

# **THE LIVED EXPERIENCES OF SERVICE USERS IN A MENTAL HEALTH EMPLOYMENT SERVICE**

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## **Abstract**

The impact of employment in individuals with mental health problems is multi-faceted especially for those who manage their mental health problems in the community. Research suggests that supported employment may have a positive impact on some aspects of recovery. Nevertheless, little research has been carried out on the lived experiences of service users in mental health employment services. The current study examined this within a supported employment service, who offer opportunities for learning and development, and work experience to individuals with mental health problems. A total of 11 participants took part in semi-structured interviews, which were analysed using interpretative phenomenological analysis, *IPA*. Three superordinate themes were identified which together captured the way in which participants felt they belonged. It was found that participants felt a sense of acceptance in the service, whilst being given the opportunity to be themselves and rediscover an identity that may have been lost because of their mental health problem. However, participants also suggested that, although the service improved their self-value and gave them somewhere they felt they belonged, they feared the 'real world' outside of the service. Leaving the service was inevitable, and participants were unsure whether they would be met with the same level of support as they had become accustomed to. The current thesis recommends that other services in relevant areas, may wish to consider the approaches used in the current service, whilst taking some consideration of the need for transgression in such services.

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## **Chapter 1 – An Introduction to the Literature**

### **1.1 Introduction**

The current research aims to explore the experience of taking part in a supported employment service for people with mental health difficulties. The impact of employment in mental health is, at times, overlooked. This may be due to the complex relationship employment and mental health have with one another, particularly for those managing chronic mental health problems in the community. In the past, individuals with mental health problems were often thought to be incapable of entering the world of work, with many questioning if employment had a negative effect on those with mental health problems (Puri, 2012). In recent years however, research has demonstrated that there may be a positive relationship between employment and living with a mental health problem. Prior et al, (2013), describes work as a basic human right, which provides a positive effect to both mental and physical health. The position of being 'employed' offers many non-mental health sufferers a sense of value within the community and can offer an increase in an individual's self-esteem. This may be even more beneficial to those who are suffering with a mental health problem and is something being considered more in the present day (Nieminen et al, 2012).

This chapter will be reviewing literature that has looked at the relationship between mental health and employment. To begin, a history of mental health and employment will be given. Stigma in the workplace, and the interactions between mental health and employment will then be examined. The impact of social role valorisation within employment and the recovery model in mental health will also be discussed. Finally, the literature on supported employment will be considered, and research on service users' experience of this will be reviewed before the current research is introduced.

### **1.2 A History of Mental Health and Employment**

The history of mental health and employment helps our understanding of how far the care system has come, as well as identifying what further changes may need to be made to provide the best level of care to those with mental health problems trying to access work. This section will outline the changes in legislation, public policy, and care practices, that have shaped the context for employment. These changes have had significant effects on access to employment for those with mental health problems and will be discussed.

#### ***1.2.1 Legislation, Mental Health and Employment***

The legislation surrounding mental health and employment has changed in many ways since the introduction of the Disabled Persons Act (1944) (Mercer & Barnes, 2004). This was the first policy to consider disability alongside employment and required employers with more than 20 employees to hire a minimum of one individual defined as disabled (The Disabled Persons Act, 1944; Ch. 10).

However, this policy did not consider mental impairment as a disability and stated that it would be up to the employer whether they would employ a mentally unwell individual. Because of the beliefs surrounding mental health at the time, many employers chose not to hire such individuals (Mercer & Barnes, 2004).

In 1970, the Chronically Sick and Disabled Persons Act (1970) was introduced, which aimed to help those labelled as disabled by making day-to-day living easier, including in the workplace. Again, this Act did not consider the mentally impaired and suggested voluntary changes to employers, advising that changes could be made if employers could fund them (The Chronically Sick and Disabled Persons Act, 1970; Ch. 16). Due to a lack of funding, few employers chose to make these changes (Heginbotham, 1998). These policies did not encourage employment of people with mental health problems, and those who were perceived to be mentally unwell were shunned by their communities as well as potential employers. With no place to earn an income, discrimination against mental health worsened in the workplace (Mercer & Barnes, 2004).

The first policy to consider mental impairment as a disability was in 1995, and legally required employers to make 'reasonable adjustments' to help those with a disability. This was the Disability Discrimination Act (1995) and required that employers removed barriers that would prevent a disabled person's participation in day to day activities whilst in the workplace. The concept of equality was also introduced within the Act, stating that an individual would not be treated negatively in the workplace if suffering from a disability, whether it be a physical impairment, or a mental impairment (The Disability Discrimination Act, 1995). Employers were also required to offer support and ensure equality to those who declared their mental impairment (The Disability Discrimination Act, 1995). If discrimination was suspected, this Act allowed the employee to take legal action against their employer. However, unlike the Disabled Persons Act (1944), employers were no longer required to meet a quota when hiring employees (Puri, 2012). Instead, Puri (2012) reports that individuals refrained from declaring an unnoticeable disability, i.e. a mental health problem, and could not take legal action if they felt there were levels of discrimination in the workplace against them.

Succeeding the Disability Discrimination Act (1995), the Disability Rights Commission Act (1999) was passed, to reintroduce the regulation requiring employers to meet this quota of hiring the 'disabled.' Those with mental impairments were still discriminated against, due to few employers being aware that the term 'disabled' also referred to those with mental impairments, and few attempted to enter the workplace due to their fear of stigmatisation (Lockwood et al, 2012).

Following the 1999 policy, the Equality Act (2010) combined many acts including; the Equal Pay Act (1970), the Sex Discrimination Act (1975), the Race Relation's Act (1976), the Disability



Discrimination Act (1995), and three other major legislative instruments protecting religion, sex and age to protect equality. It adopted the same philosophy inherited by the Disability Discrimination Act (1995), as well as many other considerations to protect those prone to discrimination and prejudice. The Equality Act (2010) was introduced as it was more plausible to have equality policies grouped together. As it still stands, the definition of a disabled individual includes physical and mental impairments, and that these should be catered for in the workplace (Barber & Martin, 2012).

As discussed, legislation has changed in many ways since the introduction of the Disabled Persons Act (1944), beginning in 1995, when the Disability Discrimination Act (1995) included those with mental health problems under the term 'disabled.' In each new legislation there has been an emphasis on trying to remove the barriers that individuals with mental health problems may face. There has been a stronger assumption that people with mental health problems want to and are able to work. Legislation has also noted that the problem is not that there is a lack of ability to work, but that there is an issue of discrimination. As policies in mental health and employment have improved, Siegel (2013) reports that mental health services have had to change and improve also. This is to reflect the rights that each new legislation has introduced, and to provide care which is in keeping with the law. A history of these changes in care will be discussed further in the next section.

### *1.2.2 Mental Health Care*

Over the years there has been a move away from assuming that people with mental health problems should be cared for away from mainstream society, as well as the assumption that they are often incurable. There has been a gradual move instead towards community-based care and an assumption that people may fare better if they are engaged in a community, including employment. A discussion of these changes follows.

One of the first recorded lunatic asylums in Europe to admit the mentally unwell was the Bethlem Royal Hospital in 1407 (Andrews, Briggs, Porter, Tucker and Waddington, 2013). During this time, treatment of the insane was carried out by unlicensed practitioners, who ran 'madhouses' as commercial businesses. Patients, many of whom were not mentally unwell, were mistreated in these establishments (Scull, 1981). To control madhouses, the government introduced 'The Madhouse Act' in 1774, which required madhouses to have licenses, and were inspected once a year. To minimise the number of people wrongfully confined, madhouses were also required to register each patient (McCandless, 1978).

However, mistreatment of patients continued, and following the death of a Quaker in 1790, William Tuke opened the York Retreat in 1796 (Nolan, 2017). Here, patients were treated as people, and received 'moral treatment,' within a therapeutic environment. This included the use of employment, where patients were able to work on the farm where the retreat was located, and take part in

meaningful occupation (Charland, 2007). Tuke pioneered 'moral treatment,' including the use of meaningful occupation and therapeutic settings. He influenced the way the mentally unwell were treated, and in 1807, county asylums were introduced (Killaspy, 2006).

These Victorian asylums were isolated from the community, in remote areas to promote a therapeutic environment. Patients were not required to be certified as insane prior to being admitted until 1890. Certification did not require psychiatric opinion; this decision was made by a parish doctor. Those who had capacity were not given a voluntary treatment option. Instead, patients were marked as 'curable' and 'incurable' according to the length of their illness. Those with severe disabilities were 'incurable' and were not to be discharged (Killaspy, 2006).

In 1903, outpatient departments were introduced to shorten the increasing length of stay in hospital for existing patients. In 1925, 25 outpatient departments were in existence, and by 1935 this rose to 162 outpatient departments (Andrews et al, 2013). Then, in 1948, the National Health Service (NHS) was introduced. This, as well as the introduction of antipsychotic drugs, and the social and political changes that were occurring at the time, influenced the steady closure of Victorian institutions. This also led to an increased awareness that keeping patients in asylums after they had recovered from the most acute stages of their mental health problem, was breaching individual human rights (Killaspy, 2003). This led to the first Mental Health Act (MHA) to be introduced in 1959, which was to distinguish between voluntary and involuntary treatments. Following this, the Minister of Health, Enoch Powell, made his 'Water Tower' speech in 1961, and introduced the Hospital Plan for England and Wales, which planned for the closure of half of all mental health inpatient beds by 1975 (Andrews et al, 2013). Powell's 'Water Tower' speech highlighted the poor standards of care and quality of life being experienced by mental health patients and powered the political and social movement to close all Victorian asylums (Goffman, 1968; Wing & Brown, 1970; Killaspy, 2003).

In 1971, a complete closure of the mental health hospital system was suggested (Long, 2013). All services were instead to be given by district general hospitals with inpatient and outpatient facilities within the hospitals building. From this, outpatient departments became a resource for both assessment and follow-up for patients. This also led to further developments, including supported housing, day services, and community-based teams specialising in mental health, such as community-based mental health nurses (Killaspy, 2003). These changes moved towards a community presence and the engagement of people with mental health problems, which made employment more feasible.

However, in 1990 an incident occurred where an outpatient suffering from schizophrenia stabbed a member of the public in an unprovoked attack (Ritchie, Dick & Lingham, 1994). This showed that community patients could lose contact with mental health services at times where they may need the support the most (Killaspy, 2003). From this, Crisis Teams and Early Intervention Teams were

introduced, and these, in turn, minimised readmission rates for those who had been inpatients. It was following this that the Social Inclusion Unit (2004) identified the need to improve access to education and work facilities for individuals with mental health problems, as well as access to mainstream employment to promote independence whilst maintaining support.

Although care policies and legislation changes have had some effect, access to employment also depends on acceptance of those with mental health problems in the workplace by the wider society (Killaspy, 2003).

### 1.3 Stigma in the Workplace

There is increasing recognition that those with mental health problems experience stigma in the workplace. This is demonstrated by a growing body of research evidencing prejudicial attitudes on the part of employers and experiences of discrimination by employees with mental health problems, who then need to make difficult decisions regarding disclosing mental health problems. The following is a brief review of these areas of research.

As stated by the Social Inclusion Unit (2004), employment can be beneficial to those with mental health problems and their recovery. However, research has shown that stigma of mental health problems can prevent these opportunities. Corrigan (2004) examined how stigma of mental health problems can interfere with the level of care given to individuals, and found that;

*'[...] public stereotypes and prejudice about mental illness have a deleterious impact on obtaining and keeping good jobs.'* (Corrigan, 2004, p. 616)

Wahl (2012, p. 9) stated this may be due to a level of 'protectiveness' from health care providers. Wahl (2012) carried out a survey of stigma experienced by individuals with mental health problems and found that they were often discouraged from seeking employment by health care providers. This discouragement was not without reason, with many of those suffering with mental health problems facing stigma from employees and employers. Research has shown how this concept impacts employment success for those with mental health problems. Fossey and Harvey (2008) interviewed employers' and employees' opinions of a colleague with mental health problems. Findings suggested that many employers and employees who had no experience of mental health problems, felt that employment was more likely to cause relapse in an individual with mental health problems. The employers and employees in the study reported that such individuals would be unable to balance the stressors of employment alongside their mental health problems. Fossey and Harvey (2008) concluded that individuals looking for employment whilst suffering from a mental health problem were consistently questioned about their ability and experienced a reduced level of opportunities available.

This reduction in opportunities for those with mental health problems could also be due to an employer's lack of confidence with hiring such individuals. For example, when interviewing employers about mental health, McArt (2014) found that many stated that they lacked the confidence to communicate with existing employees who appeared to be suffering with mental health problems, and this reinforced their choice to not hire someone with the same problems. McArt (2014) asserted this was due to a lack of knowledge surrounding mental health issues. Research has also found that this lack of knowledge was apparent in policies surrounding mental health. For example, Woodhams and Corby (2007) examined what employers believed a disability included in relation to the Disabilities Rights Act Commission (1999). Many employers were unaware of the different areas covered by the term disability. They had an unawareness that those suffering from a mental health problem were included under the definition. If employers are unaware of this classification and lack knowledge surrounding the area, stigma of mental health is to be expected (Lyon et al, 2009). McArt (2014) suggests that educating potential employers about mental health and the policies surrounding it, would reduce the level of stigma in the workplace, and would increase the opportunities available for those with mental health problems.

In addition to this, Corrigan et al (2007) reported that the type of condition an individual has, can affect employment. Corrigan et al (2007) showed potential employers (N=815) a vignette of a potential employee called Chris, who displayed one of three disabilities; a mental health problem; a physical disability; or drug dependency. Mental health problems and drug dependency were seen as behaviourally driven, in that the conditions were seen as under the person's control. Participants were asked to agree or disagree with several statements regarding Chris, including whether he should be given help in finding employment and maintaining it, how much they agreed with him being responsible for his condition, feelings of pity and anger towards him, how dangerous he was, and how fearful they were of him. Findings showed that when Chris had a mental health problem or was drug dependent, he was perceived as someone to blame for his condition and someone to be feared, in comparison to when he had a physical disability. Corrigan et al (2007) noted that prior assumptions were made about certain disabilities and could affect employment rates for each group. Lyon et al (2009), reports that continuing stigma could be due to a lack of knowledge about mental health, and existing prejudices of those with a mental health problem. This could lead to individuals not disclosing their mental health problems when seeking employment, fearing that if they did disclose, they would not be given the job. However, this could have a negative effect. For example, Goldberg, Killeen and O'Day (2005) interviewed 28 participants seeking employment whilst suffering from a mental health problem. It was found that if an individual chose to not disclose their problem, negative assumptions were made if they relapsed. Employers assumed other factors were causes for changes in their behaviour, such as drug addiction or alcohol abuse.

However, disclosure can also have negative connotations. Goldberg et al (2005) found individuals with disclosed mental health problems in employment, reported they were mostly offered 'blue-collar jobs' (Goldberg et al, 2005, p. 475), and felt that employers believed anything with a higher demand

may cause a relapse. This resulted in individuals with mental health problems choosing ways to disclose their mental health to minimise a negative impact. This was to either not disclose their mental health problem at all; to selectively disclose their mental health problem, e.g. an individual with bipolar disorder may instead disclose that their mood can change drastically; or to strategically time their disclosure by waiting until they had proved that they were able to carry out the job. Elraz (2013) suggests that this leads to individuals constantly trying to live up to a 'sellable self' who has no faults, weaknesses or limitations. However, this is difficult. The effects of disclosing mental health problems may lead to concealment. This in turn, may restrict how the individual acts, feels and behaves, and could intensify their mental health problem. In addition, this concealment is not only due to opinions of employers, but employees too. Research has found that employees without mental health problems can have negative ideas about employees with mental health problems. Olesen et al (2013) reported that employees without mental health problems feared their workload would increase due to a level of inability from employees with mental health problems, although there is little evidence of this happening. As well as this, many employers and employees believe that employment could be detrimental to an individual with mental health problems (Lyon, 2009).

