity

Consistent with a Grounded Theory approach the sample was small and, inevitably, it did not have a great deal of diversity. It was unfortunate that only one woman could be recruited and the entire sample was white British. Ideally, a more representative sample would have been used. Consideration was given to removing Fiona from the sample and framing the research about men's experiences. However, with just eight men it would not be possible to establish that their experiences were representative of all men, and issues of gender could not easily be asserted. Indeed, another sample of only women would have been required to make even tentative suggestions that different employment and recovery experiences were associated with masculinity and femininity. Most of the older male participants articulated a strong work ethic and, though it was beyond the scope of this research, it is interesting to speculate whether this was an aspect of their masculinity.

Interviews

Each participant was interviewed using a semi structured interview. These were taped and transcribed into NVivo software by myself. At the beginning of the interview the research question was introduced and the participants were invited to tell their story starting from their childhood and their first thoughts about employment. Some participants (Andrew, David, Boris, Leonard) needed little prompting, whilst others waited for questions to elicit their stories. There was no interview script but participants were encouraged to talk about their experiences of illness, unemployment, recovery and employment. Once the participants had told their story in a chronological they were asked about the parts of the journey that seemed to be significant or which needed greater explanation. The interviews with Wilbur and Noel also took this structure. In addition I asked these two specific questions in relation to the emerging framework.

Once the first three interviews were completed with David, Mark and Andrew the transcribed interviews were read line by line and coded. Typically a few sentences were assigned a code so that the context of the passage was retained. Many passages were coded to two or more codes. Only a very small amount of text remained un-coded and this was carefully reviewed to ensure that there were no new emergent themes. In total seventeen codes were created and descriptions produced for each, as follows:

Acceptance - The coming to terms with mental illness; insight; accessing services; identity; positive use

Admission - Admission to hospital including the period before admission (change in symptoms, decisions to admit) and the time spent on (mental health) wards

Diagnosis - The process and impact of being given a diagnosis

Discharge / aftercare - Progress of discharge from hospital and on going follow up care

Disclosure - Extent; decision to tell other people about own mental health problems / history. Coming to terms with. Coming out. Pride in mental illness. Use of illness as a positive

Doctors - Comments and decisions of medical staff (GP, Consultant)

Education - Formal education including school, university and college

Jobs - Actual periods of paid employment

Meaningful occupation / Work - Use of time, Voluntary Work, Service User and Carer Movement. Day services. Attitudes towards work, employment, work ethic, hopes aspirations

Medication - Medical treatment for illness, compliance, efficacy, side effects, titration, own choices (demands)

Recovery - Process of self management of illness, education about illness, acceptance, developing own plan of action, monitoring. Subjective experience of wellness. Enjoying life

Reoccurrence of Illness - Periods of relapse, course of illness, readmission,

Social Network - Friends, carers, relatives, social inclusion, carer network

Start of illness - First indications of illness: explanation, perception, symptoms, accessing treatment / Services

Stigma - stigma, prejudice, including direct, indirect, self stigma

Unemployment - Not being in work, including unemployment and being on sickness benefit

Welfare Benefits - Welfare benefits, benefit trap, financial implications of work and unemployment

These codes are also set out in table three (pages 66-67) where they are linked to the categories and concepts, and major themes. Appendix two lists all the codes with their definitions and appendix three lists the properties and dimensions of the codes.

Virtually all of the text was coded to one of these seventeen codes. This coding was done before I looked in detail at the systematic approaches described by Corbin and Strauss (1990) or Charmaz (2006). I discuss the impact this had on the research in the next

sections. Four more interviews took place between February and May 2007 (Pete, Fiona, Leonard and Boris). These were coded using the above codes. In July NVivo was used to produce a report of all the passages coded to a particular code from all the interviews. Each was read and further codes were added. These were: Decision, Education about illness, Epiphany, Hope, Negotiate own care, Other people's problems, Out and Proud, Respect, Value mental health problem, Work as negative, Work Placements, Written off, and Reasonable adjustment. A full list of codes and descriptions is contained appendix two.

In August 2007 each of the interviews were re-read to identify whether:
- there were still some missing codes
- there were any areas that needed coding or recoding

This part of this process had been intuitive. As themes emerged they were coded to the broadly defined codes above. Only a few minor changes were made and the conclusion was reached that a point of saturation had been reached.

Using the Methodology: Strauss and Corbin

This was the first time I had undertaken grounded theory, the research was conducted in a systematic fashion, as described by key writers on the methodology. Initially this was based on the work by Strauss and Corbin (1990).

Many grounded theorists discourage extensive background reading before commencing the research so as not to influence the coding process. Strauss and Corbin (1990) discuss what the researcher brings to the subject area. They suggest that there are three sources of theoretical sensitivity: literature, professional sensitivity, and personal experience. The professional experience may come from years of practice in a field. Theoretical sensitivity is the ability to recognize what is important in data and to give it meaning. It helps to formulate theory that is faithful to the reality of the phenomena under study.

Some reading had been undertaken to move from the initial point of inquiry to the submission of the research proposal; it was a difficult balance to read enough to know that the area of research had some merit and would contribute something new without reading so much that it would unduly influence the coding process. In a similar way my professional background meant that I was very familiar with the stories and events that I heard during the interviews. In the last chapter I reflect on this in more detail in the section on reflexivity.

Strauss and Corbin (1990) identify that once the data have been collected, the first task for the grounded theorist is to code the text. Coding represents the operations by which data are broken down, conceptualised, and put back together in new ways. It is the central process by which theories are built from data (Strauss and Corbin 1990:57). They describe a very detailed account of the different types of coding and the sequence in which they occur. However they stress that the lines between each type of coding are artificial. The different types do not necessarily take place in stages. In a single coding session, you might quickly and without self-consciousness move between one form of coding to another, especially between open and axial coding (1990:58).

This was certainly my experience of using this approach. It was very easy to become confused about the type of coding that was been undertaken and became lost in the sequence of events. Strauss and Corbin set out the following definitions to help establish the distinction between the coding processes:

- **Concepts**: Conceptual labels placed on discrete happenings, events and other instances of phenomena

- **Category**: A classification of concepts. This classification is discovered when concepts are compared one against another and appear to pertain to a similar phenomenon. Thus the concepts are grouped together under a higher order, more abstract concept called a category

- **Coding:** The process of analysing data

- **Code Notes**: The product of coding. They are one type of memo

- **Open coding**: The process of breaking down, examining, comparing, conceptualising, and categorizing data.
  - **Properties**: Attributes or characteristics pertaining to a category
  - **Dimensions**: Location of properties along a continuum
  - **Dimensionalization**: The process of breaking a property down into its dimensions.

- **Categorizing** The process of grouping concepts that seem to pertain to the same phenomena. The phenomenon represented by a category is given a conceptual name; however this name should be more abstract than that given to the concepts grouped under it. Categories have conceptual power because they are able to pull together around them other groups of concepts or subcategories.

- **Axial Coding:** A set of procedures whereby data are put back together in new ways after open coding, by making connections between categories. This is done by utilizing a coding paradigm involving conditions, context, action / interactional strategies and consequences.

(1990:61-65)

In retrospect it seems that the initial 17 codes were at a higher level than the process described above. They are more like categories than concepts and the coding was done at the level of sentences and paragraphs (rather than line by line). I did approach the data with some degree of professional and theoretical sensitivity and was a little reassured by Strauss and Corbin about stressing that the lines between the codes can be somewhat artificial and need not occur in stages.

As mentioned above there was something intuitive about the generation of the codes. They seemed to naturally fall out of the data and to be the significant components in the stories the participants told. However Strauss and Corbin's methodology is helpful as it provides a range of techniques that allowed me to analyse the categories identified. Strauss and Corbin say the techniques are helpful to the researcher during analysis as they help to remove the blinkers composed of assumptions, experience, and immersion in the literature.

The techniques used were:

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- Establishing the properties and dimensions of all of the categories. This led me to consider their dynamics and pose questions about causality, context and consequence within and between codes (see Appendix Three).
- The use of questioning: who, what, why, how, how much, when and where. For example, asking the questions about the text coded as 'admission' helped me think about the diversity of experiences attached to going into acute mental health care:
    - **What** Acute care, crisis, chaos, compulsion (risk), safety. Useful, boredom, bad experience
    - **When** who determines when?
    - **Where** Stigma of local "mental ward"
    - **Who** Experience of being with others (with MH Problems) - self comparison with other ill people
    - **Why** Increased symptoms, Illness, Doctor say so,
    - **How** Requesting admission and being refused; being admitted by others; compulsion.
- Analysis of a Word, Phrase, Sentence. For example I was really struck by the phrase "and I thought this is where I turned into a schizophrenic" used by Andrew to describe the experience of working as a waiter while he was still unwell. Thinking about this phrase raised lots of questions about the nature and timing of that job and its impact

on Andrew's mental health - especially in relation to identity.

- Further analysis through comparison. The different work experiences prompted me to ask question about the nature of work that could be described as harmful or beneficial.

This links in with the next stage in the Strauss and Corbin methodology, a process they call axial coding. However as I attempted to work through it, it became confusing and problematic. These processes seemed convoluted and did not seem to add value to answering the research question. Attempts to link subcategories to a category in a set of relationships (causal conditions, phenomenon, context, intervening conditions, actions/interaction, and consequences) became confused. In hindsight it seems that the earlier coding had not created neatly separated subcategories and categories. In the midst of this confusion and anxiety, views of another author on grounded theory were explored.

Using the Methodology: Charmaz

Kathy Charmaz is a contemporary writer on grounded theory. I found her approach more accessible and the process she describes for completing grounded theory appeared more straightforward.

Charmaz (2006) has developed her own philosophical perspective on grounded theory. Whereas Glaser and Strauss talk about discovering theory as emerging from data separate from the scientific observer, Charmaz assumes that neither data nor theories are discovered. "Rather, we are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvements and interactions with people, perspectives and research practices" (Charmaz 2006:10).

Charmaz also presents a much simpler analysis of the coding process. She says that grounded theory consists of at least two main phases: 1) an initial phase involving naming each word, line or segment of data followed by 2) a focused selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate, and organise large

amounts of data. While engaged in initial coding, you mine early data for analytical ideas to pursue in further data collection and analysis (2006:46).

For Charmaz grounded theory coding generates the bones of the analysis. Theoretical integration helps to assemble these bones onto a working skeleton. Coding is the pivotal link between collecting data and developing an emergent theory to explain these data. Through coding, you define what is happening in the data and begin to grapple with what it means. Memos are used as a step between coding and completed analysis, they help in the thinking and defining of theory, they record analytical steps and link the analytical with the empirical. The theory is defined by theoretical sampling. It is a defining property of grounded theory and helps refine ideas and theoretical constructs.

Charmaz (2006) is cautious about the value of axial coding. For her it is questionable as to whether it offers a more effective technique than careful comparison. As Charmaz puts it:

> At best, axial coding helps clarify and to extend the analytical power of your emerging ideas. At worst, it casts a technological overlay on the data - and perhaps on your final analysis. Although intended to obtain a more complete grasp of the studied phenomena, axial coding can make grounded theory cumbersome (2006:62).

Finding my own way

Charmaz's was helpful in making progress past the stumbling block of axial coding. Charmaz's description of the need for a process of comparison and analysis - going back and forth between theory and data - set the direction for the next part of the process. The process continued with a combined approach using both Strauss and Corbin, and Charmaz. It became difficult to see what the data meant. At one level the data seemed very straightforward - the accounts of people's journeys are fascinating but it was hard to establish any emergent theories.

Helpfully Strauss and Corbin acknowledge the difficulty at this stage of integrating one's materials. They quote a personal communication from Paul Atkinson which sums up the difficulty:

> This aspect - making it all come together - is one of the most difficult things isn't it? Quite apart from actually achieving it, it is hard to believe, it is hard to inject the right mix of (a) faith that it can and will be achieved; (b) recognition that it has to be worked at, and isn't based on romantic inspiration; (c) that it isn't like a solution to a puzzle or a math problem, but has to be created, (d) that you can't always pack everything into one version, and that any one project could yield several different ways of bringing it together (1990:117).

Having avoided axial coding I returned to Strauss and Corbin and to the next phase which they call selective coding and core category.

- **Story:** A descriptive narrative about the central phenomenon of the study.
- **Story Line**: The conceptualization of the story. This is the core category
- **Selective Coding:** The process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development
- **Core Category:** The central phenomenon around which all the other categories are integrated. (1990:116)

Strauss and Corbin (1990) set out several steps through which identifying the storyline is achieved. They stress that it is important to understand that these steps are not necessarily taken in linear sequence, nor are they distinct in actual practice. In reality one moves back and forth between them. As they say:

- The first step involves explicating the story line. This involves moving from description to conceptualization. The analytical ordering looks something like this: A (conditions) leads to B (phenomenon), which leads to C (Context), which lead to D

(action / interaction, including strategies), which then leads to E (consequences).

- The second consists of relating subsidiary categories around the core category by means of the paradigm.
- The third involves relating categories at the dimensional level.
- The fourth entails validating those relationships against data. Validating theory against the data completes its grounding
- The fifth and final step consists of filling in categories that may need further refinement and / or development.

There were two problems at this stage: (i) understanding the process, and (ii) applying the theory to the data which seemed unforthcoming in generating a grand theory. Both these problems were addressed by simply using the data to provide a worked example of a storyline to help understand the process. This was the nearest point to a 'Eureka!' moment in the whole process. In effect a story was made up from the data. There appeared to be a series of processes that meant that work either contributed to good mental health or was detrimental to it. This led to a conceptualisation of virtuous and vicious circles that respectively impact on good or negative experiences of mental health.

Returning to the Data

Within supervision I was encouraged to consider if all the codes appeared in all the interviews. My initial assumption was that this was the case. However reports were run on NVivo to try to clarify this. The results were recorded in a spreadsheet.

- Only one interview (Andrew) contained all the codes.
- 16 Codes were in every interview
- 14 Codes appeared in some but not all of the interviews
- The newer codes were less likely to be in all the interviews.
- Fiona and Leonard were the ones with fewer coding types:
  - Fiona 22
  - Leonard 23
  - Pete 25

- Boris 25
- Mark 27
- David 28
- Andrew 30

This led to further considerations on the implications for the data analysis:

- Is there evidence of saturation?
- Are the categories there, but not coded?
- Is there something different (which has not been coded) evident in the ones where codes are missing?
- Is there something significant happening? Are there any patterns to be discovered?

In addition there were areas which needed to be explored by returning to the data:

Vicious and Virtuous Circles

- What is the evidence of the virtuous and vicious circles? Is it mentioned? Can it be seen implicitly? What are the drivers / context? What does it look like? Is there a sequence? Are the same components in both circles? What shifts it one way or the other?
- Are there cases where there is no evidence; what are the exceptions and gaps?
- Use the coding to bring the data into the memos

Storyline

- Is there an emergent storyline in the data (can quotes be identified to support it)?

Moving from focused coding/categorising to axial coding

- Is there evidence of causality between the codes? Where is there dependency, symbiotic relationships, mutual exclusions, sequencing, mutual inclusions?
- Phenomenon: Employment which is successful aids recovery, or is it recovery that allows employment?

- Context location of events, dimensional range
- Intervening conditions
- Actions, who is doing what when this happens?

Reading through the interviews there were some pieces of text that could be coded to the missing codes for that interview and the occasional additional coding of text with codes already used in that interview. A few seemed like significant oversights. In some cases text coded to one code could equally coded to another similar code. A comparison of the results was produced.

It became clear that Mark, David, Andrew and Boris had the fullest experiences of mental health problems, unemployment and recovery, as part of employment. Fiona and Pete had a relatively shorter period of illness, but also a diagnosis of depression with the absence of psychotic features. Participants with most of the codes were Mark, David and Andrew. All three have some experience of a recovery model and all have worked in mental health services.

Boris and Leonard have some codes missing. They both have significant psychotic illness and periods of unemployment.

Table Two: Use of Codes

	Original (30 codes)	Re-coded (with 4 new codes)
Fiona	22	24 (27)
Leonard	23	25 (29)
Pete	25	27 (29)
Boris	25	26 (30)
Mark	27	30 (34)
David	28	30 (34)
Andrew	30	30 (34)

When approaching this a number of things were observed:

- People's journeys are similar but also unique, so there is a danger that the individual story is forced into the codes and theory.
- There was a consistent message about reaching a level of wellness or recovery before work was possible or helpful. The notion of three-quarter recovery was expressed, meaning that if total recovery were a hundred percent then one needs to be at about seventy-five percent before employment was helpful as a mechanism to maintain recovery.
- There are differences in factors identified as helping recovery compared to those that maintain it. Gaining recovery was about personal development, learning, experiencing, whereas maintaining was more about self monitoring and knowing self and taking action to stay well.

Earlier work led to a belief that saturation had been reached in relation to coding, but going back to each interview and considering the missing codes enabled more text to be coded. Charmaz (2006) warns that some researchers who use grounded theory methods discover a few interesting findings early in their data collection and then truncate their research. The intention of repeatedly returning to the data was to review the coding in a variety of ways. Transcribing the interviews myself proved crucial in gaining a working familiarity with the data.

A conceptual framework appeared to be arising from the data with the conception of virtuous and vicious circles. The idea was that the participants sought normalization and for them any recovery process would not be complete or sustained while they were not employed. Recovery without employment was also insufficient; but recovery with the right type of employment represented a wholeness. A process of theoretical coding in Grounded Theory methodology was undertaken. New codes were added and amended to match the virtuous and vicious circles:

- Normalization - Defining being in employment as normal
- Insufficiency & Work - Experiencing work which does not equate to a feeling of

normalization

- Stability & Insufficiency - Recovery process which does not achieve normalization
- Wholeness - Recovery process and work which equates to normalization

However these proved not to be useful. They did not add any conceptual or theoretical value. There was a lack of distinction between the codes and they were not evidenced (grounded) in the text. The theory of normalization, insufficiency and wholeness had not proved to be a useful theoretical concept. They were subsequently amended:

- Insufficiency (found in all but one interview) "The process of receiving treatment and intervention but continuing to feel that this is not sufficient - that it does not feel like wellness or wholeness"
- Recovery and Work (in all interviews) "Identification / experience of work as being a component of recovery and wholeness"
- Wholeness (found in 4 of the interviews) "Process or experience that work has contributed to a wholeness / recovery."
- Work as normalization (in all interviews) "Belief / experience that work is 'normal' and its absence is abnormal."

At a later date (11/11/07) a further code was added:

- Maintaining Recovery (in all interviews) "Process and factors in maintaining recovery"

The codes of Jobs; Recovery and Unemployment were very large in the range they covered. Advice on the tutorial for using NVivo was that it was better to use broad codes and although the software allows for a hierarchy between codes it is easy to create problems by establishing relationships too early in the process. It was now clear that these three codes needed more detailed exploration.

NVivo was used to re-read the parts of the interviews coded to Recovery. For each interview the key "storyline" processes were identified. In addition the components which led to recovery and the mechanism that maintain recovery were listed. It would have been helpful to copy key quotes and use the same terms for similar themes. This was done with later work on Jobs and Unemployment.

A similar process for Jobs and Unemployment was adopted. NVivo was used to pull all the text coded to Jobs into one memo. Once done the lists were sorted for similar themes which were listed together on the same line and grouped under broader headings. Mind maps[7] were used to explore and depict relationships. A number of rough drafts were completed before the final version was done.

Memos

Memos are an essential part of grounded theory methodology. They chart, record and detail a major analytical phase of the journey. Since beginning the professional doctorate a monthly reflective portfolio has been kept, which has charted progression through the research. Memos were kept about the data collection (notes were taken immediately after the interview and following transcribing), memos in the form of notes for supervision were generated about the coding process. More formal memos were kept about the theoretical categories and throughout the research process. Writing memos expedites your analytical work and accelerates your productivity according to Charmaz (2006).

In the process of learning and taking notes about grounded theory methodology the data were used to test out my understanding. For example, as detailed above, as I read about the techniques I applied them. These notes on how to do the process became memos in the process. In my reflective accounts as I thought about emerging themes I included raw data to illustrate my thinking. Memos were also useful to ask myself and the data questions - which continued the interplay between analysis and data collection. An example of one of my memos is contained in appendix four.

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[7] Mind maps are similar to spider-grams and were developed by Tony Buzan (1974)

Defining the conceptual framework

As a novice to grounded theory it was still hard to work out what needed to be done next in relation to the methodology. There was a tension between simply doing what seemed logical and following the methodology. The risk of doing what seemed logical was that it may not be productive and lead down a path which cannot be claimed as grounded theory. The danger of following the texts is that it was difficult to understand and easy to get lost in the processes. On reflection it became clear that the work undertaken on Jobs, Recovery and Unemployment was a form of axial coding - as they explored context and sought causal conditions. To progress I returned to the central research question: Is there a relationship between employment and mental health recovery and if so what is it?

Mind maps were devised in an attempt to answer this. Combining creative thinking with reference back to the mind-maps generated in relation to Recovery, Jobs and Unemployment (appendix four) it was possible to identify four statements which were grounded in the data:

1. There is a relationship between employment and recovery (not merely a correlation or an absence of the negative impact of unemployment).
2. The relationship between employment and recovery is: that for some people employment is an essential component and vehicle for recovery. It results in a wholeness and if absent there is an insufficiency in relation to the recovery process.
3. Employment can have both a positive or negative impact on mental health depending on a number of key factors. (These factors are often the opposing properties of the same dimension). These are set out in detail in table seven (page 170).
4. Positive experience of employment helps maintain recovery.

The hypothesis emerging from returning to the data in this way was: Employment is acting as if you don't have a mental health problem. In other words employment facilitated participants to adopt the 'wellness behaviours' expected in the workplace. This functions in a number of ways including: conformity, cognition, subjective experience,

expectations, adjustment (both behaviour and social stigma).

Testing the hypothesis through data collection

The codes were explored using the techniques described by Strauss and Corbin. Adopting Charmaz's approach the interviews were re-read in the light of all of the codes that had been identified. Mind maps were used to develop some conceptual frameworks. These emergent concepts subsequently needed to be tested out as part of developing a grounded theory.

Charmaz (2006) advises that theoretical sampling helps you move from tentative theory to something more substantial. By collecting more data about properties of the category, you can saturate its properties with data, becoming more analytical as you proceed. Data collection and analysis should continue until saturation is reached.

Two processes were undertaken to conduct theoretical sampling. Firstly (in January 2008) I interviewed Wilbur and Noel, and secondly I invited all the participants to attend a workshop to explore the emerging theory. The interviews with Wilbur and Noel were coded and the data fitted the existing conceptual framework. Some new codes were added - though on reflection these were not substantial additions to the existing codes. It felt that saturation had been achieved.

Three of the nine participants attended the workshop (Noel, David and Mark). The conceptual frameworks were presented and a number of exercises undertaken to test out the conceptual frameworks. This is discussed further in chapter six. These processes of theoretical sampling provided support for the conceptual frameworks, but also added and refined the concept about "acting as if" to one of "taking to the stage". It is unclear how coincidental the similarity of these metaphors is. The modified metaphor was offered spontaneously and not as a direct alternative to the acting as if concept. A fuller exploration of the development of the conceptual frameworks is discussed in detail in the next chapter.

2.3 Rigour, Trustworthiness and Ethics

2.3.1 Rigour and Trustworthiness

The key aim of a qualitative research study is to produce a credible, trustworthy account that resonates with participants and readers. Each member of the sample was given a copy of the transcription of their interview. They were asked to check it for accuracy and make any suggestions to ensure anonymity. Most participants were happy with the transcript, but one person pointed out that by leaving in the name of the major industry it was easy to establish which town he lived in, therefore this has been described as just a "major industry". This proved to be a useful reminder of the difficulty of ensuring confidentiality.

Lather (1991) identifies four types of validity:

- Triangulation (multiple data sources, methods, and theoretical schemes)
- Construct validity (recognizing the constructs that exist rather than imposing theories/ constructs on informants or the context)
- Face validity as "a click of recognition" a "Yes of course" - rather than a "yes but"
- Catalytic validity that energizes participants toward knowing reality to transform it (Creswell 1998:199).

It is helpful to think of validity in terms of a 'click of recognition' and as being catalytic. The findings of this research have not unearthed any as yet undiscovered relationship between employment and recovery - indeed there may be a sense of "isn't that just common sense". However, it does provide a rich exploration and explanation of the processes involved and it is hoped that readers familiar with the subject area will have a click of recognition - a sense of authenticity and consistency with their experience. It is hoped that the findings are in their own right honest, compelling and have a feel of integrity about them. It has been a stated hope, and indeed the rationale for using grounded theory, that the research will generate new theory and activity in this area. The catalytic aspect of the research is an important part of the validation process - but one

which is likely only to be realised following wider dissemination of the research.

Creswell (1998:203) recommends that researchers engage in at least two of the following verification procedures:

- Prolonged engagement and persistent observation
- Triangulation
- Peer review or debriefing
- Negative case analysis (refining working hypotheses in the light of negative or disconfirming evidence)
- Clarifying researcher bias
- Member checks soliciting the informants views of the credibility of the findings and interpretations
- Rich, thick description
- External audit

The research phase and my work around employment and recovery go some way to count as prolonged engagement and persistent observation. In the last chapter I set out how I have tried throughout the process to clarify researcher bias. The interviews and their transcripts provide a rich thick description which has been used to ground the theory. Various methods of triangulation were also undertaken.

Triangulation

Triangulation is essentially the use of different vantage points and takes a variety of forms; it allows illumination from multiple standpoints, reflecting a commitment to thoroughness, flexibility and differences of experience. Tindall (1994) discusses the various types of triangulation: data, investigator, method and theoretical.

It was outside the scope of this research to undertake investigator (use of more than one investigator) or theoretical triangulation (use of multiple theories). The gathering data in phases with periods of analysis in between and the use of the workshop are forms of data

and method triangulation. The redefining of the theory following the workshop is evidence that this approach did add understanding to the resulting theory.

Reflexivity

Wilkinson (1988) develops the concept and identifies personal, functional and disciplinary reflexivity:

- *Personal Reflexivity* is about acknowledging who you are, your individuality as a researcher and how your personal interests and values influence the process of research from initial idea to outcome.
- *Functional Reflexivity* entails continuous, critical examination of the practice/process of research to reveal its assumptions, values and biases (1988).

In order to make explicit how my understandings were formed I have kept a detailed reflective portfolio and memos. These not only explore what I bring to the research process but also to the area of research. In particular I intended them to capture the rationale for decisions and how I felt; for example, confusions, anxieties, misinterpretations, and the things that led to clarification, confidence and understanding.

Some forms of qualitative research, notably phenomenology, limit the researcher's involvement by requiring a process of "bracketing off" preconceptions so as not to inject hypotheses, questions or personal experience into the study (Creswell 1998:33). In this study my knowledge of some of the participants' histories would be an example of information that should be bracketed off, I am not persuaded of the extend to which anyone can successfully achieve this. Other qualitative traditions require the researcher to be reflexive - thoughtful, self-aware of the inter-subjective dynamics between the researcher and the researched. Reflexivity requires critical self-reflection of the ways in which the researchers' social background, assumptions, position and behaviour impact on the research process (Finlay and Gough 2003).

Maso (2003) argues that it is more than "coming clean" about one's influence - being

reflexive improves the quality of research by developing an understanding and articulating one's motivation and passion for the enquiry. Accordingly a section on my place and influence in the research is included in chapter eight.

2.3.2 Ethics

Consent

Before the interviews took place, information was sent to all the potential participant about the nature and purpose of the research (see appendix five). I also spoke to most participants ahead of the interview and then when we met I went through the information and gained their written consent - explaining that they could withdraw consent at any time. I explained that the end product will hopefully be published but that pseudonyms would be used to maintain confidentiality, in addition references to towns and regions will be replaced with "an area of social deprivation" to further protect identity.

Confidentiality

There was a need for acceptance of loyalties of the researcher and participants to: others, own environments, causes, employers and services as these can get in the way of honest disclosure and analysis. As with any confidentiality agreement there was a need to be explicit about the boundaries and exceptions. Both the researcher and interviewee need to take time to reflect and ensure they are comfortable with possible repercussions. I recorded my explanation of this and their understanding and agreement to it.

Interviews were conducted either in my home (David, Mark and Fiona) or at the participants' homes (Boris, Andrew and Leonard). The interview with Pete and Wilbur took place in a meeting room in the building where they worked, and with Noel in my office - at his request. They were deemed to be suitably private, safe environments conducive to open disclosure.

Misrepresentation

The interviews were taped and then transcribed. The transcripts were annotated to reflect points of laughter, crying, and where the language used may lose meaning in the written form (sarcasm, irony, double negative etc). The transcripts were sent to each of the participant to check that they were a true reflection of what was said and meant. A simple acknowledgement slip (with self addressed envelope) was devised for this process.

It is difficult to know if the participants read the transcripts prior to returning the form. A more thorough approach would have been to have a second meeting to go through the transcript; however this needs to be balanced against the time commitment expected of the participants. Only Andrew made comments on a few points of fact that he wanted to clarify in his work history. As noted earlier, Andrew also requested that the nature of the industry where he worked and his current job title be made vaguer to protect his identity.

Role Boundaries

At the beginning of the interviews it was necessary to discuss boundaries. Within the context of the interview I was a researcher - not a social worker, work colleague or senior manager. It is unrealistic that these other roles could be completely 'bracketed off'. There were points in the interviews where it would have been easy to switch to another role. However being explicit about role expectation at the start of the interview facilitated both the participant and myself to keep to the boundaries.

