AN EVALUATION OF AN EMPLOYMENT PROJECT FOR MENTALLY ILL PEOPLE

Allyson McCollam

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Name of Candidate Allyson McCollam

Address [redacted]

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This thesis is concerned with the rehabilitation and employment of mentally ill people. It focusses on a Community Programme which offers a year's employment to people with a mental illness. Fifty-three people recruited to the Sprout project were interviewed at various stages during their career on the project. The study sets out to evaluate the project's impact on participants, both during their employment there and subsequently. Participants' views on employment in general and on Sprout were obtained, along with details of their employment and psychiatric histories and of their social circumstances.

At a time of high general unemployment, there is much debate about the emphasis work should be given in rehabilitation. In the thesis, I rehearse some of the arguments and counterarguments and consider what light the views of service-users can throw on the issue. It emerges that many mentally ill people believe that they benefit from being in work. They want to work and, given a supportive setting, are capable of doing so. However, there were few opportunities for those leaving Sprout to take up either sheltered or open employment elsewhere.

The outcomes for Sprout participants were highly diverse and it seems imperative that such diversity should be reflected in a range of provision which catered for variations in ability and interest. To polarise discussion and debate whether or not work has a place in rehabilitation seems unhelpful.

The project had, on the whole, disappointingly little long-term effect on the abilities and quality of life of participants. However, when viewed in the context of other research findings, these results are not surprising as rehabilitation rarely succeeds in bringing about lasting improvements in ability. Moreover, it was evident that Sprout participants often faced substantial difficulties in their lives outside work and yet received little or no support from health or welfare services. This may have affected outcome.

The thesis points up deficiencies in current services for mentally ill people and suggests ways in which the employment opportunities of this group might be enhanced. It is insufficient to look only at the employability of the individuals concerned, without also considering the wider social factors which influence access to and retention of employment.

DECLARATION

I declare that this thesis has been composed by myself and is all my own work.

signed :

Allyson A McCollam

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CHAPTER 1

INTRODUCTION

The Sprout Market Garden project was set up in Edinburgh in January 1983 by the Scottish Association for Mental Health. SAMH, a voluntary agency concerned with mental health services in Scotland, was acutely aware of the employment problems mentally ill people faced, particularly at a time of high unemployment, and of the difficulties they experienced adapting to life in the community. The Association availed itself of funding from the Manpower Services Commission (MSC) to establish the Sprout project as part of the Community Enterprise Programme which has since become the Community Programme (CP). Sprout offers a year's paid employment in horticulture to mentally ill people. Work in a semi-sheltered environment is used as a medium for rehabilitation with the objectives of '(re)-introducing participants to the disciplines of work and of developing their ability to cope with their lives in the community' (SAMH, 1984). At the time this study was undertaken, the project could employ 25 participants at a time for a maximum of 12 months. The target group were individuals who had had a mental illness and had experienced employment difficulties. Most participants had spent some time in a psychiatric hospital although only a minority were hospital residents when they joined the project.

The establishment of Sprout marked a new departure for SAMH which had until then not been directly involved in service provision. Moreover, Sprout was an experimental project, designed to explore the value to mentally ill people of a year in rehabilitation. The Association was therefore eager that the project should be evaluated. Funding was obtained from the Mental Health Foundation for a pilot

study and this was carried out in 1984 by a social worker, Jill Prentice, under the auspices of Edinburgh University's Department of Social Administration. So that a more extensive evaluation of the project could be undertaken a research proposal was submitted to the Economic and Social Research Council for a PhD studentship under the CASS scheme. Collaborative Awards in the Social Sciences (CASS awards) were designed to foster research collaboration between academic institutions and public and private sector organisations. The proposal was approved and I took up the award in October 1984. My research was also supervised by staff in the Department of Social Administration. At the same time I enjoyed regular contact with SAMH, mainly through the Director. Access to information and staff was available from the outset, which enabled me to embark promptly on fieldwork.

There are 3 main fields of interest in the Sprout study: mental illness, rehabilitation and employment. I shall discuss rehabilitation and employment in later chapters in detail. At this juncture, by way of introduction, I wish to consider the nature of mental illness and the effects it has on individuals. I shall then go on to describe mental health services in Scotland. The chapter concludes with an outline of the organisation and contents of the thesis. For reasons of space, this chapter has been deliberately kept brief.

The Nature of Mental Illness

The nature of mental illness and its possible causes have generated much debate. Current writing on the subject indicates that there is little consensus about what the term mental illness denotes and that our understanding of the phenomenon is still only partial

(Wing, 1978b; Clare, 1980; Busfield, 1986). Furthermore, definitions of mental health and illness are constantly shifting:

> Whether a particular deviation is classified as illness in a society largely depends on its being seen by people as a deviation from health, and as such in the domain of expert healers, and on their acceptance of it as belonging in their province. (Miles, 1981, p.4)

As scientific knowledge advances, the possibility develops of treating conditions which were not previously treatable and therefore not necessarily regarded as illness (DHSS, 1975). The fact that society's concept of mental illness undergoes continual redefinition and is therefore relative has led some people, such as Szasz, to question the very existence of the phenomenon. He argues that concepts of mental health and illness are value-laden and that it is spurious to regard psychiatry as objective and scientific. Szasz maintains that mental illness is essentially a metaphor for what he calls 'problems of living' and that only those forms of human suffering which can be shown unequivocally to be caused by biological factors (such as lesions or infections) should be construed as illness (Szasz, 1987).

However, Roth and Kroll (1986) contend that all societies throughout the ages have recognised the existence of insanity or mental illness among some of their members and have distinguished these conditions from others, such as criminality or feeble-mindedness. Moreover, indigenous descriptions of mental illness within disparate cultures contain remarkable similarities and have basic elements in common. A further weakness of Szasz's argument is that it is premised on an outdated distinction between mind and body. This overlooks 3 important facts: firstly, many physical illnesses are affected by mental states; secondly, there is an important

social component in physical illness; thirdly, definitions of physical illnesses are not fixed and absolute (Clare, 1980).

How, then, can mental illness be recognised? Physical illness is often manifested as some alteration in functioning, such as pain or vomiting. Roth and Kroll (1986) suggest that mental illness is manifested as abnormal psychological functioning. That is not to deny that there are considerable difficulties in judging what qualifies as 'normal' psychological functioning and it is important therefore that behaviour should be assessed in its social context. Roth and Kroll describe the form which deviations from 'normal' adaptive functioning might take as follows:

> Those persons whose characteristic patterns of thought and behaviour are transformed in a manner that renders them unable to communicate or to maintain the emotional control needed for their peace of mind and safety and for sustaining the interpersonal relationships and social endeavours on which their survival as independent individuals depends can usually be said to have an illness. (Roth and Kroll, 1986, p.70)

Thus, dysfunction and distress are the criteria of mental illness. The severity of disturbance can vary greatly and a major difficulty has been to discern where the dividing line should be drawn between 'emotional difficulties' or 'responses to stress' and full-blown 'mental illness', or whether indeed it is possible to do so. It is perhaps most helpful to envisage a continuum stretching from 'normality' at one extreme to 'mental illness' at the other, with a grey area between the 2 in which most people would be situated (Clare, 1980).

Competing interpretations of mental illness have tended to emphasise different causal explanations: for example, labelling theorists have stressed the importance of societal reactions to deviants, while others have focussed on life stresses. Increasingly,

however, it has become recognised that the causes of mental illness are multiple and complex, involving genetic, biochemical and familial and social factors. The importance of each set of factors varies according to the nature of the disorder and the personality and circumstances of the sufferer.

Mental illness manifests itself in many different ways. Classification of the various disorders is difficult in view of the overlap between categories. Clinical diagnosis of itself gives little indication of the severity of symptoms or impairment, as this varies considerably from one person to another. In the following paragraphs I use the framework employed in the 1975 White Paper for England and Wales, 'Better Services for the Mentally Ill' (DHSS, 1975). This document is concerned, as we are in this study, with the effects of mental illness and ways of minimising them and puts forward a working definition of mental illness rather than entering deeply into the philosophical debate.

The main distinction generally made is between psychotic and neurotic disorders. Psychotic disorders include schizophrenia, manic depression and some other forms of depression which are apparently not precipitated by a change in circumstance alone. People suffering from a psychotic disorder tend to have a distorted view of the world and to lose their awareness of reality. The patterns of behaviour associated with psychosis generally entail a significant departure from what is seen as 'normal' behaviour.

Neurotic disorders include anxiety states, phobias and depression. Sufferers do not lose contact with their surroundings. Rather, the various disorders manifest themselves as exaggerations of normal behaviour patterns and may be viewed as reactions to real or imagined stress.

The neurosis/psychosis dichotomy excludes 2 other sets of disorders which should be mentioned here. It is debatable whether personality disorders are illnesses and many psychiatrists believe they are not susceptible to treatment (McNeill, in Drucker, 1987, Vol.1). People said to have a disordered personality often have difficulty adapting to society and adjusting to prevailing social norms. The final category encompasses alcohol and drug addiction. While dependence on either substance does not necessarily constitute mental illness, it may give rise to or be accompanied by mental illness. The responsibility for treating alcohol or drug-dependence tends nowadays to be ascribed to psychiatric services. This, then, is an example of a deviation which has come to be seen as a deviation from a health norm and therefore belonging in the province of expert healers - psychiatrists.

As we shall see, many of the Sprout sample reported they had been given one of the diagnoses discussed here. We turn now to consider how mental illness may affect sufferers. In ensuing discussions I shall employ 'mental illness' as a shorthand term to denote the range of different disorders.

Mental illness alters the lives of sufferers in 2 different ways. Firstly, it can impair a person's ability to function and, secondly, it is likely to influence the reaction and attitudes of others to him/her. The 1975 White Paper enumerates the far-reaching and debilitating effects of mental illness as follows:

> The sufferer may lack his former energy and drive, and have difficulty in making or resuming personal friendships or family relationships. He may have lost the power of sustained concentration, and the ability to organise even relatively simple daily routines may have to be relearnt. If he is to resume his place in a busy competitive society he will need help in regaining social skills. (DHSS, 1975, para.1.25)

In a subsequent paragraph, the authors note that someone's ability to meet the demands of employment may also be affected.

Importantly, the disruption occasioned by illness is often long-term and likely to persist after primary symptoms have been treated. It is necessary to exercise caution, however, and avoid generalised statements about 'the needs of the mentally ill'. Not only does illness manifest itself in different ways in different individuals, the form it takes and its effects are influenced by the individual's social environment. This is a central tenet of rehabilitation theory and is supported by the findings of the Sprout study.

Mental illness also affects sufferers indirectly by colouring the attitudes of others. Many have argued that, unlike physical illness, mental illness has a distinct, negative public image. It is generally believed that mental illness has a poor prognosis and enduring effects. Sufferers are seen as 'undesirably different' and are consequently stigmatised (Goffman, 1963; Miles, 1981; Baruch, in Reed and Lomas, 1984). Preconceived ideas and prejudices can restrict the types of opportunities to which mentally ill people have access: people in the Sprout study often believed they had been discriminated against in the employment sphere because of their illness.

As I shall elaborate in the thesis, rehabilitation sets out to mitigate the effects of mental illness by acting on the 2 sets of factors, the individual and the social.

We now move on to consider the nature of psychiatric services in Scotland.

Mental Health Services in Scotland

Scottish mental health services have certain characteristics which repay our attention here:

(1) services are heavily concentrated in the hospital sector;
(2) community based services are underdeveloped;
(3) policy seems ambivalent.

1. Historically, Scotland has tended to rely on institutional care for vulnerable or dependent groups (Checkland, 1980) and this is still the case as far as the care of mentally ill people is concerned.

The number of residents of all ages in Scottish psychiatric hospitals and units fell steadily from 19,800 in 1965 to 15,500 in 1984. Over the same period, however, admission rates rose from 19,800 to 26,700 per annum. The functions of in-patient services have altered over time and patients often now spend relatively brief periods in hospital: half of those admitted in 1984 were discharged within one month, 90% within 6 months. A considerable proportion - two-thirds - of those admitted each year have previously been in-patients at least once (Information Services Division, 1986). These changes in usage of hospital services have implications for rehabilitation, as we shall see. Despite changes, the hospital sector continues to play a central role in mental health care.

Most specialist staff are located in hospitals. Dick, a leading psychiatrist in England, has estimated that 95% of all psychiatrically trained staff work inside hospitals, while only 5% of those identified as mentally ill are to be found there (in Reed and Lomas, 1984). A recent review of staffing in Scottish psychiatric services arrived at a similar conclusion (Pollock, in Drucker, 1987, Vol.1). To take nurses as an example: in 1984, there were 5,372 qualified psychiatric nurses in Scottish psychiatric hospitals

(Information Services Division, 1986) compared with only 181 community psychiatric nurses (McKay, 1985a).

In-patient services absorb the lion's share of the hospital budget. In 1983/84, 96% of the running costs were devoted to in-patient services and only 4% to out-patients and day-patients (SHHD, 1984).

At a time when many other Western countries are running down and even closing psychiatric hospitals, in-patient services remain the fulcrum of Scottish mental health care. In 1980 twice as many people (proportionate to the size of the population) were in psychiatric hospitals in Scotland as in England (Southampton Psychiatric Case Register, 1983). There is little epidemiological evidence to suggest that the Scottish reliance on hospital care reflects a higher incidence of mental illness (op.cit.).

2. The other striking feature is the dearth of community provision. Day care services are considered later in the thesis - let us take accommodation as an illustration here. Figures published by the Social Work Services Group (Scottish Education Department, 1986(b)) indicate that in 1985 there were 181 places in local authority homes for mentally ill people, 57 places in homes registered with local authorities (mainly voluntary) and 347 places in homes 'known to' local authorities: a total of 585 places. There are, however, several question marks hanging over these figures: reliable information is not available for all areas and information on facilities provided by health and housing authorities is not systematically included (Cunningham, in Drucker, 1987, Vol.1). More importantly, perhaps, the figures make no distinction between staffed and unstaffed accommodation. An independent analysis of provision by SAMH estimated there were 270 places in supported accommodation -

either with resident staff, or visiting support staff (op.cit.). What is clear is that provision is far from adequate. A recent review of adult mental health services in Scotland, 'Mental Health in Focus', estimated that 1,700 places might be needed (SHHD, 1985).

Expenditure on community provision is negligible compared to the sums spent on the hospital sector. Compared with the £153m devoted to running psychiatric hospitals in 1984, Drucker (1986) has estimated that local authorities spent £1m at the most on specialist non-hospital services - it is perhaps telling that no official figures are available.

The corollary is that hospitals often offer the only source of care or support. People remain in hospital because no alternative exists: McCreadie et al. suggested in a Scottish survey of in-patients who had been in hospital more than one but less than 6 years, that many hospital residents need not be there. According to the staff responsible for these patients' care, more than a third could have been discharged, given appropriate facilities, such as staffed hostels (McCreadie et al. 1983).

I noted earlier that many people now have several brief admissions to hospitals. Between admissions this group is likely to be unsupported. Thus the failure of local authority social work departments to create adequate community services tends to perpetuate and justify the reliance on hospitals. Doctors are understandably reluctant to discharge patients or to defer admission if the only alternative is neglect. The effectiveness of community services which do exist is also likely to be limited precisely because they are in such short supply. As we shall see, the impact of the Sprout project seemed restricted by the dearth of welfare and health

facilities offering participants the help they needed in other spheres of their lives, beyond work.

3. A variety of reasons have been adduced to 'explain' why services in Scotland have not moved into the community (Martin, 1984; Hunter and Wistow, 1987). However, the ambivalence which prevails in mental health policy seems particularly important. Policy affirmations have a limited effect on practice. In 1980, the Scottish Health Services Planning Council published a document which set priorities in health care. The 'Shape' report recognised the mentally ill as one of 8 priority groups (examples of others were the elderly and the mentally handicapped) and advocated the development of community services. While, as Hunter (in Drucker, 1987, Vol.1) observes, work has gone in to planning a reorientation of mental health services,

> there is a vacuum when it comes to securing a sustained commitment to ensure that planning has an impact upon practice.
> (op.cit. p.116)

At the crux of the matter is the future role of psychiatric hospitals. On this issue, current policy seems especially confused, seeking on the one hand to maintain the existing hospital sector and on the other to develop alternative provision for those in the community to avoid admission. 'Mental Health in Focus' adds little clarification, noting that

> psychiatric hospitals ... will continue to play a major role in the future, complementing and supporting a community-based pattern of care.
> (SHHD, 1985, para.9.13)

No indication is given of how hospitals can play major and supporting roles simultaneously (Drucker, 1986). Despite the assertion in 'Shape' that the main policy objective is to work towards a community based service for mental illness (SHHD, 1980, para.II.65), it is perhaps telling that Grampian Health Board was recently given SHHD

approval to develop a new 700 bed psychiatric hospital, at a cost of £16m.

Recent years have seen the creation of various community-based facilities - offering services such as counselling, accommodation and occupation. Most of these projects have been small-scale and scattered, however, so that provision outside hospital remains patchy. Many of them are in the voluntary sector, financed by the Manpower Services Commission or the DHSS. The MSC's involvement can have far-reaching implications affecting the structure and operation of individual projects (Maguire, 1986) as will become evident in this study. Mainly for financial reasons, social work departments remain on the periphery (Hunter, in Drucker, 1987). SAMH has long advocated the build-up of community provision. The establishment of Sprout marked the beginnings of a nationwide effort to fill one gap in services. By mid-1987, there were 10 employment projects like Sprout sponsored by SAMH across Scotland. It seems all the more important therefore to evaluate what projects of this nature can achieve.

Organisation of the Thesis

Chapter 2 discusses the theory of psychiatric rehabilitation and considers how this differs from rehabilitation in physical medicine and from psychiatric treatment. It is suggested that the principles of normalisation provide a basis for assessing policy and services for mentally ill people in terms of the latter's social status and overall well-being.

Over the years the importance of work in rehabilitation has waxed and waned and this continues to be debated, especially in the face of a high rate of unemployment. The arguments are presented and some alternatives to work considered. I conclude the chapter by

reviewing several studies which have a direct bearing on the Sprout study, indicating what can and cannot be achieved in rehabilitation and what factors might predict outcome.

In Chapter 3, I move on to look at policy and practice relating to employment rehabilitation services for mentally ill people. The different components of the current service are described and their suitability for mentally ill people assessed in the light of various other studies. Only at this juncture are the origins and the structure of the Sprout project presented in some detail, as it seemed important to set the project in its historical and organisational context. In the same section, I elaborate on what was known about the project's effectiveness from 2 sources - the pilot study and an MSC evaluation - before this study began.

Chapter 4 is concerned with methodology and begins by considering critically some of the 'traditional' outcome measures used in rehabilitation. I argue that indices such as hospitalisation rates and employment status are not sufficient and suggest they might be supplemented by 'quality of life' measures which tap the views of consumers on the project. In addition to looking at 'outcome' it also seems necessary to consider participants' experiences on the project. I then describe the original research plan and how and why this was modified as the study progressed. Finally, details are given of the methods and timetable of data collection. Suffice it to say here that the study follows a longitudinal design.

Chapter 5 describes the total sample in terms of demographic background, psychiatric and employment histories and considers participants' reasons for joining Sprout. The total sample is then divided into 2 groups: completers who stayed the year and non-

completers who dropped out. Chapter 6 considers retrospectively the extent to which the 2 groups differed at point of entry to Sprout.

Chapters 7-10 follow the completers. Chapter 7 looks firstly at their experiences on the Sprout project, Chapter 8 at ways in which their social and personal circumstances altered over time. In Chapter 9 individual outcomes for completers at the end of their year's employment are discussed and it becomes evident that completers included at least 2 sub-groups. In Chapter 10, completers' situations 3 months after leaving Sprout are described.

In Chapter 11 we return to those who dropped out. Their reasons for leaving Sprout are discussed and their subsequent experiences compared with those of completers. There was also considerable variation in outcome among non-completers and 2 separate groups are identified.

Chapters 5-11 follow the chronological pattern of the research interviews. Interviews with completers and non-completers took place on different time scales and although they often covered similar topics, data was collected at different stages in the career of the 2 groups. It was not strictly speaking a matter of comparing like with like therefore and the chronology of interviews has been observed in the text and common themes are pursued through several chapters.