Research has identified that the level of stigma around individuals with mental health problems in employment can occur because of many different factors. This can be due to assumptions being made by employers and employees around the capabilities of such individuals, as well as a lack of knowledge of what mental health problems are. Due to these assumptions, individuals who are suffering with mental health problems may choose to conceal their problems, in fear of discrimination. As well as this, health care providers can often discourage individuals with mental health problems from finding employment, in fear that they will be stigmatised against. However, employment can be beneficial to those with mental health problems, and the interaction between mental health and employment is much more complex than it would first appear.

#### 1.4 The Interaction between Mental Health and Employment

When looking at the effect of employment on an individual's mental health, it can be questioned whether employment can be problematic or beneficial to individuals with mental health problems, and others within the workplace. This section will discuss these interactions using existing research in the area.

There has been an assumption that there is a negative interaction between employment and mental health (Puri, 2012), and this can be seen in research within the area. Harvey et al (2012) found this was the case when looking at employees with depressive symptoms and their levels of work performance. They tested a web-based screening tool for depression to find whether there was an association between employees with depression and their workgroup's performance. The Patient Health Questionnaire Depression Scale (PHQ-9) was completed by 1161 employees in a call-centre

based workplace and compared to anonymised summary statistics for each of their workgroups. These anonymised summaries measured four key areas of work performance, including the number of consultations required, the number of calls transferred, commitment and customer time. Harvey et al (2011) found that workgroups with higher levels of depressive symptoms had poor performance summaries in these four areas. This could have been due to employees with depressive symptoms struggling with their work load because of their mental health problems, although it was not made clear in the findings given by Harvey et al (2011).

Nevertheless, Knudsen, Harvey, Mykletun and Overland (2013) found similar results in their quantitative examination of common mental disorders, anxiety and depression, and sickness absences. They used a sample of 13436 participants, who each completed the Hospital Anxiety and Depression Scale (HADS). The result of this and participant sickness absence, where the employee was absent for 16 or more days over six years, were compared, and it was found that those who had comorbid anxiety and depression, and anxiety were much more likely to be at risk of sickness absences. However, it was found that participants with anxiety and depression were much more likely to have longer durations of sickness absences. Knudsen et al (2013) concluded that common mental disorders could be used to predict the recurrence and duration of sickness absences. They suggested that this may be due to common mental disorder behaviours, such as avoidance or poor coping strategies, or occupational challenges for those with depression, such as presenteeism and low productivity. However, there has been conflicting research regarding this, suggesting that if support is provided for individuals with mental health problems, these issues could be minimised.

Burton et al (2008) carried out an intensive literature review looking at employees with clinical depression within the workplace, in comparison to those who did not have a mental health problem, and their quality of work. They found that those who had depression were much more likely to be absent, in comparison to non-sufferers. They also found that those who were offered support from their respective employers were less likely to be absent overall. Burton et al (2008) suggested that absence prevention was possible if support was provided to employees with mental health problems by their employers;

*Workplace policies and benefits which support employees suffering with mental health disorders and provide access to evidenced-based care adhering to best practice guidelines may improve the quality of life of employees and lead to reduced absenteeism, disability and lost productivity. (Burton et al, 2008, p. 78)*

The issue is not simply whether people with mental health problems can be employed productively, but how they can be supported in being productive at work. This seems to provide support for the changes in the legislation. Berndt et al (2000) looked at the effects of a mental health problem when in employment, by examining the levels of annual average absenteeism and average at-work

productivity performance in employees with no mental health problems, employees being treated for anxiety, and employees being treated for several mental health problems. Berndt et al (2000) found that employees suffering with mental health problems were able to work to the same level as those without a mental health problem. This was done with no support and suggested that those with milder mental health problems experienced few issues in employment because of their mental health problem. In contrast, research has shown that employment can be beneficial to an individual's mental health.

Litchfield et al (2016) suggests that employment is vital for good health, both physically and mentally, and that people seek purpose through employment. Prior et al (2013) interviewed participants with self-disclosed mental health problems, about accessing work. They found that employment affected participant's opinion of themselves and those who had been unsuccessful in employment felt a decrease in self-value and self-esteem. In contrast, Nieminen et al (2012) found that the opportunity of employment could improve quality of life for people with mental health problems. In their study, 23 participants suffering with a range of mental health problems were recruited, interviewed, and given a 20-month employment contract if successful. Follow-up interviews then took place. Nieminen et al (2012) found that employment improved participant's social life and provided them with the confidence to openly search for employment after the study, whilst improving their overall quality of life.

However, research has found that not all employment has the same positive effect. For example, Walsh and Tickle (2013), in a meta-synthesis of the qualitative literature concerning the meaning of work for people with serious mental health problems, found that the meaning and value of the activity carried out by the individual had an impact on how beneficial the work was felt to be. Six studies met their inclusion criteria and several meta themes and recurrent themes were found. These included self-efficacy (meeting challenges, personal growth), identity (feeling 'normal,' shedding the 'patient' identity), belonging (being part of the wider world, relationships) and instrumental factors (structure, finances, nature of employment). It was in this last recurrent theme that the meaning and value of an activity was found to be important. Walsh and Tickle (2013) found that the activity carried out must hold importance to the individual, for it to hold a positive effect on the individual's opinion of themselves.

Research has shown that working can be beneficial to a person's wellbeing. However, this can be dependent on levels of support provided in the workplace, as well as the nature of the job to the individual. If work is problematic for people with mental health problems, it may not always be due to the stress of employment, but the responses of other people in the workplace setting regarding their mental health problem. In addition, as Walsh and Tickle (2013) reported, the meaning of work to the individual influences their mental health problem. By providing meaningful work, individuals with mental health problems can shed their 'patient' status and increase their sense of value overall. This

sense of value is discussed in Wolfensberger's (1983) theory of social role valorisation, discussed further in the next section.

### 1.5 Social Role Valorisation and Employment

The concept of social role valorisation (SRV) was developed by Wolfensberger (1983). He characterised this as;

*'What science can tell us about the enablement, establishment, enhancement, maintenance and/or defence of valued social roles for people' (Wolfensberger, 1995)*

SRV refers to the roles individuals hold in society, and what value specific roles have in it. The goal of this concept is to give these valued roles to people within the society they are in. Wolfensberger (1983) refers to this as role-valorising. An individual who does hold a valued role in society is much more likely to receive the benefits that come from belonging to that society. This can include social inclusion, acceptance, a sense of belonging, education and development, a voice in society, an opportunity to participate in society, a decent standard of living and a standard place to live, as well as opportunities to work and support themselves, the last being most relevant to the current study (Wolfensberger, 1995; Osburn, 2006). However, if an individual is not given these opportunities, they may experience rejection and abuse. This may be in the form of negative attributes being tied to them, or at an extreme level, being kept at a distance to the rest of society (Osburn, 2006). This devalues the individual and can be detrimental to their well-being. Although these ideas were developed in learning disability services, they can be applied to people with mental health problems who may also struggle to access valued roles.

When considering those with mental health problems, many are already devalued in their society and are at a greater disadvantage in what is expected of them (Bond, 2017). As discussed previously in the chapter, mental health has a great deal of stigmatisation surrounding it, and many negative attributes are associated with mental health problems. Some with severe mental health problems are distanced from society and placed in hospitals (Osburn, 2006). Although society has moved on from the Victorian asylums, individuals with mental health problems are still devalued and many are not supported by the society they are in. However, this devaluation can be lessened by role-valorising (Wolfensberger, 1983).

By giving individuals with mental health problems socially valued roles, such individuals would be able to benefit from all that society brings. These socially valued roles can include being integrated into society. In a mixed methods study examining the relationship between using SRV in a housing related service for people with psychiatric disabilities and community integration and life satisfaction, Aubry, Flynn, Virley and Neri (2013) found that services who utilised SRV more, increased client's levels of psychological integration, such as a sense of belonging, which in turn increased overall life



satisfaction. Bond (2017) suggests this can be done in a sheltered environment, where individuals' mental health problems can be treated, whilst helping them develop a sense of confidence.

However, Tyree, Kendrick and Block (2011), who reviewed SRV in relation to supported employment, suggested that individuals with disabilities, could be placed into negative roles instead due to a lack of knowledge of alternative roles. Individuals with disabilities could be offered low challenging roles due to assumptions made about their capabilities. These individuals may then conform to these assumptions, and 'settle' in the role given, believing it is all they are capable of (Tyree, Kendrick & Block, 2011). This can be applicable to those with mental health problems also. By placing individuals with mental health problems into sheltered or supported environments, they could be instead separated from society.

People should instead be valued because of their productivity and skills. Platts (2003) suggests role-valorising could be given by offering individuals skills which would be valued by society instead. This could be done by lessening the stigma that surrounds the group, or by offering employment opportunities, which would in turn give the individual a valued role in society. This allows for individuals with mental health problems to further their recovery and is a key concept in the recovery model.

#### 1.6 The Recovery Model in Mental Health

The recovery model also emphasises the importance of social inclusion in overcoming mental health problems. The model is utilised in many mental health services and offers a person-centred approach to mental health care. This is based on the idea that it is possible for an individual to recover from a mental health problem, and that the most effective way in which to recover is patient-directed (Thornton & Lucas, 2011). This is different to the idea of 'treatment,' as it is not about fully resolving the symptoms a mental health problem can bring. It is instead an emphasis on building resilience and gaining control over issues that occur in life (Jacob, 2015). By doing so, Jacob (2015) suggests that a meaningful life can be achieved. Through the recovery model, self-management of a mental health problem is encouraged. It is believed that recovery cannot take place in isolation, and that social inclusion is needed.

As SRV states, identifying valued social roles for an individual with a mental health problem is needed for them to benefit from society, and is also apparent in the recovery model (Thornton & Lucas, 2011; Bond, 2017). By providing these roles in local communities, rather than in segregation, social inclusion can also occur. This allows such individuals to step away from their mental health problem and discover a personal identity instead. Thornton and Lucas (2011) state that recovery allows individuals with mental health problems to focus on a positive goal, rather than focussing on the negative aspects of their mental health problem. This is most applicable to employment. Employment allows social inclusion to occur and can give value to the individual (Nieminen et al, 2012). Slade et al (2012) reported that employment provided individuals with a mental health problem independence and normality, both important for recovery.

However, in a qualitative study examining the processes used when aiding people with mental health problems in employment, Secker, Membrey, Grove and Seebohm (2002) reported that it was important for support to be available in the workplace and asserted that the best opportunity for employment for those with mental health problems was to utilise supported employment services. The following section will examine what these services are.

### 1.7 Supported Employment

Employment can be a positive experience, but can also be stressful, especially for individuals with mental health problems. This is when support may be needed. With the recovery model in mind, supported employment offers individuals with mental health problems, an opportunity to enter the world of employment with the knowledge that support is readily available if it is needed (Burns et al, 2007). This can occur in a sheltered environment, or within mainstream employment settings. This is done in the hope that individuals with mental health problems can then enter the world of work and maintain employment when it has been achieved.

Support within mainstream employment, such as Integrated Placement and Support (IPS), is where service users preferences are considered prior to finding a suitable placement for them in a working environment. Following this, guidance is given to both employers and individuals with mental health problems, on how best to manage the latter's mental health problem (Corbiere, Brouwers, Lanctot & Van Weeghal, 2014). This guidance is provided by both the mental health team and employment specialists working with the service user and focuses on supporting work integration.

As well as this, sheltered workshops are available for individuals with mental health problems. These involve the employment of clients with mental health problems and disabilities alone, separately from individuals who do not have such problems (Dick & Shepherd, 1994). However, as suggested by Tyree, Kendrick and Block (2011) this could cause issues for individuals, such as separating them further from society. This is also a problem for jobs in mainstream settings, that are reserved for individuals with mental health problems.

Further supported employment methods address vocational skills an individual with mental health problems may need. This can include qualifications and courses that may be related to a field they are interested in (McInnes, Ozturk, McDermott & Mann, 2010). This addresses the recovery model, in that individuals can distance themselves from their mental health problem and discover a personal identity.

In addition, voluntary work schemes are also available for individuals with mental health problems, and can help with social inclusion and recovery, by providing unpaid working experience (Boardman, Grove, Perkins & Shepherd, 2003).

Supported employment allows the individual to maintain a degree of independence (Mueser & Cook, 2012). As Walsh and Tickle (2013) suggest, this does not need to be paid, as it is the importance of the role that influences an individual's mental health overall. It is important to consider whether these

services do benefit individuals with mental health problems. Therefore, research looking at supported employment and individual placement support is vital. The following section will review previous research which has explored mental health service users' perspectives and experiences of support in employment.

## 1.8 Existing Research

Much research has been carried out on supported employment services for individuals with mental health problems. Due to this, a limited literature review has been carried out identifying what information is available within the area. Only research using qualitative methods have been included in the review. This was as focussing on the experiences of service users was the main topic of interest for the current research. Literature which has examined the experiences of service users within employment or an employment service have been included in the conclusion.

To begin, a discussion of literature in supported employment services has been made, followed by a discussion of literature looking at support in mainstream employment. The literature has been reviewed critically to inform the current research and ensure that it is likely to contribute to resolving any gaps in the knowledge.

### *1.8.1 Supported employment*

De Malmanche and Robertson (2015) wished to examine whether supported employment models for those with mental health problems were beneficial. They used individual interviews with six service users (who were said to not have mental health problems) in a group based supported employment service, followed by a focus group involving all participants. The semi-structured interviews allowed participants to discuss freely what their experiences were, rather than being constrained to answering specific questions. A phenomenological approach was used to analyse the data. This related to the underlying philosophical approach of the study which wanted to look at human experience to give a believable insight. The researchers immersed themselves in the data, listening to the recordings, and reading the interview transcripts several times. From this analysis, three major themes emerged; self-determination, self-efficacy and workplace relationships. In the first theme, self-determination, participants discussed their motivation to work in the service, and that working was something they wanted to do, rather than something they had to do. In the second theme, self-efficacy, participants felt more confident in finding secure work, and being appreciated in the work they did. In the third theme, workplace relationships, participants felt they had made respectful relationships, with people they knew well by the end of their training. Although the study aimed to address issues for people with mental health problems, the participants used did not have mental health problems. The authors believed their prior experiences in mental health services allowed them to extrapolate their findings to

this group. They concluded that employment services should consider the three themes in their care model.

Yu et al (2016) focused on the views of individuals with schizophrenia and their caregivers, in an integrated supported employment (ISE) programme, and its effect on their recovery. Semi-structured interviews were used for a total of 30 participants, 15 of which were participants diagnosed with schizophrenia for at least 2 years and had all successfully completed the 18-month ISE program. The remaining 15 were caregivers who had 3 years' experience of taking care of the participants. The interview schedule was similar for each group and focussed on reflecting how the ISE program had made an impact on participant's lives. As well as this, there was a focus on how participants had developed and improved relationships in the workplace. Each participant was interviewed in Chinese, and their interviews were then translated into English by 2 independent translators. A handbook regarding coding to be used was developed using 6 interviews and translated to English for use of the English-speaking researchers. This may have caused an effect unbeknownst to the researchers, where some discussions may have been misinterpreted, or may have been translated differently dependent on who the translator was. The interviews, following translation, were then analysed using an inductive process. Yu et al (2016) found that there were similarities between participants and caregivers, as well as differences. It was found that participants and caregivers had similar experiences of the service; similar understandings on the meaning of employment; how ISE had helped them understand the differences in job hunting; the useful skills shown in ISE; the positive and negative experiences of employment; and how ISE had helped solve employment problems. However, participants and caregivers differed in their expectations of the service, where participants desired for a more psychosocial approach, in that they would have liked to have built relationships with others, in comparison to caregivers who desired for a more instrumental approach, where participants would become more financially stable, and be able to minimise the financial burden on the family. They concluded that the research had helped understand subjective experiences of participants and caregivers, and finding successful employment, as well as helped build a greater understanding on the impact of the ISE program on participant's recovery.