Do no harm

I relied on my social work and communication skills to monitor and ensure the well being of the participants. Some of the interviews did prove to be difficult for some of the participants; a few became tearful when recalling painful memories. I was sensitive at these points to ensure that people had the opportunity to tell all aspects of their stories they wanted to, without being intrusive or unnecessarily going over painful memories.

2.4 Summary

In this chapter I have set out the reasons for choosing qualitative and in particular grounded theory methodology to answer the research question. The intention of the research was to enable people's stories to be told from their perspective and for new theory to emerge from the process. I have explained how I used the methodology in practice and the difficulties I faced in being a novice researcher. This involved a combination of approaches adopted by Strauss and Corbin, and Charmaz - with my own intuitive interpretation. The result, though somewhat convoluted, has produced a framework grounded in the data. The research process is described, including the use of a workshop which both validated and refined the core theory. I have detailed the steps I took to ensure that the research was sound in terms of rigour, ethics and trustworthiness. The next chapter looks at the findings in detail.

Chapter Three Findings: Mental Health Problems and Unemployment

Introduction to Chapters Three to Six

In the next four chapters I explore the data and use grounded theory techniques to identify the main concepts. The findings are organised into four chapters. The first three reflect a loose chronology of journeys that the participants described:

- Mental health problems and unemployment
- Recovery
- Beneficial employment

Chapter six examines the interplay between the themes in the previous chapters and describes the core finding of Virtuous and Vicious circles of employment and mental health.

The data are presented in two ways. Each of the three chapters starts with a vignette of one of the participants. One of the objectives of this research was to enable people to tell their own stories in their own words. I have rewritten these stories in the third person and restructured them for easier reading, but I have kept their words and used direct quotes where possible (in italics). The quotes are referenced using the participant's name and the transcript paragraph number generated from the NVivo software. I find these stories compelling and inspirational and I hope that they provide a useful means to introducing the data.

The second way the data are presented is by placing the codes and categories into concepts, which are then structured into a framework. These chapters (three to five) discuss how these concepts form the core framework which is discussed in chapter six. There are no references to any other writers or literature in these chapters. This is addressed in detail in chapter seven. For the moment the focus is only on the stories as told by the participants.

The table below sets out the structure of the chapters, categories and concepts, and codes. All the codes were used in the development of the major themes. These are listed at the beginning of the chapters. Only a selection of the codes are used to describe the categories and concepts. The codes detailed within the section 'maintaining recovery' are not included in appendix two - these emerged at the end of the process so there was no purpose in adding them to NVivo at this stage. The concepts are described in more detail in section 6.1 (page 121).

Table Three: Structure of Findings Chapters

Major Themes	**Categories and Concepts**	**Codes**
Chapter Three **Mental Health Problems and Unemployment** **Boris' Story**	3.2.1 Entering the Medical Model of Mental Health	Start of illness Diagnosis Medication Admission
	3.2.2 Redefining Self	Identity Benefits Written Off
	3.2.3 Suffering from Unemployment	Work as a negative experience
	3.2.4 Living with Illness	Aftercare services Day Services Advice and support Reoccurrence of illness Stigma
Chapter Four **Recovery** **Andrew's Story**	4.2.1 Components of Recovery: Turning Points	Insufficiency Decisions and Epiphanies Acceptance (Restoration of) Hope

	4.2.1 Components of Recovery: Taking Control	Education about Illness Out and Proud Medication
	4.2.1 Components of Recovery: Getting Out	Social Networks Meaningful Activity
	4.2.2 Maintaining Recovery:	Monitoring Complementing Treatment Planning to be well
Chapter Five **Employment** **David's Story**	5.2.1 Getting Ready for Employment	Recovery First Work Placements
	5.2.2 Getting the Right Job	Ambition Disclosure Disability Discrimination Act (DDA) Need to be understood
	5.2.3 What (Beneficial) Work does for You	Identity Need to be Mentally Active Structure in the Day Place in Society Making a Contribution Financial Independence Social Network Work as Therapy Wholeness

	5.2.4 Balancing Support	Work-life Balance Protection Reasonable Adjustments

Findings: Mental Health Problems and Unemployment

This first empirically based chapter considers the initial phase of the journey from illness and unemployment into recovery and employment. Boris is a white British male in his early sixties. He has a diagnosis of schizophrenia and, among other things, he is a retired chef. I use Boris' story to introduce the themes of illness and unemployment.

3.1. Boris' Story

Boris did really well at school. Other people had high expectations of him continuing in academic studies and securing a professional middle class job. Boris wanted to be a gardener or driver. However he went to Art School and gained a degree in painting and sculpture. After that he undertook a range of jobs: Territorial Army - Paratroopers and Engineers, Karate teacher, Civil Servant and, after doing a teaching qualification, outdoor pursuits and mountaineering instructor.

Boris returned to his home city. This was in the late seventies when there was very high unemployment. Boris continued working for the Territorial Army but he was also unemployed for a while. After a period of unemployment Boris returned to being an Outdoor Pursuits instructor, but the hours were long and the pay was low. Eventually he left, disgusted with the pay and conditions. Boris's next job was with the Youth Opportunity Scheme:

> *Supervising these absolutely delinquent kids. Who were painting and decorating these Church Halls and things... these kids had extreme behaviour, we had no sanctions whatsoever, we could do nothing with them.*

By this time Boris was married and his wife was expecting their first child. It was at this point that he began to experience mental health problems. Initially he was receiving treatment for a thyroid problem. When he told his doctor about his extreme low mood he was referred to a psychiatrist. The psychiatrist diagnosed schizophrenia and depression and started him on medication. Boris continued in employment, working with adults with learning disabilities.

The doctors stopped his medication and Boris became acutely unwell. For the next five years Boris experienced significant mental health problems. Psychiatrists kept encouraging him to remain in employment, but the only opportunities available were jobs like tomato picking. Boris sometimes only lasted a few hours in those jobs. He was prescribed large amounts of medication, but he would throw it away. His symptoms were not being controlled and he was becoming more and more psychotic. His wife had her own mental health problems and was diagnosed as having psychopathic personality disorder:

> *Literally one day I was sat in the room, unemployed and absolutely unemployable - you know - no one would take me on. I had been admitted to hospital. They had tried to get me back to work that had only lasted a few weeks that had completely failed. I was hallucinating; it was an absolute disaster. By then my GP had gone against the consultant* [psychiatrist], [he] *had issued me with a sick note for psychosis and said "we can not possibly expect you to get back to work".*

Boris was suffering paranoid delusions which impacted on every aspect of his life, making it impossible for him to function. Then one day he had a religious experience which proved to be a turning point in his life and illness:

> *I had a vision of God. I have always been very religious and prayed to God*

for help and literally one day there was this vision of God and God's voice said to me "Listen to me" and I thought: you really have gone, this is the end of it now, I really have gone completely mad. This voice just said "listen for three quarters of an hour if you really don't think that I am making any sense then ring your CPN." I remember listening to this voice for six months and it made perfect sense possible, absolutely. And the psychiatrist and CPN said we are going to do nothing about this, just keep on listening because it is talking completely good sense to you and literally one day in the middle of the night I got up and left my first wife and walked into a solicitors at nine o'clock and said I want a divorce.

The decision to leave his first wife was accompanied by a decision that he needed structure in his day. He needed money to pay for a flat and to cover living expenses. The economy was still in recession at this time and there were particularly high levels of unemployment in his home city. Boris reflects that:

You were incredibly disadvantaged when you have a diagnosis of schizophrenia and five years unemployment and no references. You are not really going to get a job but there was always the old things like community programme and job creation and things like this.

However the 'perfect job' came along and Boris successfully secured it. The post required someone with experience in horticulture and art. Prior to starting Boris feared that the previous five years of unemployment would be hard to explain and he was concerned about his mental health history. However, it turned out that the project was run for and by people with mental health problems:

But I am absolutely convinced that if I had not got that job and just sat in the flat then I would have gone under. I was absolutely convinced of the benefits of it but it had to be the right kind of job, I mean there was no point in me

being back trying to teach in a school with kids that are there to destroy you. There was no point in getting a job with YTS with trainees which were absolute hooligans. It had to be the right kind of work, that was very important.

The job lasted a year and during that time things began to improve. Boris remarried and:

Conned my way back into the Territorial Army by not telling them that I had schizophrenia.

Unfortunately they found him out and he lost his job. There then followed periods of employment including a job as a Museum Archivist and various government schemes. Boris was now in his forties and needed to gain a qualification that would lead to stable employment. At the time there was a Government scheme to provide vocational training. Boris gained a place and trained as a chef. Once trained he worked as a volunteer chef, then he got a few paid hours which over time increased, until he was able to make a living from it.

Boris' second wife was German and with her help he taught himself German. Discovering he had a flair for languages he also learnt Spanish, Dutch, Icelandic and French. This enabled him to secure some hours teaching German at the local University.

Boris spoke about the importance of meaningful employment during that time:

Put it this way if I don't do something I find...I find that if I am meaningfully and positively and enjoyably occupied you are infinitely better off, yeah, definitely and I don't mean knocking a beach ball around in a mental hospital. Like doing something where you work a fifteen hour shift you cook for two hundred and they pay you one and fifty pounds at the end of the day.

Things were going well; Boris felt well and stopped his medication. Unfortunately this led to a serious relapse and he was sectioned. His wife contacted the University and informed them that he had a rare and infectious disease which meant that he could not work for a while and could not see visitors. The result was that the University kept his post open for his return. Boris reflects that the nursing staff refused to believe that he taught at the University, that he had been in the Special Forces and had mountaineering experiences. They confused this with a belief that he was delusional.

Following this Boris met another ex-service user who opened up a new avenue for employment as a trainer; they would provide service user experience training to mental health professionals. Eventually the work at the University dried up and the Training organisation ended. However the catering work continued. Boris and his wife set up their own catering agency. In addition Boris could get relief chef work when he wanted it:

> *I carried on working for five years in old folk's homes, nursing homes, community cafes, all sorts of things. It was easy come easy go. I mean they drive you into a nervous breakdown, minimum wage, like unpaid overtime and stuff. I loved the residents; I loved the care assistants. I used to get into terrible trouble just holding the job down and things but to me it was important to go and of course I was earning money.*

During this time Boris started to be more open about his mental health problems. Sometimes his GP would help disguise period of mental illness by signing him off with a cold or chest infection. However, Boris wrote an article for the local newspaper about his experience of mental illness - from that point there was no going back and Boris has been open about his past and current mental health problems. This has sometimes resulted in employers not asking him back to cover shifts.

Boris started to experience pain in his feet. Eventually it became impossible for him to stand. He went to his GP who referred him onto podiatry - he was diagnosed with arthritis

in his feet and signed off work on a permanent basis. So once again Boris was signed off work, but by this time the rules about working on sickness benefit had changed and he is now able to work up to sixteen hours a week. Boris is in the position of choosing which jobs he wants to take, up to the permitted hours. He enjoys horse riding while not at work.

Boris has a good relationship with his GP. He has an arrangement with his surgery which means he can be seen as a priority and gets his medication increased if needed. His GP also agreed to teach Boris to administer his own injections of psychotropic medication to enable him to travel abroad for extended periods.

Boris describes that from his childhood he has been taught the importance of ruthless determination to achieve things in life. It has always been important to work and to achieve. Currently Boris is well. He has not had a relapse in many years. He has a good understanding of his illness and the medication that helps keep him well. More importantly he and his wife have a strong belief that you can not give up and give in to illness.

3.2 Codes and Categories for Mental Health Problems and Unemployment

The focus in this part of the chapter is the data and coding relating to mental health problems - especially in the early stages ahead of any recovery planning. These periods of illness were often associated with unemployment, or employment that was not helpful to their mental health. It may be significant that the participants are mainly referring to their experiences of living in this region over the last thirty years. Throughout that period in this region there have been high levels of unemployment and the area continues to have higher than the national average of people out of work (this is discussed in chapter seven).

I have pulled together data coded to the broad theme of mental health problems and

unemployed. These codes and categories are:
Start of illness; Abuse; Admission, Diagnosis; Discharge and Aftercare; Doctors; *Drugs and Alcohol; *Identity; Reoccurrence of illness; *Medication; *Stigma; *Unemployment; *Welfare benefits; Written off; stigma; *Work as Negative;
(* denotes that these codes are also used in the other empirical chapters)

The data on mental health and the information on unemployment have been structured into four temporal phases which had a loose chronology to them:

- Entering the Mental Health System
- Redefining Self
- Suffering from Unemployment and Loss
- Living with Illness

3.2.1 Entering the Mental Health System

Start of illness

The beginning of mental health problems was often associated with confusion as to what was happening.

> "*Then something happened and I don't know what it was, I have no idea what it was. Everything went weird and I found it was like going into the twilight zone.*" (Mark 18)

For three of the participants (Andrew, Noel and Wilbur) there was an association with drug and alcohol use and the onset of the illness:

> "*I was getting seriously paranoid. I went to Tenerife with friends and my girlfriend and we were smoking cannabis there and I got seriously paranoid. But then it went away until the first admission. Which was a couple of years later.*" (Noel 19).

All three were in their late teenage years or early twenties. Drug use was common amongst their friends. Wilbur recalls that he used amphetamine to help him cope with long hours and overtime.

Diagnosis

Psychiatrists were reluctant to diagnose, especially those participants who had early onset of psychotic illness and who were using drugs and alcohol. Those with a diagnosis of a psychotic illness did not initially accept the diagnosis. However some participants (Andrew and Boris) did find the label helpful, especially when they started to educate themselves about their illness. Mark reflects on the cost to him of not accepting the nature of illness at an earlier stage:

> *It's been, as I say to the people I see now, just listen - if you listen now and do the right thing now you won't follow my road and waste 10 years of my life. Because that is just what I did, because I did not listen and sort it out earlier. I had to go though all that and it was not necessary really but because until you have some insight into what is wrong with you and you stand up and say I have got this. Because if you had asked me "have you got mental health problems?"* [I would have said] *"nah it has gone now."* (Mark 108)

Medication

All of the participants (except Pete) described bad experiences with medication. Medication has either been ineffectual or resulted in side effects which meant that the participants stopped taking it. Some participants stopped taking medication because they believed they were well and did not need it. Both David and Leonard describe being given ECT against their will and expressed anger about this - believing it was unhelpful and did more harm that good.

Admission

All the participants had been admitted to hospital at some point and five of them had been

sectioned under the mental health act for at least one admission. Andrew and Leonard describe trying to get themselves admitted and being turned away, but ended up being brought in a short time after. Admission often was a time when the worst of symptoms were successfully treated, though for David, Leonard and Mark the medication and treatment seemed inappropriate.

3.2.2 Redefining Self

Identity

The issue of identity was a common theme in all the interviews. Some of the participants had clear professional identities before they became unwell (Executive Chef, Railway worker, Naval Observer). The participants also described identities that were not work-related (father, son, husband). For some of the people with early onset of illness their identity was not as well defined - for Noel, Mark and Wilbur their careers were interrupted at an early stage by illness. The acceptance of a mental health diagnosis impacted on this identity - though none of the participants used the diagnosis as a noun, rather they would described themselves as having rather than being the illness.

Andrew relates a time when he was unwell and lost his job:

> *and there was one point just standing there doing nothing that thinking this is where I turn into a schizophrenic and never recover.* (Andrew 45).

Issues around employment and identity were often referred to, especially by those who despite illness had established themselves in a new career. This was in sharp contrast to a negative perception of people who defined themselves around illness:

> *I think the fact is that, people always say to you when they meet you, "what do you do?" If you were a complete no hoper, you sat in your bed-sit, you had your disability benefits, and your depot injections and nothing else, and*

people said "what do you do?" You would think: well what do I do? Whereas people when people say to me "What do you do?" I say "I am a professionally trained chef" You have got that thing, you have a place in society with other people. (Boris 57).

There are lots of people like that who just live the illness and are happy, a lifetime on the sick... That is where the state makes a big mistake, they over pay people who are ill. (David Workshop 205)

Benefits

Most of the participants felt that welfare benefits were a necessary evil. Some of this was to do with being caught in a benefit trap, but there was also a sense of identity which meant that claiming benefits was not a desirable position for them to be in:

I am not that kind of person that can sit and rely on benefit. I need to go out and work and I never felt well unless I was working there was a definite link between the two. (Mark 66).

Written Off

All of the participants were told that they should not work by doctors or mental health professionals. For some, work was deemed to be unhelpful for recovery (Mark, Pete and Fiona) or they were told that they were too unwell to hold down a job (Noel, Leonard and Wilbur). David and Boris were signed off permanently, and Andrew was told that he should not work in mental health.

3.2.3 Suffering from Unemployment

Participants described the boredom and psychological harm that unemployment brought. A common theme was the amount of unstructured time spent in isolation ruminating on their mental health - and making the symptoms worse:

Like if you ever spent a long period of unemployment then the first few weeks are great they are just like long weekends all the time. Then suddenly the weekends become like every other day and you have nothing to look forward to. (Mark 425).

Oh those few years were terrible. I thought oh I am here until death basically without doing another days work. (David 461).

I like to think that before I got involved in the User Carer Forum that it was a downward spiral it was a shock to me and I vegetated basically. I think that some of our service user vegetate I can relate to that, you know, not give up - yeah give up - not give up on life. I don't mean it in that way [contemplate suicide], *give up ambition joy of life.* (David 489).

*And, you know my life was over, because I had tried it once and I was never going to get back into the work I wanted to do...I became quite isolated and depressed and I related it specifically to the fact that I did not have a job. I was not able to do the work that I wanted to do, that really kind of knocked me. (*Andrew 38).

*Yeah I was just sitting there stewing in my own juices basically. (*Pete120).

*Most of the time that I was unemployed I was on the ward anyway. Unemployed without being ill was most frustrating, lots of walks, lots of frustration. (*Leonard 132).

I had not worked for twelve, thirteen years and it was really, really, really difficult getting out of those four walls, getting paranoid and getting into work. I needed a lot of encouragement and people did encourage me. (Wilbur

478).

Unemployment also meant that there were gaps in people's employment record. These were difficult to explain to prospective employers - likewise participants described lying on application forms about their mental health. They believed it was the only chance they had to get an interview. This was discussed at length in the workshop. David commented:

> *If you haven't told them that you have mental health problems and then you do need time off, you can't go up to them and say. They could always say you didn't tell us - you're sacked. It is a fear thing. I was always afraid.* (Workshop 172).

Some of the participants did not give their employers the opportunity to be supportive. Fearing the worst outcome, they simply left rather than trying to explain their mental health problems:

> *If I had just sent a sick note, but I just got that down and withdrawn I did not go to the doctors and then. Errm, it just got to a point were they asked me to come in and talk about things, but I could not face it and they sent me a letter saying that they would let me go.* (Mark 22).

> *And then this new guy came in who was not so understanding and they did give me the opportunity to come in and I got as far as the car park at* [name of company] *but* [I] *could not walk through the gates because I was not very well. And then they sent me a letter terminating my employment.* (Mark 122).

Only Fiona took a different approach. For her being unemployed was an opportunity to "chill" and get her life together, although this period did go on too long and led to boredom. Unlike the others, Fiona sought out adverts that contained statements about supporting the employment of people with disability. Fiona got an interview and was

offered the job but was deemed unsuitable for employment by the company doctor. Fiona, with her knowledge of the Disability Discrimination Act, contacted her prospective employer and after some discussion successfully took up the post.

Work as a negative experience

Aside from unemployment, some periods of employment were also reported as detrimental to mental health. This could be because there was a lack of understanding or direct discrimination relating to mental health problems. Pete, Leonard and David were all subjected to derogatory remarks being made about them in the workplace. Boris believes that he was not invited back to some jobs once they found out he had mental health problems.

Sometimes it was the nature of the work that took its toll on participants' mental health. Work placements to help get people back into work were often boring or demeaning. Pete recalls breaking up pallets for a DIY store - he was given 'employer of the week', but not allowed on to the shop floor. Leonard, a highly qualified chef, was placed in a supermarket stacking selves. Others applied for jobs that they knew that they could get without too many questions being asked - these were often on factory lines or working in unpleasant conditions like on the docks or in a poultry factory. The working conditions were poor, the hours were long and the pay was low. These all compounded poor mental health. For Fiona and Wilbur there was an association between work place bullying and the start of their mental health conditions. Wilbur describes the way in which his employment contributed to the start of his mental health problems:

> *I became a bit of a loner, people picked on me and wrote things like geek on my overalls and that - I was acting a bit strange and being a bit unwell.* (Wilbur 3).

> *I think the stress of it all - the hours I did. Sometimes I would be there 17, 18 hours. I used to do a 12 hour shift from half three in the afternoon to half*

three in the morning - then I used to do another four or five hours on top. Painting the walls or being a handy man. I worked there for three years. I worked hard because my long term goal was to go into chemical engineering. (Wilbur 5).

3.2.4 Living with Illness

Aftercare services

Some participants described how they felt abandoned by services (Boris, Andrew), others of how they shunned offers of help, believing that they just needed to be left alone to get on with it (Mark, Noel). Some of the participants related an incident where doctors had not listened, overruled their wishes or generally shown a lack of interest in them (Leonard, Boris, David, Fiona).

Participants described how interpersonal relationships with front-line workers mediated their experiences with services. At various points in the interview Leonard described the people involved in his journey:

- *The CBT* [cognitive behavioural therapy] *therapist was a waste of time, bless her. Lovely lady but did not get on with her.*
- *I had a CPN* [community psychiatric nurse] *in and out of admissions, he was alright, he called the ambulance for me once when I had done something stupid. He did not understand me.*
- *And the blond nurse ...I have spoken to him last year I was phoning Crisis occasionally, just to talk to somebody, and I always ask to speak to him ...he was an encouragement.*
- *I phoned her and the DEA* [disability employment advisor] *and I just hit it off straight a way - she is such a lovely person. If I was to say that there was one lady that really brought me back and really helped me it was that lady. I spoke to her the other day and she is such a support.*

- *Dr R is a wanker ...Dr R, that man was so, so aloof, with someone, I was poorly but I am not fucking stupid, I might be poorly but I am not stupid...The man was not interested.*
- *He [Dr S] saw me and he got me out of hospital in four weeks...My road to recovery is still on going obviously Dr S started that.*

Day Services

Three participants (Andrew, Noel and Boris) describe Day Hospital as being patronising and filling time with demeaning tasks (colouring books, knitting, passing a beach ball); though they all say that in some way it severed a purpose. For Andrew it got him involved with the Charter Mark group; for Noel it passed the time and for Boris it provided him with members for his catering scheme:

> *Day Hospital. Now there was fun!* [sarcastic tone] *You don't have that any more do you? No I am not surprised it was a waste of time. Used to go there and fall asleep, this is when I was living at home I used to have to be there for 9:30 and sit there knitting or playing dominoes or doing something constructive ...I was so bored. But I suppose that it was a means to an end at the time.* (Leonard 158).

Advice and support

Mark describes a point where he started to listen to the professionals and take their advice, but then he became unwell again and refused to see anyone. At that time the Assertive Outreach Teams (AOT) had been introduced to work with people who were difficult to engage. Mark describes the AOT approach:

> *Yeah I got discharged and in the October, I lost my house in the May 2001 and then I had AOT come to see me because I was quite elusive and I would not open the door and I would not see people so AOT had the time to come 3 times a day....It was state sponsored harassment I tell you* [laughs] *but*

eventually I would open the door and they would come and see me and ...they said have you thought about doing some voluntary work for [name of charity] *so I got all the paper work filled it all in sent it all off.* (Mark 202-208).

Reoccurrence of illness

Recurrence of illness had many causes and sometimes apparently none at all. Noel, Mark, Boris and Wilbur all gave accounts of when they stopped their medication and became unwell. Fiona, Pete and Wilbur put their relapses down to stresses in their home or work life. For Wilbur, Noel and Andrew there was a clear association with drug and alcohol use. For David illness just returned every year at the same time for no apparent reason.

Becoming ill again was bad enough, but there were also other associated problems, especially around the ability to continue or find work. Mark describes the cycle of wellness and illness as periods of gaining and then losing things. Loss was a component of the text coded to reoccurrence of illness and in retrospect could have been used as a code in its own right. Through illness Mark lost lots of jobs, his house, his wife and friends:

I just thought this has go to end, what can I do to make this stop because it had been going on for just too long. At least all the way back until 18 / 19. I would get ill lose things, get ill lose things, and I just did not want to get ill anymore because at that point when I came out of hospital I had lost so much. Errm, I did not want to be in that position again. (Mark 184).

Stigma

For Wilbur living with a mental health problem also resulted in him being abused. So-called friends would financially abuse him and he was also subject to verbal and physical abuse from neighbours who knew of his, and his girlfriend's, mental health problems. This type of abuse was not noted by other participants, though stigma in some form was experienced by all the participants.

David describes something that he calls "self stigma" - his own perceptions about people with mental health problems, which impacted on what employment he thought he could realistically expect:

> *Because of the stigma, the ignorance. The ignorance, I did not know anything about mental illness. I was the first person I met with a mental illness - and I did not like what I saw.* [laughs] *I would not have employed me. You know it is ignorance. There is not enough education out there.* (David 737).

Most participants could recount an incident in the work place when they had heard derogatory comments about people with mental health problems - or about themselves in particular:

> *Some were, some avoided the subject and there were a couple rufty tufty ones that said "and you, you fruitcake" and "nut job" was banded around.* (Pete 73).

> *Stand there on your first Saturday night working away - first Saturday night doing 180 covers - 180 people, for the gaffer to come in and say "we have a great chef from the past but do you realise that he is a fucking mental case he has been in that...*[mental health unit]*" and he just said it.* (Leonard 88). (This was Leonard's first day back in a kitchen after years of illness, prior to becoming ill he was among one of countries top chefs).

Others were denied opportunities or employment due to their mental health history:

> *No he just said because the job is going to be too stressful for me and the Job Description it did say that I would have to be dealing with angry or abusive or upset customers. I thought that it was face-to-face but in fact it is over the phone. It has never been a problem at work...At the time because he said he would send me details through and then I just thought well, and I was in*

shock ...Then the CRB check came through and then it was like getting in touch with HR and saying I want to know why because I had ticked that I had a disability, ... how does this fit in with the Disability Discrimination Act and then they came back saying right I will take you on. (Fiona 219-223).

Oh yes. Absolutely, Absolutely, oh yes. Blatant discrimination. We went to social services to foster kids and they said it was nothing to do with the schizophrenia, but it was absolutely 'bugger off schizo's we don't want you'. They were horrified, horrified, that anyone with schizophrenia could even dare to apply to adopt a kid. We were turned down completely out of hand. (Boris 71).

3.3 Summary

Boris's story is the first of three recovery journeys that will be presented. It discusses his whole story, with a good account of the first recovery phase of mental health problems and illness. There were four emergent concepts common to all the participants' accounts. The concepts were about decline and loss due to illness. The onset of illness led to entering into a medical model of care and a redefining of identity. Participants experienced the harm that unemployment brings. There is a process of living with the illness and receiving services.

Within this chapter the combination of illness and unemployment are shown to have a negative impact on each other. As illness becomes worse, then so too does the prospect of holding down work. As employment opportunities become harder and there are periods of unemployment then this contributed to poor mental health. A vicious circle emerges. This idea about a vicious circle was tested out in the workshop and is described in chapter six. Within this first phase, recovery has not really begun and for some people with mental health problems they may never progress from this stage. The next chapter discusses the start of the recovery process.

Chapter Four Findings: Recovery

In this chapter I look at the middle section in peoples' journeys - the development of a recovery framework. I start by retelling Andrew's recovery story. Then, as in the previous section, I look at the codes and categories within all the interviews and describe the emerging concepts about recovery.

4.1 Andrew's Story

Andrew is a 29 year old white British male with a diagnosis of schizo-affective disorder. At the time of the interview Andrew worked for the NHS.

Andrew describes his childhood and time at school as normal. His parents and sisters have all always been in employment. Andrew says there was always *quite a good work ethic.* Andrew went to University to do a degree which he hoped would give him a good and lucrative career in Human Resources. Time at university was the best and worst of times for him. He enjoyed meeting new people, having new experiences and doing something meaningful. As part of this Andrew was drinking quite heavily and experimenting with drugs. It was at this point that Andrew first experienced mental health problems. Andrew experienced a drug-induced psychosis, probably due to the use of amphetamines and ecstasy. At the time Andrew had no idea what was happening but remembers feeling:

> *Strange, delusional paranoid feeling at the time of the event and for weeks and months after the time of the incident. Which was very scary, horrific, horrible time which led me, because I did not seek help at the time to talk to, led to very deep depression and very anxious as well.*

At the end of the first year Andrew returned home, but the symptoms persisted.