The final chapter draws together the main findings and discusses some of their implications for policy and practice, looking in particular at the matter of selection, at the suitability of community programmes for rehabilitative purposes and at gaps in provision for mentally ill people.

CHAPTER 2

REHABILITATION

The Principles of Psychiatric Rehabilitation

> Much of what passes as psychiatric rehabilitation betrays little understanding of the processes involved and frequently amounts to misdirected effort. (Watts and Bennett, 1983, p.3)

That these words appear in the opening paragraph of a recent book on psychiatric rehabilitation suggests something of the confusion which surrounds the concept of rehabilitation despite the frequent usage of the term in the field of mental health. Thus, in a study of day care services for the mentally ill, Carter (1981) observed that 'rehabilitation' was used variously to denote: an individual's return to normality; return to work or the community; treatment; discharge from treatment; the continuing care of chronic patients and a process of personal growth. Since 'rehabilitation through employment' is the broad objective of the Sprout project, it is important to consider what the concept of rehabilitation means. In the discussion which follows I shall look firstly at the concept of rehabilitation and then consider the place of work within it. The chapter will conclude with a review of some of the relevant research.

While the locus and nature and treatments for people with serious mental illnesses have altered over the last 30 years, the social and occupational disabilities of the mentally ill remain relatively unchanged (Wing, 1982). Wing has identified 3 components of psychiatric disability:

(1) intrinsic impairments or primary disabilities which are symptoms of illness, for example, slowness in people with schizophrenia;
(2) extrinsic social disadvantage or secondary disabilities, such as poverty, unemployment or homelessness;
(3) adverse personal reactions to impairment and disadvantage or tertiary disabilities, such as low self-esteem or withdrawal from the outside world.
(in Wing and Morris, 1981)

Many of the disabilities formerly thought to be a result of prolonged institutionalisation may be - as far as schizophrenic illnesses are concerned - integral features of the disease process itself (Johnstone et al. 1981). There still exists therefore a group of individuals who have substantial secondary and tertiary disabilities related to social functioning, despite advances in treatment. These may exacerbate any primary disabilities which are a direct consequence of illness. The pattern of disabilities is unique for each individual and an understanding of the nature of a person's difficulties is an important aid in planning a rehabilitative programme.

Bennett has pointed out that physical disability entails impairment in the performance of specific functions, for example, movement, whereas psychiatric disability bears more fundamentally on an individual's capacity to occupy normal social roles (Bennett, 1978). Thus rehabilitation in physical medicine is concerned with the adaptation of the physical environment, while psychiatric rehabilitation is concerned with aspects of the social environment which affect a person's capacity to function. Watts and Bennett state:

> the essential starting point for a proper understanding of rehabilitation is that it is concerned with the individual person in the context of the environment.
> (Watts and Bennett, 1983, p.3)

In psychology there has been a move away from a conceptualisation of human personality as an aggregate of fixed traits to one which acknowledges that human behaviour is affected by situational variables (Mischel, 1968). How people react in specific situations is a result of the interaction between environmental factors and personal factors. In a discussion of the sources of stress, Mechanic (1970) suggests that variations in performance can be understood in terms of 2 sets of personal and environmental factors, shown below.

TABLE 2.1 Factors which Affect the Individual's Reaction to Challenge

PERSONAL FACTORS		ENVIRONMENTAL FACTORS
Instrumental (Can A do X?)	→ CAPACITY ←	Preparatory Institutions (which teach how to do X)
Motivational (Does A want to do X?)	→ MOTIVATION ←	Reward Systems (which offer incentives)
Psychic Defences and Levels of Confidence (Can A handle his state of arousal?)	→ SOCIO-EMOTIONAL STATE ←	Support Systems (which help A handle his state of arousal)

Adapted from Mechanic, 1970.

The interaction of these 6 factors varies, giving different degrees of 'fit' between the person and the environment (Caplan, in Cooper, 1983). Rehabilitation can be seen as an attempt to achieve an optimum mutual accommodation between a mentally ill person and his environment. Watts and Bennett (1983) note that rehabilitation has tended to concentrate on one particular type of patient (such as schizophrenics) in one particular setting (long-stay mental hospitals). The person/environment model has the advantage of being applicable to a wide range of settings and client groups. The location of mentally ill people - in hospital or in the community - is of less concern than the level of functioning they can attain in that location. This model also allows for the fact that intervention may have to focus on environmental factors and not solely on the individual. This is significant since some critics, such as Scull (1981), have argued that the beneficent facade of rehabilitation conceals aspirations to impose social conformity and control deviants.

It seems important that mentally ill people and staff involved in rehabilitation have realistic expectations of what can be achieved. In its literal sense, 'rehabilitation' means a **re**storation of functioning, a **re**instatement to some previous status. However, for many mentally ill people, the restoration of premorbid levels of functioning may not be feasible, or sufficient. In some cases the optimum target is the maintenance of current performance and the prevention of further deterioration (Bennett, in Wing, 1978a). Staff may find this difficult to accept since they cannot necessarily see what they are achieving. Moreover, they must temper their efforts to encourage patients with realism. Nor is it always appropriate to talk of rehabilitation as preparation for 'life after mental

illness'. Many mental disorders are recurring and leave people with residual disabilities; in such instances, rehabilitation can denote the process of adjusting to 'life with mental illness'. However, as Shepherd notes, the quality and status of services for those with long-term needs have tended to suffer, possibly as a consequence of medicine's preoccupation with treatment and cure (Shepherd, 1984).

The promotion of individual autonomy is a recurrent theme in the literature on rehabilitation. Self-determination is valued partly on humanitarian grounds; it is also in accord with the prevailing social climate which encourages individual initiative and effort (Mendel and Allen, in Stein and Test, 1975). Nonetheless, there is a danger that this might lead to the denigration of those **not** able to be independent. Shepherd (1984) argues that some people may need long-term support to live to their full capacity and that it is not helpful to talk of 'dependence' versus 'independence': appropriate dependence is a more useful concept. Indeed to withhold such support would only increase the constraints which curtail the disabled person's autonomy.

The relationship between psychiatric rehabilitation and treatment merits discussion here, since it has implications for the nature and organisation of services (as we shall see in Chapter 3). It is not simply a matter of conceptual tidiness to wish to distinguish between a 'medical model' which treats a sick person and an 'impaired model' which rehabilitates a disabled person. Each has different implications for the role of the person involved and for the aims of intervention (Siegler and Osmond, 1974). Robinson (1972) has argued that, in the case of drug addicts and problem drinkers, recourse to the sick role and abnegation of responsibility for

outcome is not constructive. Similar conclusions could be drawn in relation to those with a mental illness, who retain long-term disabilities despite treatment. Moreover, motivation has an important influence on the outcome of rehabilitation for the mentally ill (see below) and this would suggest that the individual should be encouraged to assume some responsibility for progress.

Psychiatry allegedly borrowed the term 'rehabilitation' from the field of physical medicine. It was used to denote those activities which were applied after medical measures had achieved all that was possible (Rapoport, 1960). There was thus a temporal and substantive distinction between treatment, which sought to alleviate symptoms with drugs and other physical methods, and rehabilitation, which aimed to help someone resume normal social functioning. This distinction remained clear whilst psychiatry operated on an 'organic model' which stressed a physical basis for mental illness, to the exclusion of other factors (Clare, 1980) and restricted its treatment to physical measures such as ECT and drugs. With the increasing use of other approaches to mental illness - psychotherapeutic and behavioural approaches are 2 examples - and the growing recognition of the importance of social factors in the course of mental illness, the focus of treatment and the range of techniques used widened considerably. The psychiatric armoury has now been augmented by a panoply of social methods - therapeutic communities, individual and group therapy, behavioural techniques - in which the identified patient is not the individual, but the individual in the social environment.

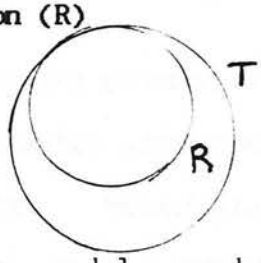
It is evident therefore that treatment and rehabilitation overlap substantially. One way of distinguishing between the 2, however, is in terms of their immediate aims:

> Treatment means all those measures by any legitimate personnel ... that have as their principal immediate aim the alteration of the individual personality towards better intra-psychic integration. Rehabilitation on the other hand means those measures that have as their immediate aim the fitting of a particular personality to the demands of an on-going social process.
> (Rapoport, 1960, p.36)

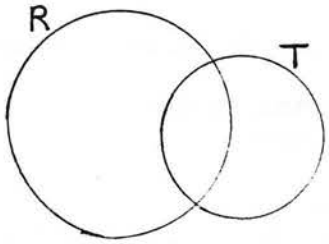
This highlights the tendency for treatment to concentrate on intrapersonal factors and for rehabilitation to focus on interpersonal and social factors, although, in view of earlier discussion, we might also want to include measures to modify the 'ongoing social process'.

The relationship between treatment and rehabilitation can vary greatly depending on temporal sequence and service patterns. Thorley (in Watts and Bennett, 1983) has depicted this relationship diagramatically. The traditional psychiatric model could be described thus:

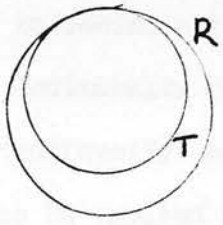
FIGURE 2.1 The Relationship between Treatment (T) and Rehabilitation (R)



Here a medical treatment model predominates and encloses rehabilitative endeavours as an integral part of the treatment process. This is particularly apposite when illness is short-term. Alternative models might be:



OR



These are more appropriate when illness is longer-term and not necessarily treatable and when chronic disability is present. In such instances the orientation is less towards symptoms which may be ineradicable and more towards disabilities which may be counteracted or compensated for (Watts and Bennett, 1983).

There are perhaps some parallels with the treatment of terminally ill people. When it is clear that treatment is no longer useful, the hospice movement advocates that the patient should be enabled as far as possible to resume responsibility for his/her own life and give up the sick role. Efforts to treat pathology and to cure are superceded by efforts to control symptoms and to care (Saunders, 1978).

Normalisation

So far I have argued that the process of rehabilitation may act upon both the individual and his/her environment in order to maximise the person's functional ability. Rehabilitation is also concerned with the status of disabled persons and aims to enhance their social value. In this context we need to consider the concept of normalisation.

The principle of normalisation was formulated by professionals in Scandinavia working in the field of mental handicap. It can be used to gauge patterns of service delivery, but also has a wider

application in relation to social attitudes and opportunities. The basic principle is that 'culturally normative means' should be used to elicit and maintain 'culturally normative behaviour' (Grunewald, 1977). Normalisation can be applied at different levels: physical normalisation denotes the location of disabled people in the community; functional normalisation denotes the use of community services and facilities, not specialist services; and finally social normalisation refers to social involvement and integration. At present, Barham argues, although the majority of mentally ill people live outside hospitals, in 'the community', they are separated by a moral distance from the rest of society (Barham, 1984). By stressing the common human experiences and characteristics of mentally ill people and playing down their abnormal experiences and characteristics, normalisation might result in a fuller recognition of mentally ill people as social agents and in their moral assimilation into 'the community'. The practical implications of normalisation for mental health services have been spelt out by O'Brien (1983). He asserts that 'traditional' patterns of provision have only reinforced the socially devalued position of mentally ill people and have failed to enhance their quality of life. To remedy this, he proposes that services should be founded on a set of principles embodying the rights of mentally ill people to enjoy the fullest possible participation in community life. Services should be offered in the natural setting where those concerned live and spend their time, and should accord with the preferences and needs of individual users. Services should be age appropriate and should follow the 'normal' routines of the day, week and year.

The aims of normalisation are twofold - to enhance both 'personal competencies' and 'social images' at levels of increasing generalisation, from the individual and his/her primary social system to societal systems and institutions (Wolfensberger and Thomas, in Lishman, 1981). Normalisation does not preclude some special treatment or priority attention because of need: for example, a mentally ill person may require special support to be able to live outside hospital. However, this can be stigmatising and can set users of special services apart. The use of special services should be minimised (Braisby, 1983) and it is thus important to ensure that such services are presented favourably to the public and the buildings used and language employed to describe services should convey a positive image of users. In addition, it is important that special services should treat users with dignity and respect (Waddle, 1987). Other conflicts may arise - as at Sprout - between the wish to treat participants as 'ordinary' and the recognition that extra support and guidance may be needed. Again the crucial issue is the manner in which extra support is provided.

Normalisation focuses on the effects of mental illness, particularly on the social devaluation of the mentally ill, and is not concerned with causation. The concept has sometimes been misunderstood: it does not mean treating people as if they were not disabled; it does not advocate pursuing integration as a goal without the necessary support services (Waddle, op.cit.); it does not assume that all 'culturally normative' practices are intrinsically desirable. This is an issue which arises later in the thesis, with reference to the employment of people leaving Sprout.

The attraction of normalisation is that it sets standards against which the operation of social systems and agencies can be adjudged. To date, rehabilitation services for the mentally ill have tended to concentrate almost exclusively on the individual to the neglect of broader social factors. Normalisation, if critically applied at differing levels of generality, can supply a useful means of broadening the perspective and of analysing how social systems and attitudes contribute to the devaluation of the mentally ill. At the same time it may also raise questions about the worth of certain culturally normative practices which seem to threaten rather than enhance individual well-being.

The Place of Work in Rehabilitation

Rehabilitation programmes for mentally ill people can include a whole range of activities, such as social skills training, occupational therapy and work. It is the last which concerns us here and in this section I shall consider the evolution of work in rehabilitation before reviewing its current place. I shall then look at some of the relevant research in the field. In what follows 'work' is used to denote productive effort or activity and 'employment' to denote the social and contractual relationship between employee and employer which involves financial exchange.

One of the tenets of the 'moral treatment' of the insane in the nineteenth century was that patients in institutions should be constructively occupied. The earliest rules of the Glasgow Asylum, opened in 1814, indicate that patients should be employed in 'useful labours' (Comrie, 1932). Skae, founder of the Edinburgh School of Psychiatry and Physician Superintendent of the Royal Edinburgh Asylum stated in 1851:

> Of all the agencies that can be brought to bear upon the insane, I believe that in the large majority of cases, occupation particularly in the open air, is the most beneficial in promoting recovery. (Fish, 1965, p.48)

The records of the 7 chartered asylums in Scotland make plain that serious efforts were made to engage patients in 'appropriate' forms of activity, including carpentry, tailoring, agricultural and domestic work (Scottish Lunacy Commission, 1857; Ferguson, 1948). Thus, some 100 years before Wing and Brown (1970) had proved empirically that an increase in activity by patients was associated with a decrease in psychiatric symptoms, occupation for the mentally ill was believed to have therapeutic value. However, the best intentions of institutions such as the chartered asylums were confounded by the growing problem of overcrowding. Moreover, many of the insane, particularly paupers, were kept in harsh, custodial conditions in poor houses, prisons and district asylums. Throughout the last century, responses to mental illness were plagued by the ambiguity of the task - to care or to contain (Checkland, 1980)? The provision of worthwhile occupation for those in institutions reflected this uncertainty and was often neglected in favour of custodial treatment or the involvement of the inmates simply in the running of the institution.

Fashion seems to have an influence on psychiatric thinking, as in other areas, and Bennett has observed that attitudes on the subject of work for the mentally ill are particularly changeable (personal communication). In the 1920s and 1930s, the value of occupational therapy and work therapy in the management of psychiatric patients regained recognition (Olsen, in Herbst, 1984). However, interest was eclipsed temporarily by the introduction of

new methods of psychiatric treatment. Moreover, work therapy came to be seen as exploitation of cheap labour (Olsen, op.cit.).

The late 1950s and 1960s saw a resurgence of interest in work for several reasons.

(1) Progress in physical methods of treatment, particularly the advent of anti-psychotic drugs, along with a growing awareness of the influence of the social organisation of mental hospitals on the well-being of patients (Barton, 1959; Goffman, 1962) heralded major changes in attitudes to psychiatric treatment.
Hospitals were no longer seen as the only means of treating the mentally ill (Jones, 1960). The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) stated that mentally ill people should be enabled to maintain themselves in the community in as normal a manner as possible. Patterns of treatment altered considerably - the population of mental hospitals declined in England, Wales and Scotland, while rates of admission increased. Few supportive community services were available to discharged patients at that time and survival in the community required the capacity to be self-supporting. Emphasis had to be given therefore to preparing them for employment (Bennett, in Watts and Bennett, 1983).

(2) Work proved to be not only a good means of assessing, but also of treating the mentally ill. Bennett reports he first introduced work to assess patients' fitness, but found it 'reactivated' schizophrenic patients who had long been unemployed (Bennett, 1975).

(3) Employment was readily available at that time and therefore the mentally ill had opportunities to find work.

(4) The discovery that mentally handicapped people were capable of employment (Tizard and O'Connor, 1952) stimulated interest with regard to the mentally ill. The Medical Research Council's Social Psychiatry Unit established a workshop at Banstead Hospital to study psychiatric disability and work (Carstairs et al. 1956). Their research findings stimulated optimism in the rehabilitation of long-stay patients and proved influential in promoting the development of workshops elsewhere (Early, 1960).

Dick notes that in the 1960s realistic and useful work was seen as an essential component of the way back to health. Industrial therapy units were set up in most psychiatric hospitals on the assumption that organised and paid work had therapeutic value in treastment and was not simply a self-contained activity (Dick, in Herbst, 1984). As a result of this enthusiasm about rehabilitation

and of changes in admission and discharge patterns (see above), many people moved out of hospital. Gradually the numbers eligible for rehabilitation fell. However, rehabilitation services remained hospital-based and this made it especially difficult for them to adapt to the fact that many people now came into hospital for short stays or relied on out-patient treatment. Rehabilitation units which had once been the showpieces of psychiatric hospitals became backwaters. Places were filled by older, long-stay patients and work was carried out as an activity in itself rather than as part of a therapeutic programme (Dick, op.cit.).

During the same period, the concept of rehabilitation was widened to include social relationships and life skills and work became less important. Many people felt that the work offered to patients in rehabilitation units was repetitive and demeaning. Patients were poorly remunerated for working a 6 or 7 hour day on tasks such as filling crackers which were of little intrinsic interest or value to them. On these grounds it was argued that patients would benefit from a more varied programme of activities, which would enhance their basic life skills and promote social interaction (McAllen, in DHSS, 1978).

The place of work in rehabilitation in the 1980s is unclear. Rehabilitation services have largely failed to devise ways of meeting the needs of the majority of mentally ill people who live outside psychiatric hospitals (Sime, in Drucker, 1987, Vol.1). High levels of unemployment have led some to cast doubt on the value of using work in rehabilitation and have also made it more difficult to use work in rehabilitation. One leading psychiatrist has recently challenged mental health professionals' continuing subscription to the 'metaphor of work' when this only causes both therapist and

patient to construe unemployment as failure (Goldberg, in Mind, 1984). Others, such as Shepherd (1985) assert that work offers a unique package of benefits with which no other institution can compete.

What then does work offer to someone undergoing psychiatric rehabilitation? (An extensive literature now exists which attests to the psychological, social and material benefits work bestows on the 'healthy employed'. This is discussed later in the context of the Sprout study. Our concern here is with work in psychiatric rehabilitation.) Bennett suggests, firstly, that work obliges the individual to conform to prescribed limits which are externally generated. The worker's performance is judged and rewarded by others. He is therefore confronted with his own abilities and limitations and has a measure of the correspondence between external reality and his own perceptions of reality (Bennett, 1975). In addition, for mentally ill people, work represents an index of normality and fitness for themselves and for family, friends and neighbours (Shepherd, in Herbst, 1984). Work also supplies social contact: as we shall see, many mentally ill people lack social opportunities and resources. It provides structured activity for lengthy periods which is important, as many of those with mental illnesses have few leisure interests and are under-occupied (Shepherd, op.cit.). People in work tend to get more money than those on benefit. Working, therefore, gives greater choice and means people are independent of the regulations and interference in their personal affairs often contingent on drawing benefit. Moreover, the ability to be self-supporting enhances the self-esteem and status of mentally ill people who are often stigmatised and devalued. Patient status is superceded by the status of worker and citizen (Olshansky

and Unterberger, 1963). Finally, working offers opportunities for people to contribute, rather than to be passive recipients of therapy or counselling. However, it should not be assumed that work is always beneficial. Much depends on the type of job and the conditions of employment - this lesson is brought out clearly in the Sprout study.