### *1.8.2 Mainstream employment*

Harris et al (2014) examined barriers faced by job seekers with mental health problems and substance misuse issues. This was done using semi-structured interviews with the job seekers, supporting family members or carers, and staff at the service. The staff at the service were asked to recruit job seekers and family members for interviews. The job seeker group had experienced mental health problems and substance misuse issues, but it is unclear whether they were open to this being discussed with family or carers. Nonetheless, participants were interviewed dependent on what their status was, i.e. job seeker, family member or carer, or staff. In total, 17 people were interviewed in the study, which included 6 job seekers, 5 family members or carers and 5 staff members. All participants in the job seeker group were male and had either schizophrenia, depression or both, as well as

current or past substance misuse problems. The data was then analysed by three researchers using thematic analysis influenced by grounded theory, and the themes were finalised by two of the researchers. Harris et al (2014) found several perceived barriers of employment which were similar across the three participant groups. These included personal history of the job seeker, such as long-term unemployment; their symptoms, attitudes and interpersonal functioning, such as poor motivation and communication skills; attitudes of the community to mental health problems and substance misuse problems, such as stigma and poor understanding; and systematic factors, such as a lack of availability of services and a competitive job market. Harris et al (2014) concluded that length of unemployment was the most commonly mentioned barrier to employment when considering mental health problems and that the employment service-delivery model must be reoriented.

Jarman, Hancock and Scanlan (2016) aimed to explore the experiences of individuals with mental health problems who maintained employment, and what strategies they used to do so. Mental health workers and employment specialists helped to recruit participants. This could have caused similar participants to be recruited, minimising transferability of the findings. Each participant was required to be living with a mental health problem which impacted their day to day living for a minimum of 2 years and to be working in a competitive work setting, either on a part-time or full-time basis, for at least 6 months. As well as this, they were required to be over 18 years old, English speaking, and to not be using any crisis mental health services at the time but had been a part of employment support services in the past. In total, 10 participants met the requirements and took part in semi-structured interviews. The interviews focussed on maintaining employment and were a mixture of phone interviews and face to face interviews. It is unclear who was interviewed by telephone and who was interviewed face to face. Telephone interviewing is often convenient; but although non-verbal communication occurs in terms of tone and loudness of voice etc., the opportunity to read other aspects of body language is lost. It would have been interesting to examine whether this held an effect on openness from the participants or caused inconsistencies in the data. Nonetheless, interviews were then analysed using grounded theory methods. Jarman, Hancock and Scanlan (2016) found there were several strategies used by participants to overcome barriers in maintaining employment. These included identifying and connecting with helpful people, including others with mental health problems; looking after themselves completely, such as maintaining a positive and healthy lifestyle; having a job that fitted who they were, including a job that matched their values and skill set; staying motivated; positive reflection and re-framing; and choosing and using strategies in the workplace, such as disclosing their mental health problem to their employer or not, and being assertive when needed. Jarman, Hancock and Scanlan (2016) found that each participant actively chose and used a combination of strategies from the mental health recovery model that were best suited to their own circumstances, needs and abilities. They concluded that occupational therapy could better support long-term employment options for individuals with mental health problems. However, it is unclear whether the authors of the paper, who were occupational therapists, had provided support to the client group in the past, and could have been potentially biased about the need for more occupational therapy support.

Olney and Emery-Flores (2016) explored the impact of the Wellness Recovery Action Plan (WRAP) on employment and how individuals with mental health problems utilised these strategies for employment success. These strategies included coming to the realisation that they wanted help; self-knowledge of their mental health problem and how to manage it; support and significant relationships; tools for daily living; commitment to a daily routine; using WRAP tools to maintain a job; and use of support networks at work. This was done using semi-structured interviews that were then phenomenologically analysed. Participants were recruited by the employment agency program manager. Olney and Emery-Flores (2016) state that a convenience sample was used, however some bias would be apparent by allowing the service manager of the employment service choose who would participate in the study. Nevertheless, Olney and Emery-Flores (2016) found that WRAP strategies were successful in employment, and many participants facilitated the techniques given by the plan. Olney and Emery-Flores (2016) also concluded that employment is important in the recovery from mental health problems.

### *1.8.3 A summary of the literature*

In much of the literature discussed, research has taken a phenomenological approach, focussing on experiences of service users, families and carers of those with mental health problems, and staff in employment services, be it in mainstream employment, or in supported employment sectors. There have also been similarities in the themes across research that has examined the experiences of services. Much of the research discussed found that many service users valued relationships in employment and felt that this aided their recovery. Others found that the service they were in gave them the motivation to seek employment. As well as this, research has found that the services had helped their users build confidence in themselves. However, the research discussed has had a relative lack of in-depth work on the experiences of people using an employment service, instead focussing on methods they use for recovery, limitations of workplaces and the success of services. It would be interesting to see what experiences service users have had whilst in a service, in comparison to their past experiences, and what difference this had made in their lives. As well as this, there have been some reservations surrounding existing research in the field. These include not utilising participants with mental health problems in the research, the possibility of losing meaning when translating transcripts to English, questions of breaking confidentiality when including carers and family members, the use of telephone interviews which could have resulted in the loss of body language, and convenience samples being used.

These are all something to consider in the current research, as well as other aspects drawn from all the studies mentioned. Careful consideration of these aspects allows the current research to ensure an exploration of individual perspective within a mental health employment service is made. This is discussed further in the following section.

## 1.9 Rationale for the current research

Given the limitations of existing research about mental health employment services, and the lack of understanding of the perspective of people using such services, the current project aimed to examine the experiences of service users in this area further. The purpose of this was to examine how a supported employment scheme was experienced by the people using the scheme. This will provide additional information about how people using one such services value the experience and will be discussed and interpreted.

The research discussed in the literature review has focused on employment services that have given paid work, or that have been in paid mainstream positions. In the current research, I have decided to focus on an employment service that offers mostly voluntary opportunities, as well as training in relevant fields of interests to their service users, to try and fill a gap within the research. However, as with the research discussed, many have used phenomenological approaches or qualitative approaches. This has allowed participant perspectives to be at the forefront of the research and is something I feel is important when looking at individuals with mental health problems and employment services. This is as many services focus on the recovery of their service users, and it is their experiences of the service that demonstrate how affective they are in helping individuals with mental health problems in their recovery. I will also recruit participants on my own accord and focus only on service users rather than considering staff in the service or families and carers, as other research has done. I have also chosen to focus on individuals who have been diagnosed with a mental health disorder, and who are fluent in English, as to not lose the meanings behind their experience in translation, and to ensure that the service is reflected by the individuals that rely on it the most.

The aim of the current study is to explore the lived experiences of service users with mental health problems, in a mental health employment service. By doing so, the current research hopes to inform services and specialists in the field of mental health problems and employment further about what the experience of being in such a service means to the individual service user.

More information regarding the methodology chosen and the method adopted for the current study will be provided in the next chapter.

## **Chapter 2 – Method and Methodology**

### 2.1 Methodology

As previously mentioned, the aim of the current study was to gain an in-depth understanding of the lived experiences of individuals with mental health problems in a mental health employment service. The aim of the current study focussed on the individual, or *service user's experiences* – it was therefore imperative to choose a methodology which accounted for this. To do justice to the accounts given by the participants, it was important to use a methodology which reflected individual experiences and focussed on *their* account of these experiences. Therefore, a qualitative methodology was a clear choice due to the current research openly focussing on first person perspectives.

As a result, phenomenology was decided as the best methodology to use in the current research. Phenomenology is our understanding of our conscious experiences in the world from a first-person point of view, and how we perceive and interpret the meanings these experiences hold in our lives (Gallagher, 2012). However, an in-depth understanding of other's experiences can be made by researchers when using phenomenology as a methodology. By doing so, researchers adopting a phenomenological methodology can begin to explore the perceptions and perspectives of participants, to gain meaningful insights into individual experiences (Merleau-Ponty, 1996). This exploration of perceptions and perspectives of participants was important in the current study, as I wanted to gain an understanding of participants' experiences of using a mental health employment service. However, these experiences could be explored in many ways, and it was important to determine which way would be most beneficial in the current research.

#### *2.1.1 Descriptive and interpretative approaches*

Husserl claimed phenomenology should be examined in the way it occurs and in its own terms (Lopez & Willis, 2004). He hoped that we would examine our own experiences to discover what the essential qualities of each experience were, and to be able to help those with the same experiences. Husserl hoped that instead of wondering what could have been, individuals would focus on the real experience and the meaning it held (Wojnar & Swanson, 2007). This meant not interpreting our experiences, but accepting it as it occurred, and reflecting on what impact it has on the individual. Husserl therefore chose a descriptive approach to phenomenology, in that experiences should not be examined and explored for their importance but accepted as they would be defined in their pure state. However, by doing so, this would not allow room for learning what impact experiences hold in an individual's life, and how the same experience could positively or negatively impact someone else's life (Lopez and Willis, 2004). For this reason, Heidegger disagreed with Husserl's descriptive approach, and emphasised the need for more interpretation, as this was a fundamental part of experience and could not be bracketed off.



Heidegger argued that we are in a world filled with many things, and our experiences are always tied to a previous experience. By interpreting these experiences, we can learn what meaning they have, and how this can shape us. If we do not, we do not have the opportunity to learn from experience (Pringle et al, 2011). This is considerably important in the current research. For services to learn what is beneficial in supported employment, it is important to interpret what individuals have already experienced, and what impact the service holds in their lives. Smith, Flowers and Larkin (2009) state that the best way to do this is to carry out interpretative phenomenological analysis (IPA).

### *2.1.2 Interpretative phenomenological analysis*

Interpretative phenomenological analysis (IPA) explores how people make sense of their life experiences by focussing on the account of an experience given by an individual (Smith, 2011). It assumes that there is a connection between what people say, how they think and what they feel (Smith & Osborn, 2007). These connections made IPA most appropriate for the current research, as the aim of the study was to explore how service users made sense of their experiences whilst in a mental health employment service. For these connections to be explored effectively, the data collected must be approached in two ways; descriptively and interpretatively (Larkin, Watts & Clifton, 2006).

The first involves the analyst attempting to understand their participant's experience of being in the world, and their being able to describe exactly what it is like for the participant, whether it be in relation to an event or relationship. This is complicated as individuals struggle to put into words what they are thinking and what they feel. Larkin, Watts and Clifton (2006) report that the description of an experience may be partial, or much more complex than it was when it occurred for the individual. It is dependent on what the participant has remembered and discloses about the event, and what the analyst understands of the participant's experience. The description provided by the analyst can never be a first-person account of the experience – and this cannot be helped. Instead, Larkin, Watts and Clifton (2006) suggest producing an in-depth, psychologically informed description of the experience as close to the original account as possible. This was useful in the current research, as it ensured that I only described facts around the experiences the participants had in the current study and helped bracket my own misconceptions at times. This will be discussed in-depth later in the chapter.

In the second approach, the analyst must give a clear interpretative analysis of the experience. This is to make sense of the way in which the participant has described the data, and question why they may have disclosed it in such a way (Larkin, Watts and Clifton, 2006). This second approach allows the analyst to ask more questions about their participant's account and explore the meaning behind it. This can be through psychological interpretation, and through interpretation of the language used (Mjosund et al, 2017). At times, this can offer interpretations that the participant may have not realised

themselves. Again, this made IPA the most useful approach for the current research, as it involved my becoming immersed in the data to ensure the most viable interpretations occurred and ensured that service user accounts of the mental health employment service, and the meanings their experiences had, were the focus of the analysis.

## 2.2 The current service and the current study

The current study worked with a service in North England, which provides employment support to individuals of the working age, who have mental health problems in the locality. For the benefit of maintaining confidentiality in the study, the service in question will be referred to as 'the service' throughout the paper.

The service aims to improve the quality of life for individuals with mental health problems. It does this by helping these individuals gain new skills whilst increasing their self-esteem and confidence, as well as providing opportunities to socialise in a working environment. The service offers education and vocational training opportunities, as well as unpaid work experience in areas of interest to the service user. The service is part of a social enterprise that also provides other mental health services, e.g. assessments, inpatients facilities, and therapies.

Users of the service are often referred to the service by the local job centre, the social enterprise in which the service is a part of, or by other mental health services. Self-referral is also available. When referred, the individual is invited to an interview, where a history of their mental health problems and employment goals are discussed with a member of the service team. If the service feels they may be able to assist the individual, the individual is then given membership to the service. Membership is given as the service does not refer to those in the service as service users, but as members. If applicable to their needs, each new member is screened for any learning disabilities that they may be unaware of, or that have been undiagnosed, including dyslexia. Members of the service can complete qualifications if they wish to, at many different levels. As well as this, there are many different opportunities to volunteer in the service and in the community, in the hope that this will provide experience in a sector that many employers seek. These include opportunities in catering, domestics, front of house, property services, grounds maintenance, retail/workshops and gardening. Some are also offered the opportunity of paid employment in the service, if they are deemed appropriate for the position.

The service offers 3041 hours of work-based training each month, including volunteering opportunities, 338 hours of which are in specialist educational training. The service has helped 300 individuals find employment, 60 of whom have been employed by the service.

The service includes many aspects of SRV, and the recovery model in its ethos, and this can be seen throughout the ways that individuals with mental health problems seeking employment are helped. A person-centred approach is given, like the patient-centred approach outlined in the recovery model, through interviewing each new member, following which they are placed in a sector that they have an interest in. This relates to the concept of SRV, as each member is given a social role that is valued by the organisation and by the individual (Osburn, 2006).

By treating each member as an individual, by giving each new member an interview for example, the service ensures that the individual feels that they are of value, and that they can gain control over their mental health problem in the end. This is relevant to Walsh and Tickle's (2013) discussion, where giving an individual with mental health problems an opportunity to work in an area they have an interest in, rather than any opportunity, makes much more of a difference to their experience in a service.

### 2.3 The use of semi-structured interviews

The first stage in collecting data for the subsequent research was to determine what form of data collection would be best suited to the aims of the current study. The use of diaries was overlooked as many of the members of the existing service struggle with reading and writing and may not have been able to complete journals. This may have been problematic when completing a diary entry on a regular basis. Because of this, self-report methods were not considered either, for the same reason. This left interviews as the most appropriate to use for data collection, as are commonly used in phenomenology (Smith, Flowers & Larkin, 2009). Rather than use a structured interview, which could have the same restrictions as a quantitative method, a semi-structured interview was chosen (Galletta & Cross, 2013). Kallio et al (2016) reported that the use of semi-structured interviews can give participants the freedom to express their experiences on their own accord and can provide reliable and comparable qualitative data. This was important in the current research where the use of supported employment is based on the individual. By using semi-structured interviews, the individual was still able to maintain their individuality and discuss topics that they felt were important to the subject matter, which, in the current research, would be their experiences in a mental health employment service. By using an interview method, the researcher could later reflect on the participant's answers systematically, and complete an in-depth analysis, as well as probe for further information in necessary moments (Galletta & Cross, 2013).