Eventually he discussed what was happening and his parents encouraged him to go to his GP. This resulted in an appointment with a psychiatrist and being put on medication. Andrew returned to University for the second year, but after three weeks things had deteriorated and Andrew came home and was admitted to hospital. Andrew was in hospital for five weeks, then returned home and for the next ten months worked through a recovery plan. Andrew recalls how difficult it was in those early stages:

> *The only way I can describe it was: hell on earth, it was horrible. Every day was the same it was severe clinical depression resulting from a psychotic episode related to drugs. But gradually and then suddenly I became better. I was introduced to a Recovery plan, which was by a former patient...through using those techniques in a combination I actually recovered from depression and was able to go back to university in my second year after taking a year out.*

Andrew describes the recovery plan that he was introduced to at that time and which he has followed everyday since then:

> *There are a few elements to it really, the first is actually learning about depression, an educational element. Then there was the element of monitoring and monitoring your depression levels so you would start off with severely depressed which is where you were at currently and you would introduce elements of the recovery plan and be able to map out your mood improvement as your depression improved. So on my monitoring plan which I have kept for nearly twelve years now, everyday I monitor both my mood, the amount of times I do my CBT which they call reprogramming statements. Supposed to do them three times a day that is my target, the amount of exercise I have done during the day and the amount of medication that I have taken.*

As part of this recovery process a social worker helped Andrew claim benefits. Andrew recalls that he was really reluctant to do this as it meant accepting the illness, but he is really thankful that she did. Andrew's consultant also encouraged him to find a job. Andrew returned to a part time job in a local chemist shop where he had worked when he was 16. A key component in the success of this job was that Andrew felt able to:

> *admit to, the then manager, that I had depression and I had been on a psychiatric unit...it was a key step to me being able to start functioning again and some kind of normality, it was really important. I hated dragging myself out of bed for the three hours. I think I was only there for nine hours a week, three hours three days a week - but I hated it. But for those months that I was doing that it was helping me on that road to recovery, you know.*

Andrew went back to university and finished his degree. He then went to work in London for recruitment firm for six months but he did not enjoy this and after a short break in employment got a job in a psychiatric rehabilitation unit in Camden. This job proved to be very rewarding and Andrew found that he loved the work. The depression disappeared and Andrew felt really well and good about himself. He exercised regularly and continued to follow his recovery plan.

Unfortunately the job involved long hours and sleep-ins which were physically demanding, but also resulted in him not being able to see friends and have a social life:

> *Just gradually started to feel quite isolated and although I was not drinking and had lost lots of weight and was not using drugs or anything the work was taking its toll, and the shift pattern was taking its toll. Eventually I became really disillusioned with it and went out on quite a big drinking binge one night and went to work on a sleepover shift the day after and I had another psychotic episode while I was at work. Really scary.*

Andrew made his own way to his home town and went straight to the mental health ward and asked to be admitted. He was assessed but sent home. Things rapidly deteriorated; the police had to be called and they took him to the hospital where he was admitted:

> [I] *made a really good recovery in about five or six days and the prognosis was really good. And the consultant was really happy with my progression although he thought that working in mental health, in that environment of mental health was not a good idea, he certainly thought that there was lots of hope for me. I was discharged after about three week.*

Andrew describes how it was at that time that his psychiatrist clearly told him that because of his illness:

> *You will never work in mental health again*

In contrast his CPN was saying:

> *They are not always right Andrew, they are not always right, if you feel that is the thing for you do to - then I will support you to do it*

By this time Andrew had been diagnosed with schizo-affective disorder. He reflects that during the first admission the focus had been on his drug use and the doctor was unwilling to "label" him with a diagnosis. [Having a diagnosis] *gave me something to peg my recovery on and my learning on as well.* Andrew reflects on the importance of understanding mental illness both in terms of his own recovery, but also as an asset in working in mental health services. This understanding can be learned but Andrew values his experiential learning:

> *And part of me actually felt that I needed to experience what schizophrenia was like, before I could understand those patients and people that I was*

dealing with ...I got to the stage that I actually was really, really poorly again, that gave me immense understanding of another side of mental illness.

Andrew spent time learning about his illness as part of his plan to remain well.

Andrew got back to following his recovery plan, but he had lost his job and was unsure what to do next. Having lost a job that he really liked he felt despondent. Although he was doing his recovery plan and was well, the lack of work began to make things worse:

I started to get twinges of depression, which actually started to become worse. And every day, although I was doing my Recovery, was based around jobs and what I was going to do for work. And, you know my life was over because I had tried it once and I was never going to get back into the work I wanted to do because I became quite isolated and depressed and I related it specifically to the fact that I did not have a job.

Andrew tried other types of work. He worked in a restaurant but this was a bad experience:

The restaurant was really slow and I was kind of stood there in an environment that... I did not get on with the boss and just felt really... really bad about working there because my mind was not active there were long periods where I was just kind of stood there thinking about things and I started to think quite delusional again and quite scary thoughts...I needed to be active I needed to be doing something that was meaningful I did not just want to be stood there given a hard time by a boss who thought that I was lazy and I could not explain to him that I had been in hospital that that everything that was associated with mental illness, through fear of stigma and fear of not being understood. He could not understand why a graduate was working in a restaurant part-time.

Following that Andrew worked in a school and considered teacher training, but he ultimately decided that the work was not for him. Then Andrew saw a job advert which changed his whole perception of mental health and employment:

> [It] *was the first advert that I had ever seen that said "experience of mental illness was a desirable criteria on the person spec." And I thought that this was perfect and* [I am] *well enough to work and they wanted somebody who had those experiences.*

Andrew got the job and started working for a mental health charity on a project in the inpatient area where he had been a patient. The work was rewarding and he was working with people who had similar experiences to him:

> [It] *felt really supportive and really safe, and the work was challenging itself. But they did it in such a way that I was able to know my limits myself...people knew I had had mental problems I was able to go to them and say "look I am having a bit of blip"... I was able to explain it and I don't think that, if I was in an environment that allowed that, then I would not have managed to survive.*

Andrew continued to run the group for over four years and during that time he gained a qualification in Community Mental Health. Throughout that time Andrew continued to stick to his recovery plan and went from strength to strength. This experience enabled Andrew to feel he was giving something back to the services that had supported him in the past, and that he was making a meaningful contribution. Andrew moved into working for the NHS, he was initially anxious about whether he would find the same supportive environment he enjoyed when he worked for the mental health charity. Andrew describes the transition as scary, but also supportive. What helped in this was that some people knew of his mental health background. Also Andrew had the confidence to tell people

about his past and challenge inappropriate comments made about mental illness:

> *And being in there and being able to influence things in an appropriate way, I am really enjoying it, and people respect the fact that I am not afraid to say where I have come from. I don't wear it on my shoulder and don't tell everybody at every opportunity. But I think that it is important to be able to share that where appropriate.*

There has been a sustained period without illness and he is now working with his doctor to reduce his medication. Andrew remains cautiously optimistic about his future:

> *You know for nearly seven years feels fantastic and being able to plot the journey from illness to Recovery, to illness again, to tentative steps back into employment and then full employment what I consider full recovery although I am still not as naive to think that I do not have to try everyday to keep things at bay.*

In addition to work Andrew is also now studying on a postgraduate psychology course.

4.2 Codes and Categories for Recovery

This section begins to look at the points in participants' journeys when they start to gain control of their illness and formulate their own recovery plans. For Andrew this was within a year of becoming unwell; for others this was often more than a decade after their first symptoms. Participants stated that a period of recovery was needed before they could move onto the next step of employment which is explored in the next chapter.

Data from the following codes and categories were used to develop the concepts around recovery:

Acceptance; Decision; *Disclosure; *Drugs and Alcohol; Education about

illness; Epiphany; Hope; *Identity; Insufficiency; *Maintaining Recovery; *Meaningful Occupation; *Medication; Negotiate own care; Other People's Problems; Out and Proud; *Social Network; Recovery; Value Mental Health Problems; *Work Placements. (* denotes that the codes and categories are also used in the other empirical chapters).

There is an important distinction to be made between successful treatment and recovery. Treatment, nearly always in the form of medication, is given to the individual by the professional; medication is deemed to be efficacious because it has predictable results with people who experience symptoms that fit diagnostic criteria. All that is required to work (in theory at least) is that it is given in the correct dose to the correct people. It is clear from the data that recovery is unique to every individual - it is not predictable, though there are some common themes.

Two very broad concepts emerge from the data, one that there are a number of key components to achieving recovery and the second that there is a programme or plan to maintain recovery.

4.2.1 Components of Recovery

Data about the components of recovery can be structured around three themes:

- Turning Points
- Taking Control
- Getting Out

Turning Points

Participants described factors that had acted as turning points in their recovery journeys.

Insufficiency

One of the themes that I tested out in the workshop was the concept of insufficiency.

Participants agreed with the themes that emerged from the data that medication alone - even if it was very effective with no side-effects was insufficient in relation to recovery.

> *The medication would just deal with the symptoms of the illness. Everything else is still missing, the holistic package, the care, the social aspect, the financial wishes, the housing issues, the social inclusion bit. Medication can't do that and when people become unwell all that untangles and disintegrates.* (Mark Workshop 257).

> *I think that medication has helped me but not all together, the positive-ness of the people has helped me the most.* (Wilbur 27).

Noel described a time when he was getting physically fitter. His medication was effective and he had been out of hospital for almost two years, but there was a sense that this was not enough.

> *Don't know if I had just settled with what I was doing before, it might not have lasted; you know what I mean. My wellness might not have carried on. Just sat there and thought, going out with my STR worker for a game of golf or snooker, working two days a week at* [name of work placement] - *it might not have been enough in the end. I needed to progress, progress with my life.* (Noel 180).

Decisions and Epiphanies

Participants described a point at which something happened that enabled them to begin a recovery journey. For some it was the right support at the right time - a professional who they could relate to and gave them good advice and support (Mark, Andrew, Pete, Leonard and Fiona). For Wilbur it was a new relationship. For David it was seeing other people in similar situations whom he found inspirational and who were role models. For Boris is was the voice of God. In Noel's case he felt that his experimentation with drugs

had hit a wall and he wanted to be healthy again.

Acceptance

Participants with a psychotic diagnosis had long periods before they accepted that what was happening to them was in fact mental illness. The cyclical nature of bi-polar affective disorder meant that for periods of time everything returned to normal. Mark was driven to acceptance by the constant cycle of illness and loss. Mark broke the cycle by stopping trying to carry on as if everything was alright, and by listening to the people who had been trying to tell him that he had an illness. Mark reflects that stopping work and accepting his illness has ultimately resulted in him returning to work:

> *Self acceptance of my problem and realisation that I had to deal with it* (Mark Workshop 178).

> *if I had listened then, like to what* [name of CPN] *told me to do - which was not go to work and take my medication maybe I could have solved the problem then. But I never, I had another hospital admission in 2000, this time I was in there 6 weeks but the difference was that at the end of the 6 weeks I listened to people. I took my medication, and for 6 years and there was no dip. No high and I have been working for what, the last five and half with not problem.* (Mark 90).

In all the recovery stories there was a point at which the participant accepted the existence of a mental health problem and took ownership of it. They began to see that they had to do something about it:

> *Yes but deep with in myself I found it hard to accept. Why me? I was feeling sorry for myself* (David 150).
> *No it is the hardest thing... For them* [mental health service users] *to actually say "I have got an illness" accept it and move on. That is a hard part in their*

getting well basically. (David 162).

(Restoration of) Hope

In contrast to the section above about being written off, there were times when professionals and others gave a message of hope that things would get better:

> *He* [the Consultant] *certainly thought that there was lots of hope for me. I was discharged after about three weeks.* (Andrew 28).

> *The psychiatrist said to my wife: "give me 28 days and we will sort him out" (Boris 27).*

David found hope in other people's success:

> *It gave me the belief that I could work again* (David 544).

The belief that things could get better, that it would not always be like this, was mentioned in all the interviews. Hope seems to be a key concept and is in stark contrast to the hopelessness that is often associated with mental health problems - especially depression.

Taking Control

The concept of taking control was typically described as the first part of the recovery journey. Participants spoke of a shift in responsibility for their wellness. This was often accompanied by a reframing of what it meant to be a person with mental health problems.

Education about Illness

Part of taking control of the illness was learning about it:

Yeah understanding what is wrong with you. Because I never understood what was wrong with me, and also how the hell could I fight that, with no understanding of what was attacking me. (Mark 346).

I started learning much more about the illness and certainly around schizo-affective disorder and schizophrenia and psychosis. Even there was some suggestion of manic depression and I started learning more about that, mainly to keep well. (Andrew 38).

There is also learning about illness through experience. Many participants (Noel, Mark, Andrew, Leonard, Boris) talked about understanding themselves. For Leonard being in control was about remembering his past:

By doing or not doing certain things a lot of it is self control, a lot of understanding of your history and remembering your history. (Leonard 100).

Out and Proud

In the previous section there were examples of stigma and discrimination. One of the most shocking was the way Leonard was introduced to his work colleagues on his first shift back in a kitchen. The second half of that quote shows how Leonard dealt with it; he got on with his work and demonstrated his abilities - rather than his disability:

Why did I stay there? I know why I stayed there, and people [who] *know me know why. I stayed there for 17 months - because I wanted to prove to the guy, he threatened me, he embarrassed me, I did not walk out either.* (Leonard 88).

For others it was not just facing up to discrimination about mental illness but recognising that their mental health problems could be used to their advantage and that their experiences were valuable. This was discussed in the workshop:

I applied for a job at [Name of mental health charity] *and all of this started when she* [voluntary project coordinator] *came to see me and she was the first person in my life, she just sat there and listened and said you are just what we want; and for the first time the biggest problem in my life - the biggest negative, was flipped 180 degrees and became the biggest positive. And that made me believe well that she believes in me, why do I have to feel ashamed? - I don't, do I? That was the epiphany point, that you mentioned, it was somebody else have a belief that I was useful again.* (Mark Workshop 193).

So it [mental illness] *has been a learning experience really, a fantastic learning experience ... because it has given me so much, it has robbed me of so much, but it has given me so much as well. I know lots of people who say similar things. I never thought that I would be able to say that, languishing on a psychiatric ward at nineteen - thinking that my world was over. That I would actually cherish my experiences, but I do.* (Andrew 63).

Medication

It has already been noted that medication was a key component for participants in controlling their mental health symptoms, that often they were reluctant to take medication because of the side effects, and that medication, even when effective, is not in itself sufficient. There is another theme that emerged in the data, where some participants had taken some control of their medication regime.

Boris described how he has an arrangement with his GP surgery to get increased medication as a priority patient and has administered his own depots. David undertook his own research and asked his doctor to change his medication. Andrew is working with his GP to reduce and hopefully come off his tablets. Leonard, Mark, Noel and Wilbur all describe how, at last, they are being prescribed a medication that is helpful to them and play an active role in their medication reviews:

I have been like a guinea pig, I have been on all types of medication. Once I was on 23 tablets a day, three anti-psychotics and you become institutionalised because you can't say anything, because you don't know anything about the drugs what they give you. Until I started becoming well and reading the leaflets and finding out about them. You realise what they can do to you how they can effect you. (Wilbur 25).

Many participants expressed a mixed feeling towards their medication. They knew that it had been effective and may be was still necessary to keep them well, but they would prefer not to take it. Most expressed the belief that stopping medication was too great a risk:

It is a necessary evil and we could not do without it - I would love to try but I would not dare. (Mark Worksop 221).

Getting Out

Having started to take control, participants described a concept of (re)engaging with the wider world. Many participants talked about illness and being on their own, never leaving their house/flat. This was not just about being out in society, but playing an active part in it.

Social Networks

In the previous section there were descriptions of the disruptions caused by mental health problems, the loss of valued relationships and social networks. Fiona said that it was the re-establishment and making of new social contacts, that she got by working, which promoted her recovery:

Being with people socialising, having someone to talk to, not necessarily about your problems but you can chat about what you are doing ... Just

having someone to chat about the weather or something, just to communicate with someone on a daily basis. (Fiona183).

For Boris his poor relationship with his first wife was part of his mental health problems - but his relationship with his second wife was part of his recovery.

Because at the end of the day, in my opinion, the majority of mental health problems come from relationships. It is some sort of thing to do with family, wives, husbands, parents something like this, it is the root cause... You have got to get some of these issues resolved, then you have to get people into work and going, but have to remember that you are going to be taking the most unwanted jobs in the town very often. (Boris 99).

Wilbur, Boris, Pete, and David all expressed the belief that their current partner was part of the recovery process - by providing support and believing in them and their ability to be well and achieve.

Meaningful Activity

A central theme in all the recovery stories was getting out of the house and engaging in something meaningful. Part of this was social contact and reducing the time spent alone. Another element was engaging in something constructive - the more meaningful the task was the more beneficial it was in promoting recovery. Adding structure into the day and having something to get up for were important elements for all the participants. This will be developed further in the next chapter on employment. At the workshop I asked if people could recovery without meaningful occupation and if that meaningful occupation had to be work. The answer to the first part of the question was a resounding "No"; there was a strong belief that people had to have "something to get up for". They said that recovery was a holistic package of social components, social inclusion and more life choices. There was more debate about the second part of the question. Examples were given of people who attended a gardening group or social activities who maintained

recovery without being employed.

4.2.2 Maintaining Recovery

The data about maintaining recovery is also structured into three themes:

- Monitoring
- Complementing Treatment
- Planning to be well

Monitoring

Most of the participants described that once they had their individual recovery components in place and they were feeling well, they needed to keep a constant vigil on themselves, watching for symptoms and being careful about what they do:

> *Yes, but at the back of my mind, but it is monitored errm on a daily basis, I understand that it is there but it does not affect me at the moment, but I am always on the look out in case.* (Mark 322).

> *I am still not as naive to think that I do not have to try everyday to keep things at bay.* (Andrew 59).

> *It is a good thing in a sense because you don't take that risk and it is a bad thing in a sense because it prevents you from taking chances. I sometimes get too laissez-faire and blasé about things and think that I don't have to worry and that I have got it under control now. I do stupid things, I stay up too late, I go on a big drinking session with my friends and then think - oh god I can feel a bit shaky and a bit juddery, and think - this is dangerous for you, you need to watch yourself. But the flipside to it is being so scared that you don't take chances, take chances on employment and going on holiday.* (Andrew 180).

[I am] *pretty much recovered, I am more aware now of the warning signs of me getting ill so that now, if I got those warning signs, I would be able to deal with it rather than just let them grow to the extend that I just have a complete breakdown.* (Fiona 247).

Complementing Treatment

Many of the participants described stories about other things that they did that helped treat the illness. For Andrew physical exercise has been part of this recovery plan. Leonard and Wilbur both used music as part of their coping mechanisms. Noel sees that in addition to exercise there is a spiritual component to his recovery:

It [Reiki and meditation] *would keep me de-stressed and would be at base in my mind, at a different wavelength that what it is like in the rat race...* [Exercise] *picks me up when I am feeling depressed or whatever. And football, I can't get enough of football. I have not got many games left in me; I need to play as many games as I can.* (Noel 119).

Planning to be Well

Some of the participants were familiar with formal recovery plans like WRAP (Wellness Recovery Action Plan). These plans set out an individual programme to achieve and maintain wellness:

Hopefully now, I am equipped with at lot more tools to deal with it [illness], *if it does come back. It is where the WRAP comes in isn't it.* (Mark 346).

Andrew, Noel and Wilbur had all written plans. Mark and David had plans in their heads which they shared with their partners, but had not felt the need to formally write them out:

I was introduced to the concept of controlling the symptoms and that has always felt right for me. Control to the point that they no longer play a part in your life is even better. (Andrew 170).

There was some caution about the current state of recovery and the fear that plan, although effective, may not be able to prevent a relapse. I asked David if he felt in control of his mental health problems:

I could not say that I could control it, I do not know anybody who could say that they could control fate and if it wants to come back, I don't think that it will, but if it wants to, I would be powerless to stop it from coming back. I'd be a bit optimistic if I said never again. But hopefully, hopefully. (David 687).

Sometimes the plans had very specific elements. Leonard knows that some anniversary dates are very difficult times - he has agreed a plan with his partner to help him through these dates and keep him safe. Noel has a list of little rules for himself and a wellness strategy for dealing with bad times.

4.3 Summary

This chapter started with Andrew's story; of all the accounts this one had the most explicit use of a formulated recovery plan. Whereas the first phase (detailed in chapter three) is dominated by being 'done to', the concepts in this phase are about resuming control. This may start with a turning point, an epiphany moment that it is often associated with feelings of insufficiency with the treatment. There is an acceptance of illness, but within a context of hope. It is an active process of working out and implementing what keeps people well. Many people with mental health problems do not reach this phase and of those that do, some do not progress to the third stage of employment which is discussed in the next chapter.

Chapter Five Findings: Employment

This chapter looks at the third part of people's stories - beneficial employment which helps maintain recovery. As with the earlier chapters I start by retelling one of the participant's stories. Following that I have set out the concepts on employment constructed from the codes and categories in all the interviews.

5.1 David's Story

David is a white British male in his fifties with a diagnosis of bi-polar affective disorder. David currently works as a Support Time Recovery worker in a community mental health team.

David did well at school and at the age of 15 he had the choice of staying on to do his exams. David chose to leave school and went into the Navy. He signed up for 12 years; it was described to him as 3 years as a boy and 9 years as a man. David laughs about this now, describing the first three "boy" years as the Navy getting cheap labour. However, David enjoyed his time in the Navy and continued to serve for 21 years. He is sad that it ended and felt that he was forced out by the prejudice of his commanding officer. David had an exemplary record and if he had been able to stay just one more year he would have been made a Warrant Officer. David describes the Navy as a family and liked the security that it provided. During that time David married and started his own family. During his career David did a stint with the army in Ireland, providing close observation of the IRA.

His last overseas posting was in Hong Kong. David loved the place and the people. The work was not demanding and was 'one week on and one week off'. He would be flown out by helicopter with provisions and beer to a lookout post in the jungle, and spent his days in "knickers and flip-flops" photographing the Chinese Navy on the Pearl River. It was during this posting that David first experienced significant mental health problems:

I went out to where the camera was - the binoculars, the radar. And I turned the radar off. I went into the actual generator shed and I turned the radar off or put it on a really low setting and all the lights dimmed and what have you. And I started throwing these beads around. And I had Freddie Mercury playing because he was one of my great singers. I was just singing and throwing these things around I had this cloth on and on my head... So they [David's Navy colleagues] *phoned up our main office out there, our main base in fact. Spoke to the boss who was somebody in Naval intelligence and said "David is not very well."*

So the next morning, I always used to go for a walk when I was off watch, I always used to walk in the hills and I would take the dogs with me to keep the snakes off. I used to quite enjoy that and did it quite often. So I was getting ready putting all my gear on, hat, shoes and that. And then this helicopter landed and I thought that it should not be due in now. There was a doctor on board and one of my friends from the regulator - the Naval Police. He said alright David we are just testing out this new vaccine for flu - everybody is having it and everybody else has had it and it's your turn now. So pulled my sleeve up and had this injection, well I don't know what it was, accuphase [a rapid tranquilliser] *or something like, that it knocked me out. And they said we are taking you home you are not too well.*

David was admitted to a Military Hospital in Hong Kong. There he was given huge amounts of medication which made David very depressed and for the only time in his life he felt suicidal and made active plans to end his own life:

I was sent home [his house in Hong Kong] *with this big bag of medication with about 6 different ... I had been told to take these on News Years Eve. To start taking these tablets that the psychiatrist had given me, he had flown off*

to England and left me there, the only other people there were the nurses that I could contact. Now my Dad used to be the assistant deputy secretary of [name of town] *Hospital and he said "I am not a Doctor but there is a lot of powerful medication here, don't take all of it." But like a dutiful idiot - oh the Major said "take these tablets on News Years Eve." So I took these and within in an hour I was seized up I was going into a rigour and they had to carry me into the lift, downstairs into a taxi and to the hospital.*

It took me three months to come out of that. I was in pain. I was in agony. When I got to the ward there was this sister there. She was the only one on this day and I had started to go into one of these rigours again. All my teeth were biting. That is why I have such bad teeth now. They were chipping away and I was tensing up and I could not move anything. I was caught up in a ball. She just came to the end of the bed gave me a smile and walked off.

David had been in the Navy for 19 years without any signs of mental health problems, but during the last two years he became unwell. The Navy moved him back to the UK and he worked in a shore based post in the photography section:

Things were going well and I had a clash with the Chief Petty Officer. He was the one above me, and I just heard him say "Oh he is just a 'welfare' case." And I just wanted to get out then. It was me spitting out my dummy basically. But he put the stigma onto me, to everyone else in the section - to everybody else in the section who were beneath me, if you know what I mean. I did not like the person anyway so I could not see myself stopping there for another 2 years - working with that guy.

David left the Navy and returned to live in his childhood home town. He bought a local grocery shop. On reflection David describes buying the shop as self stigma - he wanted to work and thought that no one would employ him, so self employment seemed like the

best alternative:

> *That was my escape. I did not want to go on to getting hand-outs and that. I wanted to work; I did not want not to work.*

After a few years a big supermarket opened near the shop and the business could not survive. David found work in a factory but felt that he had to lie on the application form about his mental health history.

While at the shop everything was fine for two years, then David became "high" again and had to be admitted into hospital. David had taken the medication that he was prescribed while he was still in the Navy. He did not really believe that he was mentally unwell and still blamed the original medication that he was given in Hong Kong for his problems. Following that David became unwell more frequently and was repeatedly admitted to hospital - during this time David began to accept that something was wrong but he still found it hard to accept the diagnosis of bi-polar affective disorder. There was a strange pattern that for about five years David became unwell on almost the same date every year. The admissions to hospital were not backed up with any community support:

> *I was just kicked off the ward. It was a just a revolving door syndrome it really was, you never saw anybody again...When I started to get a CPN I thought that was better, but that was only once a month, for about half an hour...Yes I had out patients...But you were lucky to get 10 minutes. It was a waste of time basically...I was screaming for help I really was...Advice was missing. There was no advice; it did not have to be direct advice. Just go there, go here or whatever.*

David describes the times when he was high and had to be sectioned. There were occasions that he was forcibly given rapid tranquillisation. This involved being held to the ground injected and held in a locked seclusion room. David reacts very badly to rapid

tranquillisation and his blood pressure drops, causing him to lose consciousness, one time hitting his head as he fell. The worst experience was being forced to have ECT against his and his wife's wishes.

David worked on a production line in a food factory for five years, though the last two years were disrupted by illness. This was mundane work but David really enjoyed it, especially the people with whom he worked. He describes them as living on low wages, but being very genuine. David had lied on the application form, but the company never made an issue of this and when he had periods of mental illness they supported him to return to work.

Eventually he was sent to see the company doctor:

> *I told him a brief history for about five or ten minutes and then he said, "Well" - he signed this and said "permanently unfit for work". I was put on incapacity and because of my navy pension I did not qualify for any DSS hand-outs. I was not on a lot of money then but my pension got me through.*

Following that brief interview David remained out of work for several years:

> *Oh those few years were terrible. I thought oh I am here until death basically without doing another days work....that it was a downward spiral it was a shock to me and I vegetated basically.*

David joined the local (mental health) User and Carer Forum[8]. He took part in training for professionals, speaking about his experience of mental health services. David also learned about a new medication for the treatment of bi-polar affective disorder, which he asked his psychiatrist to prescribe him. The doctor agreed and since then he has remained out of

[8] This is a mental health service user and carer self help group which works with local mental health services to improve the provision of care.

hospital. David also had a CPN at that time and attended Day Hospital. The Day hospital provided a social network and involved him in an Investors In People project. Although David remembers that on his first day:

> *I thought I am never going to last here half a morning, I was given a colouring book and colouring pens and told to colour that in. That was awful, it might suit some people - but it did not suit me.*

David explains that the involvement in the User and Carer Forum was very important in his recovery. There was a talk from a specialist mental health pharmacist who was able to explain all aspects about the medication people were taking; there was a conference about Support Time Recovery Workers (STR) and a speaker from London who has mental health problems and is now the Director of a NHS mental health trust:

> *Other people at these conferences that I went to, they had an illness and comparing that to the low proportion of people with illness that do work. I can't see why more people can't work. If they can do it why can't myself and others do it? So it is down to being stigmatised basically, yeah it is hard to get over that.*

David applied for one of the first STR posts created in the local mental health service. He recalls that his CPN discouraged him from applying. David wanted to prove his CPN wrong. He recalled when he told his CPN that he had got the job:

> *It was strange, because I said to my wife before he came round "I think that he will be pleased" when he come round...and then she said "I don't think that he was". He was very negative, very negative.*

David believes that in addition to listening to other people's success stories there is something about himself that has made his recovery possible. David believes that he

needed to do something, that long period of being off work and unoccupied is harmful. David needed to work. He also reflects on the importance of having a supportive wife:

> *She stuck by me. If it had not been for her, god knows that would have happened to me, I can't speak highly enough of her. When it comes to partners I got a good one there, because she stuck by me. I know so many people with mental illness; their marriages have broken up, so many, in fact the vast majority.*

David finds his job as an STR worker very rewarding. It gives him something to get out of bed for, he is good at his job, he is achieving something, his work makes a difference and he gets thanked by the service users he works with and he feels part of a team. *It has kept me well. It is good for me, I enjoy it.* David doesn't follow a formal recovery plan but has his own plan in his head. David believes his wellness has been achieved by a combination of family life, work and medication (in that order). This does not mean that he will never become unwell again. David said he needed to complete two-thirds of the recovery journey; for him employment is the essential last third.

5.2 Codes and Categories for Employment

According to David gaining employment is like the last third of the recovery process. All the participants had recent experience of working full-time in paid employment in mainstream competitive posts. Wilbur, Noel, David and Mark were all STR workers, though Mark was just about to embark on his nurse training. Pete had worked as a cook on an unpaid basis in a mental health employment scheme - but now had got a paid post within the project. Leonard, Fiona and Andrew worked completely outside of mental health services. Boris was now retired due to his physical health.

Data from the following codes and categories were used to develop the concepts around employment:

Ambition; *Disclosure; *Identity; Jobs; *Maintaining Recovery; *Meaningful Occupation; Reasonable Adjustment; Recovery and Work; Respect; *Stigma; *Social Network; *Unemployment; *Value mental health problems; *Welfare Benefits; Wholeness; Work as normalization; Work life balance; *Work placements; *Work as Negative. (* denotes that the codes and categories are also used in the other empirical chapters).