On the other hand, given the dearth of employment opportunities which make it especially difficult for mentally ill people to find jobs (Morgan and Cheadle, 1975), it has been argued that work should cede to other forms of stimulating activity. This argument seems to be based on the view that the value of work in rehabilitation is as a preparation for employment, i.e. as a means to an end, rather than as an end in itself. Given that employment is in many cases not obtainable, it follows that work in rehabilitation becomes redundant. Goldberg (in Mind, 1984) contends that the useful components of work - structured activity, social interaction and so on - are not wholly contingent on being in paid employment, but can be attained in other ways. He cites as an example Douglas House in Manchester, which accommodates ten former psychiatric patients. Rather than the residents going out to sheltered workshops, they participate in the running of the house as part of their rehabilitation programme, doing domestic chores under staff supervision. An important feature of the project is that residents are not left to their own devices to occupy themselves, but are offered individualised rehabilitation programmes which are highly structured and regularly reviewed (op.cit.). Goldberg goes on to argue that this type of rehabilitation could also be applied to less disabled people not living in residential care and states:

> It seems reasonable that the constructive activities of daily living should be allowed to take up a substantial proportion of each day.
> (Mind, 1984, p.10)

While this model has some attractions in that it aims to enhance life skills and give people greater control of their lives, it does not offer the same benefits as a work-based model of rehabilitation. It is unlikely that participation in domestic chores would have a positive impact on someone's self-image and his status in the eyes of others. In addition, it is unlikely to improve someone's financial circumstances. Furthermore, the model proposed by Goldberg seems to imply that mentally ill people would be occupied in the home, given the limited number of day centres. Yet most people in our society tend to work and live in different settings. This can be of particular value to families with a mentally ill member, as the amount of direct contact is reduced (Vaughn and Leff, 1978).

The improbability of a return to full employment in the foreseeable future has led some social commentators to conclude that our attitudes to employment and leisure should be reassessed and that leisure should be seen as at least as desirable as employment (Sherman, 1986). The use of recreational activities in rehabilitation is not new: this has long been one component of occupational therapy. When jobs are scarce there may be some sense in encouraging mentally ill people to develop interests to substitute for employment. However, Bennett points to the fundamental differences between work and recreational activities or occupational therapy. In the latter, for instance, a person is not necessarily subject to external demands and rewards, which, he argues, are important features of work. Furthermore, the connotations of

'therapy' reinforce the notions of illness and confirm a person's occupancy of the sick role. There seems little firm research evidence that recreational activities or training for leisure bring about improvements in the functioning of participants (Bennett, 1975).

In addition, others, such as Shepherd, have argued that it is unjust to expect the least well prepared in our society to be in the vanguard of the current supposed advance towards a new 'leisure age' (in Herbst, 1984). Popay points out with some irony that discussions about using leisure more constructively often imply that disadvantaged groups, such as the long-term unemployed or the disabled, should be taught to 'redefine' work, while those fortunate enough to be employed should go unchallenged (in Mind, 1984).

At the centre of the debate about the place of work in rehabilitation is the question of means and ends. If work is **only** useful in rehabilitation as a preparation for subsequent employment, then it could be said that it is of limited value when jobs are scarce. This suggests, however, that mentally ill people should resign themselves to unemployment and fails to consider strategies to improve their competitive position in the labour market. Moreover, if the principles of normalisation are to obtain, it follows that mentally ill people should have access to the **full** range of social roles and opportunities. To deny or inhibit access to employment is

> to heap one further devaluation on people who have already been devalued and stigmatised by society. (Heginbotham, in Mind, 1984, p.7)

On the other hand, it has been contended that work is of benefit as an end in itself to those in rehabilitation. For example, Morgan states that:

> Too many people make the mistake of regarding work as relevant only to the patient's occupational disabilities. It is well ... to recognise the existence and value of the large social element in the work situation.
> (in Watts and Bennett, 1983, p.153)

If this is so, then it is spurious to use high levels of unemployment to justify dropping work from the agenda in rehabilitation (Bennett, personal communication).

Research on Work in Rehabilitation

In the next section I shall review several studies which consider various aspects of work in rehabilitation, in order to establish whether the arguments in favour of work have any empirical foundation. After an extensive exploration of the field, it was decided, for reasons of space, to discuss selected studies here. Other research will be introduced, at appropriate junctures later in the thesis, to elucidate particular aspects of the Sprout study. I shall discuss 2 questions: what can be achieved in rehabilitation, and what factors are related to 'successful' outcome?

What Can be Achieved in Rehabilitation?

It seems that some of the more entrenched primary handicaps of mentally ill people can be substantially reduced when the latter are provided with purposeful occupation. A large-scale comparative study, which took place over 8 years, looked at the treatment of 273 long-stay schizophrenic patients in 3 British mental hospitals (Wing and Brown, 1970). The researchers assessed the disabilities of patients and also rated the regimes in each institution on the basis, for example, of the social environment, the number of personal items patients possessed and the way time was spent. Considerable differences emerged between the hospitals. Social poverty of the hospital environment (e.g. the absence of activity) was found to be

associated with clinical poverty in the patients (e.g. muteness and flatness of affect). The amount of time during which patients did nothing was the most important feature of the social environment. When constructive activities were introduced in the form of industrial work, symptoms abated, only to re-emerge when activity was withdrawn and patients reverted to doing nothing. Although this study did not explain how occupation influenced clinical symptoms, it illustrated that symptoms which had previously been considered as immutable features of the disease itself could be affected by changes in the social environment. The study also showed that improvements attained were situation-specific, not generalised - when activity was withdrawn the clinical condition of patients deteriorated.

Motivation is said to be a crucial determinant of how a person progresses in rehabilitation (Morgan, in Watts and Bennett, 1983). Studies which have examined the performance of rehabilitation participants have measured motivation in 2 essentially different ways:

(1) in terms of productivity;
(2) in terms of attitudes - such as commitment to work.

Wing and Freudenberg (1961) reported that considerable changes could be effected in work output by altering the social environment in the rehabilitation workshop. They matched 2 groups of schizophrenic patients attending adjacent workshops. Having established baselines for the performance of the 2 groups, staff in one unit were instructed to give the experimental group verbal encouragement, while the treatment of the control group was to be unchanged. Not only did patients in the experimental group work harder, they also showed a significant decrease in restlessness,

immobility and 'mannerisms'. Increase in output was maintained while reinforcement lasted, but output fell to baseline level when reinforcement was withdrawn. Similarly restlessness, immobility and mannerisms increased again. This pattern of change in output was reproduced when the exercise was repeated and both groups of patients were given the extra encouragement. It seems that the value of the occupation did not reside in the nature of the work, but in the social stimulation patients received (Bennett, 1975).

Wing observes (in Watts and Bennett, 1983) that this experiment induced a stimulus-response effect rather than a learning effect, as the desired behaviour ceased when encouragement was withheld. Again, this study underlines the difficulty of inducing generalised change in rehabilitation whereby the desired behaviour occurs under other circumstances and in other settings.

Walker (1979) found that different types of incentives had varying effects on the output of patients in a workshop. He assigned 32 patients to 5 different experimental incentive systems, while 9 other patients were used as controls. Payment for merely attending work, regardless of performance, proved to have little effect on output. Social reinforcement by itself increased output, but not significantly. The largest single increase in productivity was obtained by a combination of piece-rate and social reinforcement. Numbers in this study were small, however, and as the subgroups of patients were unmatched, differences in age, diagnosis and initial performance may have accounted for differences in outcome.

These 2 studies suggest that the willingness of patients to behave in certain ways can be modified by the provision of suitable rewards. Motivation in this sense is contingent on the availability

of such reinforcement, but there is little evidence of a more durable change in underlying attitudes.

In a controlled study of the outcome of psychiatric rehabilitation, Griffiths (1974) chose to measure motivation in terms of attitudes. The subjects of this research were 56 psychotic patients attending a day hospital rehabilitation unit. Structured interviews were conducted with patients at 2 points and were used to assess their motivation, commitment to work, attitudes to their disabilities and work level. In addition, cognitive functioning and self-confidence were rated on standardised instruments. Importantly, results gave little indication of change in patients' attitudes in the course of rehabilitation. Outcome - in terms of post-rehabilitation employment status - was found to be related to motivation, self-confidence and the patients' views of their disabilities at the outset of the programme, but not to intelligence, length of unemployment or work level. Those who entered rehabilitation at a relative advantage - better motivated and more confident - tended to retain their advantage and did better subsequently than those who were less confident and less well motivated. Low levels of motivation and self-confidence proved better predictors of outcome than high levels, suggesting that handicaps had greater prognostic value than assets for this particular group.

Thus, the relative positions of individuals seem unlikely to alter in rehabilitation. Conceivably, if childhood socialisation experiences have not nurtured a basic predisposition to social roles, it may be difficult to generate any such commitment subsequently (Watts, in Watts and Bennett, 1983). Bennett states that:

> paid work is more likely to influence a person's knowledge of how to behave and his ability to behave in that way than it is to affect his values and motivation.
> (Bennett, 1975, p.763)

He goes on to argue that work is useful to teach people how to cope with stress and that the experience of mastering increasing demands can lead to an increase in confidence. This is illustrated in a study by Wing (1966) who monitored a sample of 212 psychiatric patients during and after their time in an Industrial Rehabilitation Unit. Unit supervisors were asked to rate subjects' work performance and interviews were conducted with subjects to assess their attitudes and emotional responses. A self-confidence schedule and a personality inventory were completed for each subject at point of admission to the Unit and 4 weeks later. Those entering the Unit were characterised by low levels of confidence. However, a substantial proportion had improved in this respect by the second assessment on both objective and subjective measures. Those who improved were distinguished from those who did not by their initial attitude. Subjects who exhibited a constructive approach to their difficulties did well, in contrast to those whose attitude was 'casual' or 'passive'. In addition, those who grew more confident were more likely to be in employment 2 months after leaving the Unit. Wing attributes improvements to the opportunity rehabilitation presented to discover residual abilities in a realistic work setting and to the effects of social influences. It is surprising that participants in Wing's study seemed to gain in self-confidence, while those in Griffiths' did not, particularly as both studies used the same scale to measure self-confidence. However, in both studies the initial attitudes of participants were important for outcome and both highlighted the difficulty of bringing about change in those who appeared most disabled.

One of the areas in which mentally ill people may encounter difficulty is social relationships. The social skills of mentally ill people are often poor (Trower et al. 1978) and they tend to have fewer close relationships than 'normal' people (Henderson et al. 1978). The social contacts work offers are often seen as an important part of the rehabilitation process. However, it seems that the nature of the work and the way it is organised may have a considerable impact on the development of social relationships among participants. In a study by Miles (1971, 1972) 50 schizophrenic patients were divided into 2 groups matched for age, length of time in hospital and severity of illness. Twenty-six attended the hospital's Industrial Therapy Unit (ITU) and did paid industrial work; 24 went to occupational therapy (OT) and took part, unpaid, in arts and crafts. The first part of the study compared the ability and willingness to work of the 2 groups of patients over a 6 month period. Patients were interviewed and completed a standardised questionnaire. In addition, staff rated patients' work performance. Miles found that ITU patients improved more on both criteria than those in OT. The second part of the study looked at the formation of personal relationships using sociometric techniques. Results indicated that the extent of the patients' personal relationship was greater in the ITU. The latter were more likely than their counterparts in OT to know the names of their fellow workers and were less likely to be friendless. Miles suggests that these differences might be due, firstly, to the different ways work was organised in the 2 units and, secondly, to differences in supervision. In the industrial workshop, work required co-operation and communication among patients. Moreover, patients were expected to get on with their work unattended. By contrast, OT patients tended to work on

their own individual tasks and were treated as 'sick people' needing help and guidance.

A number of interesting matters emerge from this study. Firstly it indicates that the way in which work or OT is organised can influence the nature of the interaction among participants. Secondly, patients in the ITU expressed satisfaction with the fact that they were doing 'real work' and, as a result, felt they were part of society (Miles, 1972). The demands of the situation and the attitudes of supervisors cast them in the socially valued role of workers rather than patients. It may be that these factors had some influence on their attitude and ability to work. While the study does not explain why work performance improved more in the ITU than in OT, it is conceivable that the differences in social environment had some effect, given the findings of Wing and Freudenberg (1961) above. The personal relationships which were formed at work may have encouraged better performance.

The studies just discussed give some indication of the potential of rehabilitation. In line with the person-environment model described earlier, it seems that the nature and degree of change is affected by the interaction between the individual and the setting. For instance, the attitude of participants seems important for outcome, as do the responses of other people and the way in which work is organised. These will be important areas for consideration in the Sprout study. We now need to extend our discussion to consider rehabilitation outcome. As will become apparent, outcome measures used vary. The usefulness of these measures is examined in a subsequent chapter, with reference to the methods used in the Sprout study.

What Factors are Related to Successful Outcome?

The extent to which work performance in rehabilitation is related to outcome after rehabilitation is a complex issue. Cheadle and Morgan (1972) set out to investigate this relationship with reference to 82 patients discharged from psychiatric hospital in 1966. The work performance of all subjects had been rated on a 16-item scale during their time in the hospital's Rehabilitation Unit. Patients were classified as 'successes' or 'failures' on the basis of their post-discharge work record. Successes had started work within 4 weeks of discharge, were still in work, though not necessarily the same job, 6 months later and had worked without an interruption of more than 2 weeks. It emerged that successes and failures differed on the earlier ratings of work performance. Successes had significantly better scores on 5 of the 16 items, as well as better total scores.

Griffiths (1973) subsequently carried out a principal component analysis of the scale Cheadle and Morgan used and showed that it measured 5 aspects of work behaviour: task competence; response to supervision; social relationships; enthusiasm and initiative/ confidence. In the light of this analysis, Cheadle and Morgan's data suggested that none of the task competence items was significantly related to resettlement in work, whereas response to supervision, enthusiasm and social relationships were correlated with successful outcome.

In a different study, Griffiths (1977) examined the prediction of psychiatric patients' work adjustment in the community. This was a retrospective analysis of data collected several years earlier on 30 patients with various diagnoses attending a Rehabilitation Unit at the Maudsley Hospital. Data was obtained from records on patients'

work behaviour in the Unit and they were rated on a revised version of Cheadle and Morgan's scale. This information was compared with patients' employment status 3 months after they left the Unit. Results suggested that work assessment scores were correlated with subsequent success in employment and that all 5 factors of work performance - including task competence - predicted return to work.

This seems to conflict with the findings of Cheadle and Morgan. However, the retrospective method of completing the ratings may have distorted results. Indeed, a study by Watts (1978) substantiates the suggestion that factors other than task competence are important. He used the same work assessment scale as Griffiths with 39 patients in the Maudsley's Rehabilitation Unit doing mainly industrial work. Twenty patients were diagnosed psychotic and 19 non-psychotic. The interesting feature of this study is that it sought to measure change in performance while patients were at the Unit and, in addition, to relate performance to outcome. Ratings were completed 2 weeks after subjects entered the Unit and again 4 months later or when they left. The criterion of resettlement at work was that patients should return to work after leaving the Unit and remain in work for at least 6 months. In all, 13 people returned to work and 9 of them were still in jobs 6 months later. In analysing the association between scores on the scale and outcome, it emerged that the predictive power of the 5 factors (task competence etc.) differed for psychotic patients and non-psychotic patients. Thus the assessment of 'social relationships' proved to be closely related to resettlement in work for both groups, but on the other hand 'response to supervision' and to a lesser extent 'enthusiasm' were associated with resettlement only for psychotic patients. Task competence showed no association with resettlement in work. Watts concludes from these results that

employability is more a matter of work personality than of instrumental performance.

One disappointing finding was that there was a general tendency for patients to be given a worse rating on the second occasion. In view of the apparent importance of social relationships for resettlement, it was particularly discouraging that no improvement was evident in this area. This result seems, at first glance, at odds with Miles' findings (see above). Watts attempts to explain the absence of improvement by arguing that more lenient assessment criteria may have been used at the first rating. On the other hand, the difficulty of effecting lasting change in the social relationship skills of mentally ill people is widely recognised (Shepherd, in Watts and Bennett, 1983). Miles' study illustrated that the extent of patients' personal relationships could be increased, but it gave no indication of the depth or quality of relationships. It may be that the 'right' setting can help people maximise existing social skills, but it does necessarily follow that improvements in competence will result. Conceivably, as Watts argues (1978), behavioural training programmes may be required to improve specific aspects of social behaviour.

A number of key points emerge from the studies reviewed. It seems that work can help reduce symptoms and prevent deterioration in functioning. It may also increase participants' self-confidence and provide opportunities for social contact. In addition, given the appropriate reward systems, performance can be improved, in quantitative terms at least. However, there is little indication that these effects become generalised and endure once rehabilitation concludes. It is particularly discouraging that much of current rehabilitation practice, with its emphasis on work skills and

productivity, is unable to modify 'work personality' - the very factor which research suggests affects outcome. The extent to which lasting improvement can be brought about in crucial areas such as 'work personality' (Watts, 1978) remains unclear. It may be necessary, as Watts proposes, to devise more individualised rehabilitation programmes which seek to act on specific handicaps, rather than offering a standard programme for all.

Finally, the effect of rehabilitation is influenced by the initial attitudes of participants. Those who enter rehabilitation with more confidence, for example, tend to show more improvement and enjoy better outcomes than those who begin at a relative disadvantage. This is of crucial relevance in the Sprout study as we shall see. It seems then that the debate about the use of work in rehabilitation remains open. The evidence available indicates that work has some benefits as an end in itself. However, it has variable 'success' as a means to an end, in that outcome seems more a function of the capacity and attitude of those entering rehabilitation than of change brought about in the course of rehabilitation.

While the studies reviewed may give a somewhat pessimistic view of the potential of work in rehabilitation, I wish to argue that the nature of the research undertaken needs to be considered before conclusions are drawn.

For some 20 years, experienced practitioners have pointed out that rehabilitation is not necessarily a process of change in competence. Criswell (1968) reached this conclusion in a review of research on various rehabilitation programmes in the United States. If, as she argues, rehabilitation is to be construed as a process of accommodation between the individual and the social environment, then this has considerable implications for research. It is undoubtedly

necessary that the nature and course of the disabilities of mentally ill people should be explored. However, research has tended to concentrate on the individual mentally ill person and has rarely examined the effects of the social environment in the same depth. Possibly this has resulted from the fact that much research is carried out by psychiatrists and psychologists, whose principal concerns are the 'identified patient'. Some studies, such as that by Wing and Freudenberg, have, admittedly, looked at the effect of changes in the social environment - in this case the introduction of social reinforcement. Others, such as Watts' study of work behaviour in a rehabilitation unit, give little space even to describing the nature of the work environment. While outcome studies are valuable, there is also a place for research which focuses on the rehabilitation process itself. As will become apparent, an important element in the Sprout study is the emphasis on participants' experiences while working on the scheme and in that respect it includes a dimension absent from many other studies of rehabilitation.

In addition, it seems important to consider someone's performance in rehabilitation in the context of his wider social environment. There is evidence to suggest that work performance is affected by attitudes of significant others: Freeman and Simmons (1958) found that the social and work performance of ex-mental patients living in the community were related to the expectations of their families. Moreover, unless account is taken of the forces and processes which bring people into the ambit of rehabilitation services and of what becomes of them subsequently, there is a risk that individual rehabilitation programmes will be pursued in a vacuum. An incomplete understanding of the social environment which

influences the behaviour of participants may reduce the potency of any rehabilitative input. For these reasons I sought in the Sprout study to gather information on participants' social circumstances and what brought them to the project.