### 2.4 Participants

At the commencement of the study, a minimum of six participants was deemed appropriate. This was in response to Smith, Flowers and Larkin (2009), who report that the use of fewer participants allows a greater depth of analysis to occur, whilst maintaining the importance of each individual participant. However, this number is dependent on what is being explored in the study and can be changed to fit

the aim of the study. Following recruitment, many wished to discuss their experiences. All participants were checked to meet the following criteria;

- Participants must be a current member of the organisation.
- Participants must have been a member for more than a year.
- Participants were aged between 18 and 65 and spoke English to a good degree.
- Participants were required to provide their own full consent to take part in the study.

The first criteria was included to ensure all had experienced the same service and allowed focus on an experience that was to some extent shared, although experiences may have differed from participant to participant. Participants were required to have been a member for at least one year to allow for discussion of their experiences over a notably long period of time. Less than one year may have not allowed participants to experience the full extent of the service. The age bracket of a full working age was included to broaden the participant group and provide a wider discussion of experiences. Participants were required to speak English to a good standard, to minimise any misinterpretations by the researcher during analysis. As well as this, agreement of the terms outlined in the consent form (Appendix 4) was needed.

In the end, eleven participants met the criteria. As each participant wished to discuss their experience of the service, and to not exclude any potential experiences that were of value in the study, all those interested were included in interview process. To maintain anonymity, each participant cannot be described separately, however as a group; they had been members of the service for an average of 2 years, there were 3 men and 8 women in total, all White British, aged 21 to 60 years of age, 2 of which had undergraduate degrees, and 2 others with A-Level qualifications. The remaining participants had struggled in education. The group had had a wide range of experience in employment, with 7 participants having had full time jobs, 2 having had part time jobs, and 2 having not worked before. Each participant had experienced a mental health problem for a minimum of 2 years – these included, but were not limited to; bipolar disorder, psychosis, schizophrenia, depression and anxiety. All participants lived in their own housing, independently, or with their parents, families or partners.

## 2.5 Recruitment

Information about the current study and its aims were given to the organisation, as well as a request to recruit participants. Benefits for both parties were found, and the organisation agreed to its participation. Insurance for the commencement of the study was checked, as was the interest from the organisation's members. Potential participants were then invited to a presentation (Appendix 2) held by the researcher at the service. This was advertised using posters placed in the service and passed on by word of mouth. In total, 15 people attended the presentation. Within the presentation, the nature of the study was explained, in that the research hoped to gain a greater insight into the experiences of members who have been placed into employment, and

the changes to their lives they feel had, or had not, arisen because of the service provided. It was also explained the study hoped to explore whether such a service is impactful – either positively or negatively – to those suffering with mental health problems, from a member's point of view. In addition, it was explained that the research may provide further information to other organisations who maybe considering taking a similar approach to mental health and employment. Questions were welcomed throughout. Following this, the participant criteria were discussed, and it was made clear to all who attended that participation was not compulsory.

The ethical considerations as previously mentioned were also discussed, and it was made clear to all that pseudonyms would be used in the final thesis, and that confidentiality would only be broken under certain circumstances.

Attendees were also told that if they chose to take part in the study, they would still be able to withdraw at any point until a given date, when analysis would commence. It was then explained what would happen to the information once collected, and contact details were given to attendees who were interested in participating. Participants were given information sheets (Appendix 1), and a topic guide for the interview (Appendix 3).

## 2.6 Procedure

The interviews took place in one of the service's meeting rooms, where a member of staff from the service was close by if needed. Participants were told that if they wished to bring someone with them for support, it was fine to do so.

All participants, prior to the interview, were required to complete a consent form, signed by both the interviewer and interviewee. Within the consent form, the rights of the participant were outlined, and read aloud to the participant. It was made clear to the participant that they could withdraw from the interview at any point, and/or take a break if needed. It was also made clear that this would not affect their status as a member of the service in any way, and it was reiterated that the interview was not compulsory. It was also noted that the interviews were to be transcribed, and if the participant wanted a copy of their interview, they would need to contact the researcher.

Further contact details of the researcher were also provided on the consent form. A copy was retained by the participant and another was kept by the researcher.

After this, a topic guide of what was to be included in the interview was given and read aloud. Topics discussed in the interview included; how the individual came to join the service, what life was like prior to becoming a member, what influenced their decision to work in a particular area within the service, what their experience of the service had been, moments where the service had had an impact on their

life, if any, therapeutic effects the service had had on them as a member, the ethos of the service and what their opinion of it was, as well as any other topics they wished to discuss. It was made clear to the participant that they were not required to discuss all topics, and that if they were uncomfortable in answering a question, they did not have to. Each participant was also asked if there were any topics that they did not want mentioned at all in the interview. These were noted by the interviewer.

It was also explained that the interview was semi-structured, and this allowed for a more relaxed environment. Participants were told that there were no set questions, and that the focus of the interview was their experiences. They were told that if they did not understand a question, the interviewer could reiterate it in a different way. If participants became visibly distressed, the interview would be terminated, and help would be sought. It was ensured that participants were as comfortable as possible, and that the environment was relaxed.

All interviews were recorded with the permission of the participant, using a Dictaphone that was only accessible to the researcher, and locked away safely when not in use. A second Dictaphone was also used in the same manner. Participants were given a copy of the topic guide to refer to if needed, and a copy of their consent form.

Following this, the recordings were transcribed on a private computer, in a confidential area, where only the research team had access. The transcriptions were placed on an encrypted computer file.

After all the interviews were completed, they were transcribed ready for phenomenological analysis. Copies were printed for each participant, and hand delivered along with a debrief information sheet (Appendix 5), with further contact details of the researcher, and local support groups if needed. These were placed in sealed envelopes and handed directly to the respective participants.

## 2.7 Ethical considerations

The current study was approved by two ethics committees; the University of Huddersfield School Research Ethics Panel (SREP) and the Leeds and Yorkshire NHS Ethics Committee (through the Integrated Research Application System, IRAS).

Two main ethical issues were carefully considered. Issues of confidentiality were dealt with using pseudonyms and secure data storage. It was agreed in advance that any information disclosed relating to self-harm or the harm of others, or potential danger, would have to be shared with the service's management team. Leeds and Yorkshire NHS Ethics Committee raised the issue of others making 'educated guesses' about participants' identity from phrases participants might use. This was overcome by offering participants their transcripts and offering the opportunity of withdrawing any comments or responses they did not want mentioned, up until the date of analysis, which was the deadline for withdrawal of all data.

Participant distress, consent, and researcher safety were also considered. In the unlikely event that the participants would become distressed, the service ensured that support was readily available. In addition to this, participants were told they could leave or stop the interview at any point, with no implications. Participants were also told they could have as many breaks as needed during the interview. I have also had experience with working with individuals with mental health problems and would end any interviews if it appeared that the participants were becoming distressed. Participants were also told they could bring someone with them if they required further support. Finally, participants were given the researcher's contact details in case they had any further questions regarding the study, and the telephone numbers of several services specialising in mental health problems, that they could contact if they needed to.

To overcome any consent issues, only those who could provide full consent themselves to take part to the study were able to participate. A consent form was read to each participant and signed by both the participant and researcher upon agreement. This included information about the aims of the research, that interviews were to be audio recorded, their right to withdraw, that they gave permission for anonymised quotes to be used from their interviews, that no other person beside the researcher would have access to the information given, and that their identity would be protected through use of pseudonyms. A copy of the consent form was kept by each party. Finally, researcher safety was overcome by making sure the interview room was not in an isolated area and making others in the service aware of where and when the interview was taking place.

## 2.8 Analytic procedures

During the transcribing stage, any names were replaced with pseudonyms, and any further identifying information regarding the participants was omitted. Following this, an analysis of the data was carried out using interpretative phenomenological analysis (IPA). As Willig (2008) states in her book, the first stage of the analysis is to immerse yourself within the data. This involved reading and re-reading the data several times to ensure an in-depth understanding of what the individual had experienced, and what they felt because of this. After this stage, initial noting is advised by Smith, Flowers and Larkin (2009). Exploratory comments were made on the first transcript, as well as descriptive and linguistic comments. I took time to understand what mattered to the participant within their experiences, and how their use of language demonstrated this. Following this, emergent themes were developed. I then began relating exploratory comments to one another. For example, Lewis reported,

*'My life weren't that great – it really weren't. Before [the service], I was on drink... everything. I think, a lot of it, I just lost my way. I was drinking 24/7, that's how bad it was.'* (Lewis, lines 8-10)

Here, descriptive comments included how terrible things were for Lewis before joining the service, which was supported with linguistic comments around his emphasis on how his life was in the past in line 8, *'it really weren't.'*

From this stage, emergent themes were developed. This involved relating exploratory comments to one another. In Lewis' statement above, there is a focus on the past. This related to further quotes where Lewis makes comparisons of past services he had been in, to the current service,

*'I went to the job centre, and got made to do tests. I failed it. They showed me straight to the door.'*

*'I don't get paid here, but I feel important being a volunteer.'*

*(Lewis, lines 41-42; 59)*

From these quotes, an emergent theme, *'being who I want to be'* was created. After this, connections among emergent themes were made, which required finding themes that involved many topics found in the transcript (Smith, Flowers & Larkin, 2009). For Lewis, the emergent theme *'being who I ought to be'* connected to other themes that identified how Lewis had the opportunity to be someone he could be proud of. In turn, this was made into the theme *'becoming who I ought to be.'*

The next stage of the analysis was to repeat the process carried out on Lewis' transcript, whilst giving justice to the new individual, by not letting the previous transcript influence how the next was interpreted (Smith, 2017). This related to the concept of reflexivity and was considered throughout. Reflexivity, as stated by Bishop & Shepherd (2011), is the way in which a researcher's opinions and values influence the way in which data may be construed. Careful consideration was given to this and is discussed further in the next section.

After this, patterns were looked for across all the participants' interviews, and a reconfiguration and re-labelling of themes was carried out (Smith, Flowers & Larkin, 2009). The theme, 'a service which wants me here' was found across many of the transcripts and led to the major theme of 'belonging' in the end.

The steps discussed were repeated for the 11 interviews transcribed, and analysed using IPA, whilst considering what phenomenology aims to discover. Further discussion of the results can be found in the next chapter.

## 2.9 Reflexive considerations

Finlay (2008) defines reflexivity as the influence one's personal opinions and experiences can have when analysing data in phenomenological research, which can cause incorrect descriptions of participant experiences, misunderstandings in the interpretation of their experiences, and bias (Usher,



1993). Tufford and Newman (2010) suggest that 'bracketing' can minimise this effect; where the analyst tries to suspend their judgement about the world, to focus on the participant's experiences and the analysis. To do this, Bishop and Shepherd (2011) suggest noting down prior assumptions that may cause such effects during the analysis procedure.

As such, some of the participants in the current study had been in the organisation's inpatient unit and discussed their time there in the interviews. I currently work in an inpatient unit specialising in acute mental health in men of a working age, which could have informed my expectations of participants' experiences in similar settings. Many of our patients are sectioned, and this takes a lot of their freedom away from them. This understandably causes high levels of distress for the patients and can be quite difficult to see as an employee of the unit. I hold some prior assumptions about how inpatients are treated and I needed to be aware that these assumptions may affect the way I interpreted some of the interviews, to minimise any bias effect. Following Bishop and Shepherd's (2011) advice of noting down prior assumptions that may cause reflexive effects in the analysis, I began carrying a field diary, where I noted my immediate thoughts and prior assumptions throughout the interview and analysis processes, reflecting on them continuously. I read and reread the data collected, again trying to 'bracket' my own ideas as far as I could.

During the recruitment process, I made it clear what my employment background was. During the interview process with participants with backgrounds in inpatient care, I ensured I reflected prior to asking further questions, to ensure the questions were not unimportant to the current study, and focused on participants' experiences of the service, rather than their experiences of being in hospital. As a result, I carried out the analysis whilst reflecting on the research process as much as possible. The following chapter discusses the findings of the analysis.

## **Chapter 3 – Findings**

### **3.1 Introduction**

Three superordinate themes were developed across the participants transcripts. These related to the experience and meaning for the interviewees. Themes were developed to identify significant issues in the data that were relevant for most participants. However, some participants' experiences differed slightly, and these variations will be discussed below for each theme. Each theme included several subordinate themes which related to the superordinate theme, as shown in Table 1. These themes are introduced in this section, and developed in further detail, with examples from the interviews, later in the chapter.

**Table 1 – Superordinate themes and their subordinate themes**

<b>Superordinate Theme</b>	<b>Subordinate Theme(s)</b>
1. Becoming	<i>Participating in the service makes me now feel more positive about myself</i> <i>Becoming who I ought to be</i>
2. Belonging	<i>Being with people like me</i> <i>Building authentic relationships</i> <i>A service which wants me here</i>
3. Only part of reality	<i>I still have bills to pay</i> <i>An uncertainty for the future</i> <i>I am safer in the service than in reality</i>

These themes were prevalent in all interviews and demonstrated how being a part of the service had affected everyone's employment experience. Participants felt participation in the service enabled them to achieve their potential and become who they ought to be, or who they had in some ways always been, though this self might have been hidden. Participants felt they had not had the chance to practise who they were as an individual but felt they had previously been defined by their mental health problems. By realising who they were as an individual, they began to feel that they belonged in the service and shared this experience of self-realisation. However, some struggled with this concept, as the fear of leaving the service became more apparent, as well as an uncertainty for the future. An in-depth discussion of these superordinate themes and subordinate themes follows, alongside quotes from the transcripts collected during the interview process.

### 3.2 Superordinate Theme 1 – Becoming

In the first theme, '*becoming*', participants discussed how the service made them realise that they were much more than the mental health issue they had, and that they could do much more than they thought they could. This realisation, in turn, increased participants' self-value and motivated them to become someone they could be proud of. This was not about becoming someone new but unmasking and improving on the person the participants felt they had always been. Participants felt much more positive about who they were, including their mental health, and accepted that their experiences had shaped them for the better. All accounts incorporated a sense of change and movement, and this can be seen further in the subordinate themes.