Four concepts emerged:

- Getting ready for employment
- Getting the right job
- What (beneficial) work does for you
- Balancing support

5.2.1 Getting Ready for Employment

Recovery First

For work to be beneficial it not only has to be the right job, but it has to be at the right time. The participants agreed that there needed to be at least a partial recovery ahead of employment.

> *... you have got to be better before you can work, or getting better.* (Boris 47).

> *I would say that you have to be at a certain point before you can go back to work... I had to be in a certain position. I don't think that you can be mentally ill one week and then go straight back to work the next... I had to be well, I had to be ready, I had to be confident. Because it is a big step.* (Mark 394).

Work Placements

All of the participants (except Andrew) had been through some form of work placement,

either through mental health services or through the Job Centre. The participants did not always value or enjoy these schemes at the time they were doing them, but they all described them as helpful stepping stones. Pete, Noel and Wilbur undertook placements with the same mental health employment and training scheme, which allows people with mental health problems the opportunity to work along side paid workers in real work settings. They all valued this scheme and stated that it contributed to their recovery.

5.2.2 Getting the Right Job

Ambition

During the interviews it became apparent that the participants all had a strong work ethic (especially David, Boris and Mark) and all were ambitious to do well in whatever job they had. From the age of 18 Leonard had travelled from restaurant to restaurant, building a reputation as a top chef. His ambition and determination were rewarded with accolades. It is clear that the participants had a certain attitude and determination towards work, which may not be shared by everyone in their position. So the combination of the right job, at the right time may have been beneficial because of their personality and values.

Disclosure

It has been noted above that participants sometimes lied about their mental health history, and found not being able to talk about their mental health problematic in securing and keeping employment. Feeling confident about disclosing and trusting the employer were good indications that the employer would be sympathetic:

> *It was always that thing when you get the application form and the first pages were fine and then you would get the medical part and your heart would just sink and you would think well maybe I am not going to get this job.* (Mark Workshop 152).

There are two aspects to it really, being able to be open about my experiences and it being meaningful. And surprisingly enough, the jobs that I have not been able to be open and honest about my experiences, have not been particularly meaningful. (Andrew 158).

This was particularly true for the participants who were employed as STR workers. In the workshop I suggested, a little tongue in cheek, that:

You lot [STRs] *have had it easy, working in a mental health setting.*

All
[Laugh] *Yes you're right*

You are hardly going to be fired for becoming unwell - if you have followed all the right procedures. It was very positive (Mark Workshop 310).

Everyone knew we had mental health problems before we started. (David Workshop 313).

Disability Discrimination Act 1995 (DDA)

Fiona was given good advice that her mental health problems meant that she was covered by the DDA. She, like many others, had assumed it only related to physical disability. Fiona explained how it helped get interviews. Above, I have commented how Fiona used the DDA to challenge the occupational health decision that she should not be employed:

I was just trying to go more for equal opportunity employers because ...if you tick like you have a health problem... you automatically get an interview and even thought I did not get the job and that was disheartening. Getting the interview gave me more motivation - well at least I got an interview, I know that I have got an interview, I know that I have cheated the system a little bit

(Fiona 115).

Boris's experience was not so positive:

> *I applied to the Council for the information service and it said anybody with a registered disability will be interviewed. The first thing I got was a refusal and I said I am registered disabled and so they said "oh yes then we will interview you".*
> [Boris explains how he met the job criteria at interview] *I was turned down on the fact that my disability was a risk* (Boris 71).

The 'risk' was never explained!

Need to be understood

Andrew described a time when he felt that his boss could not understand why a graduate was working part-time in a restaurant and Andrew felt unable to explain. The ability to disclose appropriately and to be understood was a common theme in the interviews. All the participants expressed the difference it made when they got a job that understood and accepted their mental health past. Most got this through working in jobs or work placements within mental health services. For Fiona and Leonard they had to fight for their right to work.

5.2.3 What (Beneficial) Work does for You

Identity

The issue of identity has been considered in the previous chapters. All the participants described the importance of having an identity as an employed person. This was explored at the workshop. Work gave people the answer to the standard opening question: what do you do? But it also gave people a sense of status. For Mark working is an essential component of what makes him him:

I don't feel right unless I am working. (Mark Workshop 207).

You lose that feeling when you walk around and "look at him, that schizophrenic" [since working] *I have lost that feeling.* (Noel Workshop 267).

Your words don't carry as much weight without a job. (Noel Workshop 316).

Need to be Mentally Active

All the participants spoke of the importance of being mentally active. Many associated not being mentally active with an increased risk of becoming ill:

It [work] *is very important, if I was not in work I would be in hospital. If I did not have something to think about I would be in hospital.* (Leonard 75).

I believe that employment is a big distraction for somebody like me. (Leonard 120).

Structure in the Day

Another key factor was structure in the day:

Just the structure for a first. I mean when I was depressed, I would spend however much time I could in bed. However much time was there I would pull the covers over. It is very true what they say, you shut the curtains, and you pull the covers over your head and just having to get up for something, albeit at twelve o'clock midday for just three hours until three - was a real struggle. But it allowed me to have some focus: that I had to do this. I had to do this. (Andrew 147).

But I have not really, I have not had any health problems since I have been

there it is having structure in my day and doing things. (Fiona 235).

Place in Society

In a similar way to the comments above about identity, having a role in society was identified by participants as important:

> *When people say to me "What do you do?" I say "I am a professionally trained chef" You have got that thing; you have a place in society with other people.* (Boris 55-57).

> *Yes being a viable part of society, rather than just something. I don't feel right when I am off work for a long period of time. It is part of my makeup that I should work, you know, I used to hate collecting my benefits, I felt ashamed going into the dole office every fortnight drawing my... I just felt like not doing it.* (Mark 304).

Making a Contribution

Even better than feeling part of society was the feeling that they were playing an active part in it - giving something back.

> *I started with* [name of employment project] *in March. I am not sure what day, and I went straight in the kitchen. And if I do say so myself, right from day one I have been an asset.* (Pete154).

Andrew had done lots of reading about mental health as part of his recovery and wanted to use this knowledge to help others:

> *And, because I had done that I felt again that I wanted to put something back.* (Andrew 38).

Financial Independence

Money did not feature largely within the interviews. Participants talked about needing to earn money to survive, but this was mainly at times prior to recovery and before they had accessed benefits. Many participants reflected on the benefit trap. For Fiona working meant having only slightly more income than claiming benefits:

> *It is quite important as well, but this is kind of the lowest pay that I could afford to take coming off benefits, so it was like important but not, well like I thought I would take this job even though I know money-wise I was not going to be greatly well off, but that I was better off than on benefits.* (Fiona 303).

For Leonard his pay reinforces his belief about the value of his contribution to the restaurant where he works.

> *They pay me £11 an hour down there* [in the restaurant] ... *I am very expensive compared to the other guys that are on £5.85. So I am like nearly double. They think that it's worth it; I know that I am worth it.* (Leonard 122).

Social Network

All the participants described the importance of getting out of the house and being with other people. It was described both in terms of the potential harm of being in your own company all day (ruminating on your problems, feeling sorry for yourself, fearing going out) and also in positive terms of meeting people (having a chat, taking an interest, putting things in perspective - acting "normal").

Work as Therapy

All these aspects of work were therapeutic, in that they promoted recovery. However in addition to this, the STR workers talked about their work as having an active role in helping them work through their own problems. The work was a form of therapy, not just therapeutic. A key element in this was reciprocity within a professional caring

relationship:

> *Yeah thought that it* [work] *would be therapeutic, I thought that by working it would occupy my mind. Whereas a dull mind, not being active I would become unwell again. I definitely think that, because I know that when I was out of work it was... I would turn into the laziest thing about, you give up hope.* (David 258).

I asked Wilbur: What does that give you in terms of recovery?

> *It gets me up in the morning, gives me something to live for. I have had dark times when I felt suicidal; I don't get that now.* (Wilbur 61).

> *I get a lot of therapeutic value from doing the job I do. It is not just about helping the person I am seeing it is about getting help back...but the rapport you get, that good feeling when you can help someone.* (Mark Workshop 298).
> *It can energise you - can't it.* (Noel Workshop 301).

> *I think that it has done a lot for me. I think that it has probably done more for me than I have done for the job. (*David 620).

Wholeness

Many of the participants, especially those who expressed a strong work ethic, talk about work as a process of normalisation. In contrast to the earlier comments about the insufficiency of medication, work provided wholeness:

> *I truly believe that appropriate meaningful employment for me was the missing link between a life of not been able to cope and learning strategies to get by and moving on into what I would consider real life.*

(Andrew 63).

5.2.4 Balancing Support

Work-life Balance

Even the right work at the right time had the potential to be harmful to mental health, if it was not in a healthy balance with other aspects of participants' lives:

> *I know when to say "No". I have got to look after me and over the last few weeks I realise that I have got to look ...Putting yourself under vast amounts of pressure to prove a point ... I have realised now, that I am going to live. I am going taper what I do and how much I do.* (Leonard 75).

> *You need your own life as well; you need your own time out of work as well. You need to have a balance, work to live and live to work.* (Wilbur 39).

Protection

Participants spoke about how work can be harmful and that with good work there was an understanding employer and a feeling that they could be open about their mental health problems. However, for some of the participants this was also accompanied by a fear that they would never be free of the mental health label. I asked Noel: Do you think that there is a danger that people forget that you had mental health problems?

> *No I don't;* [the danger is] *that they never forget.* (Noel 290).

Reasonable Adjustments

Participants generally found it hard to identify what reasonable adjustment would be, or what have been, helpful. All David wanted was a workplace free from discrimination. There was also a hope that employers would show some understanding if mental health problems reoccurred. However, Mark, David, Andrew and Boris were all concerned that

employees with mental health problems might exploit special and favourable treatment.

> *Yes people might play on it - yeah I think that people would play on it. It is quite easy just to start weeping if things are going wrong or you have done something wrong. I want some time off or I want some more time off and what have you.* (David 725).

> *I'd like to be able to be understood. If I thought things were wobbling then I thought I needed a couple of weeks then I would be able to come* [name of boss]..., *but that is the only thing. I would not expect anything, like I said I consider myself recovered and I would not want any special things done I am just like any one else really.* (Mark 444).

Summary

This chapter started with David's story; within this account the connection between recovery and employment is clearly demonstrated. Employment is more than a by-product of recovery, is it a component within it but it has to be the right employment at the right time. Finding and obtaining beneficial employment may not be easy. The participants described a wide range of advantages that work had brought them. This is an on-going phase, rather than one participants finished; it is not about achieving wellness but more about maintaining it. Within chapter three the vicious circle of illness and unemployment was highlighted. In this chapter an opposite force emerges. In this virtuous circle, good work experiences lead to improving mental health and better employment prospects. The next chapter explores in more detail what it is about work that is significant in creating and maintaining recovery.

Chapter Six: Core Framework and Summary

In the previous three chapters data were used from the interviews to develop concepts, although some apposite quotes from the workshop were also included. Some of these concepts were presented and developed in the workshop attended by Mark, David and Wilbur. In this chapter I present summaries of the concepts already detailed, together with data from the workshop, to explore the relationship between employment and mental health and recovery. This is used to develop the central question in this research. This chapter sets out the core framework and acts as a summary of three previous chapters.

This chapter is in the following parts:

- Summary of the concepts
- Understanding the relationships - summary of workshop
- Core framework

6.1 Summary of the Concepts

The first part of this chapter synthesises the previous three chapters. The phrase 'people' (meaning people with mental health problems) rather than 'participants' is used and the present rather than past tense. This reflects a move from being descriptive about the participants' experiences grounded in the data, towards speaking in more conceptual terms.

Summary of Concepts on Mental Health Problems and Unemployment

- *Entering the mental health system.* When people start to have mental health problems they usually enter (sometimes by compulsion) a medical model of illness which seeks to diagnose and treat. The nature of the illness and the dislike of medication can mean that people are often reluctant to accept they are ill and/or refuse treatment.
- *Redefining self.* Mental health problems often mean a redefining of identity,

especially in relation to the loss of employment. People are given messages like they will never work (again) - they are more likely to be defined by their illness.

- *Suffering from unemployment and loss.* People can be harmed psychologically by unemployment. Being unemployed, especially on the grounds of mental health problems, makes it harder to find meaningful employment. Unemployment often results in loss, for example: finances, resources, professional identity, status and even the break up of relationships.
- *Living with illness.* Services are not always made available and are not always appropriate or helpful; people sometimes refuse services because they believe that they are not ill or better left to deal with their problems themselves. People often have to live with the experience and knowledge of a recurring illness. People suffer stigma and discrimination, and sometimes abuse.

Summary of Concepts on Recovery

- *Turning Points.* People with mental health problems may be compliant and benefiting from a medical model intervention, but still feel a sense of insufficiency. There may be a critical decision or moment when the person begins to think differently about their mental health problems and the impact it has on their lives. This is often a point of accepting the mental health problem and taking increased responsibility for it. This is in the context of increased hope, that things will get better and that they have an active role to play in their improvement.
- *Taking Control.* People begin to take control by learning about the illness and understanding how it manifests itself for them. With increased ownership there is often a greater confidence to identify with other people with mental health problems, and more confidence to be open about their illness. Some people even begin to value the experience and insights it has given them. People play a much greater role in the treatment they receive.
- *Getting Out.* There is a re-engagement with other people, and the amount of time spent with others increases. There is an increase in the amount of time engaged in activities that the person finds meaningful.
- *Monitoring.* People have increased awareness about their own mental health and start

to monitor themselves, taking action to maintain or improve wellness.

- *Complementing Treatment.* In addition to medication, people may identify other activities that help them, like listening to music, meditation, exercise etc.
- *Planning to be well.* An individual programme to promote wellness is developed; sometimes this is in the format of a written plan.

Summary of Concepts on Employment

- *Getting ready for employment.* At some point, once the recovery process has started to be effective, the right type of work will be beneficial to mental health. Initially this may be in the form of voluntary work or a work placement - which often acts as a stepping stone to more mainstream work.
- *Getting the right job.* People who want to work find that jobs where they feel able to disclose their mental health problems are more successful. The DDA may be helpful in getting a job. Good employers have a level of understanding about mental health problems.
- *What (beneficial) work does for you.* People find that work is beneficial to employment because it gives them (back) status and identity as a worker. It provides mental stimulation which has a positive impact on symptoms and can provide structure in the day. People have a sense of being an active member of society and are able to make a contribution. Work provides financial independence and sometimes more money. Work increases social networks, but these are not always functional. Some times the nature of the work itself acts as a therapy. For some people working is an essential part of their make up - and sense of self; for them work provides a wholeness.
- *Balancing support.* The ability of work to be beneficial has to be monitored to ensure that it does not start to become harmful to mental health - this may be caused by too much work stress or long hours. The need to be understood needs to be balanced with being treated normally and fairly; workplaces should be free from discrimination.

6.2 Understanding the Relationships between the Various Concepts.

> *I would put it, that it is like being a really, really good actor, but no one will give you the film to act in - you know that have all those acting skills, but nowhere to display them. Employment gives you the stage to show other people what you are capable of ...Before you do it, you don't know. It is like you have taken two steps and the third step is employment and before you take it, you are apprehensive. It is like the actor on his first night. Opening night nerves, before you do it - you don't know. But once you do it and it goes well, you do know; and that just spins the circle again. It makes it go faster and better.* (Mark Workshop 322,328).

The workshop was used to test out the emerging theory about the vicious and virtuous circles, and the notion that work is a form of: "acting as if" the person did not have a mental health problem. All the participants were invited to attend a workshop one Saturday morning at the Tukes[9] conference centre in town, travel expenses were offered. Three of the participants agreed to attend the workshop. The workshop was an opportunity to explain what I had done with the data they gave me and for me to use a selection of exercises to checkout the emerging themes. I used my experience of group work, training and NLP (neuro linguistic programming) to devise the exercises.

I provided a presentation of the data and some of the concepts (in a similar format to that above). I asked a number of questions about the relationship between unemployment, employment, mental health and recovery (these questions are in bold below). This was completed on a flipchart and the responses were agreed by the group. The first question was about an emerging concept that the nature of some work is toxic for mental health. The concept of toxic employment is explored in the last chapter (8.1.2).

[9] Tukes - is the local mental health training and employment service.

Why is some work damaging to mental health?

- Not stimulating
- Other people have stereotypical views; stigma
- It is a tightrope - not able to tell other people - afraid to tell other people about mental health problems
- Have to lie to get the job, can't disclose medical history; this may mean that only certain job opportunities are available
- Work doesn't match ability; doing a job that does not meet the potential of the employee
- Placed in box of "mental health service user"
- Can't disclose (because they lied on application) so can't ask for support.
- Not able to sell self as a person with a mental health problem

These responses reinforced the findings reported in the previous chapters, but also emphasised the two-way relationship between poor mental health and toxic employment.

Can people recover from mental health problems without:
- meaningful occupation?
- employment?

This two-part question was about the relationship between recovery and meaningful occupation. I wanted to establish if there was an additional component in paid work (other than the money).

Meaningful Occupation

- No, need something to get up for
- Know of one person who only attends the gardening group one day a week and is maintaining recovery
- Medication (may be a necessary evil) but is not sufficient - only deals with the

symptoms

- Devil makes work for idle hands - leads to OCD[10]
- Need holistic package: social components, social inclusion, more life choices

Employment

- More options - financial benefits, more spending power and improved lifestyle
- Have bills to pay
- Could just be meaningful occupation with paid work
- More status in paid employment
- Social role
- Self confidence / respect
- Some things I have to do; some things I want to do. Ideal if work does both for me.

There was a very strong perception that *meaningful* occupation was essential to recovery. When that meaningful occupation was paid work there were a range of additional benefits - all of which promoted and helped maintain recovery.

Work is a ..... for recovery

The next question explored the relationship between work and recovery. An incomplete sentence was presented and the group was asked to fill in the missing word. I gave a few suggestions (in bold). The group responded to a few of these and then added their own alternatives.

- **Hook** - not sure on use of language
- **Vehicle**
- **Necessity** - not for everyone, subjective
- **Expression**

[10] Obsessive Compulsive Disorder

- **Template**
- **Means**
- **Final piece**
- Part
- Step
- Goal
- Channel / conduit
- Aim
- Opportunity
- Culture / catalyst
- Environment

There was then some discussion and the group decided that the best fit was "catalyst"; meaning that work provides an ideal context in which recovery can flourish, accelerating the process.

Five Perspectives on Recovery with/without employment

The last part of the workshop was to consider recovery while in employment and recovery without employment. The group was asked to do this from five perspectives, so as to explore if there was any added benefits from employment in relation to recovery. This utilised a NLP technique[11] called logical levels (Dilts 1999). It is a process of asking the same question from five perspectives (or levels).

Identity - what I think about who I am

Belief - what I believe about myself, others, the world

Capability - skills, what I can achieve

Behaviour - tasks, what I am doing

Environment - the places I go

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[11] NLP Neuro Linguistic Programming - Dilts' work is based on Bateson's seminal book *Steps to an Ecology of Mind* (1972)

The participants were asked first to consider the recovery process while being in employment, from each of the five levels. They were then invited to repeat the task, but consider recovery while not being in employment.

Table Four: Workshop Exercise: Logical Levels

	recovery in employment	**recovery without employment**
Identity **What were you thinking about who you were during:**	Self esteem / worth "Made it" makes me want more, ambitious Part of society, paying own way	Self esteem/worth. Pride Not part (totally) of society No icing on the cake
Belief **What were you believing about yourself during:**	Making a difference to others, passing on knowledge Changed - learn so much Achievement / success Challenges negatives -proving people wrong Challenging negative thoughts	No or less opportunity to make a difference to others Words don't carry weight Same belief in self - but not reinforced
Capability **What were you thinking that you could achieve during:**	Skills to make a difference Learn from service users and other STRs	Inner knowledge - but not seen important, by others. Like being a good actor, but not allowed on stage. Apprehensive before performance

Behaviour **What were you doing during:**	Therapeutic Disclosure - Helping - two way process Establishing rapport with others Make a difference, positive Energises the last 25% of recovery Topping on cake Shared experience, empathy	[less valued] Tasks No recognition
Environment **What was the place like during:**	Opportunity to meet others - different types of people Gets you out of house Chance to learn Friendship and understanding	There are places to go and safe spaces to be in Home can be therapeutic

The framework is not easy to understand so the replies were recorded as given rather than trying to make sure they fitted into the right box of the matrix. This was a useful way to explore initial answers and prompt new ways of thinking about a familiar question (unless prompted people tend only to articulate a response from one or two of the levels). This was certainly the case during this workshop. Mark's comments (at the start of this chapter) were made during this exercise.

One of the central themes to emerge from this was the concept that work allowed people who were recovering and (re)gaining skills, confidence and wellness the ability to try it out and show it off to others. This acting out of recovery serves as a validation of the wellness and that validation perpetuates and increases the rate of recovery. Mark summed it up well in the quote at the start of this section.

This was in contrast to my conceptualisation of work as an opportunity to 'act as if'. Following the workshop the framework was refined in relation to this aspect. My original thoughts were that work created an expectation of wellness which workers adopted. The emerging framework is much more about beneficial employment being an environment in which pre-existing wellness is demonstrated and reinforced.

6.3 Core Framework and Summary

After completing the first seven interviews, I tested out the emerging concepts with the last two interviews and the workshop. Pulling together the summary of the concepts from the three phases of participants' journeys and the refined understanding of the relationship between employment and mental health recovery, a framework grounded in the data was induced. The framework is set out below and describes two processes which I have called the vicious and virtuous circles. One describes how toxic work experience and unemployment can compound mental health problems. The second describes how the right work can act as a catalyst for mental health recovery.

Vicious Circle: Why some work and unemployment are harmful to mental health

The vicious circle starts with an experience of poor mental health (which in some cases is caused by problems at work!). Both unemployment and some ("toxic") work negatively impact on mental health. Poor mental health impacts negatively on the ability to work which in turn compounds problems of unemployment and reduces the prospects of finding anything other than toxic employment. This further deteriorates mental health, and so on. Traditional support for mental health problems, especially medication, may only help with symptoms and achieve periods of stability, both of which are insufficient in creating a sense of completeness in relation to wellness.

Unemployment and toxic employment are not the same, but both are detrimental to mental health. They are also in a circular pattern of their own: a poor employment and

sick record make it harder to get work, resulting in unemployment and poor mental health. People often only apply for low skilled or paid work which is generally easier to obtain, for example factory work, repetitive tasks in conjunction with unpleasant working conditions. This work is often easier to secure, but is typically in "toxic" work environments which give the employee little in the way of respect or self esteem. It also lacks meaning or a sense of contribution. In addition it is often physically tiring and can involve long hours. In this situation people may avoid disclosing or lie about their mental health problems to employers, but this makes it difficult to be open about a recurrence of illness. Consequently it is harder for individuals to seek support if required and to feel free from stigma or stereotyping. This also may result in self stigmatising - a self limiting of the potential options for employment.

Periods of illness and unemployment are often reasons for not being short-listed or employed. Sometimes people are too scared to disclose mental health problems, leading to a choice to be open and hope that they are given a chance, or lie and risk being found out. The DDA may be helpful in overcoming this, but it requires that people know their rights and employers acting in the spirit of the law rather than just ticking a box. In addition, during episodes of illness people are often given the message that they will never work again and may be placed on benefits which may make it hard to find quality employment which would pay as much as social security benefits. These both compound the sick role. The result is that illness makes people less employable.

Unemployment has a negative impact on self esteem and worth. This may also be compounded by a strong work ethic and a sense that people have to work. There is a perception that people on benefits are scroungers - especially for non physical/visible disabilities. This perception is sometimes held by the benefit recipient themselves. Sometimes there are financial commitments like families, mortgages and debt repayments which force people into a labour market before they are ready or able to choose the right type of work.

This can be a downward spiral into a sick role which is devoid of hope and opportunities to (re) gain employment. In this journey downward other important social components may also diminish or become lost, for example social networks, decent housing, driving licence - car ownership, family contact, leisure and social activities. There may also be an increase in vulnerability to abuse, bullying and harassment, increased debt, and drug and alcohol use.

Virtuous Circle: Why some employment is good for mental health recovery

Employment that is helpful to recovery often occurs when people are already part way along a recovery journey. This journey into recovery has components of an acceptance of the mental health problems, hope that it will improve, a belief that the individual can act to make things better and being on the right medication. Often there are triggers for this change from illness to recovery, for example hitting a low point, ending/changing the use of drugs and alcohol, seeing their mental health problems as a positive, or someone believing in you. The character of the person is also significant in determining if employment is helpful in recovery. It seems likely that valuing a work ethic, being ambitious and determined are key factors in employment success.

Employment that leads to an improvement in mental health usually occurs during the later part of a recovery journey and represents a positive career choice. People have a sense of acceptance about their mental health problems. They are able to tell employers and others about their mental health problems and negotiate what this might mean in relation to employment. In some cases the experience of mental health problems is viewed as a positive asset. Work is meaningful and strikes a healthy-work-life balance. It is rewarding in terms of being worthwhile, valued and affording the person opportunities to make a contribution. There is a social network, a structure to the day and a sense of achieving something.

It may be that unpaid, part-time or voluntary work does not meet all of the above criteria, but meet enough of them to act as a stepping stone to more hours, paid work, promotion

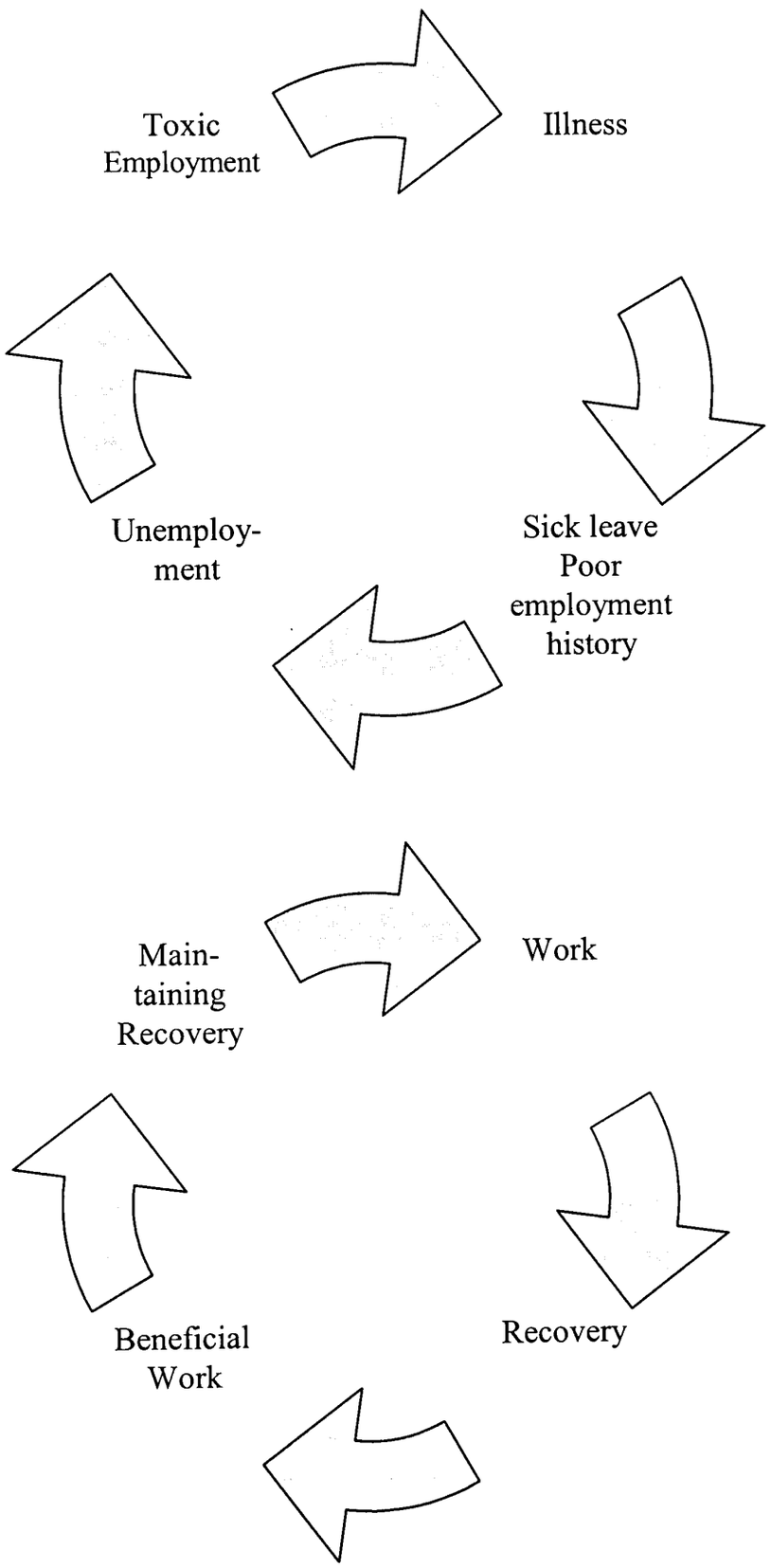
or alternative work. There is enough confidence and support to get out of the "benefit trap". There may be a need for some reasonable adjustment, but attitudes and values towards mental health appear to be the most important components. The working environment is one that encourages interest in the development of employees and fosters ambition and supports training.