Research in this field has largely been concerned with measurable change and has been predicated on a positivist model which assumes that human behaviour follows logical patterns of causation. However, the practice of rehabilitation tends to be founded on the notion that people are not simply 'acted upon' in the rehabilitation process. Participants' attitudes to and involvement in that process are crucial to outcome, as we have seen. It would therefore seem useful, if not indispensable, to take account of the views and purposes of people in rehabilitation when considering the effects of intervention. Consequently in this study I have used a combination of approaches. As we shall see in Chapter 4, objective measures of outcome are combined with perceived outcome and supplemented by a consideration of the nature and quality of participants' experiences on the project and thereafter.

Conclusion

In rehabilitation, diagnostic labels are less relevant than an understanding of someone's disabilities. Rehabilitation is concerned with the capacity of mentally ill people to perform social roles. However, research indicates that an increase in competence may not always be feasible. This in turn underlines the crucial point that rehabilitation involves a process of accommodation between the individual and the environment: if the individual lacks the capacity to meet the demands of his environment, then the environment should be the target for change. Furthermore, a preoccupation with change and improvement in individual functioning may mask other achievements

in rehabilitation, such as the prevention of deterioration. These matters have important implications for the selection of methods to evaluate a rehabilitation programme, as we shall see in Chapter 4.

The evidence available indicates that work can be a useful tool in rehabilitation; however, it is important to recognise it is not a panacea. The Sprout study explores some of the limits to its usefulness and highlights the fact that the effectiveness of a short-term rehabilitation programme hinges to a large extent on the availability of other forms of provision. I return to this theme in the final chapter.

The debate about whether or not it is helpful to provide those in rehabilitation with work when they may not find employment subsequently, seems likely to continue. The arguments I have presented have been those of professionals. The opinions of service-users are less frequently iterated in discussion. Yet, as noted, their involvement in rehabilitation is vital. The Sprout study will cast further light on the debate by considering the views of mentally ill people themselves to ascertain their preferences. But first, we need to set the study in context. The next chapter surveys policy and practice relating to employment rehabilitation and considers the extent to which these are in line with the principles of rehabilitation outlined in previous sections.

CHAPTER 3

EMPLOYMENT REHABILITATION FOR THE MENTALLY ILL

This chapter considers policy and services relating to employment rehabilitation for mentally ill people . Before turning to these matters, 2 notes of caution are needed. Firstly, as far as possible I shall focus on Scotland. However, not only are there gaps in services available, but also in information about provision and usage of services. For example, it is difficult to ascertain from regularly published official statistics, how many people use day hospitals: 'Scottish Health Statistics' refers only to 'day cases', while 'Scottish Hospital Costs' refers only to 'attendances'. Moreover, information on the numbers of mentally ill people in sheltered workshops 'is not kept centrally' (McKay, 1985b). The second note of caution is related to the concept of disability. Employment rehabilitation services were originally designed for the physically disabled and although the mentally ill are now covered by the same provision, 'disability' inevitably has connotations of physical impairment. Mentally ill people may therefore not count themselves as disabled, or be viewed as disabled. However, in the discussion which follows the term will include the mentally ill.

I shall begin by reviewing the policy background before considering the rehabilitation services offered by different agencies. The chapter concludes with a description of the Sprout project.

Policy

Historically, rehabilitation services for the mentally ill have evolved from services for the physically disabled. The current system of employment rehabilitation services which includes the quota system, employment rehabilitation centres, sheltered work and disablement resettlement officers, was established in 1944 under the Disabled Persons (Employment) Act and has remained relatively unchanged since. This Act embodied the recommendations of the Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons (the Tomlinson Committee, 1943) which examined the needs of a wide range of disabled persons, including those with neurosis and psychosis. In its report, the Committee acknowledged that disabled persons, given the opportunity, were capable of normal employment and recognised the need for a strategy to ensure that they had access to such opportunities. The Committee recommended that any schemes established should be open to **all** disabled persons, whatever the nature of their disability. However, at that time psychiatric care was largely custodial and there was little explicit rehabilitation of the mentally ill (Bennett, in Watts and Bennett, 1983). Moreover, the primary concern among policy makers was to rehabilitate those who had been disabled in the war. Wansbrough and Cooper (1980) observe that while policy did not deliberately exclude the mentally ill, their particular needs were given little attention.

Since the 1944 Act, 3 committees have reported on rehabilitation services for the disabled: the Piercy Committee in 1956 and the Tunbridge Committee in 1972 covered England and Wales and the Mair Report of 1972, which looked at Scotland. These reports paid greater attention than Tomlinson to the needs of the mentally ill: for

example, the Committee of Enquiry into the Rehabilitation, Training and Resettlement of Disabled Persons, chaired by Piercy, classified the mentally ill into 4 categories, according to the nature and severity of impairment and recommended that services be matched to these different needs (Piercy, 1956). While the Tomlinson Report had been concerned with the restoration of physical fitness and reinstatement in employment, the concept of rehabilitation was broadened over time. The Piercy Report interpreted rehabilitation in a wider sense, to signify the process of restoring a disabled person to a condition in which he is able to resume a normal life. This was reiterated by the Tunbridge Committee who noted the need to move the emphasis in rehabilitation towards a greater concern with chronic disabilities. The Report identified 4 main groups of disability, one of which was 'psychiatric conditions'. The same Committee observed that the importance of rehabilitation for psychiatric patients had not been recognised. It also pointed out that while rehabilitation had previously been directed towards long-stay psychiatric patients, changes in patterns of admission and discharge had created different needs. It was necessary to devise services which catered for those who spent little time in hospital, but nonetheless were seriously psychiatrically disabled.

In Medical Rehabilitation: the Pattern for the Future (SHHD, 1972) which considered services in Scotland, psychiatric rehabilitation was again subsumed under medical rehabilitation. The Report recognised that severe psychiatric illness could result in 'dislocation from work and disruption of an individual's social pattern' (para.1.9). In relation to employment, the Report noted with regret the persisting dichotomy between hospital-based

rehabilitation services, provided by the Scottish Home and Health Department, and services provided outside hospitals by the Department of Employment. It recommended that steps be taken to review rehabilitation services for the mentally ill in each area and to define more clearly the roles of the various parties involved. It also stressed the importance of providing other support services in the community to offer rehabilitation in its wider sense.

However, the policy model contained in the Mair Committee's recommendations was that of a pathway of services, whereby patients would progress from in-patient to out-patient care to rehabilitation. While this model may be appropriate in physical medicine, it is less so in psychiatry. Firstly, as noted in Chapter 2, improvement or restoration of functioning are not realistic goals for many mentally ill people and a succession of short-term programmes may not therefore be appropriate (as we shall see later). Secondly, patterns of care have altered substantially over the last 30 years, as I described in Chapter 1. The Mair Report adheres to the notion of a territorial division between hospital-based care and care which is given beyond the hospital's walls. This notion still goes largely unchallenged, (Affleck, personal communication) although it appears to have little substantive basis. For example, the mechanisms of joint planning and support finance are predicated on this division between 'the hospital' and 'the community' which lies outside it and the task is construed in terms of the transfer of resources from the hospital base to the community base. Service patterns continue to reflect the principle of administrative convenience based on administrative divisions, rather than clinical efficacy whereby services would follow the needs of patients.

Despite the apparent evolution of principles in rehabilitation, service development has not been in step. The Tunbridge and Mair Reports elicited little practical response from the relevant government departments. The 1975 White Paper 'Better Services for the Mentally Ill' (DHSS, 1975) which covered England and Wales, laid down guidelines for provision but these were not prescriptive and recommendations have not been attained, leading one commentator to observe that 'community-based provision for the mentally ill remains woefully inadequate' (Wansbrough, in Herbst, 1984). The recent Scottish report 'Mental Health in Focus' (SHHD, 1985) goes some way to delineating the types of services required, but has been heavily criticised for failing to give a clear policy lead. Drucker (1986) asserts that the Report lacks adequate analysis and discussion of policy alternatives and fails to elucidate how objectives are to be achieved. In relation to the issue of integrated services versus specialised services for mentally ill people, the Report does not offer any set of principles on which to base provision and yet, as we shall see, this debate is crucial when considering the adequacy of MSC rehabilitation services.

Against this background, we now turn to look at rehabilitation services for the mentally ill in the community.

Provision

The Manpower Services Commission offers a range of employment rehabilitation services to disabled people under the 1944 Act. Employment rehabilitation services for the mentally ill in the community are also provided by local authorities, health boards and voluntary bodies, under the general rubric of 'day services'. However, day services perform a whole variety of functions such as treatment and recreation and employment rehabilitation may not have

priority. Thus the figures on provision which follow should be treated with caution.

In discussion, I refer to several empirical studies and analyses of policy and it may be helpful to describe these briefly before we progress. Details are shown in the table below.

TABLE 3.1 Sources Used in Discussion of Rehabilitation Services

Author	Date	Nature and Location of Study	Size	Purpose
Birch	1983	Consumer study in England	36 ex-psychiatric patients	To explore the sample's experience of employment and unemployment and their views on services available
Cornes *	1982	An evaluation of employment rehabilitation centres in England	307 users of whom 35 were 'psychoneurotic' and 28 'psychotic'	To describe ERC clients, their attitudes and reactions to ERC courses, and post-course outcome in terms of resettlement
Floyd et al	1983	Longitudinal study in England	143 patients suffering from schizophrenia	To examine the employment experiences of schizophrenic patients after discharge from hospital
Gladstone *	1985	Analysis of employment policies for disabled people in Britain post-1944	N/A	To review the history of measures to help disabled people. To evaluate the success of current strategies and suggest directions for the future
Lonsdale *	1985	Similar to Gladstone	N/A	As above

Author	Date	Nature and Location of Study	Size	Purpose
McCreadie et al	1984b	Survey of day patients in Scotland	422 day patients	To describe day patients in terms of demography, clinical condition and psychiatric history. To assess needs. To identify different practices in care and management of patients
McCreadie et al	1985a	Survey of psychiatric rehabilitation and support services in	Psychiatric hospitals and units serving ⅔ Scottish population	To describe services and examine relationship between rehabilitation provision and numbers of new chronic in and day patients
Merchant *	1977	Observational study in a job centre in Edinburgh	N/A	To examine the work of the DRO
National Audit Office *	1987	Review of employment services in Britain	N/A	To investigate the assistance provided by the Department of Employment and the MSC to disabled persons in the employment field

Author	Date	Nature and Location of Study	Size	Purpose
Scottish Office Central Research Unit	1981	Survey of day services for mentally ill	23 day units	To compare the users, staff and activities of different units
Walker and Townsend *	1981	An examination of the relationship between employment and disability in Britain	N/A	To assess employment measures for disabled people
Wansbrough	1980	Action research project in Southampton which placed mentally ill people in open employment	13 mentally ill people	To monitor and evaluate feasibility of sheltered work in open employment for the mentally ill
Wansbrough and Cooper	1980	Series of studies in England and Wales	1,216 employees + 240 employers and occupational health physicians	To examine rehabilitation and resettlement in employment of mentally ill people

* These are concerned with the disabled as a whole and not specifically with mentally ill people

Provision by Local Authorities, Voluntary Bodies and Health Board

In Scotland, local authority involvement in day service provision for the mentally ill is minimal. In 1984/85, there was one local authority day unit for the mentally ill, providing only 35 places (Scottish Education Department, 1986a). While places in centres for physically and mentally handicapped people have increased steadily since the late 1970s, no such expansion is evident in day provision for mentally ill people (op.cit.). In the same year, social work departments spent £8,000 on day centres for the mentally ill, compared with £15 million on day centres for mentally handicapped people (op.cit.).

Many voluntary bodies provide day services in the community. In 1985, 10 local associations for mental health were involved in such provision (SAMH, 1986), running drop-in centres and social clubs. These tend to be run on a part-time basis only and do not therefore figure in official statistics.

Health boards provide the bulk of day services for mentally ill people in Scotland. As indicated earlier, information on hospital day places is confused. Statistics compiled by the Information Services Division of the Scottish Health Service Common Services Agency refer to day cases and day attendances, but not to places. Mental Health in Focus estimated that in 1982 there were 1,200 day places. Fuller information is available in a Ministerial letter to Anna McCurley, MP (McKay, 1985a). This stated that in 1983 there were 1,342 places in day hospitals (excluding psychogeriatric units). The number of patients in the preceding year was given as 15,535 and the number of attendances was 240,919. However, the figures suggested considerable geographical inequalities in the

distribution of places. Forty-two percent of these day patients lived in Lothian and under 10% lived in Greater Glasgow.

It was noted earlier that rehabilitation services have tended to concentrate on in-patients, to the neglect of those living outside hospitals. This was borne out by a Scottish survey of hospital-based rehabilitation services (McCreadie et al. 1985a). They found that twice as many places in industrial therapy units in hospitals were used for in-patients as for day-attenders. It seems therefore that the figures on day places cited above must be treated circumspectly as a considerable proportion may be taken up by hospital residents. It is clear, nevertheless, that the level of provision is far from sufficient.

The Scottish Office has set no planning targets for day service provision, but, on the basis of the DHSS recommendations based on population, Scotland should have some 3,000 places in local authority units and 3,250 in health board units, totalling 6,250 (DHSS, 1975). In actuality, there are, from data available, some 1,400 places in total.

In addition to the level of provision, it is also necessary to consider the quality of services. Two studies have looked at Scottish day services and these will now be discussed.

The Scottish Office Central Research Unit carried out a study of adult day services in 1977 (SOCRU, 1981). The study identified 23 day units in which the mentally ill were the main user group. One was run by a voluntary body and the rest were health board facilities. Only 2 units operated as workshops, although most of the others provided industrial or contract work as part of a varied programme of activities. Rehabilitation for employment was one of a number of functions to which unit staff alluded, but it was not

necessarily given high priority. The study brought into question the extent to which programmes offered were related to users' needs. It was apparent that users were diverse in terms of social background and in terms of needs arising from particular conditions, such as schizophrenia. The authors suggested that more attention should be directed towards matching programmes to users' needs and envisaged the development of a specialised network of units based on a clear understanding of the specific contribution of each.

McCreadie and colleagues surveyed 422 chronic day-patients, attending psychiatric hospitals and units serving 56% of the Scottish population. In line with statistical evidence presented above, they too found a great variation in the availability of health board services. Alarmingly, they found that people living in the catchment area of hospitals with little or no day provision were not likely to have access to alternative facilities, such as local authority services. (This is not surprising, of course, given the dearth of such facilities.) A further disturbing finding was that over one-third of day patients in the study were engaged in occupational activities which did not match their needs and abilities as assessed by the professionals involved with them. Had a sheltered workshop been available, for instance, 18% could have attended (McCreadie et al. 1984b).

To sum up, it seems that day services for the mentally ill in Scotland are characterised by a heavy reliance on health board services. The level of provision is far from sufficient and the shortage of places means that mentally ill people receive no service or are slotted into whatever is available, rather than enjoying access to a range of services and being offered assistance appropriate to their needs. Little is known about the effectiveness

of different activities for the achievement of particular goals. Little is known, in addition, about the attitudes of users to services. Davis argues, on the basis of discussions she has conducted with English users, that the pattern of services tends to reflect the interests and talents of staff and that users are rarely involved in decision-making (Davis, 1986).

MSC Services

The development of MSC employment rehabilitation services is of particular interest here in order to put the Sprout project in its historical and organisational context. The Manpower Services Commission was set up in 1974 to run public employment and training services and to advise the government on manpower policies. In 1976, it assumed responsibility for the development of policy for the disabled and for sheltered employment. It is important to note that MSC provision for the mentally ill is an adjunct to provision for broader groups, such as the disabled in general and the unemployed. In the rest of this chapter I intend to discuss the services originating from the Disabled Persons (Employment) Act, 1944, which are of relevance to the mentally ill, before considering services for the unemployed and the Community Programme in particular.

The Act of 1944 established the following services:

- disablement resettlement services
- the quota system and the register of disabled
- rehabilitation centres
- sheltered employment.

It is beyond the scope of this chapter to give a detailed description of the organisation of MSC services for the disabled, as our concern here is chiefly with the nature of services available.

We now turn to look at these services individually.

The Disablement Resettlement Service

The Disablement Resettlement Service was created to place disabled people in employment and to supervise the quota system (see below). The Disablement Resettlement Officers (DROs) who are based in central job centres, act as specialist employment advisers to the disabled at a local level and as gatekeepers to the range of MSC services. DROs have a dual role - to develop the employment potential of disabled people and to develop employment opportunities by liaising with employers.

Officers are civil servants employed by the MSC. They are given special in-service training in interviewing, assessment and counselling, in the effects of medical conditions and in marketing disabled people to employers. It has been suggested, however, that the service is weakened by the absence of a complete career structure (Wansbrough and Cooper, 1980). Promotion often entails moving away from work with disabled people into the mainstream of MSC services. There are 45 DROs in Scotland, 4 of whom cover Edinburgh and outlying areas. DROs are accountable to their Job Centre manager not to a senior DRO, who acts in an advisory capacity only. This is described by the MSC as 'integration'; however as one of the Job Centre's manager's tasks is to maximise job placements, the DRO may be subject to similar pressure at the expense of difficult-to-place clients, whose cases would require more time. Birch (1983) suggests that DROs may also push job placements rather than rehabilitation or training for the same reasons, although she provides no evidence to back up this assertion.

In the study by Floyd et al (1983) which looked at the employment experiences of people with schizophrenia discharged from hospital in England, the authors remark on the 'uncomfortable position of the DRO'. On the one hand, the latter wants to help his client, but on the other he aims to preserve good relations with sympathetic employers and is thus unlikely to offer an 'unsuitable' applicant. Floyd et al found that DROs seemed to operate a screening procedure with clients. Of the 43 men and 12 women in the study who saw their DRO in the year following discharge, only 19 men and 3 women were submitted for jobs. Unfortunately the study did not make clear what criteria were used to screen clients. Merchant (1977) remarked in her small-scale observational study of the work of DROs in Edinburgh that client's age and motivation were crucial factors in the DROs' assessment of their potential and that there was a tendency to rank clients as more or less deserving of help on these criteria. However, the nature of the study makes generalisations difficult.

While DROs could formerly vet all vacancies and select those suitable for disabled applicants, all advertisements are now centrally organised at Job Centres and disabled people must apply at the same time and in the same way as other applicants. This reflects current policy that, as far as possible, the disabled should use mainstream rather than specialised services (MSC, 1982). Moreover, since registration for employment has become voluntary, fewer mentally ill people come to the attention of the DROs unless referred for help by welfare services and therefore may not receive specialist advice at a time when they may need it to compete for the limited vacancies available.

Generally, DROs have tended to concentrate on individuals rather than on encouraging employers to take on the disabled. The implication is that lack of work is related to a person's capabilities and personal characteristics, rather than to inadequate training opportunities, discrimination and a working world designed around the needs of the able-bodied and 'mentally healthy' (Gladstone, 1985). The preference for individual rather than structural explanations has meant that alternative strategies - focusing on structural factors - have not been developed sufficiently.

Some progress in this direction has been made following the MSC's Review of Assistance to Disabled People' (MSC, 1982). Teams of professionals were set up at area office level to form the Disablement Advisory Service. There are 8 such teams in Scotland and the one covering Lothian and the Borders is made up of 3.5 full-time workers. The service's function is to encourage employers to adopt more progressive employment practices in relation to the disabled and to encourage the development of sheltered industrial groups (discussed later) particularly in the more remote parts of Scotland (MSC, 1984a). The MSC is currently evaluating the DAS and results are not yet available.

The Quota System and Register of Disabled People

Under the Disabled Persons (Employment) Act 1944, all employers with more than 20 workers are required to employ at least 3% registered disabled people. Employers may obtain permission to be released from this duty under certain conditions, if, for example, no suitable disabled applicants are available.

The problems with the quota system are manifold. It was instituted at a time of full employment when the thrust of

employment policy was to ensure the nation's manpower resources were fully harnessed. However, the number of registered disabled has declined and the numbers on the register now only represent 1% of the workforce (National Audit Office, 1987). It is likely that mentally ill people are particularly reluctant to register, as they may not perceive themselves as disabled. Currently in Scotland, 8% of the 35,534 registered disabled suffer from a mental illness (MSC, personal communication); however, it is difficult to estimate how many would qualify for registration but fail to register.

Lonsdale (1985) suggests that the low level of registration may indicate that disabled people regard it as futile, as the quota system is not enforced. Failure to satisfy the 3% rule is not an offence and permits are readily granted to excuse employers from complying.