#### *3.2.1 Subordinate theme 1 – Participating in the service makes me now feel more positive about myself*

Participants found that working in a team where they were now a valued member also positively impacted their perception of themselves. When people in the service praised their work, participants felt they felt they were being noticed for their positives attributes in a way that they had not been previously, and this in turn increased their self-value within the service. For John, appreciation from others was particularly important;

*'I love it. And the elderly people, and even the young people say thank you. It's a great team to work with, they give me great support, great to talk to. It's so different. But I'd rather be happy in a job, doing what you want to do.'* (John, lines 67-70)

John notes that this appreciation and support is 'so different' from his previous employment experiences. Another change that participants reported was that the tasks they were assigned in the service allowed them to have more responsibility than they had experienced in the past. This alone allowed them to feel much more of value, and, in turn, made them feel much more positive about themselves, as Tom had experienced;

*'Tom: I even set up the exam thing, because poor Peter was so busy with another meeting, and he asked me to sit in on an exam instead. I was obviously delighted.'*

*Interviewer: It seems that he saw you had the skills to complete a task he was unable to do, like working in the catering department.'*

*Tom: Well, I have made dinner for my parents and brother. I even got compliments from them, which was a surprise.'* (Tom, lines 234-240)

Tom was happy to have been trusted with such a task and felt much more positive about his capabilities when given the opportunity. Consequently, Tom felt much more able to cook for his family and was also pleased with their enjoyment of the meal. When participants succeeded in the tasks, this increased their positive feelings about themselves, and gave them the confidence to help others who were struggling. Claire gives an example of this experience;

*'[...] my confidence has really built, and I'm pleased of where I am now, because I've helped supporting the learners in class. It gives me such a sense of achievement. It really does. And seeing them progress is even more amazing.'* (Claire, lines 36-39)

Claire found, after a long battle with education, she had the skills to help others who had been in similar situations as herself. Similar realisations came to many of those interviewed, and many chose to work in areas that focussed on helping others. However, succeeding in tasks was not the only contributing factor in making participants feel more positive about themselves. The praise received from people in the service allowed the participants to feel better about themselves and allowed them to see how well they could do when given the opportunity. An example of this can be seen from Lewis' interview;

*'I love the garden centre and work up there. Richard's proud of it, and I am too. Everyone's proud of it.'* (Lewis, lines 15-16)

Lewis reported that he was proud of himself, owing to Richard being proud of the work they do, and this made everyone proud of the work they do. This clarification that the participants were successfully carrying out tasks assured them that they were doing a good job and increased their own positive views on who they were as a person. Nonetheless, participants were aware that this is not only down to the service, but due to their own determination;

*'And although I had a lot of help with [the service], its taught me, you've done it yourself, because you can get off drugs, you can get stabilised, so you're receptive to counselling and things, but you've still got to help yourself.'* (Robin, lines 142-144)

Robin shared a view with many participants; that it was not only down to the service that they felt more positive about themselves, but the act of getting help and having the determination to participate in the service, made each participant feel more positive about themselves too. The service did not only help, but made the participants feel good about being helped overall. For example;

*'Well, they didn't really do anything. It's all up to you really. You can come to what you like, but they support you, and give you a shoulder to cry on. I don't think you can get that anywhere. Hopefully that will change. Hooray for Prince Harry (laughs)!'* (Alice, lines 49-52)

For Alice, and others, it was the support given that made them feel better, as it was something many had not received from other services. The fact people in the service wanted to help them made the difference in their recovery.

### 3.2.2 Subordinate theme 2 – *Becoming who I ought to be*

The second subordinate theme, *'becoming who I ought to be'*, was a theme that was mentioned in all the interviews. The service learned about the individual, and by doing so, allowed participants to recognise who they really were, outside of their mental health issue. Because of this, participants could learn and work in areas that they had existing interests in, discovering a person within that they felt had always been present. For Ella, her love of baking had always existed, and when given the opportunity to work in the kitchens within the service, she found it came quite naturally to her;

*'I wasn't in the main kitchen, I was in the other one doing the cakes and buffets and that, and when Gareth came, 'Right, I want some cakes making' and all I say is, 'Right, for how many, is it big, small, plain or chocolate.' And even before he's said anything I've got the stuff ready to weigh out. I'm always baking for other people.'* (Ella, lines 39-43)

The service helped participants learn that they had valuable existing skills that made them into the person they had become, and that they should be proud of, just as Ella did. However, some felt that they had been held back because of their mental health problems. As Lewis stated;

*'Interviewer: Before [the service], did you try to find employment?*

*Lewis: I went to the job centre and got made to do tests. I failed it. They showed me straight to the door. I think it's discrimination. All I see it as now, I just want to put something back in the community. I just want to make it better. Before [the service], life was horrible.'* (Lewis, line 4044)

Lewis, along with others, felt that his mental health problem was viewed negatively by other services, and this was what held him back from going further in his recovery, until he joined the current service. This allowed each to flourish into the person they felt they ought to have been. For Robin, she realised that she had held her own misconceptions around mental health problems, and came to realise that it did not define the person;

*'Now in my life, when you're young you can see things differently, but I never looked down on it, but I don't look at it negatively anymore, I don't think it's something bad or negative to have a mental health problem anymore, because I've seen now, even stars and famous people, it*

*can happen to anyone, even a chief executive, anybody, and umm, there is a stigma.'* (Robin, lines 153-158)

Robin explained how her self-stigma of mental health problems had caused her to have a negative view on her mental health problem and self. This prevented her being the person she wanted to be, due to the guilt she felt for having a mental health problem.

*'It was one psychiatrist who actually sat me down when I was crying and took my guilt away by saying this is an illness, you cannot and will not be able to feel uplifted without help.'*  
(Robin, lines 209-211)

Through the service, Robin learned that mental health problems were not something negative, and they could be experienced by anyone. Robin learned that she did not have 'something bad or negative', and that she was not to blame for her mental health problem. This acceptance allowed Robin to be the person she wanted to be. Most participants shared this feeling and felt that being in the service helped them become the person they were and had not had the chance to be. This was done by treating participants as individuals and learning what each person's individual interests might be. Sometimes this meant finding new interests, and participants found they flourished in areas they had not expected, and thus learned about a person they did not know existed within them. This can be seen in Jane's experience;

*'I feel good, that I can do it. I never used to bake, but now I can. Half the stuff I do in there, I never knew I could do it.'* (Jane, lines 22-23)

Like many others, Jane found an interest in baking that she had not realised. When given the chance, participants found there were skills that they had not utilised yet. This did not just include finding skills in new topic areas, but in areas they had struggled with in the past. Participants explained their struggles in education prior to joining the service, but by giving them back their individuality, they began to flourish in areas they had thought they could never succeed in. John showed what many of the participants had experienced regarding this;

*'I always thought I was thick, I got bullied, I got told I was thick, oh you're stupid, you're an idiot. And I started believing it. But I know it's because I'm dyslexic. [...] I do Maths and English here.'* (John, lines 57-59;62)

Most participants had been tested for numerous learning disabilities, and just as John had experienced, found that they suffered from dyslexia. Most participants were tested for learning disabilities in the service. For John and the other participants, this was an explanation to their struggles in education, and was something that had always existed, but had been ignored. With this

discovery, John and others could learn subjects they thought they would never be able to flourish in and found that they were able to do so when given the right resources by the service.

Contact with the service helped in their movement towards becoming the person who they felt they ought to be. However, for Kate this was problematic, as there were aspects in mental health services that she struggled with, such as her diagnosis.

*'And to accept the diagnosis, umm, what I was given. I do and I don't accept it. I accept because it is a label, but I don't want to accept it into my life, so I can still have the freedom of movement.'* (Kate, lines 48-50)

Kate had not wanted to accept her diagnosis because of the limitations she believed it would bring. However, Kate's diagnosis did not limit who she could be, and that she still had 'the freedom of movement' to be who she wanted to be. Many participants felt the same, and found they were able to find their identities outside of their mental health problem. With assistance from the service, this helped them become who they wanted to be.

For some, this meant being able to take pride in demonstrating the skills they knew they had, whilst for others it was about learning new skills. Some participants found being the person they had always been involved uncovering something they felt they ought to have always known about themselves. Overall, contact with the service and other service users had different effects on participants' identity. For some it supported the idea that they had a valid identity outside of their mental health problem, whilst for others it meant struggling with 'becoming who they ought to be', despite their identification with a diagnosis. Nevertheless, participants were able to discover a person within themselves, who had skills and abilities that had once been hidden from them.

### 3.3 Superordinate Theme 2 – Belonging

The second superordinate theme, '*belonging*', describes how, within the service, participants did not feel anomalous; they felt relaxed in a service where they had shared experiences with others, and support for as long as they needed it. Some participants had previously felt out of place in many different aspects of their lives, whether this was within education, a previous service, family or friendship groups. Now they felt at home. Those who had had positive experiences reported that the service offered '*belonging*', in that their mental health was no longer a delicate subject but openly discussed. They felt normal in the service.

#### *3.3.1 Subordinate theme 1 – Being with people like me*

The first subordinate theme, '*being with people like me*', was key to this concept of belonging.

Participants were placed in areas of interest with others who had shared their experiences. This included the knowledge that others in the area shared their mental health problem and their experiences of using mental health services. By doing this, participants felt the area they worked in was where they belonged, and importantly, felt comfortable in.

All participants felt that there was a level equality between all in the service, and the uncertainty of who was staff and who was a member, strengthened this feeling. Robin discusses this level of equality, shared by many;

*'Some people, you wouldn't even know, that they're actually a member, and you would think were staff.'* (Robin, lines 150-151)

This level of equality was felt by others in their interviews, such as Alice discussing the ethos of the service;

*'When you walk in, you can't tell who is staff and who is a member [...] no power-dressing, that's the ethos. I feel valued – I can't explain, it's amazing.'* (Alice, lines 184-187)

As Alice mentions, this equality between staff and members in the service made her feel valued, that she was needed, and therefore belonged. Participants also reported that the knowledge that others in the service also shared a mental health problem allowed a much more relaxed atmosphere, where judgement was reduced. This can be seen by the following quotes from Ruth and Lewis,

*'I still get embarrassed here in Jeff's class, but I know they're there to help and I apologise because they know where I'm coming from and don't hold it against me.'* (Ruth, lines 88-90)

*'I love the garden centre - it's a lovely place. It really is. And it wouldn't be without people like me.'* (Lewis, lines 84-87)

For Ruth and Lewis, knowing that each member had had similar experiences with a mental health problem made it much easier to relax and feel like they belonged. As Lewis reported, it would be difficult without people like him. Participants felt there was equality, a lack of judgement, acceptance and trust in the service. These feelings allowed participants to feel much more at ease with one another, shown by Jane;

*'I enjoy it, the atmosphere, and the people that work in the kitchen, just friends. We just click. When it's hard, they all help each other. You can have a laugh and a joke with everyone.'* (Jane, lines 46-48)



When problems did arise in the service, members were able to support one another in the best way. As Ruth and Lewis mentioned, this was due to their shared experiences, 'they know where I'm coming from.' Because of this, the atmosphere made it much easier to relax with one another. This feeling of shared experiences made it much more likely for participants to be who they really were, without constraints, just as Tom explains;

*'I think I was nervous at first, but I think the open attitude and the banter, that's what broke the ice. Because it allowed me to let go of my anxieties and trust, and build a bond, well, essentially banter.'* (Tom, lines 41-43)

As it was for Tom, building a bond was much easier in the service, as the openness of others in the service 'broke the ice.' This 'open attitude' will be discussed further below. Nevertheless, for other participants, being with others who were like them made the experience much less lonely.

### 3.3.2 Subordinate theme 2 – Building authentic relationships

The second subordinate theme, '*building authentic relationships*', links to the previous subordinate theme. By being placed in an area where they had shared mental health problems and experiences of using mental health services, participants felt much more relaxed and open to talking to others within the service. This allowed friendships to build with people who understood mental health problems and could share experiences with one another. Participants explained that there was a lack of authenticity in their past experiences, and people in many previous relationships did not understand the impact their mental health problems had. They experienced a difference within the service, in that the topic of mental health was not ignored and was openly and honestly discussed by staff and members. Participants felt that being in a service where they were not a rarity, but of a common group, made it much more likely to build genuine relationships.

Most participants commented on the open and honest relationships that they had gained whilst in the service, which held a high level of authenticity in their opinion. Participants did not fear judgement, as they knew the open nature of the service could not allow it, and everyone was clear about what they thought. Claire, who has artificial legs, explained this after an incident in the classroom;

*'I remember doing my first English class with Jeff, and I was about to stand up and all of a sudden, my legs fell off (laughs)! Well, I just laughed, and Jeff laughed. One of the learners got angry, and said, 'You can't laugh at Claire! It's not funny!' But it's the best thing he could have done. I didn't care, and I will talk to anybody about it.'* (Claire, lines 139-143)

Despite others being upset with the reaction given, Claire felt much better when someone accepted the incident as it was and did not magnify the issue. This openness is something that many participants admired in their interviews;

*'I found people attached to [the service] are indeed more open than those in the streets' (Tom, lines 24-25)*

In the following quote, Tom explained how a staff member in the service did not feel the need to agree with him in his opinion, and that this something Tom admired much more.

*'It's like, one of the staff members at the gardens, he, he's open minded, but he's closed minded at the same time. He's like, I need proof [...] I say if it's white, why is it not black, or something? It's the kind of person he is, and I like that kind of argument. Because what's white to one person may be black to another.'* (Tom, lines 189-193)

The staff member was open minded due to his understanding of mental health but closed minded as he would not change his opinion without evidence. He did not feel the need to appease Tom by falsely agreeing, but maintained his authenticity, which Tom admired. For Tom and others, disagreements in opinion were a sign that there was honesty in a relationship and felt that people within the service were generally more authentic to past experiences. They were not treated as fragile individuals who needed to be sheltered, as had been experienced in previous services, but treated as an adult.

*'They don't treat you like a child here. It's a job. That's what the job centre didn't know.'* (Lewis, lines 126-127)

At the same time, people in the service understood each other's mental health problems and accepted them as they came. For Claire, her low mood was preventing her from trying courses in the service;

*'Jeff always tells me you're not thick, you can do it, you can do it. Even when I told him to fuck off! On numerous occasions (laughs). But he gave me that kick that I needed, and never got angry. He gave me a kick start. He was fantastic. He was amazing.'* (Claire, lines 122-124)

Jeff, in this quote, did not give up, and continued to support Claire. This persistence resulted in Claire trying a course, and finding she could succeed when supported, whilst learning that Jeff genuinely wanted the best for her. The understanding he had of her mental health problem also aided in building an authentic relationship, and can be seen in other participants' interviews, such as Robin;

*'[...] I did these hours upstairs at [the service]. But gradually, over time, I came into full time employment and it was perfect really. I had managers supporting me, very close supervision.'*

*They knew when they took me on, that I would likely relapse, since she was incredibly unwell.’ (Robin, lines 97-102)*

Here, Robin’s mental health problem was acknowledged openly, as was Claire’s. It was accepted that Robin would relapse as her mother became unwell and demonstrated that the relationships she had built in the service were authentic. Those in the service wanted the best for each other, and their actions were noticed by the participants, who valued each relationship for its authenticity.

For Sophie and Kate, this idea of building relationships that were more authentic than previously, was not found in their interviews. Sophie had built authentic relationships in her previous employment, and it was a breakdown in a romantic relationship that caused her to leave. She kept in touch with many of the friends she made in her previous job,

*‘At [previous workplace] we had meetings with the managers, who were my friends and everything, and they asked if I wanted to stay, because they wanted me to after I got better, but I didn’t want to because of him, so I left. They said it was entirely up to me, they did a lot with me and for me, [...], they took me in their car. They invited me to parties and stuff, [...], things went better eventually. I talk to Rebecca, to let her know things were okay’ (Sophie, lines 87-94)*

Nonetheless, for Sophie her existing authentic relationships were of importance to her. In Kate’s interview, she explained how she was in a place where she did not feel comfortable.

*‘In [inpatient unit], I still get that sense, when you’re around patients, that they’re on the ward, you’re around all the staff that supported you when you were there. I didn’t want to work there, it was an opening. But I learnt to deal with it.’ (Kate, lines 60-62)*

For some, it was the shared experience of being a user of mental health services that enabled authenticity, but for Kate, her service user history and status was difficult for her. Kate had been an inpatient with the service prior to becoming a member of the service, and now worked in the inpatient ward, where she found it hard to build authentic relationships with people within the area, focussing more on how to ‘deal with it.’ With these two exceptions, this building of relationships made a difference for members in relation to happiness in the service, and to their overall experience.