There is a general feeling of hope and belief in the ability of the person to succeed. Work is a demonstration that the person is able to progress and reinforces achievements. There is greater financial independence. There is an increase in self esteem and worth. Work has meaning and is worthwhile and carries with it some status. There is an identity around employment rather than illness. The person is perceived, by themselves and others, to be contributing to society and achieving independence from welfare benefits. These all contribute to greater social inclusion - increased social networks, access to leisure and exercise, more choice around accommodation and financial planning.

It may be that a recovery process that led to employment involved a (written) formulated plan like a WRAP. These plans often set out a structure especially in relation to use of time and getting out of the house to engage in meaningful activity. They may also include things like: concordance with medication, setting of standards and rules for the person to follow. They are developed and owned by the person. There is a need for the person to work on that plan - applying effort, dedicating time and doing more. This is often around an increase in meaningful occupation and could be anything from making themselves leave the house or doing a social activity, to doing a day's work in a safe environment. Employment is often perceived to be an extension of this process, the 'icing on the cake' in terms of meaningful recognised use of time.

Each participant's journey was unique and there is no predictable pathway. In the memos I have drawn several variations of the vicious and virtuous circles, many of which were too complicated to convey meaning, below are simplified diagrams of the circles.

Diagrams of Vicious and Virtuous Circles



Employment can also be seen as a catalyst to recovery - it creates a culture or climate which nurtures and accelerates recovery. Employment requires the same components of being in a situation where there is a need for people to apply themselves in a structured way to achieve an outcome. Work in the caring profession may itself be therapeutic. The nature of working with others enables reciprocity of helping and caring - a process of helping others which improves the person's own mental health and increased enjoyment. In the end work becomes its own reward.

It is also acting out - a performance of recovery. This metaphor of taking to the stage can be expanded to think of the recovery journey as learning acting skills, having rehearsals, getting into the role and the anxiety of the first night nerves. There is recognition and reaction from the audience who see and respond favourably to a good performance. The sense of achievement at carrying off the performance and the applause of the audience perpetuate this virtuous circle.

Chapters three to six have detailed the data which has been conceptualised and build into a theoretical framework. This framework has been tested out, amended and validated. This chapter has concluded with a summary of the core frameworks of vicious and virtuous circles. The next chapter compares and contrasts these frameworks with the literature.

Chapter Seven: Literature Review

In this chapter I discuss how I returned to the literature with the knowledge of the data and experience of the foregoing analysis. This chapter is divided into two sections. The first section explains the reason and methodology for returning to the data. The second section looks at the literature and is itself divided into the three phases of recovery that I identified in the previous chapters. To try to avoid confusion where I am talking about my research I describe it as "this research" (as opposed to research described in the literature).

7.1 Returning to the Literature

As detailed in chapter two I conducted a search of the literature in order to substantiate my research proposal. This material is contained in the rationale for the research (chapter one). Grounded theory purists support that researchers do not complete the literature review until the later stages of the process, so as not to be influenced by the existing theories. The notion of bracketing off previous experience, so as not to influence the findings, is advocated within some qualitative methodologies. In this study I have tried to reflect on and acknowledge the influences which I might bring. Restricting the amount of reading prior to the data gathering and analysis was helpful in focussing on what was there, rather than what one might expect to find.

There has been an increase in papers published on employment and mental health since I started the research (2006-08). I undertook a more focused literature review once the data had been collected and analysed in order to further test out the emergent constructs for theoretical sensitivity (Strauss and Corbin 1990) against the literature.

7.1.1 Conducting the Literature Review.

The following process was used:

1, Selecting the databases. Using the Sheffield Hallam University Literature Search facility I selected the subject area of Health and Social Care and the subcategories of Social Work; Occupational Therapy; Nursing. From these the following databases were selected:

CINAHL

Medline

Cochrane

Health Source Nursing

Assia

Psych Info

Social Services Abstract

2, Selecting the search terms. In order to save time, some words used in the search were truncated. The # denotes truncation - so the search would return all the words included the in brackets; * denotes plurals. Three individual searches were run (1, 2, 3) and then combined in a final search (4).

Search 1: Psychosis or Neurosis or Neurotic or Depressi# or Psychiatr# or Mental#

Psychiatr# (Psychiatrist; Psychiatry; Psychiatrically)

Mental# (Mentally; Illness; Health; Disorder; Well-being)

Depressi# (Depression; Depressive)

Search 2: Employ# or Work# or Job* or Vocation# or Occupation#

Employ# (Employment; Employee; employer)

Work# (Worker; Working; Works)

Job* (Jobs)

Vocation# (Vocational)

Occupation# (Occupations; Occupational)

Search 3: Recovery

Search 4 = Search 1 And Search 2 And Search 3

Other terms for recovery could have been used, for example: Wellness or Rehabilitation. However I required literature that related to the more tightly defined term of recovery and this was used to ensure that the volume of material was relevant and manageable.

3, Other parameters. Where the databases allowed further restriction, then the following parameters were used:

Last 10 years - again to ensure that the material returned was the most relevant and manageable:

- Adults - including older people but excluding children
- English Language

4, Locations of Words. The databases searched for keywords. Some of the returns were so large that the search was further refined to look for the words only in the title and/or the abstract.

5, Relevance of the returns. Once the search had been refined to provide a manageable return (I judged that to be up to 150 returns per database). Then each article title was read. Many could be discounted because they were not relevant to this research. Some of the common examples of excluded articles were where they primarily related to: drug and alcohol dependency, (emergency) recovery services, post traumatic stress, physical disability, eating disorders, children, and dementia. The table below sets out the number of returns.

Table Five: Literature Search Results

DB	MH	Empl	Rec	Para-meters	Search 4 Returns	Selected
Cinahl	15724	16779	5533		52	18
Assia	31499	45788	1824		145	33
Pysch Info	37720	179500	1427	Abstract and recovery in title	66	15
Medline	52908	51176	12916	Title	13	5
Cochrane	30336	25061	138		5	1
Health S	9160	13841		Title	67	12
Soc S Ab	13543	36755	1364	Title	114	3

The 87 selected results were exported into Refworks and sorted for duplications, this resulting in 65 journals. The abstracts of these were read in more detail:

- 37 were relevant and downloaded or ordered;
- 28 were, on closer inspection, not of use. These were not predominantly about mental health, or did not focus on paid or meaningful employment, or were medical model rather than recovery.

Within the 37 relevant articles there were references to other papers which I identified as being potentially useful. These were also located and if relevant added to the literature search.

Most of the research is not based in the United Kingdom. Below I note the country of the research when discussing it. I only searched for articles written in English. With the

exception of one study in Switzerland all the research is based in English-speaking countries[12]. It is difficult to gauge the international work on recovery and employment outside of the English speaking countries - I note that none of the literature made any reference to such research. Not all of the articles I read are detailed below.

Summary of Returning to the literature

A systematic approach to a literature review was undertaken. There is a relatively small amount of research into this specific area and the majority of what is published is from North America, Australia and New Zealand.

7.2 Phases of the Recovery Journey

In this section I set out the literature around the three phases of recovery identified in the previous chapter: Mental Health Problems and Unemployment, Recovery, and Beneficial Employment. Some links to this research are made, but the next chapter will discuss this in greater detail. The subsections are drawn from the themes within the literature, many of these match the codes and concepts within this study.

7.2.1 Mental Health Problems and Unemployment

This section looks at the research around the concepts that I identified in the first phase of people's recovery journeys.

Three Phases

Bradshaw et al. (2007) interviewed 45 people with mental health problems over a three year period. Broadly they were able to identify three recovery phases, one in each of the three years. The first year was characterized by demoralization, the experience of being overwhelmed by disability and the attempt to get some degree of control over the illness.

[12] I include Canada and New Zealand in this - though I appreciate that English is not the only language spoken in these countries

The second year was defined by the development of mastery and coping with the consequences of illness. The third year was characterized by the theme of reintegration into community. The authors note that the first stage often is dominated by loss, loneliness and a desire for meaningful human contact. There are few social contacts and these are characterised as one-dimensional in that they receive more than they give.

Young and Ensing 1999 also develop a three phase model. They described recovery as starting with an overcoming "stuckness", and the second phase as being about undertaking vocational activity. In the third stage, vocational activities demonstrate a striving to reach new potential and higher functioning.

Woodside et al. (2006) also discuss three themes in recovery which broadly match the three stages described above:

- Self-assessing mental health
- Working to maintain and improve mental health
- Feeling connected to others

There is some resonance here between these models and with the three phases that are identified in the participants' accounts in this study. The similarities are an initial problem related phase, then a searching for solution phase followed by a connection and reintegration. In this study this is related to employment. The importance to practitioners of recognising and developing strategies to manage each of the three stages is developed in the next chapter.

Diagnosis

The sample size in this research was far too small to make any generalisable comments about the experiences of recovery and employment for different diagnoses. However the accounts of the participants' journeys with a psychotic illness were longer, included more examples of unemployment and losing jobs and described more severe symptoms compared to those with neurotic illnesses.

There is however some research that has been conducted with specific diagnostic groups. Tse and Walsh (2001) drew on existing literature about people diagnosed with bipolar affective disorder. They concluded that while employment rates amongst individuals with bipolar disorder may improve over time, and are relatively better compared to some other chronic mental disorders, employment prospects do not match the high scholastic achievements seen amongst this group of people before the onset of their illness. They use two case studies to discuss how occupational therapists can help clients with bi-polar affective disorder through the stages of recovery.

Millward, Lutte and Purvis (2005) conducted a qualitative investigation into the attitudes to work among people diagnosed with clinical depression. Their results were that the health care system can unwittingly reinforce the 'sick-role' and in doing so provide a continued justification for an 'off-work identity'. Some participants saw it as the role of the professionals to make them better. Participants who saw themselves as in recovery were more vocationally orientated, taking up the offered opportunities. This enabled them to resume a work identity. A key in this was that they were able to dissociate their symptoms from themselves.

In addition to the two latter studies there are other studies involving people with schizophrenia (Meddings and Perkins 2002; Hoffmann & Kupper 2002). However none of these have shown any significant difference between different diagnoses in relation to the phases or components of the recovery journey. While it may be the case that people with the same diagnosis can have similar journeys, fundamentally recovery is an individual and non-linear process. This research suggests that it is factors like the age at the onset of the illness, social impact of illness and disruption to work history which prove to be more significant when considering employment and mental health, rather than the diagnosis.

Insufficiency

Within the first phase of their journey participants in the present study described entering what can be constructed as a medical model experience. They were given a diagnosis and a treatment plan and, if they were lucky, an explanation into what was happening to them. Whether they chose to accept it and comply with it, is a different matter. What comes with the "medical model" construct is also what it means to be well. Fundamentally recovery is about the person themselves defining what wellness means for them.

Meddings and Perkins (2002) explored constructions of what getting better meant for staff and service users. The participants lived in London and had a diagnosis of schizophrenia. The results show that both staff and users have quite complex multi-faceted notions of getting better. Staff focused more on activities of daily living and access to help. Users focused more on improved material well-being and physical health. The concept akin to the one described in this study as insufficiency was identified:

> The removal of symptoms does not guarantee a worthwhile, satisfying and purposeful life; neither does the presence or recurrence of symptoms preclude it. While relief from distressing symptoms was identified as important by both staff and service users, the present results indicate the need for a broader approach to intervention that is tailored to that which is important to each individual (Meddings and Perkins 2002:232).

Getting better was construed as involving not only improved mental state, but also improved well-being and relationships, empowerment, confidence and self worth, greater engagement in work and activities, being able to cope with everyday life, having access to help and support, improved material well-being and improved physical health.

Although outside the scope of this research it might have been illustrative to examine any existing care plans for the participants - to consider what, if any, services were being offered; and the extent to which they focused on dimensions of people's lives other than

medication and symptoms.

Linked to the construction of what constitutes wellness and the insufficiency of "just" being symptom free is the notion of quality of life. Renwick and Brown (1996) describe how the Centre for Health Promotion (CHP), University of Toronto, developed a conceptual approach to quality of life. The conceptual framework is summarised as Being, Belonging and Becoming. It recognises that individuals have physical, psychological and spiritual dimensions. People have a need to belong in both a physical and social sense as well as to distinguish themselves as individuals by pursuing their own goals and making their own choices and decisions:

- *Being* (Who a person is as an individual) encompasses the most basic aspects of who people are as individuals.
- *Belonging* (How environments and others fit with a person) is there fit between the individual and their various environments?
- *Becoming* (What a person does to achieve hopes goals, aspirations) Focuses on the purposeful activities in which the individuals engage in an attempt to realize their goals, aspirations and hopes. Renwick and Brown (1996:82).

Having the symptoms under control may reduce or stop the violent mood swings, falling into despair or the distress of psychosis. It is surely the start of an improved quality of life; but absence of illness is not the same as wellness. What the participants described in their first phase of illness and unemployment (and sometimes being unemployable) - or being in toxic work - was an absence or a frustration of goals and more significantly hope. There was no or very little quality to their lives. Their *being* was often an identity, defined by others, that was about illness. There was a lack of *belonging* and feeling excluded from society. Their attempts and ambitions of *becoming* were often frustrated and they were written off - never to work again.

What seems to be described is a combination of the social aspects of the illness as well as

the collateral damage of having a mental health problem. By the social aspects I mean the impact the illness has on social function, enjoyment of life and motivation. The collateral damage is the social exclusion which is often suffered by people with mental health problems as a result of lost income, stigma, and stereotyping. It is not uncommon for people to retreat to the safety of their own four walls and only if they do venture out it is to mental health service spaces and places. Within this study it was experience of the right work at the right time which proved to be the essential component in 'becoming'.

Stigma and Discrimination

The Mental Health Foundation conducted research in 2002 on the experiences of people in the UK with mental health problems in the workplace. A postal questionnaire was completed by 411 respondents. Some of the findings relevant to my study findings were as follows:

- People with bipolar or psychosis/schizophrenia were more likely to report being turned down for a job because of their mental health problems than people with other mental health diagnosis (Mental Health Foundation 2002)

- 56% of the survey respondents reported to have experienced possible discrimination in the recruitment process and only 25% of people with bipolar affective disorder and 29% of people with schizophrenia felt that it had never happened to them.

- The research looked at the number of people who told people at work about their mental health problems:

    - 11% declared that no one at work knew
    - 11% declared that everyone at work knew
    - 67% said that colleagues knew
    - 61% said that their manager knew

Within this study there were examples of direct discrimination. More significantly it was the ability to disclose that was a consistent and very important theme for the participants. Not disclosing was sometimes associated with lying and always with a feeling of not being understood and not being able to explain. Disclosure was not only important for the individual's sense of integrity, but was also associated with "beneficial" work. Participants had enough confidence in the employer to disclose and know that it would not be used against them in some way.

Written off

The pessimistic and over cautious views of professionals that are described as being "written off" in this research are also reflected in the literature (Deegan 2001). There is also research to suggest that, despite professionals' perceptions that patients have unrealistic expectations (Becker et al. 1998) it is in fact the people with mental health problems who have mostly realistic and informed job preferences (Mueser et al. 2001, Bond 2004).

Unemployment

Waddell and Burton (2006) identify research that demonstrates the negative impact unemployment has on physical and mental health. There is a strong and positive association between unemployment and increased rates of overall mortality (from cardiovascular disease, lung cancer and suicide) and poorer mental health and psychological well-being (more psychological distress, minor psychological/psychiatric morbidity, increased rates of parasuicide). There are a number of possible mechanisms by which unemployment might have an adverse effect on health. The psychosocial impact of being without a job can affect psychological health and lead to psychological/psychiatric morbidity.

There is extensive research on the negative impact of unemployment on mental health (Warr 1987) and between unemployment and suicide (Platt 1984; Bolton and Oatley 1987; Lewis & Sloggett 1998). Two main themes in this research associated with

unemployment were identity (not wanting to be an unemployed person) and lack of activity (the dangers to mental health of being stuck in the house all day).

All of the participants live in a region which has higher unemployment rates, poorer health outcomes and greater social deprivation than other parts of the country. This is demonstrated in the report: Health and the Economy in Yorkshire and the Humber (Yorkshire Forward 2007).

Table Six: Yorkshire and Humberside Employment and Earning

2006	Unemployment	Employment	Average Income
Y & H Region	5.7	74.6	£27,247
England	5.5	75.1	£31,904

Much of the literature is based in other countries with different health care and welfare arrangements. However, even when considering this research with other studies in the UK, the regional socio-economic context needs to be taken into account. Participants not only faced employment difficulties due to illness and stigma, but also faced living in an area with social deprivation with lower than average employment prospects. Within this research I was struck by Boris's description feeling the lowest of the low - when there are hundreds of people chasing one job and he had a psychotic diagnosis and poor sick record.

Summary of Mental Health

A number of writers have divided the recovery journey into three phases. These broadly fit with the three phases identified in this research. In order to maximise efficacy of mental health services it is important to recognise and tailor vocational interventions around these three phases.

Although there is some work on individual diagnoses there seems to be more commonality of the recovery journeys for all types of severe mental illness than

differences. Paying attention to the individual experience of illness, especially the resulting impact on employment and other social factors, may prove more reliable in understanding the problems associated with employment and mental health

The "insufficiency" of the medical model to overcome loss of a life worth living is well documented in the literature, within this research achieving a life is directly linked with achieving employment. The key barrier to gaining employment is stigma and discrimination, this is also well documented. Within this research it is not just the absence of direct discrimination that made employment beneficial - but the extent to which the culture of the workplace supported disclosure of mental health problems.

The literature supports the idea that the professions are too quick to "write off" people with mental health problems. Demographic information has been included to describe the socio-economic context in which participants in this research live and work. Boris's reminder of trying to find work at a time of high unemployment is poignant when describing employment prospects for people with mental health problems.

7.2.2 Recovery

In this section there is a great deal of consistency between themes already identified in this study and the existing literature. Recovery has already been discussed within chapters one and four and will be further developed in the next chapters. For this reason the literature is presented without making explicit references to the similarities in this study which should be self evident.

Concept of Recovery versus Medical Model

Carpenter (2002) argues that despite the construction of mental health services around the concept of chronicity, research does not support the concept that mental illness is a life long condition. In fact there is evidence that many, if not all, people diagnosed with schizophrenia or other psychiatric disabilities experience either complete or significant

remission of symptoms. Carpenter argues that the dominance of the medical model is detrimental to service user's sense of hope and self efficacy.

Fundamentally, recovery is about the hope, borne out of experience, that people with mental health problems will get better. This 'getting better' is defined by the person themselves and is often despite, rather than because of, support from mental health services. The recovery model shifts the focus from symptoms to having a life that is both vital and valuable, whether or not symptom relief is ever achieved (Anthony 1993; Deegan 1988).

Part of the process the participants described was gaining an understanding about their illness. This was often by educating themselves but it also included reflecting on their own experiences. Psychiatry has the concept of "insight" (Markova 2005) to describe the extent to which the person understands and accepts their mental health problems. It is in the nature of some mental health problems, especially psychotic disorders, that people experience paranoia and find it difficult to distinguish what is real. It is also the case that the term insight is used to express the extent to which the person agrees with a professional, the diagnosis and is compliant with the treatment plan. Understanding the problem is vital to the recovery process (Anonymous 1989; Deegan 1988; Young & Ensing 1999). However this does not necessarily mean agreeing with the professional's model of the world; rather it is more important that the person defines for themselves what the 'illness' is and what it means for them (Leete 1989; Pettie & Triolo 1999).

As mentioned in the previous section, recovery is often as much about overcoming the impoverished social aspects and the collateral damage that have been created in someone's life as it is from the illness itself. (Anonymous 1989; Anthony 1993; Leete 1989; Deegan 1996, Houghton 1982).

Unique

Recovery is not a consistent pattern but is a process that varies in degree from person to

person and also within each individual's experience over time (Hoffmann & Kupper 2002; Anthony 1993; Deegan 1988, 1997; Frese & Walker-Davis 1997; Pettie & Triolo 1999. The process requires the person to be proactive and take responsibility for her or his own recovery (Deegan 1996; Fisher 1994; Leete 1989). It is about finding a way to live with and where possible improve life with illness (Anthony 1993; Deegan 1988).

The search for identity is central to recovery and is about defining a unique and positive sense of who one is (Deegan 1996; 1997; Frese & Walker-Davis 1997; Pettie & Triolo 1999; Young & Ensing 1999).

Common Components of Recovery

The development of recovery literature has been from a number of sources. In the beginning individual recovery journeys were written in academic journals (Anonymous, 1989; Deegan 1988; Houghton 1982, Leete, 1989). Anthony (1993) challenged services to make recovery their practice guide. These individual stories have led to researchers seeking out other recovery stories to see if the components of recovery can be distilled.

There is no one recovery model (Jacobson & Greenly 2001; Spaniol, Koehler, & Hutchinson 1994). The research however, around the concept of recovery is still evolving but there is an emerging set of central beliefs, values and concepts within the literature (Bullock, Ensing, Alloy & Weddle 2000).

Mary Ellen Copeland (2001) had her own experience of recovery and has also collected and analysed other people's stories. Copeland has developed the WRAP which some of the participants referred to. WRAP is the Wellness Recovery Action Plan and is a highly structured plan that people with mental health problems are encouraged (with support if needed) to write in order to plan and maintain their own recovery. It contains the following steps:

1. Developing a Wellness Toolbox

2. Daily Maintenance List
3. Triggers
4. Early Warning Signs
5. Things are Breaking Down of Getting Worse
6. Crisis Planning

Each step has a number of parts which help the person work out what is helpful in their wellness and to structure that into a daily plan. There is a process of monitoring and taking action to keep well. The final step is planning for others to step in if the person can no longer maintain their own wellness.

Mancini (2007) used grounded theory to identify factors that influenced the recoveries of 15 'psychiatric survivors' (in north-eastern USA). The participants identified the development of a more competent and efficacious sense of self as a central aspect contributing to their recoveries. Mancini identified four factors related to this development: meaningful activities, supportive professional relationships, peer support and choice among a variety of treatment alternatives.

Mancini suggest that self efficacy may be a useful guide for creating the contexts for facilitating the recovery process. The study suggests that the contexts that facilitate self-efficacy beliefs are those in which clients:

(1) are encouraged to take risks and engage in meaningful and challenging activities;
(2) have warm and egalitarian professional relationships;
(3) have access to self-help and peer support networks; and,
(4) can make informed choices among a variety of formal and alternative treatments.

Mancini uses the term self efficacy to encapsulate an individual's personal assessment of their competence to perform tasks and their belief in their capacity to achieve that task.

This again makes a link, evident in this study, that engagement in and support from the social networks are significant in generating and reinforcing a sense of hope and self belief. In particular the taking of risks is consistent with Mark's comments about taking to the stage - taking the risk to perform.

Cohen (2005) gathered the recovery stories of 36 (USA) participants, the most common recovery strategy was self help (95%) compared to one-on-one therapy (58%) or group therapy and psychiatric drugs (25%).

Cohen notes that it was not one "magic bullet" that "cured" people but a combination of methods and circumstances which allowed participants to improve their sense of well-being. A common theme in the interviews was that people did not get "better" or "recover" until they took control of their own "treatment," whether it was meditation, exercise, peer support, or psychiatric drugs.

Andrew had a specific recovery model, whilst Mark, David, Wilbur and Noel all used WRAP either overtly or by integrating the components into their thinking. All the participants identified social networks and meaningful activity as components in their recovery. Cohen's work is interesting as it presents recovery components as percentages. That said the overriding conclusion from the literature and this study is that recovery has common components but is essentially unique to the individual.

Hope

Hope is one of the consistent components identified in accounts of recovery (Jacobson & Curtis 2000; Turner-Crowson & Wallcraft, 2002). Hope is a driving force (Anonymous, 1989; Anthony 1993; Deegan 1988; Frese & Walker-Davis 1997; Houghton 1982; Russinova 1999, Young & Ensing 1999) and may be generated internally (Russinova 1999); or externally by supportive relationships (Russinova 1999; Deegan 1988). It is part of taking control of one's own life (Hoffmann & Kupper 2002).

Snyder et al. (1991) quote that a typical dictionary definition of hope emphasizes the perception "that something desired may happen". They go on to say that recent scholarly writings on the topic of hope have amplified this definition principally by emphasizing the importance of goals. Most writers have postulated that hope is a one-dimensional construct involving an *overall perception that goals can be met.* However they test out and provide support for their hypothesis that hope is defined as a cognitive set that is based on a reciprocally derived sense of successful (a) agency (goal-directed determination) and (b) pathways (planning of ways to meet goals). For Snyder et al. 'hope' is not a case of: 'Where there is a will there is a way' but that there needs to be both a will and a way.

Hope is an essential component that is well established in the literature and clearly emerged from my data. The Snyder et al. modified definition is helpful in beginning to unpack this term. It emphasises that hope does not just reside in the individual as an inactive attribute; it is a dynamic process of planning to shape one's destiny. One of the key messages that emerged from this study was the role of professionals to ensure that they don't write people off and that they do actively communicate a message of hope. This is translated into implications for practice in the next chapter.

Summary of Recovery

The last two decades have seen an increasing interest and evidence base for a recovery model in mental health. This has been initiated by autobiographical recovery stories and developed by research that demonstrates that while each recovery journey is unique there are some common shared components (education, hope, understanding own illness, self belief, planning to be well). Recovery is an active emancipatory process which is about taking ownership and control of a life with illness; it involves taking action to create and maintain wellness. Fundamentally it is a process about hope. There is a great deal of similarity between the finding of this study and the literature in relation to recovery.

7.2.3 Beneficial Employment

Is Work Good for Mental Health?

At the start of this research I had uncovered very little research that made a positive link between employment and mental health. There is some work that looks at the benefits of employment from the objective circumstances rather than the subjective experiences of the person with mental health problems (Lehman 1995; Crowther et al. 2001b; Dewa & Lin, 2000; Royal College of Psychiatrists 2002; Bell et al. 1993; Cook and Razzano 2000; Warner 1994; Drake et al. 1999).

Work is more than a means of earning living. It provides social contact and support, status and identity, structure and occupation, activity and involvement, and a sense of personal achievement (Jahoda et al. 1972; Rowland and Perkins 1988, Shepherd 1989, Nethering et al. 1993, Pozner et al. 1996).

Waddell and Burton (2006) have completed an extensive review of evidence surrounding the question: Is work good for you? I have selected some of their findings. All these statements were ranked in their top category for scientific evidence. Health is used to refer to both physical and mental health.

- Work meets important psychosocial needs in societies where employment is the norm.
- Work is central to individual identity, social roles and social status.
- At the same time, various aspects of work can be a hazard and pose a risk to health.
- Job insecurity has an adverse effect on health.

This study has also shown participants expressing the belief that the right work at the right time improved and maintained their recovery. In addition it made a direct link between employment and improved mental health.

What Work is Good for Mental Health?

There is some literature about the factors which create a work environment that is conducive to people with mental health problems. Work is beneficial where there is a belief in the worker's potential (Krupa 2004). Where there is a match between the culture, and values of the person, and the work environment (Kirsh 2000). Rebeiro and Cook (1999) describe a "just right" environment in their research into an occupation based women's group for mental health consumers[13]. The group members experienced affirmation, confirmation, actualisation and anticipation which led to occupational spins offs. What constituted a "just right" environment was the provision of opportunity and choice in a place with "the own" - meaning other women who had experienced mental health problems.

These factors were all evident in this study; in addition the relative nature of beneficial employment was identified. Participants described the importance of having the right job at the right time. Work too early in the recovery journey is more likely to be harmful and some work may only be helpful if it is a stepping stone. Being with people with similar experiences was very beneficial to many of the participants in the second phase of recovery. In the third phase more socially inclusive environments were also beneficial - providing there was a level of understanding so participants felt they could disclose their mental health problems if they wanted to. Employment as stepping a stone is discussed in more detail in the next chapter.

Predictors

Studies seeking to identify which groups of people with mental health problems are able to work (Anthony & Jansen 1984; Crowther et al. 2001a) found it is difficult to predict who will be successful. Employment history appeared to be one indicator of future success. A range of clinical and demographic factors have been considered but with no clear result; indicating that few variables confidently predict employment outcomes at the

[13] Consumers is the more widely used term to refer to service users in Australia and new Zealand.

individual level. Tsang et al. (2000) found that diagnostic and psychiatric symptoms were inconsistent predictors of vocational success. The IPS model (Bond et al. 2001) advocates that selection of people into programmes to help people (re)gain work should be based purely on the willingness of the person to achieve employment.

A limitation in this study is that only success stories were reported. This may have influenced participants' beliefs about the importance of meaningful occupation, especially employment, to act as a catalyst for recovery. I am persuaded by Bond et al.'s approach that selection should be based on the willingness of the individual to work. In taking this approach, there needs to be an acceptance that intervention to support people to develop the desire to work is also required.

Getting Work

There are two studies which hint at the dynamics described in this study as virtuous and vicious circles respectively. Inman, McGurk and Chadwick (2007) explored the experience of service users on a vocational rehabilitation scheme. They found that transitional vocational schemes could have a positive effect on vocational status, quality of life and the mental health of participants. The themes that emerged were:

- *Moving on*; this included experience of a change from negative to positive thinking; aspirations changed and increased; and they regained confidence in work skills that had a knock-on effect in the amount of social inclusive activities they undertook outside of the scheme.
- *Being on the scheme*; there were benefits in doing "a regular thing" - it provided a structure and consistency in the day; it was also seen as a stepping stone - it was not an endpoint, nor was there a tangible outcome.