Only 10 prosecutions have been brought under the 1944 Act since 1949 and the proportion of employers meeting the rule fell from 53% in 1965 to 27% in 1986 (National Audit Office, 1987). Few local authorities and government departments have taken a moral lead as the following figures illustrate.

TABLE 3.2 Quota Compliance among selected Government Departments

	Proportion of Disabled Among Employees
Scottish Office	1.5%
Lothian Region	0.9%
Lothian Health Board	0.3%
Edinburgh District Council	1.2%

(Employment Gazette, 1986)

Opinion on the usefulness of the quota system remains divided. The government has reviewed the system several times, in 1973, 1981 and 1986. The conclusions to emerge were that employment services were being asked to act as salesmen and policemen vis-a-vis employers. The decline in numbers on the register was cited as evidence of public loss of faith in the system. The MSC recommended in 1982 that policy should rely on persuasion rather than coercion, hence the creation of the Disablement Advisory Service (MSC, 1982). In the recent 'Review of Employment Assistance to Disabled Adults' it is stated that:

> the quota system is ineffective, unenforceable and incapable of achieving its aim of getting employers to recruit 3% of their workforce from the disabled adult workforce.
> (National Audit Office, 1987, p.4)

However, in 1985 the Secretary of State, indicated that more research was needed to ascertain the numbers and characteristics of the disabled before the future of the scheme could be decided and this has not yet been completed. In the interim, the system persists unenforced.

Organisations representing consumers, on the other hand, have called for a strengthening of the system. The Snowdon Working Party on the Disabled stated that:

> a statutory framework is vital if the employment of the disabled is to be kept to the fore as a specific objective of employment policy.
> (Snowdon, 1976, p.21)

In its response to the 1981 review of the quota system, the Disability Alliance also objected strongly to abolition. Others, such as Lonsdale (1985) and Gladstone (1985) have argued it is impossible to say the system is unworkable since it has never been properly enforced. Both commentators point to other countries, such

as West Germany, where a system of levies and subsidies is used to ensure compliance with a 6% quota.

The MSC has increasingly promulgated integrated services for disabled people, asserting that the latter have much in common with the unemployed in general in terms of age and lack of skills. Specialist services are only justified to meet needs which differ in kind from those of other unemployed people (MSC, 1982). One advantage of this policy is that it avoids the stigma involved in suggesting that disabled people are in any way 'inferior'. However, this stance could be regarded as politically expedient at a time when services are being streamlined and staff levels cut. Moreover, Gladstone (1985) criticises 'integration' in that it represents an administrator's perception of the issue and ignores the views of consumers. This discussion throws up 2 crucial issues, to which I shall return. The first concerns the views of mentally ill people on specialist services; the second relates to the extent to which the needs of mentally ill people constitute 'special' needs, distinguishing them from the unemployed in general and from other categories of disabled people.

Employment Rehabilitation Centres

In addition to offering assistance to find work, the MSC also provides assessment and preparation for employment in Employment Rehabilitation Centres (ERCs). There are 27 centres in Britain and of the 4 Scottish ERCs, one is in Edinburgh. Centres aim to enhance the work skills, motivation and self-esteem of clients. Clients are assessed by psychologists, social workers and medical advisers and are assigned to one or more work sections. The work is mainly industrial or commercial and predominantly manual. Courses usually last 6-8 weeks. The fact that they are based on a through-put model

means they are not necessarily suited to the needs of the mentally ill. Many psychiatric disabilities are chronic and the sufferer is likely to require longer periods to settle and to be assessed (Shepherd, in Herbst, 1984). It was estimated recently that 15-20% of ERC clients fall into the 'mental illness' category (Employment Gazette, 1985). There are, however, 2 ERCs at Egham and Leicester specially for the mentally ill. These have longer courses and have developed close links with local psychiatric hospitals. Thus, while the MSC is promoting a policy of integration in various respects, as mentioned above, it also recognises to some extent that the mentally ill have certain unique needs and that these may require a specialist response (MSC, 1982).

The effectiveness of ERCs seems constrained by the ambiguity of their role. They were originally conceived as assessment centres, where participants' aptitudes and training needs could be ascertained. These functions are of questionable relevance, however, when jobs and training facilities are scarce. In relation to mentally ill people, Wansbrough and Cooper (1980) noted that a higher than average proportion of mentally ill participants failed to complete the course. ERC statistics classify mentally ill clients as psychotic or psychoneurotic and the respective drop-out rates were 21% and 17%, compared with 14% for all disabilities. Wansbrough and Cooper speculate that one reason for this high rate may be inappropriate referrals, indicating a lack of liaison between ERCs and referring agents. This is borne out by Affleck on the basis of extensive clinical experience (in Forrest et al. 1978).

Cornes (1982) carried out an evaluation of ERCs and observed that the distribution of psychiatric disorders among clients was closer to that found in the general population than in a population

of psychiatric in- or out-patients. This suggests that the more severely ill may not be selected. Cornes attributed many of the problems which clients confronted to the social and psychological effects of prolonged unemployment and to their unequal position in the labour market, rather than to the direct effects of illness or disability. This seems an important finding. Many clients were critical of the limited range of work available and of the absence of feedback from staff. Less than half of the clients believed the course had enhanced their chances of working. In this, they may well have been right. Recent figures on the outcome for ERC clients indicate that only a minority obtain employment (unfortunately the figures are not broken down according to disability). In 1985/86, 3 months after leaving the ERC, 55% were unemployed, 10% were in further training and 35% were employed **or** on a Community Programme (National Audit Office, 1987).

To sum up, it seems that a selection process may screen out the more seriously mentally ill and a significant proportion of those who do start drop out prematurely. There is evidence to suggest, moreover, that the courses are not suited to the particular needs of the mentally ill who often have a slower rate of learning (Wansbrough and Cooper, 1980). Only a third of all clients obtain employment after completion of the course and it is likely that the proportion of mentally ill may be lower still, in view of the prejudices they often encounter (MIND, 1978).

The MSC published a review of their employment rehabilitation services in 1981, which noted that the effectiveness of the ERC service for the disabled was limited in several ways. Firstly, the proportion of clients drawn from the non-disabled unemployed population had increased steadily. In 1976, only 6% of ERC clients

were non-disabled, but by 1981, this had risen to 15% (MSC, 1981). Clearly this had implications for disabled people and the mentally ill among them. More recently MSC has declared its intention of reducing the non-disabled complement to 8% by 1987 (National Audit Office, 1987). This seems a further implicit acknowledgement of the need for specialised services for the disabled, but it perpetuates the assumption that **all** disabilities can be treated uniformly.

Secondly, about one-third of the working population lived outside daily travelling distance of an ERC. Furthermore, the minimum economic size of an ERC was 70-75 places and, given the expense of providing the necessary staff and equipment to offer a full rehabilitation programme, it was impossible to offer a flexible service nationwide.

Finally, existing policy dictated that the responsibility for post-rehabilitation placement should not lie with ERC staff, thus severing the link between the centre's activities and its objectives.

In the light of these considerations, the 1981 review recommended that 6 experiments be set up and evaluated to indicate possible future developments in rehabilitation services (MSC, 1981). These experiments were known as the RER developments. They covered a number of purposes and locations and not all were in ERCs: for example, Development C focused on the assessment and rehabilitation of recently disabled people; in Development E clients were placed with employers but offered counselling and support by MSC staff. The sixth development, F, was designed to encourage voluntary bodies to mount projects for the mentally ill and mentally handicapped with a view to providing temporary work and rehabilitation. This was a means of exploring the potential of longer-term rehabilitation, contrasted with the services offered by ERCs (MSC, 1984b). Sprout

was one of 6 such projects. Development F therefore clearly ran counter to notions of integration in that it catered not just for 'the disabled', but for specific categories of disabled people.

In 1983 the MSC conducted an evaluation of the 6 Development F projects and the results were summarised in a report published in 1984 (MSC, 1984b). The 6 projects varied considerably in terms of participants - some were exclusively for the mentally ill or the mentally handicapped, others were mixed - of selection and of service delivery. Individual projects are not referred to specifically and conclusions are therefore highly generalised. The evaluation was based on open-ended interviews with project staff, sponsors (i.e. the relevant voluntary bodies) and participants. Staff reported that the self-confidence of participants improved while on the projects, as did their relationships with others. However, in most instances staff did not consider that participants leaving the projects were suitable for open employment. A common problem was that participants experienced a fall in morale and an increase in anxiety as the end of their time on the project approached. Participants felt that the experience was beneficial, that it enhanced their self-image and improved their general health. However, the evaluation of Development F concluded that the benefits participants derived from the special projects were short-lived, unless other employment was available when projects ended.

The RER experiments showed that the MSC was aware of shortcomings in provision and that it acknowledged that what happened to participants after rehabilitation was important. However, this led to little in the way of service development. Following the evaluation of the RER developments, the MSC proposed 2 main courses of action to improve rehabilitation services (MSC, 1984b). The first

was a progressive programme of change within the ERC network to incorporate better assessment techniques, increase client involvement and transfer the responsibility for employment placement to ERC staff. These changes have since been implemented. Secondly it was proposed that Vocational Assessment Teams be set up in areas not served by ERCs. Teams would be multi-disciplinary and would provide some services directly and commission others from local employers and institutions to provide work preparation and experience. Three such teams are now in operation (National Audit Office, 1987) but results of their work are not yet available.

Thus, these responses entailed a refinement of the ERC service and expanded coverage, using more flexible means. The lessons learned from Development F have, sadly, not been used to adapt services to the needs of mentally ill people, or to ensure that rehabilitation feeds into other forms of provision, such as sheltered employment. As we shall see, the Sprout study illustrates the consequences and further underlines the inadequacy of MSC provision.

Sheltered Employment

The legislation of 1944 enabled the establishment of sheltered workshops for the registered disabled unable to compete for work in open conditions. Workshops were to be run as non profit-making companies and to be subsidised by public funds. As originally conceived, sheltered employment was a transitional service acting as a bridge to open employment. The 3 providers of sheltered employment are local authorities, voluntary bodies and a national organisation, Remploy, and they receive subsidies from the MSC (Lonsdale, 1985). Workshops are exclusively for disabled people, but an alternative form of sheltered employment is available in the guise of sheltered industrial groups (SIGs). In these, several disabled people form an

'enclave' in an open employment setting under supervision. Alternatively, placements can be single and this pattern is becoming increasingly common.

In 1986, the number of places in sheltered employment in the United Kingdom for all disabled people was as follows:

> 8,950 places in Remploy establishments
> 5,500 in local authority and voluntary workshops
> 2,400 in SIGs or single placements.
> (National Audit Office, 1987)

Official figures do not give any indication of the proportion of places held by the mentally ill. However, Wansbrough asserts they are substantially under-represented (in Herbst, 1984). Moreover, Remploy's policy is that no more than 10% of their workforce should be mentally ill people.

Information on sheltered employment in Scotland is even sparser. The Scottish Home and Health Department has no record of the number of mentally ill people in sheltered workshops (McKay, 1985a). In McCreadie et al's study of Scottish day-patients, there were only 2 workshops in the catchment areas of the 16 psychiatric hospitals and units surveyed. Turning to sheltered industrial groups, there were only 67 places available in Scotland in 1984, 2 of which were occupied by mentally ill people (McKay, 1985a). In Lothian, sheltered workplaces are provided mainly for people with physical disabilities and, as we shall see, this creates considerable difficulties for people coming off the Sprout project.

Commentators have pointed out various disadvantages of sheltered workshops. Gladstone (1985) states their adherence to out-dated methods and types of work exclude workers from new technological developments. By their very nature, workshops segregate disabled people from other workers. SIGs or sheltered placements, on the

other hand, give disabled people greater access to culturally normative patterns of work and to a wider variety of work. Interestingly, a recent MSC survey found that disabled people preferred sheltered placements in open employment to placements in a workshop (quoted by National Audit Office, 1987).

In discussing the findings of the Sprout study, I shall look more closely at the need for sheltered employment for mentally ill people and consider some of the difficulties entailed.

This completes the review of special rehabilitation services for the mentally ill in Scotland. The picture presented is a dismal one. Local authority provision is minimal and the valiant efforts of voluntary bodies are plagued by funding difficulties and insecurity (Maxwell, in Drucker, 1987, Vol.1). Day services provided by health boards are insufficient in terms of places and, while individual units often offer a valuable service to users, there is no coherent national policy.

The MSC provides a network of services for the disabled, but these are not geared to the specific needs of the mentally ill and many aspects - such as sheltered employment - are underdeveloped. Before commenting further on the Commission's work, we need to consider the services it provides for the general population, particularly the unemployed. The mentally ill have been drawn into the ambit of a number of MSC training and employment measures. However, for our purposes here, discussion will concentrate on the development of the Community Programme (CP) since its history is relevant to Sprout and since it is the largest employment programme for the adult population.

Community Programme

The Job Creation Programme, an antecedent of the Community Programme, was set up by MSC in 1975 to provide temporary employment for those over 19, on tasks of benefit to the community. Most projects were sponsored by public bodies, particularly local authorities. In 1978/79, the Job Creation Programme was replaced by the Special Temporary Employment Programme (STEP) which provided temporary work for those aged 19-24, continuously unemployed for more than 6 months and over 25's unemployed for more than one year. STEP schemes were mainly in Scotland and the north of England. In 1981 STEP was superceded by the Community Enterprise Programme (CEP) and geographical coverage was extended nationwide. Eighteen year olds were now eligible and by March 1982, 3,500 CEP schemes were in operation with 27,500 places. CEP was replaced by the Community Programme (CP) in 1982 with 130,000 places, of which some 16,000 were in Scotland.

The CP offers the unemployed the chance to work full- or part-time for up to a year on projects of benefit to the community. Against a background of ever-increasing unemployment, the government cut wages paid to CP workers in 1984 from an average of £100 to £65 per week as a means of expanding provision for the long-term unemployed. By July 1987, the number of CP places in Scotland was just under 30,000. However, since rates of pay had to remain in line with national union rates, a reduction in wages per participant inevitably involved a decrease in hours. Thus, in the year up to August 1983, almost 30% of CP participants were full-time, whereas by June 1987 only 25% were full-time.

Eligibility criteria were altered in 1984 to restrict access to those eligible to receive Supplementary or Unemployment Benefit in

their own right. This debarred most married women and some older men from participation and confirmed the suspicions of critics who alleged that CP was merely a device to massage the unemployment figures. Current conditions limit eligibility to under 25s unemployed for 6 of the previous 12 months (or 4, in the case of the disabled) and to over 25s and under 65s unemployed for 12 of the previous 15 months (or 8 for the disabled). The low wages and reduced hours mean that part-time posts are only financially attractive to single people living at home (Finn, 1986). In the year up to June 1987, 78% of participants were single and 75% were male. Furthermore, figures show an increase in the number of young people working on CP; while 18-25 year olds constituted only 33% of the target group, they represented 60% of the CP workforce by June 1987. Simultaneously there has been a drop in the proportion of participants unemployed for more than a year. This would suggest that older groups, and particularly the longer-term unemployed, are less likely to avail themselves of the opportunity of temporary employment.

Critics of the CP argue that the government's main concern is to reduce the unemployment figures, rather than to improve the quality of experiences offered to participants. An internal scrutiny report on the CP was critical of the ambiguity of the programme's objectives and of the lack of attention to the employment prospects of participants. As the report pointed out, the programme is not subject to any systematic appraisal or evaluation (MSC, 1986). Others have noted that insecure funding and the short-term nature of schemes makes long-term planning difficult. Training opportunities hinted at have been curtailed by cuts to the training budget (Finn,

1986). Much of the work undertaken is of little value to participants in terms of subsequent employment (MSC, 1986).

A postal survey of CP participants in 1984 found that fewer than 25% went directly to employment on leaving CP. Eight months later 32% were employed. The author concludes that the programme benefits participants by providing work experience and employment references, but does little to improve skills (Turner, 1985).

It is possible to conceive of ways in which CP could be used more effectively as an escalator back into the employment market. I shall return to this, in Chapter 12, after the findings of the Sprout study have been presented. Ideally the programme would allow greater flexibility and responsiveness to individual needs and command more resources (Ashby, 1986). As it stands, untrained and often inexperienced staff have to deal with participants who are socially disadvantaged in an insecure and underfunded set-up.

Since the Development F initiatives became extinct, it is not known how many mentally ill people take up employment on the Community Programme. The fact that access to places on CP and other special programmes is available to the mentally ill is another sign of 'integration': however, the question remains whether the experiences and opportunities CP provides are suitable for or acceptable to the mentally ill, or whether they simply represent a short-term, low-cost solution which is politically expedient. This is one of the themes explored in the Sprout study.

Conclusion

This survey of policy and provision has highlighted various ways in which services are ill-suited to mentally ill people and has raised a number of questions for consideration in the Sprout study.

Policy on employment rehabilitation is designed on a model which assumes a logical progression through services, towards the goal of open employment. Practice experience and research suggest that this pattern is not consonant with the needs of mentally ill people. The experiences of Sprout participants illustrate the difficulties adherence to this model creates when jobs are not available and when comprehensive services are not there and I shall return to the question of service patterns in the final chapter.

The MSC's activity is impressive if measured in terms of reports, reviews and reorganisations, but is much less so in terms of impact on the mentally ill. It emerged that Sprout participants had little assistance from employment services with obtaining work after leaving the project, for example. Ambivalence about specialist services persists. On the one hand disabled people are encouraged to use mainstream facilities and, on the other, ERCs are undergoing a reorientation towards the disabled and away from the unemployed in general (National Audit Office, 1987). Moreover, the extent to which the specific needs of mentally ill people are recognised varies - although they are as a rule included under the rubric of 'disabled', 2 specialist ERCs exist for mentally ill people. The Sprout study explores the views of service-users on the issue of specialisation/integration and considers whether there is a legitimate basis for treating the mentally ill as a separate group in rehabilitation.

It is clear that when unemployment is high, the MSC gives lower priority to disabled people - it may, for example, be harder to find employers willing to hire disabled people. This raises important questions concerning the rights of mentally ill people to employment, which I shall discuss more fully in the final chapter.

The general direction of MSC policy is perhaps best illustrated by patterns of expenditure. While the Commission's annual expenditure has grown progressively since it was first established, the proportion of the annual budget devoted to employment services and support for the disabled has fallen, as shown below.

TABLE 3.3 Proportion of Annual MSC Expenditure Devoted to Services for the Disabled and to the Community Programme

	1980/81	1982/83	1984/85
Employment services and support for the disabled	25%	18%	11%
CP or antecedents	5%	13%	25%

(MSC, 1985)

MSC spending suggests that policies of integration have been accompanied by a definite change in emphasis in practice. Yet there is little evidence that the interests of mentally ill people are furthered as a result. The Sprout study affords an opportunity to investigate the needs of a group of mentally ill people and to assess whether existing provision is capable of responding satisfactorily to those needs. This will be one of the subjects discussed in the final chapter of the thesis.

The Sprout Project

Although Sprout began life, in 1983, as a Development F project, this status was withdrawn in 1985 when the initiative was terminated across the country. Sprout remained a 'specialised' project for mentally ill people, but became part of the mainstream Community Programme, with funding renewed on an annual basis and subject to CP conditions.

The research project began in October 1984. At that time Sprout occupied a site in the grounds of the Royal Edinburgh Hospital (REH), a large psychiatric hospital within the city. In 1985, a successful application was made to the European Social Fund (ESF) for additional funding. This funding was used to obtain a shop and a second gardening site elsewhere in the city. It was decided to use these new resources to offer former Sprout participants the opportunity of a second year's employment after an interval of 6 months 'out'. The research is concerned solely with the original Sprout CP project, but the creation of a second tier inevitably had repercussions. There was a period of uncertainty whilst decisions about expansion were in the air and subsequently Sprout participants have known there is a possible second year of employment available, should they be accepted. Both these factors may have coloured workers' perceptions at different stages in the research.

At the time the research was underway (1984-87) the project was staffed by one part-time and 5 full-time supervisors, a project manager and a training and development officer. The latter is a relatively new post, filled in February 1986. Staff are selected for their personal attributes and knowledge of horticulture, rather than on the basis of professional qualifications in, say, social work, psychology or nursing. All bring a commitment to horticulture and an interest in working with people, although often a limited experience of working with mentally ill people. However, the intention is to create a near-normal work setting and not to reproduce a therapeutic milieu.