### 3.3.3 Subordinate theme 3 – A service which wants me here

The final subordinate theme, ‘a service which wants me here’, discusses how participants had felt unwanted in previous services, in comparison to the current service. Interviewees reported that, in previous services, they felt like they were being rushed through steps, to make way for others who required the service. It was reported that participants felt they were a number, and if they were

struggling in finding employment, their efforts were questioned and they were made to feel unwelcome. In the current service, the time given to everyone gave them the feeling that they could take as long as they needed, and the same level of support would always be given.

For all participants, the feeling of being wanted within the service allowed them to have positive experiences there. For many, a comparison of services from the past, and the current service, was discussed in depth, revealing how the different approach given by the current service made them feel much more valued. For example, Ella, who had struggled at a previous service,

*'I just didn't know what to do and had to go to the job centre and sign on twice a week, and I hated it there. They made me feel like a nobody. You had to fill in forms, and I hated it. No one helped me do them, they said you can't do that, I had to do it myself. Here, somebody will help me. It's like doing me English, writing a letter. I know what to write, it's just getting it from here (points to head) and getting it down on paper.'* (Ella, lines 160-165)

By feeling wanted, Ella and the other participants felt they received help tailored to their needs, rather than being left to their own devices. By identifying individual needs, participants felt that the service genuinely cared for their members. This can be seen in Jane's experience,

*'Yeah, I moved into this flat and Jeff helped me get a new cooker, even though I couldn't afford it.'* (Jane, lines 50-51)

Although she could not afford a necessity, the service ensured she would still be able to live comfortably, despite financial issues. Participants discussed how this made them feel like the service was concerned about their welfare, rather than just completing their job role. Robin discussed this, recalling her time as an inpatient in the service,

*'[The service] was brilliant, even at the time, Grant, the chief exec came to see me on the ward. They made you feel, like, you know, in any business it is a business, but they made you feel valued and that you weren't just a number.'* (Robin, lines 110-113)

Robin still appeared amazed that the Chief Executive of the service would be concerned about her and described what all the participants felt throughout their time in the service, that they felt 'valued and that you weren't just number.' Participants were made to feel wanted, and that this was where they belonged,

*'I feel something when I come here, I feel like a sense of belonging, that I've belong here. I haven't felt that any other place before.'* (Alice, lines 76-78)

In the second superordinate theme, participants discussed how they felt they belonged in the service. Participants discussed how they were able to meet people that shared the same experiences as

them, in both their mental health problem and previous experiences in other services, whilst having the opportunity to work in an area they had a genuine interest in. The relationships participants were able to build in these areas were different to those they had built in previous services and experiences. Participants felt the relationships gained were much more authentic and genuine in nature, where they no longer feared judgement, and were no longer treated as a child. In the end, this allowed them to feel that they were in a service that wanted them there, instead of feeling like the service was required to help them. By feeling wanted by the service, participants felt that they were in a service they fitted in to, and belonged in.

### 3.4 Superordinate Theme 3 – Only part of reality

In the third theme, 'only part of reality', participants felt that the service offered an escape from issues they were facing in their lives. Because of this, participants felt that life within the service was almost 'unreal', in that when they left the service, some of the issues they had escaped from in the 'real world' were still there. For example, participants discussed the financial instability of unpaid employment in the service, and that they still had bills to pay. Participants feared the lack of support they would receive in the 'real world', as opposed to the support given in the service, or the 'unreal world.' For some who had had negative experiences in mainstream employment, this fear was justified. For those who had not had any experience in mainstream employment, a fear for the unknown was experienced. There was also an awareness in some participants that they would not be able to stay within the service forever, and they were uncertain whether reality would be as supportive as they had become accustomed to in the service. For some, the idea of leaving the service was not considered, and they wished to stay in this sheltered environment indefinitely.

#### *3.4.1 Subordinate theme 1 – I still have bills to pay*

Many of the participants reported their gratitude for the service but discussed their worries regarding the fact that they were in not paid employment. The inevitability of having to face these financial issues worried many of the participants, and they feared how their mental health would be affected. This worry also led many to realise that they would not be able to stay in the service if they wanted to overcome these issues, and developed into a fear of what mainstream employment, or 'reality', might bring.

Although participants had a mostly positive outlook on their place within the service, many still struggled with the issues that awaited them at home. There was a clear differentiation between life within the service, and life out of the service. The issue that arose in most interviews was the concept of having no paid income from working in the service. Participants discussed how their real-life issues and commitments did not disappear and feared how their mental health might suffer in the long run.

*'But there's time where things get on top of me, that I'm not earning any money from it, and I'm scared of where I might end up.'* (John, lines 71-73)

John, as with many of the participants, was aware of financial strain due to lack of paid employment, and although he tried to have a positive outlook, he was still aware that there were bills to pay, and knew that this could not be permanent. This was similar for Kate, who enjoyed the work she did within the service, but was also aware of the repercussions of unpaid employment.

*'I feel less discriminated against, the only thing is, because it's not a real job, its voluntary, you haven't got that ethos of being paid.'* (Kate, lines 80-81)

Kate demonstrated what many participants felt, that the work they completed within the service was not 'a real job', and that there was no paid reward for doing so. This was not just due to the lack of money, but the significance of money when working, i.e. feeling undervalued when not being paid. This also related to the idea that many participants were on benefits. Many did not wish to be on benefits, and wanted to be self-reliant, earning a wage themselves. For Lewis, this was especially true,

*'I only get £146 every fortnight, because they don't think I have a mental health issue. That's why I want a job, because I don't want to be on benefits. I want to do it myself'* (Lewis, line 121-123)

For four participants, this worry did not seem to be a concern. For two of the participants, Sophie and Tom, who were the youngest of the participants, the worry of financial stability was not a concern as they lived with their parents. Ella had financial stability due to an inheritance, and there were additional physical disabilities that posed challenges for Claire in relation to seeking paid employment. Nonetheless, financial stability was an issue for many participants, and may have had a negative impact on their experience within the service.

### *3.4.2 Subordinate theme 2 – An uncertainty for the future*

The second subordinate theme, 'an uncertainty for the future,' revolved around the perception that participants could not remain within the service forever if they wanted to progress, and they were unsure of what would become of them if they left. A hope that things would work out was apparent throughout the interviews, but a sense of uncertainty was included nonetheless. This sometimes elicited a need to stay in the service, or the 'unreal world', for as long as possible, rather than the unknown reality.

For some, their mental health was an issue, and they were unsure whether they would be allowed to return to work at all.

*'I don't know if I can go back to work, they haven't given me a deadline on how soon I can work.'* (Kate, lines 73-75)

For others, like Jane, the prospect of a job was up to the employer once they have sent their application, but the possibility of discrimination, if they chose to disclose their mental health, was real.

*'I've been applying but haven't heard anything back from any of them. But what can you do. I always tick the box for mental health, but I think it's my age that makes them not call me back'. (Jane, lines 36-38)*

Jane, however, highlights what many other participants had thought – they it was not their mental health that was an issue for some employers, but other things, such as age. Many participants felt that there would be no change,

*'Well sometimes I think I'm doing all of this for nothing. It just seems sort of pointless sometimes, and it makes it hard.'* (John, lines 80-81)

John voiced the concern of many participants, in that all the work they were doing may end with no employment prospects in the future. This demonstrated their uncertainty for the future. For three participants, the futures uncertainty was not an issue.

For Robin and Claire, moving on from the service was not under consideration. Robin worked for the service as a paid member of staff, and Claire was unable to work in mainstream employment indefinitely.

### *3.4.3 Subordinate theme 3 – I am safer in the service than in reality*

The final subordinate theme, 'I am safer in the service than in reality', revolved around participants reporting that reality was unforgiving from their past experiences, whilst this 'unreal world' will always protect them. All had had negative experiences out of the service. By joining the service, where they had had a majority positive experience, many felt they were better off staying in the service, in fear of the discrimination and stigma they would experience out of the service, once again. Many hoped for paid opportunities arising in the service, so they would still be able to receive support when it was needed. Others noted that this was not healthy, and that they would have to leave the service to progress, stepping out of the 'unreal world' and back into reality.

The service was much safer than reality for many participants, many of whom had negative experiences in the past, and feared this would happen again. Because of this, most participants did not want to leave the service, in fear of being met with no support in future workplaces or experiencing discrimination as they had in the past. This led to participants hoping for future paid positions in the service, so they would not have to consider this issue,

*'I would love to work here properly. I would be able to relax and chill, and I'd have the support here and everything when I needed it.'* (John, lines 82-84)

As many participants did, John felt that working with the service as a paid member of staff would be ideal, and it would be like their current membership. Because of this feeling, many wanted to stay in the safety of the service,

*'I'd stay here as long as I can. (Ruth, lines 92-93)'*

Some participants were aware that they were at risk of becoming institutionalised, but this did not prevent them wanting to stay within the safety of the service.

*'And you do become institutionalised, you know, it's a safety net, so it was a bit scary, but I knew that if I didn't take that step, and because there was nothing at [the service's] office because of the budget cuts, I knew I might have to go to outside employment instead, which I wasn't ready for and I didn't want to.'* (Robin, lines 93-97)

On the other hand, two participants did not feel the service was safer than reality. Kate, who had been an inpatient within the service, had negative experiences as well as positive experiences in the service, and was waiting to be able to move on from it. Sophie had had positive experiences outside of the service, within the employment sector, and she did not feel the service was any safer than reality. For others, it appeared that the service was the last destination in their recovery, despite the service aiming to help members gain paid employment. Many could be said to be at risk of becoming institutionalised if they did not move forward.

### 3.5 Conclusion

Participants felt that the service helped them find their identity, whilst acknowledging that their mental health problem did not define who they were. By doing so, participants felt that they were able to learn much more about themselves and be the person that they had wanted to be. This resulted in participants becoming more aware of the person they were and helped them to find relationships with others in the service that wanted the best for them. Through this, they learned the value of a service that wanted their presence and found new relationships that were authentic. However, participants were also aware that this was not the end, and they would have to leave the service to progress further. Possible explanations of these findings will be discussed further in the next chapter, with reference to research discussed in previous chapters, as well as the concepts of SRV and the recovery model.



## Chapter 4 – Discussion

### 4.1 Introduction

This research aimed to examine service users experiences of a mental health employment service, and to understand the meaning it had for the service users. In the analysis, three superordinate themes were identified, each with several subordinate themes. The first superordinate theme, 'becoming,' discussed participants feeling more confident about the person they were, whilst in the second superordinate theme, 'belonging,' participants voiced how they felt people in the service wanted them there, and how they felt they fitted into the service. In the third superordinate theme, 'only part of reality,' participants acknowledged they would not be able to stay in the service and discussed their uncertainty for a future when they were no longer members. In this chapter, these themes will be explored and discussed in depth. As well as this, I will discuss how far the aims of this research were achieved, the limitations of the research, and implications for practise, research and education.

To begin, I will focus on themes one and two, in relation to Kitwood's ideas on personhood and Buber's theory of I-Thou and I-It. From this, I will discuss other concepts applicable to the themes, such as Maslow's idea of the hierarchy of needs and self-actualisation, Roger's concept of unconditional positive regard, and Cooley's idea of the looking glass self.

### 4.2 Theme one and theme two

The concept of personhood, as defined by Kitwood (1997) is;

*'A standing or status that is bestowed upon one human being by others, in the context of relationship and social being. It implies recognition, respect and trust. Both the according of personhood, and the failures to do so, have consequences that are empirically testable.'* (Kitwood, 1997, pp. 8)

Although Kitwood (1997) discussed personhood in relation to dementia, it can be applied to other mental health problems. Personhood is the importance we give to each other through our relationship with them. This can be done through three discourses; transcendence, ethics and social psychology (Kitwood, 1997). It is in the latter that personhood relates to the current research most prominently. From a social psychological perspective, personhood allows individuals in a social group to build a stronger sense of self by giving each person a place in the group. This can be seen in the first superordinate theme, where the participants discussed how taking part in the service, allowed them to find their individuality, and feel much more positive about who they were. The service gave roles to each member, and in turn made them feel like they could be proud of themselves. As in Kitwood's

(1997) quote, this resulted in participants feeling that they were recognised and respected for their individuality and trusted to complete tasks to a high standard.

This feeling was increased for some of the participants by their past experiences of services. Kitwood (1997) discussed that by not giving an individual personhood, negative consequences can occur. In the second superordinate theme, participants discussed how previous services had not helped them as the current service had, and it felt like they were being discriminated against. In comparison, participants felt the current service made them feel welcomed, and wanted. This feeling of belonging was increased by participants building authentic relationships with alike people. After feeling like an outsider for a long time, the knowledge that others had had similar experiences was comforting. Participants no longer felt like the anomaly in society and came to the realisation that many shared their experiences. This allowed them to build authentic relationships with others. This authenticity in relationships has also been discussed by Buber (1958) in his book, *I and Thou*, where he referred to two types of relating – I-It and I-Thou.

In Buber's (1958) concept of I-It and I-Thou, Buber (1958) discussed how we as human beings communicate and relate to one another. In I-It we relate to one another in a basic sense, where we do not allow the full extent of our being to be shown. This form of relating is objective and is intentional. We are aware of how we are communicating in these moments of relating – however this awareness prevents our true selves being acknowledged, and in turn, prevents another from showing their true self. According to Buber (1958), forming an I-Thou relationship is much more subjective, and allows a more authentic relationship to be built. In an I-Thou relationship, we are less conscientious about communicating with another being, and allow our true selves to be acknowledged. This gives permission to the other being to allow their full self to be shown, and together, with openness and honesty, a genuine relationship can occur.

This can be seen in the second superordinate theme, where participants discussed their feelings of belonging. In the subordinate themes, this feeling of belonging was due to building authentic relationships with those in the service, in comparison to their past relationships in other services. Buber's (1958) idea offers an explanation as to why the relationships built in the current service were more authentic than those in past services. As Buber acknowledges, for an authentic and genuine relationship to be built;

*Each must expose himself wholly, in a real way, in his humanly unavoidable partiality and thereby experience himself in a real way as limited by the other, so that the two suffer together the destiny of our conditioned nature and meet one another in it. (Buber, 1947, p. 7)*

Here, Buber (1929) mentions that through I-Thou relating, we can allow ourselves to be seen fully, and share any problems with others, in the hope that a genuine relationship can be found in common

suffering. In the current research, participants discussed how the open and honest relationships they experienced in the service made them feel less alone – they were able to meet alike people who could share the problems they had experienced in their mental health. There was no need to hide each other's mental health problems, as everyone had had some experience of them. Instead, each other's mental health problems were openly discussed, and relationships without fear of judgement and discrimination were able to be built. This allowed participants to find their true self and is something discussed by Maslow (1943) in his concept of the hierarchy of needs and self-actualisation and developed further by Rogers (1959).

Self-actualisation, according to Maslow (1943) is the stage where we reach our full potential. This is where we have become the most that we can be as a person. Maslow (1943) suggested that for us to reach this point of self-actualisation, we must first reach our basic needs, which include our physiological needs, e.g. food and water, and our safety needs. After gaining these needs, we can move onto our social needs of love and belongingness, which in turn leads to our need for respect and esteem. Only after this can we attempt to reach self-actualisation. In the current study, participants had the first two needs, but struggled with their needs of love and esteem, prior to joining the service. However, in the service, they discovered that these needs could be met – they received love from people in the service and in turn felt that they belonged, as seen in the second superordinate theme. This then allowed the participants to have a higher level of self-esteem and feel more positively about the person they were. Participants, through their participating in the service, were more likely to move onto the final stage of self-actualisation and be their ideal self. This is could be seen in the first superordinate theme, where participants felt that they were becoming the person they should have always been. However, in Maslow's (1943) idea of self-actualisation, reaching it is much rarer than first perceived, and most of us may never reach it despite covering each stage in the hierarchy of needs. On the other hand, Rogers (1959) offered a different view on the hierarchy of needs and self-actualisation, introducing his ideas of unconditional positive regard.