Lloyd and Waghorn (2007) explored the literature about the barriers to young people with psychiatric disabilities participating in education and vocational training or seeking and maintaining employment. They identified three types of barriers:

- The impact of mental illness on the individual.

- External barriers such as the nature of the labour market.
- Other systemic barriers; stigma found in a variety of locations: community, internalised (self stigma), health and vocational professionals and workplace.

Secker et al.(2002) compared five mental health employment projects (in Britain) by interviewing their clients, employees and work place managers. They identified that two projects offered very different approaches; one underpinned by a clinical model of recovery the other a social recovery model. They concluded that the social model offered more promise. Within the social recovery model clients were not expected to have already recovered, and there was an understanding that mental health problems may have implications for work. The client and worker relationship was one of interdependency, with initial vulnerability. Recovery and entry into the workplace was seen as ongoing and incremental, involving adaptations and adjustment, and support at least for some time.

The findings in this study are broadly consistent with this literature. The overriding message is that attention to social factors both in understanding barriers and overcoming them is essential. Again what is essentially different about this study is the description on the vicious circle. Unemployment and toxic employment exacerbate the existing barriers and lead to a deterioration in mental health.

Studies on Employment and Recovery

There are six studies which are similar to this research. They all identify the potential for employment to be beneficial to recovery. They are discussed in detail below.

Provencher et al. (2002) explored the role of work in the recovery of employed and unemployed people with "psychiatric disabilities". They conducted semi-structured interviews with 14 people who used mental health services in New Hampshire. The research showed that experience of recovery was based on six major dimensions: self-definition, empowerment, connections to others, meaning of work, vocational future and meaning of recovery. Differences in these six dimensions led to the identification of three

profiles of recovery: recovery as uncertain, recovery as a self-empowering experience, and recovery as a challenging experience. Each profile described a specific context in which participation in work or avoidance of work can be understood and vocational interventions can be designed:

- Recovery as uncertain. People in this profile had a vulnerable sense of self, low sense of empowerment, limited contact with others, saw work as a means of passing the time, were unclear about their vocational future and uncertain about the possibility.
- Recovery as a Self Empowering Experience. People were in a process of expanding a sense of self, they were redefining themselves and developing strategies to control emotional problems, there was increased self-efficacy and connection to others. Work was seen as self empowering and people had a positive outlook to future work.
- Recovery as a challenge. By contrast people in this profile had a multi dimensional sense of self, felt empowered, had strong connection to others, saw work as a means of self actualisation, felt they had a promising vocational future and looked for opportunities to challenge themselves in relation to their recovery.

This research concluded that vocational activities contributed to the recovery process in two ways: it was perceived as a means of self-empowerment (also found by Young and Ensing 1999) and it promoted a sense of self actualisation.

Self empowerment and self actualisation as a product of employment are clear examples of phase three recovery themes as described in this study. Mental health services are often constructed around the first and second phase of recovery (for example the focus of the NSF on Assertive Outreach and Crisis). Within this third phase individuals may choose not to access mental health service, but if they did, it does raise the question: How well equipped are mental health services at providing appropriate support to people who are empowered and have a strong sense of self actualisation? It is important to remember that recovery is not about cure but rather about living with illness. The need for professionals to provide different interventions in different phases is discussed in the next chapter.

Buckle (2004) interviewed ten (British) people whose employment had been arranged by a mental health service. The purpose of the research was to investigate the social outcomes of work. Buckle found that work enabled people to obtain beneficial social outcomes, in particular the forming of friendships: with positive impacts on existing friendships, developing friendships in the workplace, and friendships outside the work place. The quantity and quality of social contact does appear to be in a direct relationship with the recovery journey. This relationship between social contact, employment and recovery helps us to understand the dynamics of the virtuous and vicious circles.

Honey (2004) undertook grounded theory research, interviewing forty-one (Australian) mental health service users in order to explore their perspectives of the benefits and drawbacks of employment, the factors influencing these, and how they affect their decisions and actions. They identified six domains which have potential benefits and drawbacks that individuals have to weigh up when making decisions about working or changing employers. The domains were:

- Employment and Disability (in Australian society)
- Social networks
- The individual and their mental illness
- Job properties
- Disclosure
- Perceived alternatives to employment

Participants' perceptions of benefits and drawbacks were influenced by individual and contextual factors, were dynamic over time, and were instrumental in determining their employment-related actions. Honey's analysis could be used as a cost benefit framework for people thinking about employment. This is particularly helpful in the third phase of recovery when individuals have the strongest sense of confidence and self determination. As people work up the virtuous circle they begin to have more employment choices and

therefore are able to be more discerning about what employment decisions they make. This is turn is likely to lead to better job fits and enhanced employment experiences.

Kennedy-Jones, Cooper and Fossey (2005) interviewed four (Australian) participants who were clubhouse[14] members now in mainstream employment. Their narratives described unique stories of the development of their worker-roles. They identified four 'impelling forces' which contributed to their sense-of-self as a worker:

- *Support of significant others*; these people consistently encouraged them to develop their worker-role.
- *Personal meaning of work*; paid employment provided a source of meaning, purpose and the means of structuring the day.
- *Experiences with the clubhouse programme*; all participants regarded The Clubhouse as a place where they felt welcome and accepted, which provided opportunities to develop social supports and social networks.
- *Ongoing struggle with illness;* despite the ongoing disruptions experienced within their lives, each of the participants appeared to have found ways to manage their illness sufficiently to maintain their worker-role.

This study is broadly consistent with that of Kennedy et al. The support of significant other was mostly associated with epiphany moments rather than on going support. The personal meaning has been discussed in relation to the importance of a work ethic. Participants had not experienced a Clubhouse environment but did describe the importance of a work environment where they felt able to disclose their mental health problem if they chose. The ongoing struggle is consistent with the participants account of ongoing maintenance.

Woodside, Schell and Allison-Hedges (2006) conducted a qualitative study to better understand participants' insights regarding vocational success following at least one psychotic episode. The sample size and criteria were broadly the same as this study. The

[14] Clubhouse is a model where members with mental health problems meet together, sometimes with

research was conducted in Canada. The results were summarized in three themes which are broadly consistent with the data in this study. Theme one (self assessing mental health) concerned participants' self assessment of their health and level of their symptoms as they considered their ability to work. Those who considered themselves healthy placed great importance on the power of their medication to keep them healthy. Within theme two (working to maintain and improve mental health) there are three components (taking control, making positive life changes and benefiting from the illness). Again there is similarity with the middle recovery phase in this research. The Canadian authors were surprised that the participants who had been deeply ill said that gifts had resulted from their illness. This is wholly consistent with Mark and Andrew's claim about how they were able to value their experience - I too was surprised by their strength of feeling on this issue. The third theme (feeling connected to others) related to the "comfort" that participants felt with the interpersonal relationships that work brought them. It was concluded that occupational therapists need to continue to focus their attention on listening to where clients are in the recovery journey, enabling them to collaborate on interventions consistent with a specific phase of recovery.

Boyce et al. (2008) interviewed twenty (UK) users of mental health employment agencies who had succeeded in returning to work. They identified a number of key themes:

Perceived and actual barriers to work

When participants were asked about the barriers they had faced in getting back to work, the perceived stigma surrounding mental ill health was the most frequent response. This was associated with fears about disclosing their mental health problems to a potential employer. Alongside the issue of disclosure, a disjointed employment history was seen as a major barrier to work for participants.

Job satisfaction

Factors associated with job satisfaction included the right balance for the individual

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support, to take part in recovery activities often associated with vocational skills and employment

between work demands and sufficient challenge, a sense of achievement and using and expanding work skills. A supportive workplace was also very important. Understanding managers or supervisors played a central role in this respect, as did supportive colleagues.

Problems at work

The less positive views expressed by some participants revolved around discrimination, working conditions, lack of support and the impact of mental health problems on work. In addition people also stated that they sometimes felt isolated, that their work was monotonous or boring and for one person the problem was being reliant on colleagues to deliver information on time.

The impact of work on participants' lives

All participants identified positive impacts that working had had on their lives, including those who were dissatisfied with their job in some way. Many felt that working was helping them to deal with their mental health problems, improving their self-esteem and inspiring optimism about the future. These positive impacts appeared to centre around five factors:

- A more structured day
- Making a contribution
- A sense of achievement
- Social contact
- Financial rewards

It was noted that the benefits as described, including improved mental health, self-esteem, achievement, social contact and financial rewards, have long been recognised as important (Jahoda 1972). The identification of stigma as the main barrier to employment and as a problem at work demonstrates the need for this to be a key concern in supporting people with mental health problems into employment. Boyce et al.'s study also highlights some of the elements that have been described in this research as toxic work and explored in relation to the vicious circle.

Employment in Mental Health Services

Carlson, Rapp and McDiarmid (2001) consider the increased number of (New Zealand) mental health service users that are seeking employment as mental health support workers. They consider three prevalent barriers: dual relationships, role conflict, and confidentiality. They propose alternative solutions to each.

Dual Relationships, being both a provider and consumer of services.

Role Conflict and Confusion, The historical roots of treatment where there has been a clear delineation between the "sick" and the "well" are blurred with the introduction of consumers working within the mental health system. The discomfort of people who are not consumer-providers in accepting consumer-providers as equals.

Confidentiality, This is often raised as a concern. However, there is no empirical evidence suggesting that consumer-providers are more likely than non consumer providers to breach confidentiality.

The Carlson et al. study argues that the benefits easily outweigh the perceived barriers. The solutions proposed are:

- clarity of policies and job descriptions.
- creation of structures and expectations for dialogue.
- provision of supports like quality supervision, mutual aid groups and training.

The potential benefits of employment in mental health services are noted above. Carlson et al. describe some of the prevalent barriers from the perspective of non-consumers. Within the present research some of the participants described how it felt to make the transition from service user to worker within the same organisation. While some professionals had been supportive others had not. Noel expressed the fear that people would never forget that he was also a service user.

Summary of Employment

The literature is consistent with the finding of this study and there is a small but growing body of literature on the benefits of employment from a recovery, rather than a clinical, perspective. It is more than the absence of unemployment that is harmful to mental health; employment can result in self empowerment and self actualisation. It has the potential to increase social networks; but not all work is beneficial. It is hard to predict who will be successful in employment, but the willingness of the individual may well be the best criterion for recruitment into employment services. There are numerous barriers to getting work, vocational and employment services based on recovery model may be helpful stepping stones to permanent employment.

Within this study there has been a greater focus on employment and recovery. Though hinted at, other studies have not discussed the processes described as virtuous and vicious circles. Employment as a demonstration of wellness (taking to the stage) is also not detailed in the literature.

7.3 Summary

The advantages of leaving the literature review until after the data collection and analysis is that it does not influence the process. The risk is that within the existing literature there is something which would have been useful in designing the study. Having conducted the search it is clear that the majority of the themes in this study have previously been identified. This is particularly true for the section on mental health problems and unemployment, and recovery. This has provided another component in the triangulation and validation of this study, as mentioned in section 2.3.1 (page 60).

Existing literature has many of the components about beneficial employment which form the central concepts in this study, but they do not articulate them in such detail. In

particular the concepts of virtuous and vicious employment, and work as a taking to the stage - a demonstration and testing out of wellness.

One surprising conclusion of the literature review is the extend to which other studies have described recovery as a three phase process. There are some differences in what is meant by this, but enough commonality to suggest it is a significant finding. The importance of understanding the different phases is discussed in the next chapter, where is it used to shape different vocational interventions at each stage.

Chapter Eight: Conclusion and Discussion

In this final chapter I seek to integrate the findings of this research and the literature review to consider what it all means, both as a conceptual framework and also in relation to mental health services. In addition there is some reflection on my influence on the research (reflexivity), and a final section on the limitations of the research, and my thoughts about what further research would be useful and plans for dissemination. The chapter is divided into the following sections:

- Making sense of it all.
- What does it mean for practice.
- Reflexivity.
- Limitations, future studies and dissemination.

8.1 Making Sense of it All

The main findings of this study can be summarised in the following ways:

- There is a positive relationship between employment and recovery.
- The right work at the right time helps achieve and maintain recovery.
- Some work at the wrong time can be toxic for mental health.

8.1.1 What is New?

To help establish what new contribution this research makes I mapped out the literature against the headings in chapter three (these are the concepts that were formed out of the codes and categories)(appendix six). This is by no means an exact science and no firm conclusions can be drawn from it. However, it was helpful in identifying some broad themes:

- The structuring of the recovery journey into three phases seems to be a frequently

adopted framework for making sense of the process.

- Concepts identified in the first phase are consistent with existing literature. However this study has concentrated more on the journey through the phases than other studies. In addition this study has had a greater focus on unemployment both as a consequence and cause of mental health problems (within a recovery context).
- This study identifies that some employment is toxic to the recovery journey.
- In phase two, although it is hard to neatly map the literature against the recovery concepts identified in this study, they are broadly consistent. This confirms that recovery is a unique process with a number of common components.
- In phase three there is little written about employment as part of an overall recovery journey.
- This study has added to the very small body of existing literature on why work can be beneficial to mental health.

This study is one of only a handful of similar studies and one of only a few conducted in the UK on the subject of the role of employment in mental health recovery. It is distinct from the others in that it looks both at a whole recovery journey and the role of employment in it. This whole journey approach has enabled this study to gather and analyse data which demonstrate that employment has the ability to be toxic as well as beneficial to mental health.

There is a need to set out clearly what is meant by toxic employment. The background to this study was a concern that too few people with mental health problems who wanted to work were in employment. There is a danger that this study is misrepresented as justifying a notion that work is harmful. What this research is saying is that:

- For those that want to work, the right job at the right time is a catalyst within the recovery process.
- It is also the case that unemployment and forcing people (by policy, limited options or socio-economic necessity) to undertake the wrong type of work at the wrong point in their recovery journey is likely to do more harm than good.

In the rest of this section there is a more detailed discussion on the themes of toxic employment; the benefits of employment; and the virtuous circle.

8.1.2 Toxic Employment

The data supported the idea that some employment was damaging to mental health, not only in its nature (though some clear examples were given) but also in its timing. What emerges is that the toxicity of work is relative to the person undertaking it. Sweeping a factory floor with little social contact with the other workers, long periods working alone, low status and pay, doing a repetitive and thankless task which requires little mental effort would meet the criteria of toxicity as set out by the participants. However if the person undertaking the task, has up until that point has had no social contact, no status and no work role then such a job may well offer some benefits to their mental health.

In addition mental stimulation and demands need to be in a balance with the person's ability to cope with that demand. The Psychosocial Intervention (PSI) stress vulnerability model (Zubin and Spring 1977) identifies that we need a certain amount of stress to function, but too much leads to illness. That balance is again relative to the individual. The final component is timing. Sweeping a floor may be the job that maintains a well established recovery. For others it could be one of the stepping stones that the participants referred to, that helped them get out of bed and their house and supported the earlier stages of recovery ahead of moving on to more demanding and rewarding employment.

Using the codes and the concepts from this study and the themes identified in the literature search the factors associated with toxic and beneficial employment were listed. It was often the case that the same factor could be toxic or beneficial depending on the extent to which it was evident. Therefore thinking of toxicity as a continuum, a matrix can be established to identify the components of toxic and beneficial employment:

Table Seven: Toxic - Beneficial Continuum

Toxic	**→ Continuum →**	**Beneficial**
Little social contact	→	Accessible social network
Feeling isolated, lonely	→	Connected to others
Low status	→	Valued role
Boring / Repetitive	→	Mentally stimulating
Stigma	→	Stigma free, discrimination challenged. Acceptance and protection of rights
Can't disclose / have to lie about mental health	→	Feel confident to disclose or not
Working below potential	→	Provides an appropriate challenge. Opportunities for advancement and self-realisation
Mental health seen as problem	→	Mental health experience seen as a benefit
Being defined as "the mental health placement"	→	Treated like everyone else, equitable reasonable adjustment

Toxic employment and unemployment both contribute to a downward spiral that makes getting employment (of any kind) more and more difficult. These both compound mental illness and the social exclusion associated with it.

8.1.3 The Benefits of Employment

Work is more than the absence of unemployment which is harmful to mental health and compounds many of the social problems that are already faced by people with mental health problems. Meaningful occupation, and especially work, appears to be most beneficial in the second and third stages of recovery.

In the second stage it may need to be supported, part-time or voluntary. It needs to be in a safe environment that reinforces hope, is sensitive to people's needs, is free from discrimination and believes in the success of the person. Even toxic work at this stage may help as a stepping stone, but the more beneficial the work is, the more likely it is to help people move to the third recovery phase.

In the third stage beneficial work can act as a catalyst to recovery and help maintain wellness. The person is more able to cope with more toxic work but again the more beneficial the work, the better for maintaining recovery.

Work is beneficial to mental health recovery not just because it is meaningful occupation and offers pay. It is beneficial because it provides:

- social contact and support
- status
- meaningful occupation
- involvement
- a sense of personal achievement
- a belief in the worker's potential
- a worker identity
- structure to the day
- a place in society
- mental activity
- financial independence

- a means of making a contribution

And it is most beneficial when it is in an environment where:

- there is a match between the culture, values of the person and the work environment.
- there is an understanding of mental health - people feel able to disclose.
- there is a culture that does not discriminate and is stigma free.
- there is healthy work life balance.
- there is job protection.
- reasonable adjustments (if required).

In some cases, in addition to the above, the nature of the work is psychotherapeutic. It is unlikely that any job would have all these components and the importance of each factor is likely to vary for each individual.

8.1.4 The Virtuous Circle

Using the codes and the concepts from this study and the themes identified in the literature search the factors associated with recovery were listed. A similar matrix to table eight can be drawn up to describe the continuum of recovery.

Table Eight: Pre-recovery - recovery continuum

Pre-Recovery	**→ Continuum →**	**Recovery**
Denial that there is a problem	→	Ownership of illness
Professionals in charge	→	Taking control of wellness
No understanding of what is happening	→	Knowledge about illness (experience)
Settling for insufficiency of symptom management	→	Pursuing vital and valuable life
Written off, no expectation of improvement	→	Hope
Too scared to tell - self stigma	→	Appropriate disclose (even cherish experience of illness)
Empty time	→	Meaningful use of time
Social isolation	→	Social network
No helpful treatment or controlled by others	→	Control of treatment and therapies
No understanding of triggers or early warning signs	→	Active monitoring
Reactive / passive to reoccurrence of illness	→	Plans to maintain wellness
Existing from one day to the next	→	Celebration and enjoyment of a life worth living

Mapping the two matrices against each other, it is easy to identify how employment will aid a shift to the right along the recovery continuum. In the third stage of recovery beneficial work is a public demonstration of wellness which perpetuates and maintains recovery. The paradigms of work and recovery share a structure: work is the application

of self to a set task as defined by the job, which mirrors the application of self to tasks needed to achieve wellness. In most industrialised countries recovery is not possible without meaningful occupation and paid employment is still the most powerful statement of social engagement. In as much as work offers prospects for the realisation of citizenship, then it has the potential to contribute to high level recovery.

8.2 Implications for Practice

Given the nature of the research methodology, the similarity of the participants and the small sample size, it is difficult to make too many general statements about implications for practice. In understanding the transferability of the findings it is important to consider that eight of the participants are male, all the participants are white British and live in areas of social deprivation, six are employed in the NHS, four of whom are Support Time Recovery workers. It could be argued that the findings are more likely to be significant for others of a similar demographic and that the findings in this study are, therefore, less applicable to women or people from black and minority ethnic backgrounds, for example.

As identified earlier, this research has contributed to the existing literature about mental health and the impact of unemployment, and the phases and components of recovery. In addition, there are some specific new findings:

- The wrong work at the wrong time can be toxic for mental health recovery; it leads to a vicious circle of poor employment, unemployment and deteriorating mental health.
- The right work at the right time can be beneficial to mental health recovery; it helps create a virtuous circle of employment and improving mental health.
- In the second and third phases of recovery employment can act as a catalyst in maintaining recovery.

Accepting the limitations in transferability, some implications for practice can be

identified from this research. I have explored this around these themes:

- Understanding the three phases of recovery
- Understanding the significance of employment
- The Support Time Recovery Worker role

These are addressed in more detail below. Finally, an alternative account of David's story is provided.

8.2.1 The Three Phases of Recovery

This research shows that professionals were only occasionally helpful in the recovery process. They were sometimes helpful and this was mainly focused in phase one, but they settled for the insufficiency of symptom control. Some participants felt that professionals were scared of supporting them to phase three. In my experience the focus is often on monitoring for, and responding to, crisis and chaos in people's lives. Many mental health practitioners have a good proportion of their caseload with people still within the first phase of recovery - perhaps with the perception that they are stuck there forever.

Phase One

The person is in a process of losing things (identity, hope, social networks, employment, financial independence status etc.) and being defined, sometimes reluctantly, by a medical model of mental health (diagnosis, admission, treatment). In addition to their illness they are likely to be facing increasing social pressures and exclusion. The mental health professional may be seen as part of the problem.

Phase Two

In this phase the service user is living with the reality of mental health problems and starting to make sense and take control of their lives. They are defining for themselves what illness is and more importantly what wellness is. They are becoming experts in their

own care. There is a (re)connection with the wider world and all other parts of their life which is not their illness / diagnosis. Professionals need to aim for their service user to have a vital and valuable life - not merely to have their symptoms under control. This process needs to be one which hands over the care planning to the service user. The role for the professional is less one of expert, more one of facilitator. Specifically, the professional is not the best person to judge if someone is capable of work. Offering support to help people with mental health problems who want to work to get employment is more successful than waiting for a time when professionals think that they are well enough. The building of hope is, therefore, fundamental.

Phase Three

In this phase the service user may or may not have a role for the services of professionals in their wellness. Services are one of a number of resources that the person may, or may not, use in their recovery plan. Participants reported that it was not unusual that professionals became scared that they had aspirations beyond what the professional felt was safe or advisable. Typically, there was a focus on illness not wellness.

8.2.2 The Significance of Employment

The implications of the toxic/beneficial work matrix may help someone preparing to return to work to consider how toxic a particular job might be and how far they are on the recovery journey. In particular it is hoped that it provides a sense of optimism and re-engagement with employment or meaningful occupation. Also, that a bad work experience could simply be the wrong job at the wrong time. There is a danger that a bad experience may compound a belief that someone will never do *any* work *ever again*. Maybe, like Mark, they need to stop trying to work, taking whatever toxic work they can get, and move out of phase one well into phase two, before finding work that can act as a stepping stone to more beneficial work and move into phase three.

People with mental health problems are unlikely to achieve recovery unless they are meaningfully occupied. Being unemployed is likely to harm physical and mental health.

People need to have something to get up for, and get out and engage with the world. This does not have to be paid work, but the person must consider it meaningful occupation. The wrong work at the wrong time is likely to do more harm than good. The participants described paid work as being the icing on the cake, as it brought a range of benefits in addition to those gained by other forms of meaningful occupation. The main benefits identified were around status, influence, ability to progress and formal structure of time and activity.

People need to be in a process of recovery for work to be the most beneficial. Recovery means people taking control of their own mental health problems and knowing what keeps them well and planning to stay well. People may need to start off small (a few hours) and possibly working in a less than ideal situation. This is often a stepping stone. There is a "right job" - but it varies from person to person. Things that participants found important are jobs that:

- Provide a social network - people who they can get along with.
- Help them connect to others.
- Give them a valuable role.
- Are mentally stimulating.
- Are stigma free and discrimination is challenged.
- They feel confident to tell people about their mental health problems if they wanted to.
- Provide them with a challenge, which they can rise to.
- See mental health experience as a benefit.
- Treat them like everyone else, maybe with some agreed support and understanding for their mental health problems.

8.2.3 Support Time Recovery Worker Role

Four of the participants were Support Time Recovery (STR) workers; these were the first and last two interviews. Had the composition of the sample been known from the

beginning, an additional research question could have been formulated about the STR role. However, data from the STR participants, especially from the workshop, raises some interesting points. Some aspects which appeared significant were their belief that they would experience greater understanding of their mental health problems and that the NHS was generally a good employer. They also talked of the STR role as one in which they could make best use of their mental health experiences and give something back. I believe that the data raises more questions than answers, specifically:

- What reasonable adjustments were made when they came into post and how successful have they been?
- How has deteriorating mental health and sick leave been handled?
- What is the experience of being both a service user and employee?
- How were issues of confidentiality handled?

8.2.4 David's Story: An Alternative

Here I build on David's story (detailed section 5.1 (page 104) and Appendix One) to suggest how things might have worked out differently, I have drawn on the implications for practice suggested in the previous subsections.

David became unwell in his thirties with a diagnosis of bi-polar affective disorder. The mental health professionals took time to explain to David and his wife what this meant. They were given information about a range of treatments and interventions and agreed what worked best. David had very bad experiences with some medication and was clear that he never wanted ECT; this was acknowledged, respected and recorded in an advance statement so that everyone knew what David wanted to happen - even if he was too ill to tell people. David was given a clear message of hope that he can continue to have a full, rewarding and enjoyable life despite the illness. He was told that the symptoms may in time reduce and disappear.

From the start the Navy (David's employer) was keen to keep David at work. They were sensitive and supportive, and agreed a plan to ensure that David was able to keep working in a job that was meaningful and rewarding. The Navy had already done lots of training with all their staff about mental illness and the Disability Discrimination Act. So when David did have a problem with a senior officer making offensive remarks, colleagues realised that this was not part of the culture that they wanted to work in and felt confident that they could raise their concerns. This happened and the officer who made the remarks was dealt with in a clear way - there was no repeat of such remarks.

Eventually David and his wife decided that they wanted to move on from life in the Navy and move back to their home town. There was a smooth transition of care, but the stress of the move resulted in a relapse and David became high, David and his wife recognised the signs and the professionals listened to them and agreed that a short period in hospital was needed.

The new care team included an IPS (Individual Placement Support) worker and he spent time with David looking at employment options. David liked the idea of becoming an STR (Support Time Recovery) worker, but was unsure because a doctor had once said that this would not be a good idea for him. His IPS worker had challenged this straight away and explained that the person who knew best what he could do was David himself. David and the IPS worker agreed that some form of work placement may help him to move from life in the Navy into working as an STR worker. The care team sorted out welfare benefits and helped David find a range activities to keep a regular routine and social life. They introduced David to WRAP (Wellness Recovery Action Plan) and David joined a group of service users who ran a group on writing WRAP plans. There was an active service user and carer forum in which David became a member. This introduced him to lots of people with similar problems who were working full-time which gave him great encouragement.

David did 16 hours a week in a care setting. This was a very different work environment for David. Initially this was challenging but he quickly liked the work and was soon beginning to feel that he could do something more challenging. David also started to attend college to gain a qualification in Community Mental Health Care. He worked with his care coordinator to assess his own needs and got an individualised budgets which he spent on running a car so he could get out of the house and also go to work. This also helped to fund some of his hobbies which he identified were helpful in occupying his mind and time, keeping him well.

It was not too long before David decided he wanted to make the transition back into full-time work as an STR worker. The IPS worker spent some time with him preparing for the interview - David got the job and started work. This did not go too well to start with and the employer and David knew that they needed to have a meeting with the IPS worker to sort things out. The IPS worker listened to both sides, and was able to suggest some small reasonable adjustments. Once the employer knew that at times David needed to work in a quieter environment he was able to create a hot desk arrangement in smaller office - this quiet space was made available to all staff and was greatly valued as a place to work in a more tranquil setting outside of the shared office.

8.3 Reflexivity

As set out in chapter two an important element of qualitative research methodology is to recognise the researcher in the process. To help me in this process I have kept a portfolio of learning in which I made monthly entries (this started one year prior to submitting the research proposal). I made reflective notes following all the interviews about how I felt that they had gone, together with my first impressions. I have also kept memos as part of the grounded theory process to capture any significant events, thoughts, concepts or theories. These processes have helped me keep track and think about my place in the research. I have identified the following four areas:

- My professional background
- My status as a senior manager
- My values
- My identity

8.3.1 My Professional Background

All of the participants knew that I had worked as a social worker in local mental health services. In fact I knew three of the participants from my days in practice, though they had never been my clients. This was not ideal and not part of the initial research plan. However, it is a strength of the Professional Doctorate that candidates have ready access to a work environment. My intention was to recruit from other parts of region, rather than my home town. However in the end the most effective recruitment method turned out to be word of mouth and the people who volunteered were mainly living and working in the same area where I had practiced as a social worker and now worked as a senior manager.

My fears were that participants would not be as open and honest with someone they knew or might make assumptions about shared knowledge and understanding without actually expressing them. Occasionally when talking about workers or services we both knew they might say "you know what they are like." This did not seem to impede people being frank, though I did sometimes have to encourage participants to actually say what they meant rather than just assume I knew.

There were some benefits in having prior knowledge of the participants. It was easy to strike up rapport, the participants seemed relaxed and a warmth and humour helped the interview process. It also added an element of validity. For example with the five participants that I had never met before and knew nothing or little about them, I had no idea about the authenticity of what I was being told. Obviously it is in the nature of qualitative interviews that what you get is that person's re-telling and perception of what happened. However, with the others there were points when I had my own experience of

what they described. Hearing their perceptions of events that I had witnessed increased my sense of credibility with and trustworthiness in the data.

My professional training as a social worker, with its emphasis on empowerment and social perspectives, have also had an influence on the research process. There is a danger that division between a medical and a social model of mental health becomes overstated and seen as a dichotomy. Being honest I never expected the participants to say that it was solely their medication that had helped them recover and enabled them to return to work. If they had it would have been difficult to complete the research in the way I intended. This has meant that I have tried to be very clear about asking for, recording and analysing the data about the more medical model components of people's journeys. I think that it is fair to say that for a researcher whose professional background was medical or nursing then there would have been a different emphasis in the data gathering and analysis.