Because of CP rules, not all staff have permanent tenure. Two posts (one supervisor and the manager) are 'designated', i.e.

holders may retain their job as long as the project lasts. The part-time post is for 52 weeks only and the rest are initially for 52 weeks, but the MSC can agree to an extension to 104 weeks in total.

The project manager has responsibility for oversight of all sites, for co-ordinating activities and implementing plans drawn up by the Management Committee. The training and development officer is concerned with the recruitment of new workers, with developing training initiatives within and outside the project and with supporting supervisors. The latter are respcnsible for the day-to-day functioning of the garden and for overseeing the workforce.

This staff team is assisted by a Management Committee, originally comprising representatives of the hospital rehabilitation team (with inputs from a psychiatrist, psychologist, social workers and occupational therapists) and of SAMH and, more recently, supplemented by volunteers with commercial experience. The Committee meets monthly to discuss policy and forward planning. As necessary, subcommittees are convened to discuss and act on specific issues, such as staff selection or participants' assessments. The project manager is accountable to the Committee and via them to SAMH. Two supervisors and 2 participant representatives attend Committee meetings on a rotating basis, to present the views of their colleagues and to relay to them Committee decisions. The staff team meet weekly to plan the subsequent week's work and also on a separate occasion, to discuss personnel matters, such as problems arising with individual workers. A participant representative attends the planning meeting and feeds minutes back to the worker group.

Because the project is exclusively for mentally ill people, conditions of eligibility differ from those which apply to CP projects for non-disabled groups. Sprout is open to people aged 18-64. Those aged 18-24 must have been unemployed for 4 of the last 12 months and those 25 or over, for 8 of the last 15 months. MSC rules further influence the characteristics of those recruited, e.g. by excluding most married women.

The project circulates information about its services to agencies and professionals in the area and, as it has become more established, a relatively constant flow of referrals has come in. Self-referrals are not uncommon, mainly from patients of the Royal Edinburgh Hospital. Applications to the project are initially dealt with by a Disablement Resettlement Officer (DRO). Applicants are asked to complete a form giving details of previous employment, psychiatric and other health problems and reasons for interest in Sprout. Two references are requested, one of which must be medical, and these are taken up by the DRO. The same DRO has worked with the project since its inception and she is therefore well acquainted with the criteria staff use to select applicants. A very few people (it is not possible to state the proportion) are screened out at this stage, mainly on the basis of medical recommendations.

Vacancies arise throughout the year as workers leave, either on completing their 52 weeks contract or prematurely. The DRO is kept informed of places available and applicants are referred on, to be interviewed by a panel drawn from project staff and Committee members from the hospital rehabilitation team. The interview takes place at the project and is used to emphasise the rehabilitative nature of the project, to explain working conditions and to explore the candidate's motivation for applying. Initially employment is offered for 3 days

a week with the opportunity to progress to 4 or 5 days, depending partly on capability and partly on places. Because the MSC stipulates that the weekly wage cost per person must average £65, the number of 4 and 5 day places is limited. Seven participants work 3 days a week, 11 work 4 days and 7 are on a 5 day week. Participants are remunerated in line with the current rates for hospital garden labourers and wages start at approximately £50 for a 3 day week and rise to approximately £80 for 5 days (gross rates).

The Nature of the Work

The Sprout project leases 10 acres of land from the Health Board for a low rental. The land had once been cultivated and was used to provide occupation for in-patients, but had fallen into disuse. The garden comprises 3 non-adjacent sites - a large orchard area, where field-scale crops are grown, a site used for vegetable beds and soft fruit along with an ornamental garden, and a third area which houses 5 polythene tunnels.

By growing a wide variety of crops, it has been possible to provide a range of tasks and working environments to accommodate the preferences and requirements of participants. Work in the orchard area, generally done by squads, is often heavy and one task may take several days to complete. In the tunnels, by contrast, more attention to detail is necessary and work is suitable for individuals or small groups. New participants generally begin work on the vegetable beds, where tasks are small and varied. All produce is grown organically without artificial fertilisers or weedkillers. It is marketed to a number of catering establishments in the city, to the project's shop and to the public, at a weekly stall on site.

Individual supervisors assume responsibility for specific areas or tasks in the garden and each morning volunteers are requested for work in hand. This allows participants to select work they enjoy and staff members with whom they feel at ease. Participants are encouraged to take on responsibilities for a task or an area; this varies according to individual aptitude and some need a great deal of reassurance and prompting, while others need to be guided away from taking on too much.

The degree to which participants are supervised 'on the job' varies. Supervisors are sometimes involved in the same task, or they may demonstrate what to do, give instructions and withdraw. Much depends on the task, participants' competence and other demands on supervisors' time. Participants are expected to follow normal employment disciplines, for example regarding attendance and punctuality. In practice, supervisors use their discretion in individual cases, but sanctions are at times applied for repeated inadmissible behaviour (generally wages are docked).

Each participant is allocated to a key supervisor responsible for his welfare on the project. Participants do not necessarily work with their key supervisor on a day-to-day basis however. Reviews are held with each participant every 2 months to assess progress, set goals and discuss any problems encountered. Supervisors seek to make reviews informal and nonjudgmental and to build up a relationship of trust with participants.

Within the limits of the budget, opportunities are made available for staff and participants to attend external training courses (ranging from horticultural topics to basic literacy and numeracy). Since 1985 an Adult Basic Education course has been offered to participants approaching the end of their contract.

Attempts are also made to develop individuals' interests and direct them to appropriate resources in the community.

In the months preceding the end of employment, supervisors endeavour to direct people towards vacancies they hear of, towards Job Centres and courses. Help is offered with job applications and references, but until mid-1986 follow-up contact was informal only. Former participants were invited to 'call in for a chat' if they wished and some arranged to continue work in the garden on a voluntary basis. There is little or nothing in the way of formal provision to which workers can be referred on leaving. There is no mechanism for the DRO to pick up leavers automatically and it is thus left to individuals to apply to a Job Centre. More recently the training and development officer has set about maintaining contact with ex-workers in the 6 months after they leave to offer support. There is a limit to how much he can do, however, given the other demands on his time and his primary responsibility to those on the project.

This straightforward description of the project risks being superficial and blurring some of the ambiguities which beset its operation. On the one hand Sprout sets out to be an attractive, efficient market-garden and, although it may not be economically viable, to create the atmosphere and ethos of a 'normal' work setting. On the other hand its objectives are rehabilitative and concerned with individual well-being and development. There is considerable tension between these two poles which, at best, generates a creative dynamic, at worst, confusion and uncertainty. On a practical level, a great deal is perforce left to the discretion of the supervisors. The content of their task can be prescribed to the extent that horticultural goals can be set and the nature of

their interaction with participants broadly delineated. Details depend largely on personal style, capabilities and aptitudes. Furthermore the exigencies of the work can conflict with the needs of participants. In order for the garden to thrive, certain jobs must be done, and done satisfactorily, and from time to time practical demands may take precedence. A balance must be sought constantly and supervisors occupy a pivotal position. More will be said later, when we consider the study itself, about how these and other factors affect the project's operation.

Before proceeding to the research itself, we need to look at what was known about Sprout's effectiveness before the study began. One source - the MSC evaluation of the 6 RER developments has been discussed above. The second source was the pilot study (mentioned in Chapter 1) which set out to examine the Sprout project in relation to its rehabilitative goals. Fifteen participants were interviewed to gain information on their perceptions of the project, details of their employment and psychiatric histories and of their social and material circumstances. They were interviewed twice: as the end of their year's employment approached, and 3 months after leaving.

The mean age was 30, ranging from 21 to 40. The majority were male (11) and single (14). Schizophrenia was the most commonly reported diagnosis (8), followed by personality disorder (3). Almost half the sample had had more than 3 admissions to psychiatric hospital, the range being 0-10.

The profile of participants which emerged was of poorly qualified, unskilled people who had considerable experience of unemployment (on average 6 years per person) and a poor employment record. Sprout attracted mainly as an opportunity for work and

companionship within a supportive setting. During the year on Sprout, a number of changes occurred in respondents' circumstances associated with increased independence, social activity and number of friendships. There was, however, a group of 5 respondents who remained friendless throughout. Most of the sample could identify gains derived from employment at Sprout, particularly in respect of self-confidence and physical and mental well-being. For many, being employed was a step towards 'normality' and away from the status of ex-patient.

There was some evidence that participants felt increasingly apprehensive as the time to leave approached. All but one were eager to continue in employment, but few had found other work before leaving. It was estimated that about half were likely to require some form of sheltered employment.

At follow-up, two-thirds said they needed support of some form after leaving the project, but only 6 had received adequate help. The study found that 4 people were in employment at follow-up. Half the sample had been offered jobs, but offers had been refused or jobs given up because of their unsuitability (such as long hours and low pay). None had been readmitted to hospital since leaving Sprout. In all, a third were said to be leading busy, settled lives and appeared to be functioning well. It was suggested that these individuals possessed the ability to sustain relationships and to concentrate on tasks.

The pilot study also included interviews with Sprout staff. Their views on the project's goals were broadly consensual, but diverged on where the project should draw its boundaries. Some felt that counselling workers was a legitimate and necessary part of the job, while others laid more stress on providing a realistic work

setting. Staff appeared to feel they lacked adequate support and feedback on their own performance and one of the main sources of stress for them was the tension between 'work' and 'therapy' which permeated the project. While staff could point to instances of 'success' (workers who had gained in confidence or sociability, for example), there was also a suggestion that the project failed some participants, either because expectations were unrealistically high, or because selection procedures were unsatisfactory.

To conclude, despite the small scale of both the MSC evaluation and the pilot study, a number of common themes emerge. Firstly, participants on Sprout appeared to gain by their experience. There was some suggestion from the pilot study that positive effects spilled over into, or at least were accompanied by, changes in non-work areas of life, such as social relationships and living situations. Secondly, the time-limited nature of employment lead to a decline in morale and an increase in anxiety among participants as the end of the year approached. The importance of what came after Sprout was highlighted: achievements on Sprout often seemed short-lived in the face of difficulties arising afterwards. Finally, both pieces of research suggested placement in sheltered employment was indicated for at least half the sample. The pilot study follow-up found that only a small proportion were in open employment and none in sheltered work. These themes will be explored further in this study.

We now move on in Chapter 4 to consider the design of the Sprout study and the methods employed.

CHAPTER 4

METHODOLOGY

Evaluation

In this chapter I begin by considering evaluation as a research method, before focussing on the evaluation of rehabilitation programmes in particular. This discussion serves as an introduction to the Sprout study and the design and methods used in the study are presented in the latter sections of the chapter.

Evaluation is of necessity located within some goal-oriented activity, where value is attached to certain objectives. Broadly speaking, the function of evaluation is to determine how successfully these objectives have been attained (Suchman, 1967). However, a review of the literature indicates that evaluation is not some monolithic research method, but a wide range of processes which need to be carefully selected for the investigation in hand (Tibbitt, in Lishman (ed) 1984). Evaluation can have various aims: the emphasis may, for example, be on 'effort', on 'effectiveness' or on 'efficiency' (Tripodi, 1971). Our concern here is to evaluate the overall effectiveness of the Sprout project and the extent to which it achieves its objectives. It seems apposite to consider the following 3 components using the frameworks suggested by several investigators (Polansky, 1960; Goldberg and Connolly, 1982).

(1) Objectives : what does the project set out to achieve?
(2) Process : what means are employed?
(3) Outcomes : how successfully are objectives achieved?
what factors indicate 'success'?
are there any unanticipated consequences?

Objectives

It has been said that all organisations have 2 superordinate sets of goals concerning survival/maintenance and change/growth. Within any organisation, different members are likely to hold various conceptions of the organisation's objectives (Katz and Kahn, 1966). To rely solely for evaluation purposes on formal declared objectives may be misleading and cause one to overlook alternative conceptions held by other parties involved. Consumer studies, for example, have suggested that considerable discordance may exist between the perceptions of service providers and users (Bayley, 1973; Rees and Wallace, 1982). In defining a programme's objectives, it is important therefore to ascertain **whose** objectives are being explored (Key et al. 1976). Objectives are themselves subject to a wider social determination in that social values influence the ways in which social problems are defined and also the nature of remedial action deemed appropriate (Suchman, 1967). The Sprout project, for example, fits in with the current policy of establishing special employment programmes for the unemployed in a society where work continues to be highly valued.

Process

Consideration of 'process' involves attending to structural factors, the organisational context and the content of the programme. It has been suggested that such considerations are not strictly speaking a part of evaluative research (Suchman, 1967), while others have argued that it is important to describe and understand the medium of change as well as its effects (Polansky, 1960). An exploration of the process may establish or refute causal connections and refine knowledge about which components of a programme produce which effects (Goldberg and Connelly, 1982). In addition, attention

to what takes place on a programme requires one to consider the issue of service quality, which is, as Shepherd remarks (1985), an often neglected dimension of effectiveness.

Outcome

Successful outcome may not simply be equated with the attainment of objectives (Hyman, in Carter and Wharf, 1973) since unintended consequences both beneficial and negative may be of significance (Polansky, 1960).

In any evaluation, the selection of criteria to measure success is problematic. Firstly, one must have grounds for believing that the intervention is capable of affecting the variables selected as indices of success. This presupposes that theory and knowledge have been developed sufficiently to allow such assumptions to be made. Secondly, the question of 'success in whose terms' poses itself, particularly where objectives are broad.

It might be said there is no definitive outcome measure. Measures selected reflect the nature of objectives (Markson, 1976), the level of sophistication of relevant theoretical knowledge and the relative weight attached to different views, such as consumers' and professionals'.

The emphasis in the Sprout study is on outcomes: the effects the project has on participants. The study does not include a systematic analysis of the 'processes' by which these effects are produced, but looks at service quality by examining how service users perceive the project. In view of the orientation towards outcomes, it is necessary to consider in some detail the choice of outcome measures in rehabilitation, before proceeding to the study itself.

Outcome Measures in Rehabilitation

Comparisons of the relative effectiveness of different rehabilitation programmes have often been confounded by the use of different outcome measures. One attempt to promote the application of a uniform measure proposed 2 standardised criteria: employment rates and 'recidivism rates' among discharged psychiatric patients (Anthony, 1972). On the basis of a number of studies undertaken in the United States, Anthony established baseline rates for both criteria in order that rehabilitation programmes could adjudge their performance relative to these norms. The rates set were based on the effects of a 'traditional' hospital regime of drugs and some form of psychotherapy.

While such efforts constitute a step in the right direction, the 2 measures chosen as indicators of outcome have certain fundamental weaknesses. Both employment status and readmission to hospital may be influenced by a number of extraneous factors, so that outcome measured in this manner may not accurately reflect an individual's level of functioning, or the impact of a particular rehabilitation programme. For example, the general level of unemployment can impede resettlement (Morgan and Cheadle, 1975) and changes in demand for certain types of labour also influence employment opportunities (Bosanquet, 1985). Hospital admissions may depend on a variety of social and administrative factors, not only on severity of illness (Mann and Cree, 1976; Holmes and Solomon, 1980).

Moreover, it could be argued that employment status and independence of in-patient services are in themselves neither appropriate nor accurate measures of 'community adjustment' or 'adequate social functioning' which regularly constitute the goals

of rehabilitation. The use of such measures tends to polarise and oversimplify the issues involved - the fact that someone has obtained a job tells us little, for instance, about the satisfactoriness of that job, and employment can often incur as many costs as it brings benefits (Warr, 1984). As noted in Chapter 2, it is important to guard against the assumption that all culturally normative patterns of behaviour are desirable and, as we shall see, this proves to be an important lesson in the Sprout study. Patient status may also bear little relation to someone's functioning - conceivably he/she might be in hospital for a brief period only following an acute episode of illness, or might need long-term in-patient care because of a serious, chronic illness.

It seems important therefore to take account of the wider social context when assesing outcomes, as noted in Chapter 2. The patterns of services and types of employment available may have a substantial impact on how a person functions.

On the basis that the broad aims of rehabilitation are to enable a disabled person to achieve an optimal level of functioning and maintain current capacities in the face of possible deterioration, employment status and hospital admission might be supplemented by other indices which tap different dimensions of 'community adjustment'. These could take cognisance of the views, subjective experiences and goals of the individuals concerned and might also include quality of life in and out of work (Mechanic, 1980; Martin, 1985). If mentally ill people are to be accorded the status of social and moral agents, it follows that evaluation should pay heed to their views and intentions. An illustration of this type of approach to evaluation would be a study by Okin (1983) which elicited the views of 31 discharged patients, living in residential

facilities and using a range of day services with a 'rehabilitative emphasis'. Compared with a group of hospital patients with similar disabilities and chronicity, the community group showed little or no clinical improvement over the 8 months after discharge, but expressed preference for their new way of life and described positive changes in their quality of life.

Quality of Life as a Measure of Outcome

Quality of life is an abstraction which brings together diffuse features of people's lives and summarises what they find desirable and satisfying. It has been suggested that, while quality of life can be measured by objective indicators, such as employment status or income, subjective factors may be more informative (Briscoe, 1982) as individual goals and values vary (Hall, 1976). Interestingly, in a large-scale study in Australia, the gap between aspirations and attainments was the factor most closely associated with the presence of psychiatric disorders (Krupinski, 1980). Quality of life seems a useful concept to employ in this context as it refers not only to the individual and the environment, but also to their interrelationship.

The concept of quality of life links quantitative data on material circumstances and performance with qualitative data on subjective perceptions and intentions (Bigelow et al. 1982). It is not, however, without conceptual and practical problems, since individual aspirations may be limitless and unattainable and it may be more useful to speak of 'needs' and levels of need satisfaction (Edwards, in Robertson and Osborn, 1983). Nonetheless, it offers a valuable supplement to the more 'traditional' outcome measures in rehabilitation which have tended to focus on individual functioning

in isolation from personal goals and from environmental contingencies which may have constrained performance.

Concern with the quality of life requires that investigators look at services from the users' perspective and consider how provision affects the pattern of their daily lives in a wider social context. For example, does a service stigmatise users (Sinfield, in Robertson and Osborn, 1983)? Given that mentally ill people have tended to occupy a marginal position in society, emphasis on quality of life represents one way of giving them a louder voice and of reducing the distance between service providers and users.

In Chapter 2 I noted that rehabilitation is not solely concerned with change and for some people improvement in competence is not a realistic goal. In evaluating a rehabilitation programme it therefore seems important that measures selected should not be exclusively oriented to monitoring change in performance. For people with severe and chronic disabilities, rehabilitation may be an exercise in damage-limitation and quality of life measures may be more apposite than assessments of performance.

We turn now to the Sprout study to look at the methods used in the light of the preceding discussion.

Evaluating Sprout

An evaluation of the Sprout project could have assumed various forms. It might, for instance, have looked exclusively at the extent to which the project met the objectives of service providers. However, I have chosen to concentrate on the views of consumers - Sprout participants - for several reasons:

(1) rehabilitation aims (**inter alia**) to improve self-esteem and autonomy. Evaluation should therefore pay heed to individual's goals and purposes;

(2) underlying any rehabilitative activity is the assumption that human beings have the capacity to change. Moreover, individuals are not merely 'acted upon' but are capable of making choices and generating plans and intentions (Harré and Secord, 1972; Lukes, 1973). It seems important to take cognisance of this in evaluating a rehabilitation project;

(3) traditional measures of outcome can be extended by including the concept of quality of life, as mentioned earlier. This requires that attention is paid to the views of consumers, which have often been neglected;

(4) as noted above, different parties may hold conflicting conceptions of a project's objectives. It is of interest therefore to go beyond the 'official view' of objectives and also look at objectives from the users' perspective. In the Sprout study, I have taken the objectives of the service providers - SAMH and project staff - as a framework, but used project participants as the primary source of data to gauge outcomes;

(5) SAMH, Sprout's sponsoring organisation, has consistently advocated that the views of mentally ill people on needs and services should be respected and the Association was therefore eager that an evaluation of Sprout should build in the views of participants;

(6) the fact that Sprout was an employment project and not treatment-oriented implied that methods of the type used in clinical assessment were not appropriate. In any case, project staff were reluctant to act as assessors since this would not have been in keeping with the ethos of the project: they tended to adopt a non-judgmental stance in their dealings with participants and sought to avoid any connotations of 'professional' and 'client'. Using consumers' views to evaluate Sprout was thus in keeping with the ethos of the project;

(7) the use of consumers' views provides a means of evaluating the nature and quality of the rehabilitation process. I noted earlier that this dimension has often been absent in other studies which focussed exclusively on outcome.