In Rogers' (1959) idea of the hierarchy of needs, he believed that the qualities needed to reach self-actualisation were nurtured early in life, and that self-actualisation was a constant growth process. For self-actualising growth to occur, a growth promoting climate must be made. According to Rogers (1961), two conditions must be met for a growth promoting climate. These are that growth must be nurtured when an individual is being genuine and open. Participants discussed genuineness and openness in their interviews, as seen in the second superordinate, where they were able to build authentic relationships with those in the service. Rogers (1961) goes on to say that this genuineness and openness must then be accepted by others. It is this acceptance that is most important and should be done with no conditions. Rogers (1961) called this unconditional positive regard. This is the love given that does not change dependent on the actions or behaviours of the individual but is given no matter the circumstances. Again, this can be seen in the second superordinate theme, 'belonging.' The current service specialised in aiding those with mental health problems and gave an

unconditional form of acceptance. Rogers' (2007) suggestion of unconditional positive regard from others could offer explanation as to why this was so important for participants to feel as though they belonged in the service. Participants discussed that past services had been discriminatory of their mental health problem and did not provided a growth promoting climate for self-actualisation. In contrast, the current service gave members a chance to discuss their feelings and experiences, with the knowledge that the service would accept them no matter what. This knowledge of other's acceptance allowed participants to be more accepting of the person they were. This idea of other's perceptions shaping our own self was looked at closely by Cooley (1902) in his theory of the looking glass self.

Cooley (1902) suggested that our perceptions of ourselves are dependent on what we think others think of us, as well as what we think of ourselves. This occurs in three stages where we question how we appear to others, and then question what others think of us. This causes the final stage where we change how we think about ourselves based on what we think others' perceptions of us might be. This can occur both positively and negatively. In the latter, we may believe a person has a negative opinion of us, which may be or may not be true, and in turn reflects negatively on our opinion of ourselves. Participants discussed this from the perspective of other services they had been in, in the first and second superordinate themes. Participants discussed their past experiences of services and school, who they believed had a negative view of them, such as through feelings of discrimination, or that they could not learn. These impacted the participants' opinion of themselves as well as their feelings of belonging. However, Cooley (1902) also suggested that this can occur positively, which participants experienced in the current service. The service made participants feel positive about themselves, through support and trust in their abilities. This made the participants feel that they were wanted in the service. In addition, the positive perception participants felt people in the service had of them, allowed them to be more positive about their abilities. By doing so, participants were more inclined to try new things, and found that they were able to succeed in areas that they had once felt they couldn't. Again, this made participants feel positive about who they were in the service.

Participants were able to re-relate to a person they had either forgotten or repressed within due to their past experiences. The service allowed them to be the person they ought to have always been, by taking a genuine interest in their service users, and supporting them to become proud of themselves. However, participants did feel that these positive feelings would not be permanent, and the inevitability of having to leave the service was discussed in the interview process. These thoughts will be looked at further in the next section.

#### 4.3 Theme three

In the third theme, 'only part of reality,' participants discussed their being in the service, and how they felt it was not part of the 'real world.' These findings showed that there were dilemmas for the service, as well as benefits and costs of supported employment, in contrast to using a real-world approach. These will be discussed respectively in the current section.

Participants discussed in the third theme that, although the level of support they received from the service was valued, they were aware of the real-life implications that not having a paid job had, the most obvious being a lack of financial stability. The participants were offered employment experiences in a field of their interest, which Walsh and Tickle (2013) noted was important in mental health recovery. However, the current study showed that, although this was important for the participants, once they had achieved a placement in an area of interest, other desires became apparent, such as they need for a paid position. This was not because of economic reasons alone. As Kate noted, in line 81, '*it's not a real job, its voluntary, you haven't got that ethos of being paid.*' The act of being paid for work is what made it a job for Kate. However, for the service to offer paid opportunities to the participants would mean that any benefits many of the members receive may be stopped. The wages the service could offer may not be substantial enough for the participants to live, and without their benefits, they may find they have a lower quality of life. As individuals with mental health problems, this added stress could cause a relapse in their recovery instead. It may be that the participants were unaware of the financial implications if the service were to pay them.

However, for many participants, to be on benefits was a negative attribute and something they wanted to move away from. This may have been due to participants wanting to gain their own income. This need might have increased whilst being in the service, following the realisation that they could work to a good standard, and yet were unable to find paid employment. This raises another dilemma for the service – what is the next step for their members who have achieved the skills they need to work in an area of their interest? The service does try to encourage its members to find other employment opportunities and offers support in doing so. However, many participants described the safety they felt in the service, and the fear of what would happen if they left. This implied that the participants felt the support may stop once they leave the service and may be the reason many do not wish to leave the service. As participants had been in the service for an average of 2 years, they may have become accustomed to the support received, as well as the nature of work to complete. This comfortability of a service can have negative repercussions, as discussed by Tyree, Kendrick and Block (2011).

The service utilised two ways of providing supported employment to the participants – through teaching vocational skills and qualifications, whilst giving unpaid work experience in fields of interest – with a focus on SRV throughout their approach. However, as Tyree, Kendrick and Block (2011) suggest, this can have limitations. Participants may have not been challenged enough, and instead, separated further from society. Participants became familiar with an employer who was both supporting and understanding of their mental health problem. As Wahl (2012) suggests, health care

providers can discourage their service users from accessing real world work, in the fear that they will be met with discrimination. Although the current service did not purposefully do this, participants past experiences may prevent them from wanting to move on, as they acknowledged how unsupportive other services and mainstream employment had been and can be, resulting in their own discouragement from leaving the service. This may have caused feelings of uncertainty for participants around their futures. The implications of this are discussed in a later section.

As well as this, theme three identifies the cost and benefits of supported employment and real-world approaches. Supported employment, as experienced by the participants in the current service and identified by literature in the area (Burns et al, 2007) can offer guidance and support to those with mental health problems whenever it is needed in a working environment, as well as an in-depth understanding of mental health by the employer and its employees. This is something that many of the participants had not experienced until they had joined the current service, with many discussing their feelings of discrimination. However, as previously mentioned, this can separate individuals with mental health problems further away from society (Tyree, Kendrick & Block, 2011; Wahl, 2012). This can be seen in the current research, where participants described their feelings of no longer being part of the real world when they are in the service. This issue could be overcome by taking a real-world approach to supporting individuals with mental health problems in employment. However, this has its limitations also. In a real-world approach, there would be no protection from stigmatisation, which much research has found in mainstream employment (Corrigan et al, 2007). However, this could be minimised through teaching, and is discussed later in the chapter. Instead, individuals with mental health problems could be placed in paid employment opportunities, where they are present in society and challenged accordingly. Support would still be readily available when it is needed, which many participants valued in the current service. The current service is valuable as it helped participants gain many qualifications that are essential requirements for places of employment, as well as other vocational skills. However, following the gain of qualifications and skills, Platts (2003) suggests that individuals with mental health problems would further their recovery more so if placed in employment sectors where their specific skills are needed.

To conclude, participants in this theme were aware of the temporary nature of the current service and raised several dilemmas that the current service could consider. Although they valued the skills and opportunities offered by the service, economic struggles still existed for them outside of the service. This was something not considered by participants in the previous research looked at. This may have been as the current service met many of the requirements previous research has outlined for a service to be valuable. The current service offers opportunities for its members to become the individual they had always wanted to be. Participants described that they were placed into areas that they had genuine interests in. They were able to meet alike people and build authentic and meaningful relationships. They knew support was available when they needed it. Most importantly, they were in a service where they felt wanted and valued each day. However, these experiences

allowed participants the opportunity to find what was missing – uncertainty, economical struggles and the inevitability of leaving the service. These raise several implications for the service, as well as other services that may adopt their approach, and will be discussed in the following sections.

#### 4.4 Limitations of the research

As previously mentioned in Chapter 2, the concept of reflexivity is often an issue in phenomenological research, and plays a part in the current research, as discussed in the methods chapter. In brief terms, reflexivity is the concept that one's thoughts and opinions could cause a bias effect in the research's findings (Finlay, 2008). Tufford and Newman (2010) suggest that this effect can be minimised through epoché, or bracketing. Bracketing involves trying to suspend judgement about the world, to focus on the participant's experiences and the analysis. As discussed in the method chapter, I currently work in an inpatient unit, and have my own opinions and experiences regarding this. However, as I was aware of this, I tried my hardest to ensure my personal experiences of inpatient wards did not affect my analysis of the interviews, through several ways outlined in Chapter 2, including carrying a field diary, reading and rereading transcripts, being open and honest with participants, and attending supervision meetings each month. I feel I was able to bracket my assumptions well, and found that the supervision meetings I had attended offered the most reflection. As my supervisors were aware of my background, they were able to ensure I questioned myself through each stage of the analysis.

However, LeVasseur (2003) argues that the act of bracketing can never be completed fully. She reflects on this idea using phenomenology, in that we are conscious beings, unable to fully bracket our own experiences, let alone our assumptions when looking at participant experiences. The act of bracketing is prevented from the beginning of the research. The participants in my study would have had their own assumptions on the research, as well as about me. This would have affected the way in which they discussed their experiences, shaping them in a way that may have not given the actual experience and their feelings justice. This would mean that the data I had collected was affected before I had carried out my analysis as we are unable to separate our thinking from rest of the world. However, being able to bracket ourselves would cause its own issues. LeVasseur (2003) suggests that if we were able to bracket our assumptions when carrying out analyses, different issues would arise instead;

*'If by bracketing we mean to achieve a pure, reflective attitude, then the world would become our interpretive project and we are then open to accusations of idealism and relativism.'*  
(LeVasseur, 2003, p. 416)

Instead, LeVasseur (2003) suggests we do not attempt to eliminate any assumptions we have but pause them as much as we can whilst carrying out an analysis, in the hope that other perspectives may be able to emerge. Although bracketing can never occur completely, the steps I took minimised the effect my experiences had on the analysis – they allowed my curiosity to emerge instead, which LeVasseur (2003) suggests is the closest and purest form of bracketing that can be carried out.

An additional limitation was that many participants spoke of the service outside of the interview's, when they were not being recorded. Some of these conversations were very relevant but could not be included in the analysis as permission was not given. Instead, the conversations out of the vicinity of the recorder were more critical in comparison to those in the interview rooms, and it seemed that the participants were reluctant to discuss such topics whilst being recorded. This may have been due to their gratitude for what the service had done for them, and they're not wanting to appear ungrateful. In retrospect, I could have considered this prior to carrying out the interviews and thought of prompts and questions to ask in the interviews if these opinions were mentioned prior to recording. I could have also included an item in the consent form signed by participants that gave permission for any discussion outside of the interview room to be included. These may be methods to consider in any future research. As well as this, the chosen method design required only a small number of participants and was specific to a service. This could be argued to allow little transferability to other services, but without a small sample, further depth and exploration of the data would not have been possible (Smith, Flowers and Larkin, 2009).

As a final note, there is a possibility that my presence may have influenced what was disclosed in the interviews. When beginning the research, I felt my position as an outsider of the service was beneficial for the research and would allow for more open discussion in the interviews. However, upon reflection, this may have restricted participants in discussing their experiences. As mentioned, I disclosed what my employment history was, in the hope that this would begin the interviews with a sense of openness. Upon further reflection, this may have also affected what participants chose to discuss in the interviews. They may have felt I had prior assumptions to such services as theirs, and other services under the social enterprise, and chose to discuss items according to what they believed I would value in their interviews. It is difficult to explore whether this was the case, but if I were to have the opportunity to carry out such a piece of research again, I would consider this in my method design. As such, implications for possible further research will be discussed in the following section.

#### 4.5 Conclusion

The current service helped feelings of belonging in their participants by maintaining open and honest relationships when engaging with its members, whilst having an in-depth understanding of mental health problems, and not shying away from discussing them. The service ensured that the



participants and other members were placed in areas of interest to them, which ensured they had likeminded members around them. They were also given the time to discuss what they're individual needs were, whilst many participants found that others in the service were willing to go out of their way to help one another. This learning about the individual also helped participants learn more about the person they were, whilst the service aided them to become a person they felt they ought to have always been. People in the service nurtured the participants learning and development in ways that many described they had not experienced in other services, or in education before. This allowed each participant to discover that they could do much more than they had thought they could in the past and made them feel much more positive about the person they were. By doing so, the service and those in it, improved participants self-worth and confidence, whilst making them feel no longer alone in their struggles or mental health problem. The current research found many similarities to past research looking at supported employment, and the current service appeared to meet a lot of the requirements that participants from other studies noted were important in employment services. However, by doing so, dilemmas arose for some participants around the moment when they would have to leave the safety of the service. Many had had negative experiences outside of the service – their struggle of leaving the service was understandable. This highlights several implications for the current service.

The current service may wish to focus further on the transgression from the service to paid employment opportunities. It may be the case that there is a great deal of focus here already, however members may need to be made more aware regarding the inevitability that they will have to transgress. The current service follows much of the ideas behind the recovery model – motivation, social inclusion – and SRV – being given a valued role – but could offer more knowledge to surrounding employers in the area, in the hope that this would increase awareness of mental health problems, and possibly create more susceptibility to hiring individuals with mental health problems. In addition to this, the current service may wish to examine how those who do leave the service successfully do so, whilst exploring whether those who stay within the service are still receiving the maximum benefit possible for them personally. Nevertheless, the current service has shown the importance of a personal approach to interests of members, which can result in them feeling valued, feeling that they belonged, as well as getting and offering peer support. However, this is not universal, and there are many other forms of supported employment that are available. The current service is unique in the kind of support it provides to its members, in that it provides work experience, vocational skills and qualifications under one service, whereas other services in supported employment may focus on a singular method of supported employment.

Nonetheless, the current research can still offer some suggestions to other services. As noted, the current service is special in the way it approaches employment support for those with mental health problems. Other services looking at supported employment may wish to consider how the current service made their participants feel like they belonged and aided them to become the person they felt they had always been. However, important consideration should be given to potential service users

transgressing into paid employment. This also identifies implications for further research. The current service may find it useful to research how their members successfully transgress from the service, and this may be useful for other services to examine also. A final implication of the current research includes the use of it to educate people working in supported employment and mental health problems. For example, services focusing on the recovery model could be enabled to understand that it is not employment alone that benefits individuals with mental health problems, but it is the presence of a community where an individual has a sense of belonging which enables them to develop to a point where they can leave the community successfully.

Overall, the current research found that offering work experience is not enough for those with mental health problems. Instead, individuals should be placed in a place of interest, whilst utilising the personal benefits employment can give, such as being a part of a service and the relationships within it. Beyond the importance of having an area of interest to work in, it is the sense of belonging and feeling valued that held the most value for the current participants. The current research has also shown that employment gives much more than something to do or a distraction. It gives an individual motivation, value, social inclusion, an identity, and an understanding of who they are. Employment is much more than financial stability and can have a great effect on an individual's mental health. The findings in the current research hopes to aid future services and professionals when considering the relationship between employment and mental health.

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## **Appendices**

### Appendix 1 – Participant information sheet



## **What is it like to be a member of [the service]?**

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### **INFORMATION SHEET**

You are being invited to take part in a research study as you are a member of [the service] organisation. Before you decide whether to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

#### **What is the study about?**

The purpose of this study is to explore the lived experiences of a member using a mental health service.