8.3.2 My Status as a Senior Manager

In a similar way five of the participants all work in the same mental health department that I manage (although I had not met one of them until the day of the interview). I do not directly supervise any of them but they all know me in my role as Assistant Director of Mental Health. Again this did not seem to prevent people being open about how they found services or staff, though it is impossible to know what else might have been said to a researcher they did not know. I started each interview explaining that I was in the role of researcher not senior manager though, as any researcher, I would not be able to ignore dangerous practice, concerns about their health and safety or illegal acts. Many described bad practice in areas for which they knew I now have responsibility.

For my own part I was aware that people's recovery journeys were often despite, rather than because of, the intervention of services. There were cases where well-meaning staff got it wrong, but also cases where services clearly failed the participants. I am not aware that I felt defensive about staff or services. This is helped by the fact that services have

radically changed and many comments were about historic services for which there was widespread agreement that they were not fit for purpose.

The role of power needs to be considered here, because with any interview between "professional" and "service user" there is an inherent power imbalance. Though I stated my role was professional researcher rather that social worker or senior manager it remained the case that I was in a much more powerful position than the participant, though, ironically, I was absolutely dependent on them playing the role of participant and providing me with data. It is hard to know how well I succeeded in addressing the issue of power. The choice of venue and time was up to each participant. I stated that all I wanted was to listen to their stories. They could withdraw consent at any time. I tried to ensure that the interview room was relaxed and set a tone of two people having a conversation. Noel was the only person who requested that the interview took place in my work office. The majority of interviews were conducted in my own or the participant's homes.

8.3.3 My Values

Perhaps the most fundamental thing that I brought to the research and which I need to reflect on are my values. My own life experiences have shaped these. In my own personal experience education and employment have been a means of liberation and emancipation. My childhood was dominated by a very strong protestant work ethic. People were valued not only by the fact they worked but also what work they did - an honest hard day's labour having a much higher ranking than bureaucratic pen pushers. The question: What do you do? was really about: "What do you achieve?"

Cleary this has had an impact on why I undertook this research topic and the way that I have conducted it. It also seems the case that the selected participants share similar experiences and values to me. They all could point to the importance of work as a value judgement, made by themselves and others, and the potentially emancipatory role employment has had in their lives. Through the interview process I encouraged them to

tell a 'triumph over adversity story' which is consistent with an empowerment paradigm. Again I have tried to be careful in eliciting and handling data that suggested that things other than work have been significant in their recovery and that their journey is not now a "living happily ever after" but an ongoing process of managing (potential) illness.

8.3.4 My Identity

In addition to the values that I hold there is what makes me who I am and how I define myself. One of the themes that emerged from the data are the identities we choose and are given. Aspects of my identity include: male, middle aged, white, British, gay, professional, employed, mentally and physically well. Again it is difficult to know what, if any, influence this has had on the research process. For example would I have asked different questions and got different answers if I had my own experience of mental health problems? It seemed significant that I had a knowledge and sound value base around mental health that helped people talk about the experience of being ill. But might I have got more or different data if I could have disclosed some shared experience of life with psychosis?

One factor that was significant from the start of the data collection was the theme of disclosure. This was described to me in terms that made immediate connections with my experiences of gay and lesbian people "coming out". I coded this data as "out and proud" which clearly betrays my own thought processes about what I was hearing. I reflected carefully on whether I was making more out of this than was grounded in the data. I deliberately did not ask direct questions about this in subsequent interviews so as not to lead the participants down a path of my making. However the theme continued to emerge and was described in terms consistent with a "coming out" process. This was also evident when I undertook the literature search (Honey 2004; Deegan 2001). Maybe my own experience of feeling outside the mainstream, subject to stigma and discrimination and balancing the risks and benefits of telling other people including employers has had a positive impact in relation to recognising and understanding this process.

8.4 Limitations, Future Research and Dissemination

8.4.1 Limitations

It is unfortunately the case that the qualitative nature of this research may mean that it does not carry the same influence in the science-dominated field of mental health as quantitative research (Corby 2006). Without going over the epistemological arguments outlined in chapter two about the nature of truth, it is fair to say that what has been captured is *only* the subjective experience of work and recovery. For me the fact that it is a, hopefully honest, retelling of subjective experience is its strength. However in positivist thinking I am sure that it would be seen as a limitation. Other data sources could have been gathered (case notes, interviews with participants' families, employers, support staff), but the stated purpose of this research was for the participants to tell their own stories. Issues of validity, triangulation and trustworthiness have been achieved not by going outside of the participants' experience but by returning to it and to them (via the transcripts and the workshop).

One factor that is significant is the transferability of this research. This is particularly true given the criteria for participant selection. The research has asked people for whom employment has been successful (and by implication part of their recovery journey) to take part. It is not surprising therefore that the data reflect the positive impact that the right employment has had in the later part of their recovery journeys. There would be a great danger in generalising this to all people with mental health problems. There was no attempt to find and gather data from people for whom employment had not been beneficial in recovery. In addition, as has been previously stated, all the participants had a strong work ethic; it could be argued that it is only this component that makes work beneficial. In other words it becomes a tautology: that it is because work is valued by them then it is valuable to them to achieve it.

Four of the nine participants were employed as STR workers. In addition Pete worked as a cook in the mental health service and Andrew worked in another part of the NHS. There is a danger that one is overly optimistic about the expectation that the NHS would be a sympathetic and supportive employer, but the participants all commented that their employment success was due in some part to finding an understanding employer. The balance to this it that all were all employed in mainstream jobs for which they had to go through a competitive interview. As the data showed, none of them wanted or received special treatment on the grounds of their mental health problems.

The participants had similar demographics. The small number of participants in qualitative data always makes this an issue, as does the value attached to how many of the participants agreed with a particular category (Boyce et al. 2008). Researchers are dependent to a large extent to who steps forward to participate, in my case eight middle aged (30-60), white British males and one young white British female. They all lived and worked in an area of relatively high unemployment and social deprivation. It may well be the case that being a young black male living in London would have a very different experience of identity, mental health services and employment opportunity.

8.4.2 Future Research

The body of literature on the benefits of employment from a recovery perspective is still small and further work would be a helpful contribution in this important area. The concept of toxic employment is not described elsewhere and further research may help develop further the concepts outlined here. The role of work and citizenship is also an important paradigm within this research. Exploration of recovery for individuals or cultures/countries that do not have such a strong work ethic would be interesting.

This research had a small and demographically similar sample; research into a more diverse sample would be of interest. The research only focused on the experiences of the people with mental health problems. Future research could explore this from the

experiences of employers, mental health professional and carers.

Longer-term studies could explore job retention, especially how employers and employees experience dealing with deteriorating mental health, and career development aspirations of individuals. Half of the current sample were employed as STR workers, so specific studies on this role might prove interesting especially if contrasted with similar roles outside of mental health services.

8.4.3 Dissemination

There is a great deal of material published on recovery and a smaller but growing body of work on recovery and employment, most of it is not based in the UK and there are only a few, but important, indications that it is impacting on practice. This research has used the recovery stories to distil some important messages about how people with mental health problems can use employment to live a valuable and vital life and what services can do to support that. This research is a unique contribution to existing literature and should be disseminated as it has some important messages for service users, mental health professionals and social policy. An article for an academic journal has already has already been written, but not yet submitted.[15]

One of the key drivers of the research methodology was to hear peoples' stories told in their own voice. I want to share those stories and in particular I would hope to disseminate the work to other people with mental health problems. Permission from the participants has been sought to publish beyond the doctoral project report, ideally the participant will work with me to write and publish. One of the themes in the research was participants' experience of being motivated by hearing other people's stories of success and achievement over adversity. Fundamentally recovery is about a restoration of hope - I believe that these stories provide a clear message that there is hope of a better life for people with mental health problems. In the first instance I will be talking to our local

[15] The article has been written with the intention of submission to The Journal of Mental Health

service user and carer group - but I also intend to write for service user publications and other user media.

I think that the research can offer mental health practitioners, especially social workers, some help in working with people with mental health problems to achieve recovery and employment. Listening to the participants' stories has taken me back to my days in practice, and left me wondering whether I would have been a force for good in their journey. I suspect I would have been very well intentioned but fallen short of offering anything that made a significant impact. I hope that my research can provide some simple messages and tools for practitioners in their work.

Dissemination to practitioners I think is really very challenging. Professional journals are rarely read in my experience (except for the vacancy pages). Within my own Trust I have instigated a social work forum where research can be, though seldom is, discussed. Nurses and doctors seem more organised and often have journal clubs. I intend to try to link in my research skills to help social work colleagues with their Post Qualifying training - in my experience this is the one time mental health social workers do seek out research.

The third area is around strategic planning and service design. Decisions at this level are often informed by budgetary constraints and performance targets. In my experience there is an absence of simple guidance about how to configure services in line with evidence based practice on service user experience. Even when it does exist it is often overtaken by the pile of things that must be done rather those that merely could be done. I would hope to do this by presenting at conferences aimed at professionals rather than academics. Such venues have been very influential to me in reshaping services. I therefore intend to disseminate the research in the following ways:

- Publish articles in academic journals.
- Write for service user publications.
- Write for professional social work publications.

- Seek to join and contribute to regional/national networks and conferences on recovery and employment.

Conclusion

This research set out to tell the recovery stories of people for whom employment had been part of their recovery. A small sample of participants were asked about their experience of mental health problems, employment, and recovery. Grounded Theory has been used to explore and explain the subjective experiences of their journeys and develop a conceptual framework, from which it emerged that, for them, the right work at the right time was beneficial to mental health recovery. Recovery is a journey of empowerment, knowledge, hope and taking control, by which the person defines for themselves what wellness is, and actively works to achieve and maintain that wellness. The participants described three phases to their recovery journeys: life dominated by illness, gaining control and living a life worth living. Unemployment or the wrong employment at the wrong time, were harmful to their mental health. However in the second and third stages of recovery, meaningful occupation and especially paid work has the potential to be an essential component to recovery which can act as a catalyst for improved wellness.

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Glossary

Accuphase Rapid tranquillisation given to produce sedation, sometimes described as a chemical cosh

AOT Assertive outreach team,- these teams were designed to work in creative ways with difficult to engage service users

CBT Cognitive Behaviour Therapy recommended as an effective brief intervention for mild to moderate mental health problems

CPA Care Programme Approach, Sets out the requirement of mental health service is in England and Wales to complete holistic assessments and care plans, and appoint a care coordinator

CPN Community Psychiatric Nurse

DDA Disability Discrimination Act

DEA Disability Employment Advisor, employed by the Benefits Agency to support disabled people back into employment

ECT Electro convulsive treatment. Electric shock treatment

IPS Individual Placement Support. Evidence based model for supporting people with mental health problems into work

OCD Obsessive compulsive disorder. Neurotic disorder that sometimes co exists with other mental health problems

PTSD	Post traumatic stress disorder
STR	Support time Recovery worker. Support workers, often people who have (had) their own mental health problems, employed to work with a small case load, to offer time and support to aid recovery
WRAP	Wellness Recovery Action Plan. A form of recovery plan developed by Mary Ellen Copeland

Appendix One: Vignettes

Mark

Mark originally wanted to be a Police officer, however he did a lot better than expected in his GCSE exams and this led him to start a career in electrical engineering. Mark did well at college and in the work place apprenticeships, but mental health problems started to emerge. At the age of 18 he became a father and had to provide for his girlfriend and child. There were periods of sick which became harder to explain and although Mark continued to work he had disrupted employment record. Mark did get support from some services but the cyclical nature of his illness meant that he had periods of being well. Mark did not really accept that he had an illness. Over the next few years Mark would continue to try to work but because of his mental health problems and poor employment record it became increasing harder to find work and then remain employed. There were also periods of being in hospital. Mark was given a diagnosis of bipolar affective disorder, the periods of illness were often times when Mark would lose things like employment and money eventually his relationship ended and he lost his house. Through the support of an Assertive Outreach Team Mark began to accept the nature of his illness and take medication, after periods of worklessness he undertook voluntary work with a mental health charity that recognised that his mental health experience would be a great asset in working with carers of people with mental health problems. This was part of a whole recovery programme where Mark took control of his illness and moved from voluntary work to paid part time work then to fulltime. His ability to manage his illness increased and now he works fulltime as support worker in mental health services. At the time of the interview Mark was just about to start his nurse training.

David

David left school at 15 and went into the Navy, where he worked for 21 with an exemplary record, his last oversees placement was in Hong Kong where David lived with his wife. When David was in his mid thirties he experienced an acute psychotic episode and was treated by the Navy doctors, the medication that he was prescribed gave David

severe side effects. On his return to the UK he continued to work in the Navy but a senior office made prejudicial remarks about David's illness - in the end David left. He returned to his home town and opened up a small shop. Unfortunately illness returned and David had periods in hospital. The businesses ended when a large supermarket chain opened near him. David continued to work but the periods of illness increased and became a yearly event. It became harder to find work and David worked in a food factory on the production line for some years. However the company doctor was asked to see him following an admission to hospital and declared that David was unfit to work. With the support of his wife David got his medication changed, he also started to attend day services and became involved with the local user and carer group. This involved David finding out more about his illness and taking control of it. He successfully got a job as a mental health support worker and at the time of the interview has been well for several years and working full time.

Andrew

Andrew did well at school and went to university with ambitions of getting a highly paid job in Human Resources. During his first year he used drugs and alcohol and had his first experience of feeling mentally unwell, things got progressively worse and while at home in the summer he was admitted to hospital. Andrew returned to university but this only lasted a few weeks before he again became unwell and retuned home. The next year was a process of accessing service and self managed recovery - which also included a gradual reintroduction to work. Andrew developed a structure recovery plan. As things improved he returned to university and graduated, he moved to London for work for a while. Andrew decided that the career he wanted was within mental health services, he returned to London and worked in a mental health unit. However the combination of long shift and loneliness led to a return of psychotic symptoms. Andrew retuned home and was again admitted to hospital. Andrew once again implemented his own recovery plan - using services as he needed them. Despite being told by his psychiatrist that he should not pursue a career in mental health care Andrew found work with a mental health charity. Working fulltime and maintaining his recovery plan has kept Andrew well and he has

now changed jobs and works in the NHS and is undertaking a post graduate degree.

Pete

Pete worked in the Merchant Navy for twenty years and then on the railways for fifteen years, Pete says that he can see with hindsight there have been signs of depression in the past it was in his last few years with the railway that he experienced significant mental health problems. Following the break up of his marriage Pete suffered from depression and made a serious suicide attempt fortunately he was found and taken to hospital. Pete returned to work for the railway and despite some abusive comments continued to work. However he was eventually asked to leave, at the same time his dog died and again Pete planned to take his own life this lead to him being detained in hospital. Through involvement with employment services he got a work placement in a large DIY chain, though this involved menial tasks. Then Pete got a work placement in a mental health employment training scheme, from his first day there Pete returned to working as a cook. While there he built up his hours, rediscovered his skills and made friends. At the time of the interview he had a permanent job with the employment scheme as a cook in local hospital.

Fiona

Fiona did well at school and went on to university to do a degree in geography, though she always hoped to be fire-fighter - unfortunately due to allergies she was not able to pass the medical. When Fiona was 16 her father died and in the next two years there were further bereavements. Fiona received some counselling and support during this time. Following university Fiona hoped to complete a masters and work in a museum but ended up working for the student union. A work colleague had applied for the same job and was resentful that Fiona had got it over him, this led to bullying and sexual harassment. Despite Fiona's attempts to deal with this it continued until other people were also bullied by the same person. Eventually the person was sacked but by that time Fiona was suffering from anxiety and depression and was taking time off work. Her employers ended her contract due to her poor sick record. The depression got worse and Fiona was

admitted to hospital. On her discharge she returned to live with her mother. The next year was a period of slow recovery gradually building up social activity, meaningful occupation and a work placement. On advice from a mental health employment advisor Fiona openly declared her mental health problems on application forms which guaranteed her an interview with employers' disability schemes. After many attempts to get a job she was successful but before she could start she had to have a medical - this did not recommend employment. Fiona armed with her knowledge of the DDA challenged the decision. Fiona now works full time.

Leonard

Leonard did very well at school and could have pursued a number of careers but his passion has always been cooking. He trained to be a chef and at the age of 18 left to work in a hotel in London where he quickly rose through the ranks. He decided to travel and worked in a restaurant in Monte Carlo. On his return to England he got married and has work in many restaurants eventually ending up as an executive chef in a hotel and golf club. Over the course of a few years he turned the restaurants round and gained national acclaim winning accolades and being placed tenth in a national competition for the countries best chefs. The long hours and the strain on his marriage began to take their toll. He was diagnosed with depression and personality disorder. He left to set up his own restaurant but his mental health deteriorated until he eventually made a serious attempt on his own life, he was admitted to hospital. Over the next few years he had many admissions to hospital and his marriage ended and he was unfit to work. Eventually he got a work placement stacking shelves in a supermarket. On meeting his DEA, she instantly saw his talent and potential and got him a job in a local pub restaurant. On his first night he was subject to horrendous verbal abuse about his mental health problems. However Leonard, very much in his character, stuck at the job and proved to everyone that he was still a great chef. Leonard continues to take medication but is in a process of recovery and has a good understanding of how to keep himself well. Leonard is now the chef of a restaurant which is understanding of his mental health problems.

Boris

Boris did well at school but was not particularly motivated to get a highly paid or professional job. He went to art college and then undertook a range of jobs including teaching, working as outdoor instructor, karate teacher, Territorial Army. At this time Boris lived in a city with very high rates of unemployment. Boris began to develop a psychotic illness and had periods of admission in hospital. Boris notes that the turning point was when he heard the voice of god - this led to him leaving his wife and starting to get his life into order. Boris found work in a mental health arts project, he remarried and taught himself numerous languages including German which he taught at a local university. Despite high employment rates Boris has managed to continue working on either a paid or work placement setting. Eventually Boris gained training and experience in cooking and worked as a chef in various settings - even running a catering company with his second wife. Unfortunately physical illness means that he is unfit for work, however Boris keeps himself busy ridding horses, doing artwork, some catering and intends to make use of the rules that would allow him to work 16 hours a week and retain his benefits.

Noel

On leaving school Noel had a promising future as a professional footballer with clubs offering him trials. He studied sports studies and did work at leisure centres and factory work. With his friends Noel began to drink and take drugs, Noel recognises that the nightlife and the drinking got in the way of dreams to be a footballer. Alongside this was an emerging mental health problem, which led to Noel becoming more paranoid. Eventually he was admitted to hospital, but was reluctant to take medication or to stop his drinking and drug use. For several years Noel's life consisted of admissions for ever increasing length to hospitals. Noel started a journey to recovery by reducing and stopping his drug use, he also found that the newer medication is helpful. On leaving hospital Noel lived in supported accommodation provided by a mental health recovery team. Noel also trained in reiki and meditation. The recovery team help Noel get back into physical exercise and he got work in a mental health employment and training

scheme. Noel went to college and completed a course in community mental health and then gained full time employment as a support worker in the mental health services that supported him.

Wilbur

On leaving school Wilbur went to work in the chemical industry he was ambitious and worked hard, but the hours were long. Wilbur suffered bullying and eventually began to use amphetamines. The stress of work and the drug use impacted on Wilbur's mental health and he began to have strange thoughts he could not cope with work and started to receive mental health services. For 14 years Wilbur lived in the community with varying levels of support - all the time claiming sickness benefit. A change in medication, counselling about his relationship with his father and starting to attend an employment scheme all contributed to the start of a journey to recovery. Wilbur then met the woman who is now fiancé and his life really fell into place Wilbur was able to use his newly gained qualification in community mental health care to get a job as a support worker in mental health services. At the time of the interview Wilbur was working full time and preparing for his wedding.

Appendix Two: Codes and Definitions

1 Abuse

Description: Being abused - vulnerable adult, verbal, financial and physical abuse. Only coded to Wilbur

2 Acceptance

Description: The coming to terms with mental illness; insight; accessing services; identity; positive use

3 Admission

Description: Admission to hospital including the period before admission (change in symptoms, decisions to admit) and the time spent on (mental health) wards

4 Ambition

Description: Expression of work or educational ambitions (past and present)

5 Decision

Description: Making decisions, choices that impact on overall journey towards employment, recovery, May be made by self or others, may be linked to epiphanies

6 Diagnosis

Description: The process and impact of being given a diagnosis

7 Discharge -aftercare

Description: Process of discharge from hospital and on going follow up care

8 Disclosure

Description: Extent; decision to tell other people about own mental health problems / history. Coming to terms with. Coming out. Pride in mental illness. Use of illness as a

positive

9 Doctors

Description: Comments and decisions of medical staff (GP, Consultant)

10 Drugs & alcohol

Description: Use of illicit drug and alcohol use

11 Education about illness

Description: Gaining knowledge through reading, being told or lived experience about one's own mental health problems.

12 Education

Description: Formal education including school, university and college

13 Epiphany

Description: turning point to recovery

14 Hope

Description: Others and own belief and expression that things will get better

15 Identity

Description: Sense of self, label self worth/esteem. Sick role - working man

16 Insufficiency

Description: The process of receiving treatment and intervention but continuing to feel that this is not sufficient - that it does not feel like wellness or wholeness

17 Jobs

Description: Actual periods of paid employment

18 Maintaining Recovery

Description: Process and factors in maintaining recovery

19 Meaningful occupation Work

Description: Use of time, Voluntary Work, Service User and Carer Movement. Day services. Attitudes towards work, employment, work ethic, hopes aspirations

20 Medication

Description: Medical treatment for illness, compliance, efficacy, side effects, titration, own choices (demands)

21 Negotiate own care

Description: Taking control of own treatment plan, medication, care plan - relationship with professionals - failed attempts to.

22 Other people's problems

Description: Comparison with other people's mental health problems solidarity with others, learning from, putting own problems in a context / continuum

23 Out and Proud

Description: Pride in mental health problem, political statement of being open about mental health problems, challenging discrimination / prejudice. Stereotypes, Honesty and integrity - identity

24 Reasonable adjustment

Description: DDA what employers can do to take account of mental health problems in order to enable people to do a job.

25 Recovery

Description: Process of self management of illness, education about illness, acceptance, developing own plan of action, monitoring. Subjective experience of wellness. Enjoying life

26 Recovery and Work

Description: Identification / experience of work as being a component of recovery and wholeness

27 Reoccurrence of Illness

Description: Periods of relapse, course of illness, readmission,

28 Respect

Description: Respect through working or playing a meaningful role. Kudos, influence achievement citizenship

29 Social Network

Description: Friends, carers, relatives, social inclusion, carer network

30 Start of illness

Description: First indications of illness: explanation, perception, symptoms, accessing treatment / Services

31 Stigma

Description: Stigma, prejudice, including direct, indirect, self

32 Unemployment

Description: Not being in work including unemployment and on sickness benefit

33 Value mental health Problem

Description: Positives of having a mental health problem, could be work related - enabling people to gain employment on the grounds of their experience of mental health or more general - what does not kill you makes you stronger, insight into alternative reality (unique experience or even psychosis)

34 Welfare Benefits

Description: Welfare benefits, benefit trap, financial implications of work and unemployment

35 Wholeness

Description: Process or experience that work has contributed to a wholeness / recovery

36 Work as negative

Description: Instances where work leads to poor mental health, contributes to a deterioration

37 Work as Normalization

Description: Belief / experience that work is 'normal' and its absence is abnormal

38 Work life Balance

Description: Importance of there being a healthy balance between work and home/recreational life. Identified as being component between health and toxic work

39 Work Placements

Description: Work placement as precursor to employment, could be in mental health setting or as part of mental health service or as part of general employment scheme

40 Written off

Description: Perception, belief, being told that you will never work again or that "life" is somehow over.

Appendix Three: Dimensions of Codes

Subcategories

Welfare Benefit

Properties	Dimensions
Helpfulness	Essential Benefit trap
Access	Easy Difficult
Amount	Too much too little
Attitude	Justified Unjustified (scrounging)

Work as Negative

Properties	Dimensions
Stigma	Implicit Explicit (bullying harassment)
Status	Kudos Demeaning
Impact on MH	Little Large

Reasonable Adjustment

Properties	Dimensions
Provided	Considered Not considered
Helpfulness	Helpful Not helpful
Peers reaction	Accepted Resented
Offered	Proactively Fought for

Work Placement

Properties	Dimensions
Transitional	Stepping Stone Stumbling block
Fit to existing Skills	Matched Skills Lower Skill
Mental Health Setting	Exclusively No at all

Meaningful Occupation

Properties	**Dimensions**	
Time Use	Structure Time	Unstructured
Social Contact	High	Low
Status	High	Low
Mental health setting	Exclusive	No at all
Citizenship		

Jobs

Properties	**Dimensions**	
Paid	Voluntary	Paid
Mental Health Setting	Exclusively	Open Market
Supported	Supported	Unsupported
Status	High	Low

<u>Category: Mental Health</u>

Subcategories

Admission

Properties	**Dimensions**	
Compliance	Voluntary	Compulsion
Planned	Care Planned	Unexpected
Helpful	Helpful	Not Helpful
Necessary	Needed	Not needed

Diagnosis

Properties	Dimensions	
Given	Stated	No stated
Consistent	Consistent	Changed
Helpful	Helpful	Not helpful

Start of Illness

Properties	Dimensions	
Insight	Understood	No insight
Sought help	Wanted help	Rejected help
Concordance	Compliant	Refused medication / Treatment

Discharge Aftercare

Properties	Dimensions	
Structured	Highly	Loosely
Needs Led	Need led	Service Led
Holistic	Holistic	Illness focused
Planning	Proactive	Reactive
Creator	Shared	Imposed

Doctors

Properties	Dimensions	
Understanding	Understanding	Intolerant
Treatment providers	Treated	Failed to treat
Advice Givers	Helpful	Unhelpful
Holistic	Holistic Model	Medical model
Powerful	Shared Power	Imposed Power

Medication

Properties	Dimensions
Effect	Treatment Control
Treat illness	Effective ineffective
Compulsion	Concordance Imposed
Prescribed	Negotiated No Negotiation

Reoccurrence

Properties	Dimensions
Planning	Relapse Management Reactive
Medication	Not been Taken Concordance
Relapse Signature	Recognised Unrecognised
Insight	Insight No Insight

Category: Recovery

Subcategories

Acceptance

Properties	Dimensions
Understanding	Insight No insight
Self	Comfort Denial
Others	Open Secretive

Disclosure

Properties	Dimensions
Audience	Public Chosen few
Motivation	Political/Campaigning Necessity
Context	Free choice Requirement

Education

Properties	Dimensions	
Process	Seeking information	Being told
Focus	Individual specific	General
Liberating	Empowers	Oppresses

Epiphany

Properties	Dimensions	
Temporal	Single incident	Developing process
Locus	Internal realization	External influence
Nature	Spiritual	Rational

Hope

Properties	Dimensions	
Locus	Internal (created)	External (given)
Outcome	Cure	Accommodation / Improve

Negotiate own Care

Properties	Dimensions	
Plan	Formal/Structured	Ad Hoc
Range	All aspects	One aspect
Function	Staying Well	Preventing relapse
Model	Alternative	Complimentary/Medical

Other Peoples problems

Properties	Dimensions	
Impact	Role model	Fear of becoming like
Affinity	Solidarity	Separateness
Continuum	Count blessing	they think they have it bad

Out and Proud

Properties	Dimensions
Degree	Celebrate Acceptance
Audience	Public Private/Discrete
Motivation	Political/Challenge Needs must

Respect

Properties	Dimensions
Degree	Active citizenship Personal Contentment
Locus	Self Others

Social Network

Properties	Dimensions
Size	Few People Many People
Social Inclusion	Within Mental Health Mainstream
Awareness	Aware of MH No Awareness

Stigma

Properties	Dimensions
Degree	Explicit Implicit
Focus	Attitude Behaviour
Locus	Self Others

Written Off

Properties	Dimensions
Degree	Explicit Implicit
Who	Self Family Professionals Society
Extent	Specific Task All work (meaningful activity)

Value MH Problem

Properties	**Dimensions**	
Knowledge Skills	Help self	Resource for others
Life Enhancing	Survival	Life Enhancing
Career Opportunity	Transferable skill	Expert Patient trainer
Insight	Understanding	Managing