While the Sprout evaluation is primarily a consumer study, it also uses objective indicators to measure changes in participants' functioning and well-being and therefore employs a wider range of methods than many other outcome studies as I shall explain later in the chapter. But a crucial stage before outcome measures can be selected is the specification of objectives and the activities designed to achieve them (Carter and Wharf, 1973).

Sprout's Objectives

Sprout's objectives are shown in Table 4.1.

TABLE 4.1 The Sprout Project's Objectives

Sprout offers participants the **opportunity** to:
- re/learn work discipline;
- re/learn work skills;
- interact with others;
- experience success;
- test out capabilities;
- structure time

Sprout's **short-term goals** are to improve participants':
- work performance;
- motivation;
- social relationships;
- confidence;
- health;
- well- being;
- income

Sprout's **long-term goals** are to improve participants':
- employability;
- capacity to cope with unemployment;
- independence;
- social integration;
- health;
- quality of life.

The objectives shown in Table 4.1 were derived from various sources: SAMH statements, discussions I had with the Association's Director, informal discussions with project staff and interviews with the latter. Although individuals differed in the importance they ascribed to the pastoral aspects of the job and to maintaining the disciplines of a workplace, differences tended to be a matter of emphasis rather than of substance. It seemed that new staff espoused the same set of objectives as they became assimilated into the Sprout 'culture'. In any case, the nature of the project demanded a relatively high degree of uniformity among staff and management in practice: the horticultural work had to be done and that limited the scope for other undertakings, such as pastoral work.

The table distinguishes between short-term goals and long-term goals. Short-term goals are for participants while they are at Sprout. Long-term goals are those to be attained after they leave Sprout. Outcomes can therefore be considered at 2 different times. In addition, however, short-term goals constitute a means to an end and may also be regarded as variables which influence final outcome. Thus action taken to enhance self-esteem may subsequently enable someone to assume new social or domestic responsibilities.

The project's objectives were diverse. In evaluating Sprout, I have sought to find methods which reflected this diversity - for instance I have included measures of participants' functioning as well as measures of subjective states. Additionally the stated objectives strongly influenced what I sought to find out in interviews and from the scales. I had to 'operationalise' broad concepts such as independence which I assessed by looking at participants' living arrangements, their financial situation and their usage of health and welfare services.

The Research Study

The study sets out to establish whether the Sprout project achieves its aims. According to the objectives delineated above, participation on the project might be expected to bring about specifiable changes in functioning and in well-being. Furthermore it might be anticipated that those who worked at Sprout for a year would differ subsequently from those who did not, in terms of health, well-being, self-esteem, social functioning, employment status and reliance on services (particularly in-patient services). Finally, it might be expected that short-term changes brought about during time on the project would result in long-term changes, such as increased capacity to be independent after leaving Sprout.

However, the evidence from other research reviewed earlier suggests that this formulation of Sprout's objectives may be over-ambitious. The studies discussed in Chapter 2 indicated that the changes rehabilitation can achieve tend to be limited and short-lived. Moreover, the pilot study and the RER evaluation both demonstrated that Sprout had little long-term impact on participants' employment chances. While it was of interest to discover whether the outcomes for Sprout participants confirmed or refuted the evidence of other research, it also seemed important to go further and attempt to identify those features of Sprout which seemed particularly valuable or detrimental to participants, since they might point up ways in which the effectiveness of rehabilitation programmes could be maximised. It was also of interest to ascertain whether the project had a variable impact on different individuals. Finally the study set out to consider participants in a wider context and to investigate factors which may have affected their performance and their quality of life.

The Research Plan

The original research plan, elaborated before I took up the work, proposed a prospective study to allow the collection of 'before' and 'after' information on Sprout participants. In this way the study distinguishes itself from some of the other outcome studies reviewed in Chapter 2 which were conducted retrospectively. The turnover of participants was considered ideal for a longitudinal study without unduly prolonging it. The sample was to include:

(1) an experimental group of 30 Sprout participants;

(2) a control group, also 30 in number, made up of patients discharged from the Royal Edinburgh Hospital. They would be eligible to work on the project, but unable to do so because of lack of vacancies. This group would be matched, as far as possible, with the experimental group for age, sex, marital status, psychiatric condition and so on.

It was envisaged that a combination of qualitative and quantitative techniques would be employed. Interviews with respondents were to be conducted at 3 stages, as shown in Table 4.2.

TABLE 4.2 Proposed Research Plan

Experimental Group (N = 30)

First Interview	Second Interview	Follow-up Interview
on commencement at Sprout Month 1	at/towards end of employment on project Month 9-12	6 months after leaving project Month 18

Control Group (N = 30)

First Interview	Follow-up Interview
post-discharge from Royal Edinburgh Hospital Month 1	12 months later Month 12

Importantly, the prospective design allowed the inclusion of interviews with participants while they were employed at Sprout. Employment seems to be valuable not just as a means of rehabilitation, but also as an end in itself and participants' views on working at Sprout seemed worth investigating.

The blueprint was that of a classical experimental design with the experimental and control groups being monitored and contrasted. Data collection was to begin early in 1985 and to be concluded by September 1986. On the basis of past experience, only a small proportion of participants were expected to terminate their Sprout employment prematurely and problems were not envisaged on this account.

I began planning the study in October 1984 with the intention of using a cohort of a year's intake to the project starting from January 1985 as the experimental group. As work progressed, 2 separate sets of difficulties became evident pertaining to the control group and the experimental group. These will now be discussed in turn.

(1) The original intention of identifying a control group among patients discharged from the Royal Edinburgh Hospital (REH) has been noted. It transpired, however, that almost all suitable patients or ex-patients had either been offered a place at Sprout or might receive an offer during the research. When Sprout began in 1983, there was a waiting-list of at least 20, but by the end of 1985 this had dwindled to 2 or 3. Vacancies had to be filled promptly to avoid financial loss. Moreover, I had no authority to control access to the project and it was likely that staff would have objected on ethical grounds.

Looking further afield for a control group, I made extensive enquiries through SAMH and with psychiatrists and voluntary agencies in different parts of Scotland. Four conclusions emerged: firstly, the population in continuing contact with hospital psychiatric services tended to be older and many had had long periods as in-patients. These factors distinguished them from the Sprout sample.

Secondly, the social context of patients from other hospitals often differed from that of REH patients. One of the other psychiatric hospitals in Lothian, Rosslynlee, has a predominantly rural catchment area, for instance. Thirdly, many of those in contact with services were involved in some form of rehabilitation, such as occupational therapy. To have used this group would have substantially altered the nature of the research - it would have become a comparison between a non-time-limited hospital-based service and Sprout. Fourthly, SAMH was in the process of setting up other projects similar to Sprout in different parts of Scotland. It would not have been possible to choose an area and be confident that no Sprout-type project would be set up there.

Although it seemed likely that there were individuals in the community suitable for our purposes, they did not seem readily identifiable or accessible. It was consoling to discover that these problems concerning control groups are not uncommon in research in 'action settings' (Weiss, 1972).

The outcome was that the plan to find a control group similar to the Sprout group, but not exposed to the project, was abandoned. After consultation with various parties, including Professor Kreitman (of the MRC Unit, Department of Psychiatry, Edinburgh), it was concluded that the original classical experimental design might have been over-ambitious in view of the time and resources available. It was decided that energies might be more fruitfully directed into a thorough assessment of project participants and their experiences. This could act as a foundation for more refined research in the future.

(2) The second set of unforeseen difficulties related to the experimental group. The pattern of recruitment to the project was not of a single annual intake as the original research design assumed, but of small numbers (generally 2-4 at a time) selected as vacancies arose throughout the year. Furthermore, as the months passed it became apparent that an unexpectedly high proportion of participants was not completing their 12 months at Sprout.

The effect of these unforeseen difficulties was twofold. Firstly, it proved necessary to interview a large number of new participants to ensure that the size of the sample would be adequate. Secondly, the time schedule envisaged was no longer feasible. First interviews ran over a longer period than originally intended, again to ensure that the sample was of an adequate size. This in turn had implications for the scheduling of second and third interviews. To have continued with the original intention of interviewing subjects at 1, 9 and 18 months (see Table 4.2 above) would have prolonged the research considerably and involved exceeding both time limits and financial resources.

To recapitulate, then, difficulties were encountered with locating a suitable control group to act as a comparison with the Sprout sample. In addition, newly recruited workers were leaving the project prematurely at an unanticipated rate. There was consequently a large group with whom contact had been made and for whom baseline data had been collected, but who were not employed at Sprout for the full 12 months. This constituted a numerically respectable contrast group, similar to the 'non-equivalent control group' suggested by Campbell, in Weiss (1972b). It was felt that the contrast group of non-completers could provide an interesting perspective on the evaluation of Sprout. Before proceeding, however, it is important to

clarify what a contrast group of this nature might contribute to the research.

The classical experimental design allows the researcher to identify the relationship between the service provided and outcomes by 'subtracting' the control group from the experimental group. When the research design was modified it was anticipated that completers and non-completers could be used to compare the effects of participation with the effects of non-participation. Completers and non-completers were similar to the extent that both groups were eligible and suitable for the project, came from similar areas and had access to the same services. Nevertheless, it was recognised that it would not be possible to make causal inferences about the impact of Sprout since the groups were formed on a self-selecting basis rather than being randomly allocated. Indeed, subsequent analysis of the data indicated that completers and non-completers differed in important ways. Comparison between the two groups must therefore be treated with caution as we are not comparing like with like.

Furthermore, those who left Sprout prematurely worked there for varying lengths of time. Some stayed 6 months and had substantial exposure to the project. Consequently it was not a straightforward comparison between a group who received a service and a group who did not. Nonetheless there still seemed a case for considering those who did not complete as a distinct group. In practical terms to have treated people who worked at Sprout a considerable time, but still left prematurely, as 'quasi-completers' would have meant selecting a cut-off point of, say, 4 or 6 months, on a purely arbitrary basis.

In any case, non-completers were of interest in their own right for several reasons. Firstly, it seemed important to establish why people dropped out. In addition, follow-up interviews with non-completers provided evidence of what happened to people after leaving Sprout over a longer period than was possible with completers. Completers were followed up 3 months after leaving for reasons given below, while non-completers followed up had been away from Sprout for at least 6 months. Non-completers also seemed of interest in that little is generally known about how the mentally ill fare in the community. Jones (1986) has pointed up the need for research which traces people over time, not just while they use a particular service.

The Revised Research Plan

By November 1985 a decision was reached to modify the research plan. I was confronted by a dilemma. On the one hand I wanted to ensure the sample included a sufficient number of completers. On the other, it took 12 months to establish whether someone starting Sprout would complete and more than one-third of those I had interviewed had started in August 1985 or later. I could not afford to go on interviewing new recruits until a satisfactory number of completers had been definitely achieved. Eventually, my supervisors and I decided to push the cut-off point for the inclusion of new participants in the study on from December 1985 to April 1986 - and await the outcome. Table 4.3 shows the rates of recruitment and completion for the 53 people joining the project between January 1985 and April 1986.

TABLE 4.3 Recruitment, Completion and Non-completion Rates January 1985 - April 1986

Date recruited	Number recruited	Number completing	Number not completing
January 1985	8	2	6
February	5	0	5
March	2	2	0
April	2	0	2
May	5	3	2
June	4	2	2
July	3	1	2
August	4	3	1
September	0	0	0
October	7	3	4
November	5	3	2
December	0	0	0
January 1986	0	0	0
February	3	1	2
March	4	4	0
April	1	0	1
Total	53	24	29

Thus, of those who started between January 1985 and April 1986, 24 completed and 29 did not. While I would have liked a larger number of completers, the numbers, we concluded, were adequate. These 53 people constituted the sample in the Sprout study.

Also in November 1985 it was decided that all interviewing must be completed by January 1987 to allow sufficient time for the analysis of the data and the writing up of the thesis. The pattern of interviews was altered from that envisaged in the original research plan to that shown in Table 4.4.

TABLE 4.4 Revised Schedule of Interviews

Completer Group

First Interview Time I	Second Interview Time II	Follow-up Interview Time III
on commencement at Sprout Month 1	while still at Sprout Month 9	Month 15

Non-completer Group

First Interview Time I	Follow-up Interview Time IIb
on commencement at Sprout Month 1	Month 12

Those recruited were still to be interviewed at point of entry to the project. According to the path they took subsequently - to continue employment at Sprout or to leave - research contact differed.

The completer group was interviewed a second time, 9 months after starting Sprout. By that stage they would be able to comment on their experiences on the project. In addition, 9 months was a reasonable period within which discernible changes might have occurred in individuals. Moreover, by 9 months, the prospect of their employment on the project concluding was not yet so imminent as to significantly colour participants' perceptions.

The final interview with the completer group was conducted 15 months after initial contact - 3 months after leaving the project in lieu of 6 months as originally proposed. It had proved necessary to expend more time than anticipated conducting first interviews as the intake of new participants was spread over time. This meant that, in

order to stay within the time allotted to the study, only a small subset of 9 completers could have been followed up 6 months after leaving Sprout. The alternative was to reduce the follow-up period to 3 months, in which case a maximum of 16 completers could have been seen by January 1987. Although a longer-term follow-up would have been preferable from a research point of view, the latter option was chosen after much thought since numbers were already relatively small. Other outcome studies in rehabilitation have used various follow-up periods: those reviewed in Chapter 2 ranged between 3 and 6 months. The choice of 3 months was thus not a matter of breaking with convention and, indeed, was in line with both the pilot study and the RER evaluation of Development F projects. It is also relevant to note that studies of the unemployed have suggested that any deterioration in health and well-being stablises at approximately the 3month stage and little further deterioration is discernible by 6 months (Warr and Jackson, 1985).

The contrast group of non-completers was followed up 12 months after first contact. The interest here was to find out what became of people who dropped out of Sprout. Re-interviewing at 12 months meant people had been away from the project a reasonable length of time. To have chosen a longer follow-up period, such as 18 months, might have increased the difficulties of tracing people and would also have exceeded the research project's time limit.

Establishing Contact with Research Subjects

Applications to Sprout were channelled through the Job Centre. Potentially suitable applicants were invited to a selection interview at the project, references were taken up and appointments made by project staff. At this point the manager or training officer would alert me that new participants had been appointed and indicate their

date of commencement. Initially, there was a delay of 2 weeks between applicants' interviews and their starting on the project. In such cases I made an appointment to visit at home in the intervening period. Increasingly, however, new recruits were asked to start employment one week after interview. This was recognised as far from ideal, but was necessitated by unforeseen terminations of employment. In these instances, the initial research interview was conducted at the project, in the course of the new participant's first or second day. Twenty-two people were seen at their place of residence - home or hospital - 31 at Sprout. While interviewing people on their first or second day was not wholly satisfactory, as they already faced the stress of adjusting to a new environment, it was unavoidable.

Second interviews with completers took place at Sprout, during working hours. Details of participants who dropped out were relayed to me by project staff. Follow-up interviews with both groups were conducted in people's homes, except in one instance where it was known that home circumstances might make interviewing difficult and the person concerned was asked to return to Sprout to be interviewed.

Table 4.5 details the size of the sample at different stages.

TABLE 4.5 Numbers Interviewed at Different Stages

Completers

First Interview	Second Interview	Follow-up Interview
Month 1 (N=24)	Month 9 (N=23)	Month 15 (N=15)

Non-completers

First Interview	Follow-up Interview
Month 1 (N=29)	Month 12 (N=14)

Several points of explanation are needed here:

(1) owing to illness, one completer was unavailable for second interview;
(2) as indicated earlier, time restrictions meant that only 16 of the 24 completers could be seen at follow-up. One man repeatedly broke appointments, leaving 15;
(3) it proved difficult to recontact non-completers. I had anticipated interviewing 24 within the time available, but 3 were untraceable and 7 broke appointments.

Before discussing the research methods used, it seems apposite to make several general observations about the sample. The next chapter provides a full description of their characteristics; of interest here are the processes which affected selection and which influenced the make-up of the sample. The first set of factors included the MSC rules for Community Programme eligibility concerning applicants' age, time unemployed and status as claimants (see the preceding chapter), along with regulations about wage-levels and the availability of full- and part-time employment. The net effects of these conditions were to render Sprout more attractive to single people without dependents who lived at home, and to exclude most married women.

Secondly, the selection process itself was important. There were 2 competing forces in operation at Sprout. Pressure from the

MSC compelled the project to be relatively indiscriminate in selecting recruits in order to fill vacancies. On the other hand, there was a reluctance among staff to recruit people who were likely to be too demanding or disruptive, whose needs could not be met with the resources available. From my observations of the selection process, it seemed that the criteria used were relaxed when vacancies had to be filled urgently, but that on the whole the panel tended to reject people who seemed poorly motivated or unable to work without supervision for at least part of the time. As a consequence, the Sprout sample is quite special - it is unlikely to include married women, for example, or people who have been seriously impaired by mental illness to the extent that they cannot work relatively independently. These points should be borne in mind when we come to look at the findings.

Methods Used

In the preliminary stages, I met regularly with the project manager and had discussions with the Director of SAMH to gain an overview of the project's evolution, structure and objectives. I also attended meetings of project staff concerned with routine planning, sat in on the selection process for workers and staff and from March - June 1985 sat on a subcommittee set up to review procedures used by project staff to assess workers. These activities were beneficial in conveying a more detailed understanding of how the project functioned as well as giving pointers to aspects of policy and practice which were assumed by those involved to be particularly significant in terms of rehabilitation outcome. A fieldwork diary was kept mainly as a means of recording matters of potential relevance to be explored further. As far as possible I endeavoured to remain an observer, outside decision-making processes.

On a more regular basis, I attended monthly management committee meetings, having been asked to become a member. This was a further opportunity to observe the project in operation and to keep informed of developments. My 'active' role within the committee was deliberately kept to a minimum. Rarely was I asked to feed in information from my research, as the general view was that comments and conclusions should await the completion of the study.

My own involvement with the project as a committee member and my regular presence on site undoubtedly influenced my outlook on the research, by sensitising me to issues of concern. It is not possible to gauge the extent to which this may have contaminated findings. There was some tension and discomfort in being used at times as a sympathetic listener by different parties. It can only be said I sought to keep such occasions to a minimum and to remain as non-partisan as possible.

The work involved in carrying out the longitudinal study precluded the possibility of conducting a systematic analysis of material obtained by participant observation. Moreover, because of the physical layout of the project, (a market garden of 10 acres spread over 3 non-adjacent sites) the extent to which patterns of working and working relationships could have been observed systematically and rigorously by one person was very limited. Participant observation was used therefore as prompt and guide rather than as a research tool. In the first 9 months I took part in the gardening work, once a week for half a day. Again this afforded a valuable insight into how the project functioned day-to-day and an impression of participants' experiences 'on the ground'. It should be noted, however, that there are difficulties in combining participation in strenuous physical labour with observation of the finer details of social interchange taking place around one! The

primary source of data were interviews with project participants. Secondary sources were interviews with staff, staff assessments of participants, project attendance records and participants' medical records. I shall describe interviews first, before considering the use made of assessments and records.

Interviews with Participants

Face-to-face interviewing was chosen as the main means of obtaining information. Given that I wanted to obtain participants' views on a range of issues, face-to-face interviewing seemed more suitable than, say, a written questionnaire, as participants would probably be more willing to express themselves at greater length verbally. Additionally, several of them had difficulties reading and writing. In all interviews with participants, a semi-structured interview schedule was employed, with a combination of open-ended questions and fixed category responses. The content varied at different stages and according to whether participants were completers or non-completers. To attempt to measure the extent to which the project met its objectives, the questions I asked of participants were tied specifically to those objectives.