#### **Why I have been approached?**

You have been asked to participate because you have been a member of the organisation for 1 to 4 years, and have long term experience of the services provided by [the service].

#### **Do I have to take part?**

It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw your information without giving a reason at any time before a pre-stated date, when analysis will begin. A decision to withdraw at any time, or a decision not to take part, will not affect your membership of [the service] in any way. Please note that there is no direct benefit from taking part in the study.

#### **What will I need to do?**

If you agree to take part in the research a topic guide of questions will be sent to you to allow some thinking time before the interview. The interview process will be semi-structured and will last approximately 1 hour. However it may end before or after this time. You are not required to answer all the questions, and do not need to discuss topics which you find uncomfortable.

#### **Will my identity be disclosed?**

All information disclosed within the interview will be kept confidential, except where legal obligations would mean I had to discuss an issue with [manager], e.g. if you indicated that a member of [the service] was at risk of serious harm.

### **What will happen to the information?**

All information collected from you during this research will be kept secure and any identifying material, such as names, will be removed. It is anticipated that the research may, at some point, be published in a journal or report. However, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form.

### **Who can I contact if I have any issues regarding the conduct of the research?**

Any complaints should be directed to the University of Huddersfield's School of Human and Health Sciences Research Ethics Panel (contact details below).

Kirsty Thompson (School Research Ethics Panel Administrator) [hhs\\_srep@hud.ac.uk](mailto:hhs_srep@hud.ac.uk)

### **Who can I contact for further information?**

If you require any further information about the research, please contact me on:

Nisha Chauhan

[N.Chauhan2@hud.ac.uk](mailto:N.Chauhan2@hud.ac.uk)

Or my research supervisor

Dr Dawn Leeming

[d.leeming@hud.ac.uk](mailto:d.leeming@hud.ac.uk)

Alternatively, you can contact your key worker who will in turn contact myself. Please see below for further options.

*Thank you for your time.*

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Please complete the information below if interested, stating whether you wish for further information regarding the study, or would like to volunteer as a participant. This can be handed in to the researcher immediately following the presentation, or posted (stamped and addressed envelopes can be obtained from the [the service] reception).

**Name:**

**Contact details** (*inc. postal address and contact number*):

*Please circle whichever is applicable.*

I would like more information about the study.

**Yes/No**

I would like to volunteer as a participant for the study.

**Yes/No**

## Participant Information Presentation

A phenomenological study of the lived experience of using a mental health employment service.

Nisha Chauhan  
Masters by Research  
u1154182@unimail.hud.ac.uk

### What is the study about?

- The current study aims to explore the lived experiences of members using the mental health employment service, [the service].
- It hopes to gain a greater insight into the experiences of members who have been placed into employment, and the changes they feel have or have not arisen because of the service provided.
- The outcome of the study is to explore whether such a service is impactful – both positively or negatively – to those suffering with mental health, from a members point of view, rather than through statistics. In addition, this may provide further information to other organisations who maybe considering taking a similar approach to mental health.

## Participant Criteria

- You must be a current member of the [the service] organisation.
- You must have been a member for more than a year, up to 4 years.
- Your key worker must agree to your participation, however the researcher shall have final say.
- All ages are welcome, as are all genders and ethnicities. All we require is verbal communication, and the willingness to talk with the researcher.
- You must provide full consent to take part to the study – another individual will not be allowed to provide consent for yourself.
- There are only a limited number of spaces – spaces shall be filled on a ‘first come, first served’ basis.

## What would participation involve?

- If you do decide to volunteer and are successful in the participation process, you will then be asked to attend a recorded semi-structured interview at [the service] house. This will last approximately 1 hour, however you are free to leave at any point if you feel uncomfortable. Breaks will also be provided if wanted.
- The interview will be semi-structured, meaning there will not be required questions to answer. You shall be sent a topic guide before the interview instead, which will identify the areas we shall touch on in the interview. Again, you are not required to answer all the questions asked.
- You will begin with a briefing where a consent form shall be provided and completed. After the interview, a debrief shall be read. You will also be provided with further contact information, in case any issues arise.



## Do I have to take part?

- No – it is your decision whether you choose to take part or not. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw at any time before a pre-stated date, when analysis shall begin, and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you.
- Again, the researcher will make the final decision on who will participate in the study. This is not a reflection of the individual, and as mentioned, an unsuccessful application may be due to the spaces already being filled.

## What will I need to do to volunteer?

There are a number of ways to volunteer, if you choose to do so;

1. You can express your interest after the presentation and I will take your details
2. You can contact [manager] who will in turn contact me. A application form will then be provided
3. You can contact me through email – [u1154182@unimail.hud.ac.uk](mailto:u1154182@unimail.hud.ac.uk). This is also noted on the bottom of the information sheet provided.

It is important to note that only service users who are able to provide their own informed consent and agreement to the research will be considered.

## Will my identity be disclosed?

- All information disclosed within the interview will be kept confidential, except where legal obligations would necessitate disclosure by the researcher to [the manager], unless specified otherwise. This would include any harm or abuse occurring to yourself or another individual, in or out of the organisation.
- Due to the recruiting procedure, full confidentiality cannot be assured, however confidentiality will be maintained as far as possible. Ultimately, staff will not be aware who has participated in the interview process as it will not be made known who will have been successful in the participant selection process. Certain phrases may also be associated to a particular service user, and could enable those who know them to make an “educated guess” about who may have said what. To counter this, participants will be sent transcripts of their interview if they wish, where they will be given the opportunity to withdraw any comments they provided that they no longer wish to share.

## What will happen to the information?

- All information collected from you during this research will be kept secure and any identifying material, such as names will be removed in order to ensure anonymity. It is anticipated that the research may, at some point, be published in a journal or report. However, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form.
- [The service] will also receive an edited report, which you will be able to obtain if you wish. You may also contact the researcher for a full report, which will then be sent to you.
- Information you provide will be securely held for a maximum time of 5 years, after which it will be destroyed.

## Further Information

For further information regarding the research, please contact me by email on;

- [u1154182@unimail.hud.ac.uk](mailto:u1154182@unimail.hud.ac.uk)

In addition, you can contact your key worker who will in turn refer your details to myself, and I shall contact you. More information sheets shall be left at the [the service] reception alongside the volunteer applications.



## Participant Interview Topic Guide

Hello, and thank you for your interest in the current research. The title of the current research is,

*'An interviewed based study of the lived experience of using a mental health employment service.'*

To explore this area, I have listed the topic areas we will touch on in the interview. These have been sent to you to allow you some time to think about the topics, in the hope that the interview process will be as comfortable for you as possible. The topics will include the following;

- How you came to work with [the service]
- What life was like before becoming a member of [the service]
- What influenced your decision to come into this particular sector of [the service]
- What has been your experience of [the service] been like
- Moment's where [the service] has had particular impact on your life experiences (if any)
- Any therapeutic effects that you feel [the service] has had on you as a member
- The general aims and approach of [the service], and what you understand of it • Any topic areas you feel would be beneficial to discuss

You do not have to discuss each topic mentioned, and some may not be relevant to your experiences. Please do not hesitate if you feel you do not want to discuss a particular issue, this will not reflect on the interview at all.

The interview will last approximately an hour; however, you are free to end the interview before this time. I will also allow time for breaks, if you wish to take some time to refresh. The interview will be recorded from beginning to end, not including any breaks. This is so it can be transcribed later. As mentioned in the presentation, you are able to withdraw at any time before the date of analysis. You will also be given the option to have a copy of your transcript sent to you if you wish to review it.

All information provided during the interview will be confidential, within the limits discussed with you in the briefing.

If you have any further questions regarding the research or wish to withdraw any data, please contact me on;

[N.Chauhan2@hud.ac.uk](mailto:N.Chauhan2@hud.ac.uk)  
01484 473545

Alternatively, contact [senior support worker] who will in turn contact me.

Thank you for your time and participation,



## CONSENT FORM

### **Title of Research Project: A study of the lived experience of using a mental health employment service.**

- I have been fully informed of the nature and aims of this research
- I consent to taking part in an audio recorded one to one interview
- I understand I have the right to withdraw my interview data from the research at any time before analysis. This must be before **the end of August**
- I give permission for my words to be quoted in reports of the research (though my real name will not be used)
- I understand that the information collected will be kept in secure conditions for a period of five years at the University of Huddersfield
- I understand that no person other than the researcher/s and facilitator/s will have access to the information provided.
- I understand that my identity will be protected by the use of a made-up name in the report and that no written information that could lead to my being identified will be included in any report.
- I understand that anonymised quotes may be used in future publications of the research.

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact the researcher.

If you are satisfied that you understand the information and are happy to take part in this project, please tick each respective statement (if agreed) and print and sign below. Please ensure you retain a copy for your records.

*Participant Copy*

Signature of Participant:	Signature of Researcher:
Print:	Print:
Date:	Date:

*Researcher Copy*

Signature of Participant:	Signature of Researcher:
Print:	Print:
Date:	Date:



Dear [participant name],

I'd just like to take this opportunity to thank you for participating in my study. I hope that together we can provide further research into employment and mental health, and more services will be available like [the service] all around the UK. I have enjoyed meeting with all of you at [the service] and I hope you have enjoyed the research process so far. I am writing to you to provide an update on my research, and some of the findings I have made thus far.

As you know, employment is vital in the recovery process for people with mental health problems, and [the service] is special in the way it provides support to its members. During the analysis, I have found that [the service] makes many people feel much more confident in themselves, whilst helping them to gain qualifications and skills in their personal fields of interest. I have also found that by doing so [the service] makes its members feel like they belong and that they are ultimately wanted by people in the service. I have also found that because of the level of support [the service] gives, it is sometimes uncertain what will happen if members were to leave the service. nevertheless, from your interviews, it appears that the service is supporting its members in a way that many had not experienced before.

I will be in touch again when I have completed my thesis, and hope to be able to give you a summary of it later. Enclosed is your interview transcript for your records. If you would like any further information about my findings, or the research, please do not hesitate to contact me, using the information provided by me. If you'd prefer, [senior support worker] has kindly offered to pass on any questions to me if there are any.

I wish you the best of luck in your employment journey, and in your mental health.

I hope to see you again very soon.

Best wishes,

Nisha Chauhan

[N.Chauhan2@hud.ac.uk](mailto:N.Chauhan2@hud.ac.uk)

01484 473545

Appendix 6(i) – Coded excerpt from Lewis

- Black writing = exploratory comments

- Red square = emergent themes
- Blue circles = connecting themes

I: Could you start by telling me what life was like before [REDACTED]

P: *Use of language - emphasising lack of quality.*  
 My life weren't that great - it really weren't. Before [REDACTED] I was on drink...

SELF-MEDICATING

everything. I think, a lot of it, I just lost my way. I was drinking 24/7, that's how  
*Self management of depression through alcohol.*  
bad it was.

I: When did you feel like you had to put a stop to this?

BEFORE AND AFTER

Uses 'before' - prior to [REDACTED] was a different Lewis.

P: Before I joined [REDACTED] I didn't think I would want to be here no more. And I

mean that from the bottom of my heart. It was [REDACTED] I appreciate all that he's  
 done for me. And I do anything he says for me to do. And I can't thank him *Grateful - will give anything*

anymore.] I love the garden centre and work up there. [REDACTED] proud of it, and I am  
 too. Everyone's proud of it. *Repetition of proud - sense of self worth at work.*  
*Sense of pride and shared pride -> Collective pride.*

OTHERS PRIDE \*

PRIDE OF WORK \*

I: You should be most proud of yourself.

P: I am. I've gotten help. *Sense of self is strong - proud for getting help*  
 I used to use drink for my depression. I came to [REDACTED]

because I wanted to find work. I've got to be doing something. I can't be sat at  
*Needs to keep busy.*

Appendix 6(ii) – Coded excerpt from Sophie

- Black writing = exploratory comments
- Red square = emergent themes



- Blue circles = connecting themes

I: Did [redacted] support you?

[redacted] were very supportive of her and her mental state.

P: Well, they were the ones who sent me for help a lot of the time. [...] There not voices that I hear, although I told the doctor last time that I did, but I don't. I see things, but I suppose I thought that was the same thing.

GOOD RELATIONSHIPS

I: Do you think you have schizophrenia?

Aware of her diagnosis

P: I do, but I wish didn't. it means I never achieve my goals, like coming here today, I feel like I fall flat, I thought I'd be able to help you more.

LOW SELF-WORTH

Low self confidence - build up of school, symptoms, relations.

I: You are, there are no right or wrong answers Sophie. It's about your experiences in life and in employment – whatever you think is relevant to talk about is right.

Seems to be constant worry in her life.

P: Okay, thank you, if you're sure I'm just worried. At [redacted] we had meetings with the managers, who were my friends and everything, and they asked if I wanted to stay, because they wanted me to after I got better, but I didn't want to because of him, so I left. They said it was entirely up to me, they did a lot with me and for

Was a work-force based decision.

SELF DOUBT

More than colleagues - friends and positive relationships.

POSITIVE WORKING RELATIONSHIP

<i>Preliminary Superordinate Themes</i>	<i>Preliminary Subordinate Themes</i>	<i>Evidence in Quotes</i>	<i>Final Superordinate Themes</i>	<i>Final Subordinate Themes</i>
Feeling valued through a person-centred support	Experiencing person-centred learning and development opportunities  Becoming a better person	Ella 16-19;164-168 Ruth 29-32 Robin 60-63  John 56-63 Claire 18-30 Lewis 31-36	Becoming	Participating in the service makes me now feel more positive about myself  Becoming who I ought to be
Comparing past and present support	Then and now  Previous services (move to third theme?)  What about my future?	Lewis 41-44 Claire 46-47  Kate 42-45 Alice 25-27  Alice 40-42 Sophie 20-22	Only part of reality	I still have bills to pay  An uncertainty for the future  I am safer in the service than in reality
Social inclusion with like-minded people	Being wanted      Real friends	Ruth 88-90 Alice 76-78 Robin 110-113    Tom 187-189 John 68-69 Claire 117-119 Jane 46-48	Belonging	Being with people like me  Building authentic relationships  A service who wants me here

Appendix 8 – Risk Management

<b>Hazards Identified</b>	<b>Details of Risks</b>	<b>People at Risk</b>	<b>Risk Management Measures</b>
Interviewing service users in a designated room as a lone worker	Personal safety	Researcher	<p>Interview will take place in a room at a service location with staff on hand to offer support if any difficulties arise.</p> <p>The organization’s manager will be made aware when an interview will be beginning and when it has been completed.</p> <p>Address will be provided to the above regarding whereabouts at all time during the data collection process.</p>
Loss or theft of data	Security of data	Interviewees	<p>All electronic data will be stored in a password protected laptop.</p> <p>Data will be backed up to the university drive with password protection.</p> <p>Dictaphones carrying data will be carried in a locked case.</p>
Equipment and manual handling	Personal Wellbeing	Researcher	Carrying equipment used during interviews. Will maintain personal well-being throughout.

			Will use a well-structured chair whilst sat in good posture. Will take hourly breaks when using monitor for extended periods of time.
Transcribing and typing on monitor	Personal Wellbeing	Researcher	Will move from monitor hourly, for ten minutes at a time to prevent strains.
Slips, trips and falls	Cobbled streets to [the service] house. Stairs leading up to interview area. Travelling by public transport to carry out interviews in [service location].		Will take extra care when travelling to and from [service location]. Suitable shoes will be worn at all times, whilst taking extra care in surrounding areas.  Will review surroundings before moving off each visit.