Appendix Four: Memo and Mind maps

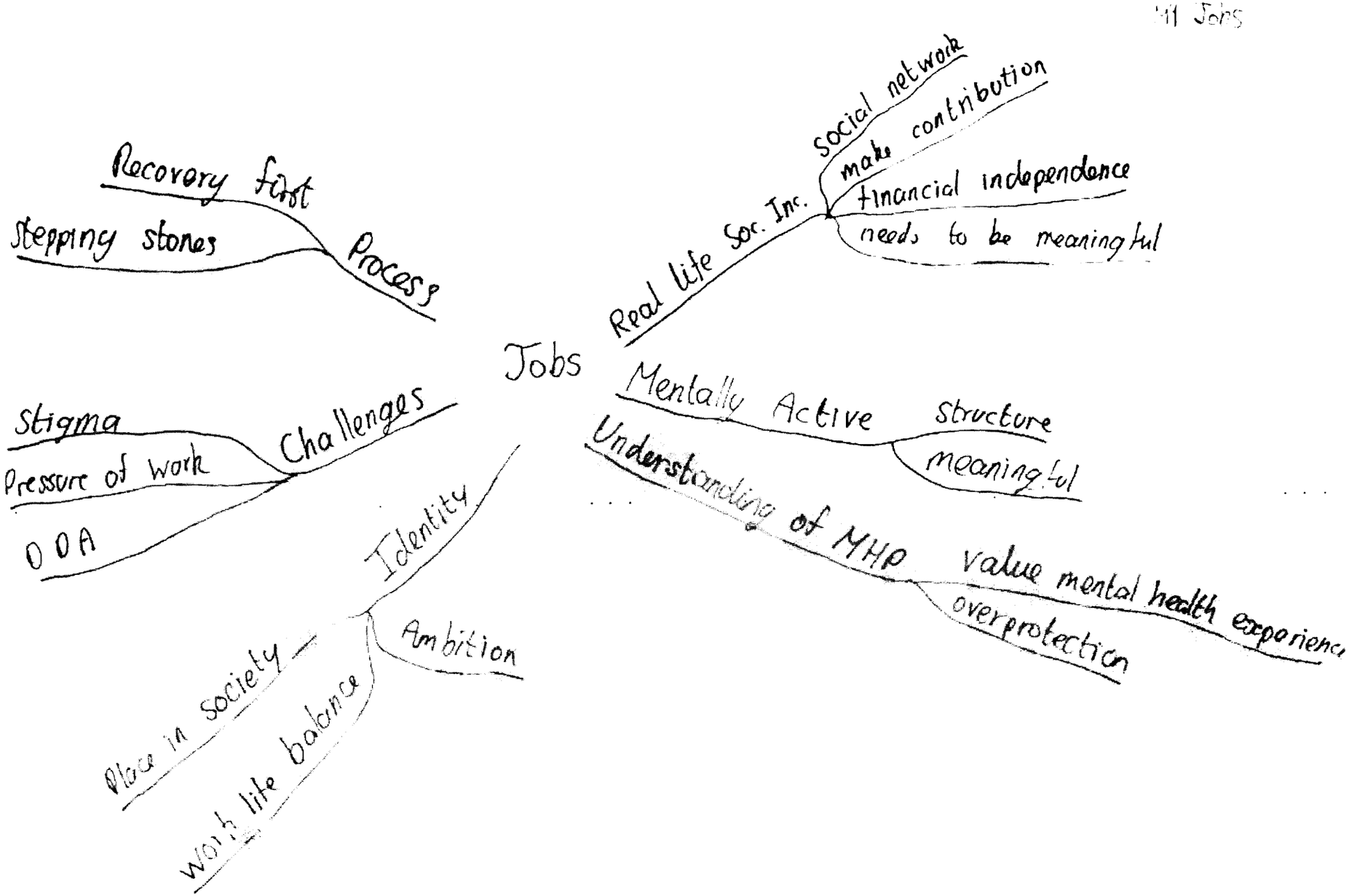
Memo 4a

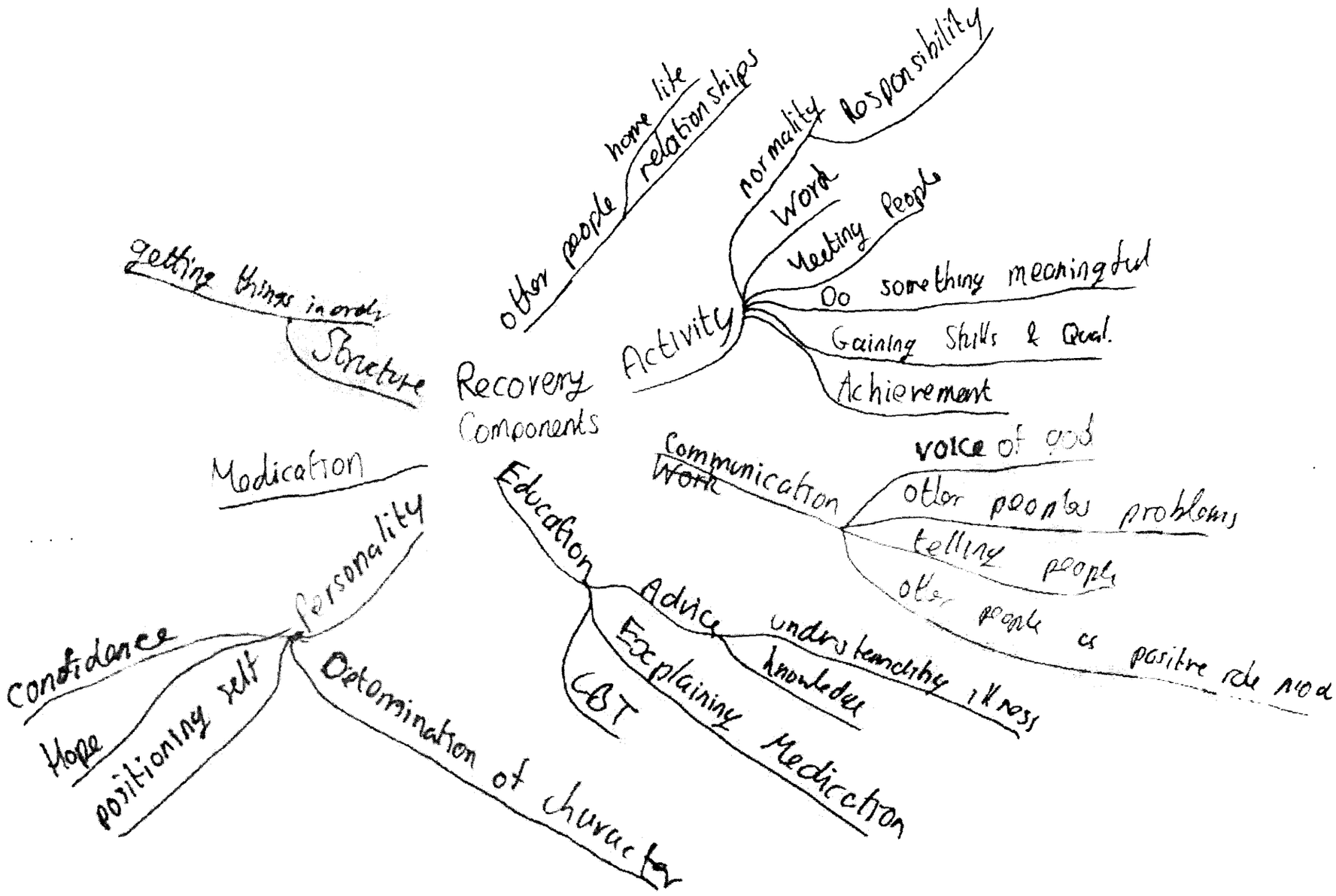
Type: Selective coding
Title Story Telling
Date: September 07

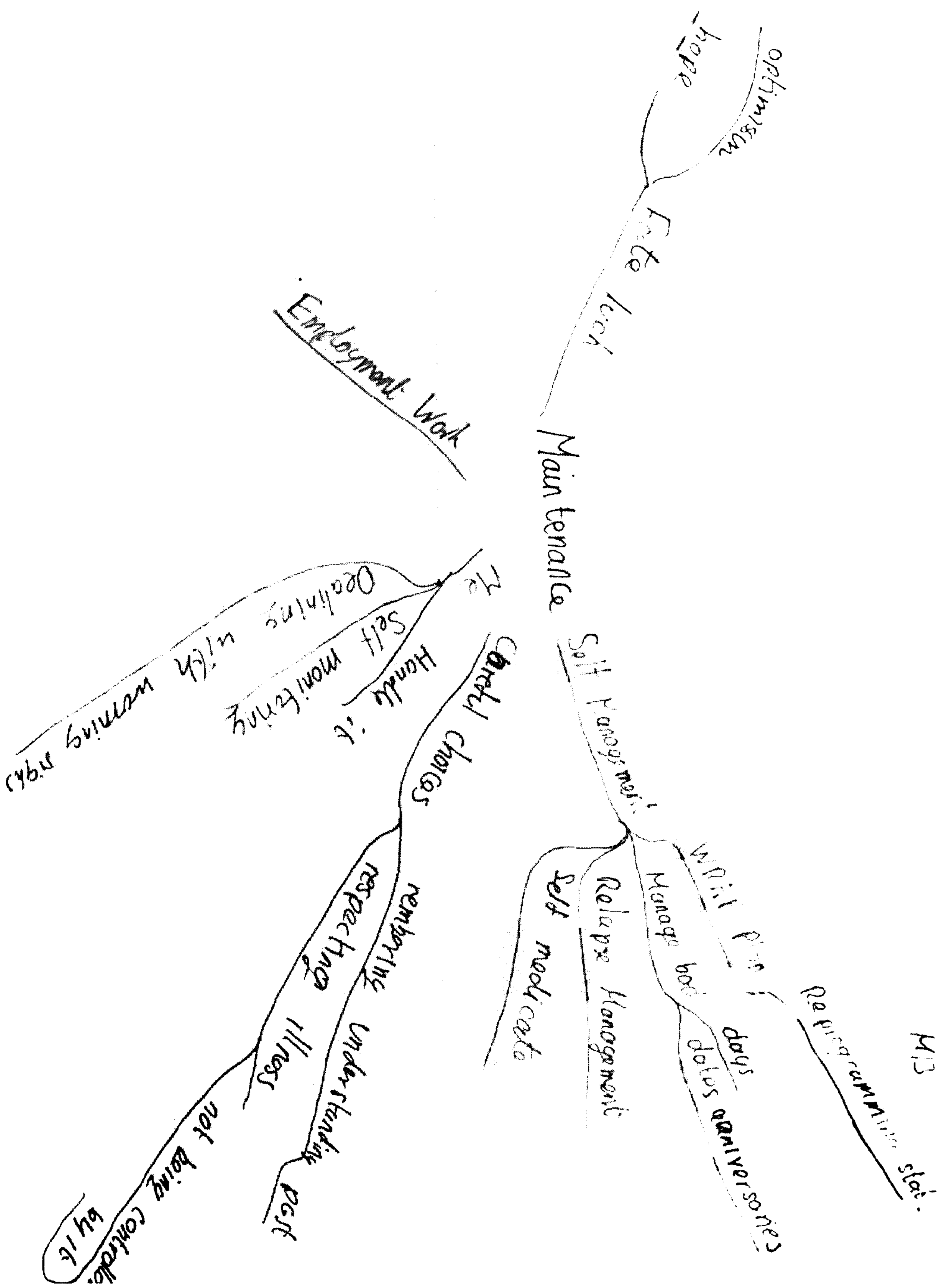
Theory

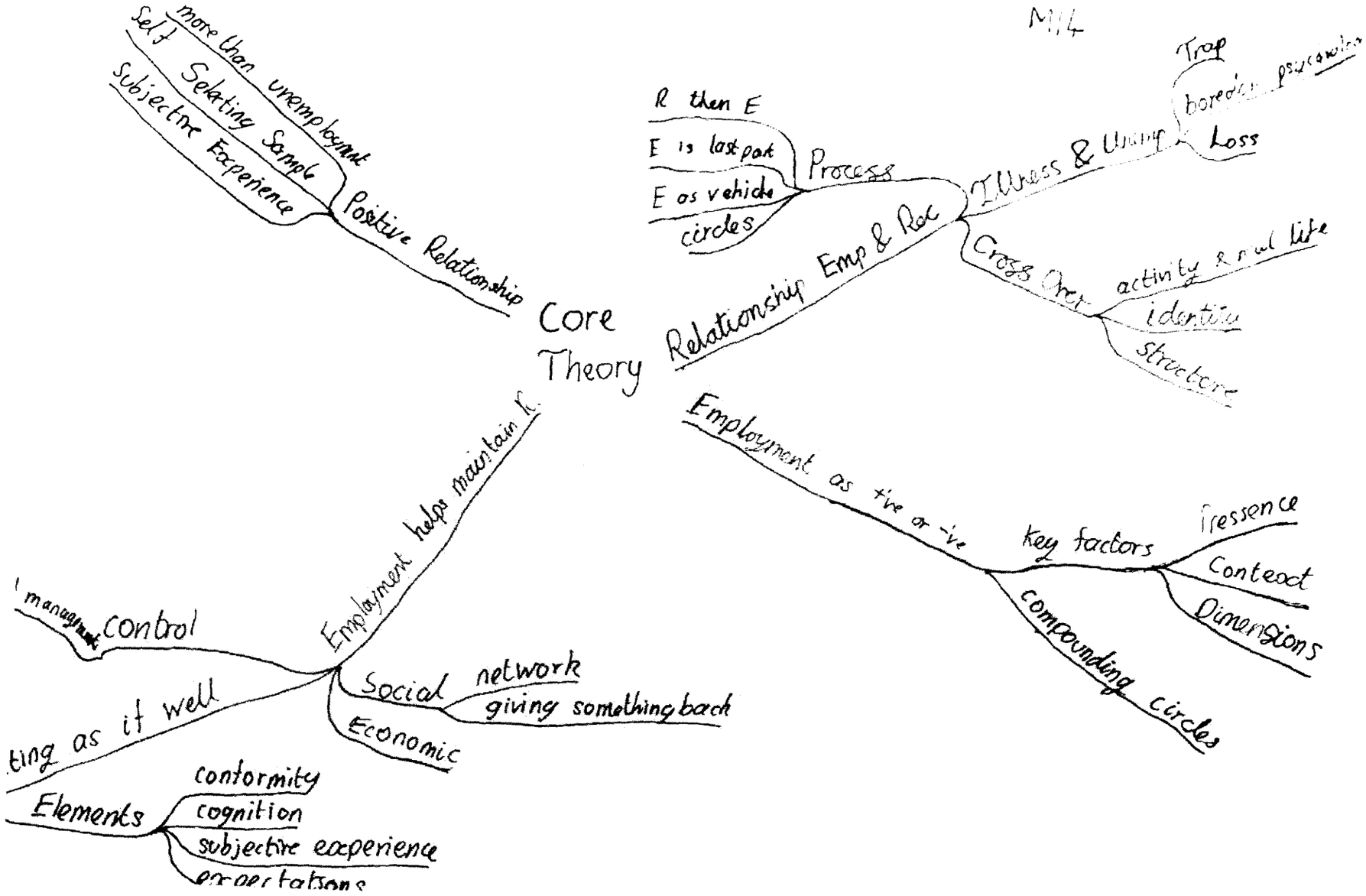
Do I have an emergent theory?
Storyline: insufficiency - normalisation - employment - recovery
Vicious and Virtuous Circles - Similar and Same issues drive both circles, their dimensions and the contexts in which they operate determine if they have a positive or negative impact on mental health and recovery

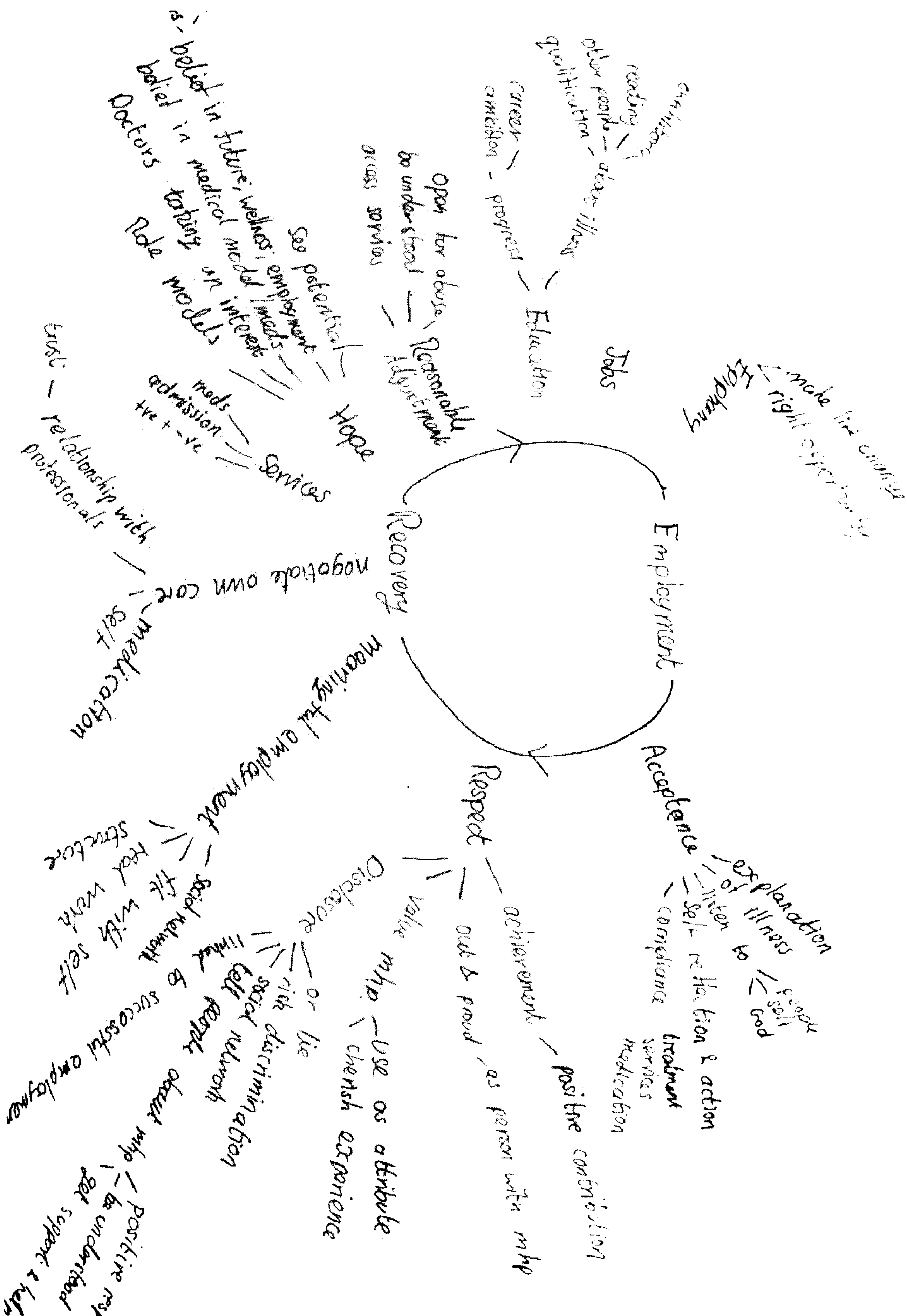
Meeting with Sarah Cook (Dr, researcher at SHU OT background) I explained my current think about the direction of my research at which point she said that it sounded like a theory. This has led me to think again about it and do more work on the codes. It seems like a good start at a core strategy, playing with the codes and drawing a diagram I realised that I had (inadvertently) completed the Paradigm and Dimension stages of Selective coding. The next logical step is to go back to the data to see if this really works (Validating) and working on what doesn't fit (filling Categories). Maybe the eureka moment has slid up on me without me noticing. Interesting it was reading the chapter on Selective coding and in an attempt to write an illustrate example I "acted as if" I had a storyline.


Jobs
Process
Recovery first
Stepping stones
Challenges
Stigma
Pressure of work
OOA
Identity
Place in society
work life balance
Ambition
Real life Soc. Inc.
Social network
make contribution
financial independance
needs to be meaningful
Mentally Active
Structure
meaningful
Understanding of MHP
Value mental health experienc
overprotection


Recovery Components
Activity
home life
relationships
other people
normality
responsibility
Work
Meeting People
Do something meaningful
Gaining Skills & Qual.
Achievement
Structure
getting things in order
Medication
Personality
Confidence
Hope
positioning self
Determination of character
Education
Advice
understanding illness
knowledge
Explaining Medication
CBT
Communication
Work
voice of god
other peoples problems
telling people
other people as positive role mod


Maintenance
hope
optimism
Employment Work
Self monitoring
Handle it
Self medicate
Relapse Management
days
dates anniversaries
understanding past
not being controlled by it


M/L
more than unemployment
Self
Relating
Sample
Subjective Experience
Positive Relationship
R then E
E is last part
E as vehicle
circles
Process
Trap
boredom
Loss
Illness & Using
Relationship Emp & Rel
Core
Theory
Cross Over
activity & real life
identity
structure
Employment as +ve or -ve
key factors
Presence
Context
Dimensions
compounding circles
Employment helps maintain R
control
Social
network
giving something back
Economic
Elements
conformity
cognition
subjective experience


Recovery
Employment
Acceptance
Respect
Hope
Services
Education
Jobs
negotiate own care
medication
meaningful employment
Disclosure
Role models

Appendix Five: Information and Consent Sheet

Participant Information Sheet

Part 1.

Study title:

What is the relationship between employment and recovery in mental well-being?

Invitation

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

1 Part 1 tells you the purpose of this study and what will happen to you if you take part.

2 Part 2 gives you more detailed information about the conduct of the study.

Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

Within the last decade there has been increased interest and work to address the issues of mental health and social exclusion. The vast majority of people with mental health problems live 'in the community', but they often struggle to be part of that community and face stigma and discrimination. Unemployment is a key factor in social exclusion. However, there is evidence that in Britain today only 24% of people with mental health problems are in work.

There is also evidence that:

- People with mental health problems want to work
- With the right support around 60% of people with mental health problems are able to work (or engage in other meaningful occupation voluntary work, education etc.)
- Unemployment is detrimental to mental health
- Employment is beneficial to mental health

The purpose of this research project is to ask people with mental health problems, who have experience of gaining and retaining employment and of 'Recovery', to tell their stories. It's intended that this research will uncover the relationship between these. Employment has the potential to improve mental health. It is this potential benefit which will be explored by this research. There is a distinction to be made between a professionals' assessment of cure and the patients' experience of wellness as put forward in the Recovery model.

This research is part of a student research project

Why have I been chosen?

This research has been advertised to local employment and mental health services.

You have been invited to take part in this research because someone has considered that you have been unemployment, mentally ill and social excluded but now are employed and in a process of Recovery. Ideally the people who take part in the research will have or have had a diagnosis of severe and enduring illness with a sustained period of unemployment (18 months for example). In addition you are in a process of wellness (reduction in symptoms, admissions, self harm etc.), and sustained employment (for 12 months for example).

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

If you decide to take part you will be contacted and a mutual convenient date, time and place agreed to be interviewed. You will be asked to tell your story of how you have moved into employment and recovery. Before the interview starts you will asked to sign a form agreeing to the interview and given information about confidentiality. The interview will last for a between one to two hours and will be recorded. You will be sent a copy of the interview and asked to confirm that it is a true record of what was said. It may be that the interviewer may want to speak to you again to check on some of the things that you said. Again this will be recorded and you will be sent a copy of what was said. It is hoped that all the interviews will be done by June 07.

Expenses and payments:

You will not be paid for giving the interview, however expenses for travel can be paid for.

What do I have to do?

You will be asked questions to help you tell your story and explain what it was like becoming employed and recovering from mental illness.

What are the other possible disadvantages and risks of taking part?

There should be no risk or harm to you. Sometimes telling important personal stories can be upsetting. You will not be asked to talk about anything that you do not want to and if you do find the interview upsetting then it will be stopped. The researcher will help you to get any assistance and support you might need if you did become distressed / upset.

What are the possible benefits of taking part?

The research may not be of any help to you but you have an important story to tell. It is hoped that it will help professionals learn more about the importance of employment and recovery in mental well being.

What happens when the research study stops?

When the interviews are done the stories will be looked at to find common themes, important points etc. These will be used to write about the relationship between employment and recovery.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The details are included in Part 2.

Contact Details:

The contact for this research is

[ADDRESS PROVIDED]

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

You can withdraw from the research at any time and any information that you have been given will be destroyed.

What if there is a problem?

If you are unhappy about anything, want more information or to complain then please contact the researcher.

Complaints:

If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions (Barry Flintoft [number supplied]). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure (or Private Institution). Details can be obtained from the PCT

Harm:

There is little chance that you could be harmed within this research however the standard research guidance is

"In the event that something does go wrong and you are harmed during the research study there are no special compensation arrangements. If you are harmed and this is due to someone's negligence then you may have grounds for a legal action for compensation against [name of] *PCT, NHS Trust, but you may have to pay your legal costs. The*

normal National Health Service complaints mechanisms will still be available to you."

Will my taking part in this study be kept confidential?

The information that you give will not be shared with anyone outside of the research project. Your name and any other information that could be used to identify you will be changed. The taped interviews will be typed up and once you have agreed with the transcript, any personal details will be changed. The original tapes and transcripts will be locked away in accordance with Sheffield Hallam University's safe storage of data policy. The information will only be used as part of this current research project and any associated publications resulting from the project.

There are some things which are too serious to be held as confidential information. If for example you tell the researcher about serious misconduct, criminal behaviour or potential harm to your health, to yourself or to others, then the researcher will have to pass that information on the relevant authorities / people

What will happen to the results of the research study?

The research will be used to write a Doctoral Thesis on employment and recovery in mental health. The information will also be used in other publications about the research, this will probably be in academic journals

Who is organising and funding the research?

The research is part of a Doctoral programme run by Sheffield Hallam University. This researcher is employed by [name of] PCT (Mental Health Services).

25. **Who has reviewed the study?**

This study was given a favourable ethical opinion for conduct in the NHS by the South Humber Local Research Ethics Committee. In addition it was granted permission to be undertaken and peer reviewed with the regulations of Sheffield Hallam University

You will be given a copy of this information sheet and a signed consent form to keep.

Thank you for considering taking part and taking time to read this sheet

Barry Flintoft
REC 06/Q1105/51
November 2006

(Form to be on headed paper)

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: What is the relationship between employment and recovery in mental well-being

Name of Researcher: Barry Flintoft

Please initial box

1. I confirm that I have read and understand the information sheet dated November 2006for the above study.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any

☐

3. I understand that the things I say during the interview may be quoted in publications about the research - but my identity will be protected.

☐

4. I agree to my GP being informed of my participation in the study.

☐

5. I agree to take part in the above study.

☐

Name of Patient	Date	Signature
Researcher	Date	Signature

When completed, 1 for patient; 1 for researcher site file.

Appendix Six: Comparison of Codes and Literature

Three Phases

Bradshaw, Peterson Armour and Roseborough (2007); Young and Ensing 1999; Woodside, Schell and Allison-Hedges (2006)

Entering the medical model of mental health

Start of illness

Diagnosis Tse and Walsh (2001); Millward, Lutte and Purvis (2005); (Medding and Perkins (2002); Hoffmann & Kupper (2002))

Medication

Admission

Redefining self

Identity

Benefits

Written Off (Deegan 2001) Blankertz and Robinson (1996). (Becker et al. 1996) (Mueser et al. 2001, Bond 2004).

Suffering from Unemployment

(Warr 1987) (Platt 1984; Bolton and Oatley 1987; Lewis & Sloggett 1998).

Work as a negative

Living with illness

Aftercare services

Day Services

Advice and support

Reoccurrence of illness

Stigma (Mental Health Foundation 2002)

Components of Recovery

(Anthony 1993; Deegan 1988).Carpenter (2002);(Bullock, Ensing, Alloy & Weddle 2000).(Jacobson & Greenly, 2001; Spindol, Koehler, & Hutchinson 1994); Roseborough (2007); Copeland (2001); Mancini (2007)

Turning Points

Insufficiency

Decisions and Epiphanies

Acceptance (Anonymous, 1989; Deegan 1988; Sullivan 1994; Young & Ensing 1999). (Leete 1989; Pettie & Triolo 1999).

(Restoration of) Hope (Jacobson & Curtis 2000; Turner-Crowson & Wallcraft, 2002) (Anonymous, 1989; **Anthony 1993**; Deegan 1988; Houghton, Fisher 1994; 1982, Frese & Walker- Davis 1997; Houghton 1982; Russinova 1999, Young & Ensing 1999) Snyder et al. (1991); Hoffmann & Kupper (2002)

Taking Control

Education about Illness

Out and Proud

Medication

Getting Out

Social Networks

Meaningful Activity

Maintaining Recovery

Monitoring

Complimenting Treatment

Planning to be well

Section Three: Employment

Getting ready for Employment

Recovery First

Work Placements

Getting the right job

Ambition

Disclosure

DDA

Need to be understood

What (beneficial) work does for you

From objective perspective: Lehman 1995; Crowther et al. 2001b; Dewa & Lin, 2000; Royal College of Psychiatrists 2002; Bell et al. 1993; Cook and Razzano 2000; Warner 1994; Drake et al. 1999a

Social contact and support, status and identify, time structure and occupation, activity and involvement, and a sense of personal achievement (Jahoda et al. 1933; Shepherd 1984; Rowland and Perkins 1988, Shepherd 1989, Nethering et al. 1993, Pozner et al. 1996)

Because it is not unemployment Waddell and Burton (2006)

Identity Provencher, Gregg, Mead & Mueser (2002); Kennedy-Jones, Cooper and Fossey (2005)

Need to be mentally active

Structure in the day Boyce, Secker, Johnson, Floyd, Grove, Schneider and Slade (2008)

Place in Society

Making a Contribution Boyce, Secker, Johnson, Floyd, Grove, Schneider and Slade (2008)

Financial Independence Boyce, Secker, Johnson, Floyd, Grove, Schneider and Slade

(2008)

Social Network Buckle, D. (2004); Woodside, Schell and Allison-Hedges (2006); Boyce, Secker, Johnson, Floyd, Grove, Schneider and Slade (2008)

Work as therapy Woodside, Schell and Allison-Hedges (2006)

Wholeness Work environment Krish 2000; Rebeiro and Cook 1999; Krupa 2004)

Balancing Support

Work life balance

Protection

Reasonable adjustments