In line with the earlier discussion concerning the importance of consumers' views in a study of this nature, interviews were designed to obtain information on participants' circumstances and their perceptions of those circumstances. Thus, a 3-fold approach was used, incorporating:

(1) information on factual matters;
(2) subjective perceptions;
(3) a set of scores from rating scales.

I shall now give more details of the content of the interviews at different stages. The interview schedules and rating scales are reproduced in Appendix A and B, respectively. The first interview

set out to obtain baseline data, to gauge whether and to what extent change occurred over time. I wanted to collect fairly comprehensive information on participants' backgrounds. Firstly, it was of interest to find out exactly who used the project. Secondly, I wanted to explore some of the areas opened up by other research and seek to establish who was 'more successful' at Sprout and whether 'success' was related to particular individual characteristics. Thirdly, I was keen to gain a broad view of participants in their social context, not simply in their workplace. The project aimed to have a far-reaching impact on participants' lives, for example to promote social integration, and it was therefore necessary to collect comprehensive information about participants. Finally, the pilot study had suggested that project participants faced considerable difficulties in their lives as well as being disadvantaged in the area of employment. This study provided an opportunity to document the nature of these difficulties.

The main areas covered in interview included:

(1) psychiatric history and diagnosis, as reported by participants: use of services, views on these and current state of health and well-being;
(2) employment history: nature and extent of previous employment, experiences of and views on unemployment;
(3) family circumstances: level of contact with family and quality of relationships;
(4) social situation: extent of and satisfaction with friendships and social activities;
(5) financial circumstances;
(6) route to the Sprout project and reasons for applying.

Subsequent interviews set out to ascertain whether changes had occurred in participants' circumstances and therefore reviewed many of the areas covered at first interview. Additionally, in the second interview, completers were consulted about their experiences of working at Sprout. This set of interviews proved a useful means of

discovering what participants thought of the project and afforded an insight into the 'process' dimension referred to earlier, albeit from one perspective only - that of users. Topics covered here included (in addition to an update of baseline information):

(1) preferences about different tasks;
(2) perceptions of own work performance;
(3) views on supervision;
(4) attitudes to work and difficulties encountered;
(5) relationship with peers and with project staff;
(6) perceived gains from working at Sprout.

According to the statement of Sprout's objectives presented earlier the project aimed to offer participants various opportunities, for example, to learn skills and have contact with other people. I was interested to find out whether, and in what ways, participants used these opportunities and to establish what participants felt were the difficulties and the advantages of taking part in rehabilitation. These topics have rarely been covered by other research in the field.

At follow-up, with both completers and non-completers, I reviewed the areas covered at first interview. In addition, attention was paid to:

(1) experiences of employment and unemployment since leaving Sprout;
(2) the search for employment;
(3) perceived need for help or support;
(4) retrospective views on Sprout.

The main aims therefore were:

(1) to establish what participants gained by working at Sprout, both while there and after they left and compare these findings with the project's objectives;
(2) to establish whether some gained more than others and, if so why;
(3) to discover the reasons for non-completion;
(4) to find out what happened to both completers and non-completers after Sprout.

Rating Scales

The interview schedule was supplemented at all stages by a range of rating scales. Because of the study's longitudinal design, I had to start interviewing at a very early stage in the research. Initially I had reservations about using a whole battery of scales as this seemed to have clinical connotations which the project strove to avoid. It proved difficult to locate appropriate scales in the time available, particularly ones which would assess social functioning/ adjustment.

One group of scales, such as Hall's ward rating scale (Hall, 1978) or the Morningside Rehabilitation Status scale (Affleck and McGuire, 1982) has been designed for use by professionals who have regular close contact with subjects and can make informed judgements about social performance. I could not, given the size of the project and the difficulties of observing and assesing systematically, and in any case I could not be privy to how workers behaved outside the project.

Another group of scales, such as that devised by Platt et al (1980) relies on the judgements of third party informants, usually relatives or hostel staff. To have used these here would not have been in keeping with the employment setting and would have constituted a breach of the divide which, for employees in most settings, separates their work lives from their private lives.

However, I did decide to use some scales from the first. These were:

(1) Affect Balance Scale (Bradburn, 1968)
(2) Present Life Satisfaction Scale (Warr, 1978)
(3) Life Events Inventory (Cochrane and Robertson, 1973).

I chose these because they could be administered in the course of the interview and could be answered by the participants themselves. By November 1985 I had interviewed 43 people using these scales and they have proved manageable. A review of the research at that stage suggested that more standardised information would be advantageous in view of the modifications made to the original research design which meant that the sample was smaller than anticipated and that there was no classical control group.

Renewed efforts to find additional suitable scales proved fruitful. The following scales were then added:

(4) Scaled version of the General Health Questionnaire (Goldberg and Hillier, 1979)
(5) Self-esteem Scale (Rosenberg, 1963)
(6) Social Adjustment Scale (Weissman et al. 1978; Cooper, 1982).

Results on these scales are only available for 10 participants at first interview. The full set of 6 scales was used with all participants in subsequent interviews.

With the exception of the Life Events Inventory, which was administered during interview, the scales were administered at the conclusion of interviews. Only in a small number of cases did the package of the interview schedule, plus scales, prove unwieldy. In 3 instances subjects appeared very distractable, but in only one case did it prove necessary to conclude prematurely without completing the General Health Questionnaire. The interview plus scales took, on average, one hour to administer. There was some variation according to the stage of interview and personality differences - some people were consistently monosyllabic in their answers, others replied at length. The range was approximately 45 minutes - 90 minutes. Generally, people were helpful and co-operative. At times I gained the impression some were habituated to discussing their lives with

'professionals' and little sense of privacy remained. Occasionally, some were reticent about discussing their experience of mental illness and psychiatric treatment (particularly in the case of those who had been in the State Mental Hospital) and this was respected. The major difficulty was in keeping the interview focussed - some people evidently welcomed an opportunity to discuss their problems at length and needed little prompting. There was a fine line between establishing a rapport and evincing interest, in order to put people at their ease, and yet retaining control over the direction and pace of the interview.

All interviews were recorded on tape and no one refused to be recorded. Any initial awkwardness this caused seemed to fade as the interview gathered momentum. After the event, I replayed interviews, categorising fixed responses and transcribing responses to open-ended questions. It was not necessary to transcribe verbatim the full interview, as factual data could be summarised under relevant headings. For example, with reference to past employment, it was only necessary to record the number of different jobs, time in each and reasons for leaving. Responses to open-ended questions which contained subjective perceptions and opinions were transcribed fully.

Description of Scales Used

The 6 instruments listed above cover different dimensions of health, well-being and social adjustment which pertain to the concept of quality of life. I shall look firstly at the 3 scales used up to November 1985, followed by those added later. Subsequently I shall consider what the scales were expected to contribute to the research.

(1) The Affect Balance Scale (ABS) was devised by Bradburn. In a large-scale survey in the United States, he suggested that positive and negative affect were independent. It was suggested that the 2

dimensions were correlated with different variables, although both were related to overall ratings of subjective well-being, arrived at by establishing the discrepancy between positive and negative scores. Positive affect was associated with higher levels of social contact and exposure to new experiences; negative affect was not correlated with these, but was associated with indices of anxiety, symptoms of ill-health and fears of a 'nervous breakdown' (Bradburn, 1968).

The ABS consists of 10 closed response questions, 5 relating to positive, 5 to negative affect. Scores are obtained by totalling the affirmative answers to each set of questions. Scores can be expressed as positive and negative separately (a high negative score indicating low well-being) and also as the discrepancy between the two scores yielding the affect 'balance'.

A study of British Steel workers by Warr (1978) using the ABS found that unemployed workers exhibited significantly lower levels of positive affect and higher levels of negative affect, compared with employed subjects. In Bradburn's original study, indices of life satisfaction and general happiness were found to correlate with both positive and negative affect in opposite directions - i.e. high life satisfaction was associated with positive but not with negative affect and low life satisfaction was associated with negative but not with positive affect. Warr (1978) found similar patterns of association in his study.

(2) The Present Life Satisfaction Scale (PLS) used in this study was employed by Warr in his replication of Bradburn's work. Respondents are asked to think of their present life and how they would describe it in terms of 11 bi-polar adjectival scales on a 7-point semantic differential layout

(e.g. interesting - - - - - - - boring).

Answers are scored 1 to 7, 7 indicating the positive pole. Both Warr (1978) and Hepworth (1980) found significant differences between employed and unemployed subjects on this scale.

(3) Whether or not life events can increase the rate of psychiatric morbidity continues to be disputed (Cooke and Hole, 1983). The measurement of life events in the Sprout study was regarded as a means of quantifying stress present in the environment of individual participants over a specific period. A Life Events Inventory (LEI) as compiled by Cochrane and Robertson (1973) was used to record the amount of 'turmoil, disturbance and upheaval' undergone, including positive, negative and neutral events. It should be noted that this is essentially a stimulus measure; assessment of individual responses requires a supplementary measure such as the Affect Balance Scale.

It seems likely that particular types of events may have aetiological significance for particular disorders (Goldberg and Huxley, 1980). Events which may be detrimental for people with schizophrenia may be beneficial for those with a different disorder, such as depression. Conclusions drawn on the basis of a quantitative rating must therefore be cautious. Nevertheless, it seems valuable to attempt to measure levels of environmental stress to complement measures of individual capacity and motivation.

(4) The General Health Questionnaire (GHQ) is a self-administered questionnaire concerned with (a) the respondent's ability to carry out certain functions, and (b) the appearance of new psychological phenomena of a distressing nature. It comprises a set of questions designed to determine the presence/absence of a core of symptoms encountered in the various differentiated syndromes of mental disorder (Goldberg and Hillier, 1979). I have used the scaled

version, made up of 28 of the original 60 items. There are 4 subscales: somatic symptoms, anxiety and insomnia, social dysfunction, and depression. In the Sprout study, I have used the overall score to give an indication of the state of participants' general psychological health. This also proved sufficient for purposes of intergroup and intragroup comparisons.

Responses can be scored on a 0-0-1-1 basis or using Lickert scoring of 0-1-2-3. The former method was employed here as Goldberg and Hillier found it more useful for screening purposes. They suggest that using 4/5 as a cut-off point discriminates clinical cases from non-cases. This is valuable in the Sprout study to gauge the level of psychological distress among participants. It is important to note, however, that the scale is concerned with recent perceived changes in respondents' health. When used with people who are subject to long-term chronic ill-health, the GHQ indicates whether health has improved or deteriorated recently, but does not provide a clinical measure of the severity of the underlying illness (Stanley and Gibbons, 1985). The scale is therefore used in the Sprout study to record changes in health rather than as an absolute measure of clinical state. It has proved useful in this respect in other studies: using a slightly different version of the GHQ, Stafford et al (1980) found that individuals' scores altered over time according to their employment status.

(5) The Self-esteem Scale (SES) (Rosenberg, 1965) was originally devised for use with adolescents, but has since been employed in various studies. It consists of 10 questions with which respondents are asked to agree or disagree. For scoring purposes, questions are grouped into 6 items giving scores ranging from 0-6. High scores indicate low self-esteem.

(6) Social adjustment has increasingly been used as a measure of success or need for treatment and some such assessment seemed apposite in this study, in the light of the project's aims. However, the measurement of social adjustment presents various conceptual and methodological difficulties (Platt, 1981). From a pragmatic angle, the only available source for information on social adjustment in this study was the participants themselves, for reasons given above. The scales used were therefore self-administered and based on the Social Adjustment Scale (SAS) devised by Weissman and Paykel (1974) in the United States.

Other studies, reviewed by Weissman et al (1978) suggest the scale can be used successfully with 'psychiatric' and 'non-psychiatric' individuals. It was shown to differentiate 4 groups: 'depressives', 'alcoholics', 'schizophrenics' and 'normals'. In an American study of depressed patients, the SAS self-ratings correlated well with scores derived from an interview version and also with ratings made of patients' functioning by a close informant on the same questionnaire. In a group receiving treatment, the self-rated SAS was shown to be sensitive to change over time: improved mental state was accompanied by significant improvements in social adjustment.

In the United Kingdom, the SAS has proved equally useful with schizophrenic patients (McCreadie and Barron, 1984). A slightly modified version has been devised for use with a British population by Cooper et al (1982) and this version is employed here. This scale covers an individual's functioning in 6 role areas: work/housework, social and leisure activities, relationships with extended family, marital relationships, parental functioning and functioning within the family unit. The scale contains a possible 45 questions

concerning functioning in the past 2 weeks and respondents only complete relevant sections. Each question is answered on a 5-point scale, a higher score indicating greater dysfunction. In this study, I have used the global score, that is the total of scores for the relevant role areas, to identify change over time and differences among individuals.

This completes the description of scales used. There were several reasons for including these scales. Firstly, while the Sprout evaluation was primarily a consumer study, it seemed valuable to employ a range of measures. Wallace and Rees (in Lishman (ed) 1984) argue that this gives different perspectives on the issues involved. Furthermore, using scales as well as interviews provides a means of cross-validating results by comparing the 2 sources. Standardised instruments also make it possible to compare the Sprout sample with other populations. As we shall see, the Sprout sample appeared more dissatisfied with their lives than other groups of unemployed and less competent socially than several other groups researched. Thirdly, it is unlikely that a social intervention, such as Sprout, will have a uniform impact on all participants. Scales provide a means of measuring differences among participants.

I shall compare the results on scales for the Sprout sample with the findings of other research more fully in later chapters. At this juncture, I shall simply make some general observations about what we might expect from the scales in view of the findings of other studies. Although scales allow one to monitor change over time systematically, I have already called into question the extent to which rehabilitation can be expected to 'produce' changes in competence (see Chapter 2). Thus, it seems unlikely that scales concerned with performance - the Social Adjustment Scale and the Work

Assessment Scale (see below) - will indicate substantial change in ability.

Other research which has looked at the relationship between psychological health and well-being has found that both tend to deteriorate when people are unemployed (Warr, 1978; Stafford et al 1980). It seemed plausible that the Sprout sample would follow a similar pattern as their employment status changed. Thus we would expect that the well-being of participants would be higher while at Sprout than when unemployed. This is important as it implies that low levels of well-being and psychological ill-health detected among Sprout participants should not be construed as a direct product of their mental illness, without taking account of their employment status.

In relation to self-esteem, other studies on the relationship between employment status and self-esteem have arrived at different conclusions and I shall return to this later in more detail. Self-esteem may be of particular importance in rehabilitation, since other research suggests that participants' attitudes may influence rehabilitation outcome (Griffiths, 1974). In the Sprout study it is of interest to ascertain whether self-esteem acts as a dependent variable and changes in the course of rehabilitation or whether it proves to be an independent variable influencing outcome.

Interviews with Staff

Staff interviews mostly took place in March/April 1985, to fit in with the schedule of work. At that point I interviewed 6 supervisors and the project manager. New staff who joined the project subsequently were interviewed about 2 months after starting. In all, by May 1986, I had interviewed 7 supervisors, 2 managers and the training and development officer. Staff were interviewed once

only, using a semi-structured questionnaire. Slightly different formats were devised for supervisors, managers and training and development officer (see Appendix A for details). Interviews covered areas such as the project's objectives, the means it employed, job content and satisfaction and views on mental illness and rehabilitation.

I used these interviews to formulate the project's objectives, as outlined earlier in the chapter. Staff interviews helped inform my thinking about the project and enriched my perceptions of it by giving me a clearer understanding of how it functioned. In discussing the findings which emerged from interviews with participants, I have also drawn on views of staff. In view of the consumer emphaasis I decided not to devote a chapter to reporting separately on the views of staff.

Assessments and Records

In addition to the data gathered in interviews with participants, I also obtained data on participants from supervisors, from the project's attendance records and from medical records.

As indicated earlier, supervisors were reluctant to carry out any standardised assessment of participants since this was felt to be judgmental. Supervisors prided themselves on the openness of their relationships with participants and were reluctant to adopt the role of assessor. It seemed important to the research, however, to obtain a third party evaluation of participants' functioning and supervisors' co-operation was gained once it was explained that this was only one component of the evaluation process.

Supervisors used the scale employed in the outcome studies by Griffiths (1977) and Watts (1978), described in Chapter 2. Two assessments were completed for each participant, at 2 months and 10

months into their year's employment. It was agreed that ratings should be made openly with participants and if the 2 parties disagreed, this should be recorded. This happened rarely and I have used supervisors' ratings throughout.

It will be recalled that the scale covers 5 areas of work performance: task competence, response to supervision, social relationships, motivation and confidence. Assessors are presented with 25 pairs of opposite statements, for example:

A **B**

Does complicated jobs - - - - - Can only do simple jobs

and are asked to rate the person on a 5-point scale, indicating whether: A applies; this person inclines to A; this person is about average; this person inclines to B; B applies. Unlike many other rating scales used to assess occupational performance in rehabilitation, this scale covers various aspects of the work role likely to be associated with acceptable work performance, in addition to task competence (Watts, 1978).

In addition, supervisors were asked to complete an evaluation of participants as they left the project. A series of 8 closed questions was devised to gain an overall rating of 'success' on the project. This covered changes in confidence; motivation; plans for the future and how realistic these seemed and supervisors' recommendations for future employment. Scores were calculated by assigning a score of 1 for each positive response, for example if someone had become more confident, giving a range of 0-8, where 8 indicated greatest achievement. While such a measure is inevitably crude, the intention was to have some means of gauging outcome at the end of employment at Sprout, to allow comparison with outcome at follow-up and with variables possibly associated with 'success'.

The final source of information was records. The project's attendance records were of interest to determine rates of absenteeism and to investigate factors associated with variations in absenteeism among the sample. I calculated the number of days each participant was absent from work for a random selection of week-long periods covering a total of 6 months. Participants may work 3, 4 or 5 days a week. All began on 3 days and some later moved to 4 or 5 days. Days absent were measured as a percentage of possible working days, taking a hypothetical 4-day week for all participants for simplicity's sake. Unfortunately it was not possible to ascertain why people were absent.

Thirty-seven of the 53 participants gave me permission to consult their medical records. In 7 cases records were unobtainable at the Royal Edinburgh Hospital: they had either been transferred to another hospital, or were required on wards at the time of enquiry. I had hoped to gain details of diagnosis, prognosis and a history of treatment from records to compare with participants' own accounts. However this proved difficult as information was not always recorded systematically and there were often several conflicting diagnoses. It became evident that spending a great deal of time on records would probably yield little of value for my purposes and I therefore decided not to chase up those which were initially unobtainable. Where I was able to consult participants' medical records, I compared the details they contained of diagnoses and treatment with the reports participants themselves gave me.

Some Problematic Features

Before moving on to the data itself, it seems apposite to conclude by mentioning certain problematic features of evaluative research with particular reference to the Sprout project.

The evaluation of Sprout was oriented towards a consideration of the project's effectiveness and used a model of 'input' and 'outcome' borrowed from the natural sciences which is in some respects not wholly appropriate for social scientific endeavours (Key et al 1976). The use of a mechanistic input/outcome model requires that goals be defined in operational terms. While this study has sought to do so as far as possible, it is not a tight piece of quantitative research as it contains substantial qualitative elements, notably consumers' views. Key et al (op.cit.) draw a useful distinction between 'rational' and 'intuitive' behaviour in social programmes. Rational behaviour is based on systematic enquiry, data analysis and planning and is more future-oriented. Intuitive behaviour is based on qualities of feeling, empathy and insight and is more present-focussed. The different types of behaviour tend to be performed at different levels - planning and management tending to be based on rationality and fieldwork practice on intuition. Different techniques are required to evaluate the 2 behaviour types and the authors affirm the value of using an appropriate mix of 'hard' and 'soft' evaluative approaches to cover both types. This study has sought to do so by combining objective measures of change over time and of goal attainment with subjective perceptions, in the belief that it is not sufficient to identify 'regularities' and 'correlations' and to transform issues concerning social life into technical questions (Bernstein, 1979). It is also necessary 'to discover and uncover the ways in which agents understand themselves and interpret what they are doing' (op.cit., p.23).

Thus it is not a matter of social science enquiry being **either** empirical **or** interpretative; a synthesis of the 2 whereby objective changes and correlations are understood in terms of subjective

meanings and intentions might do greater justice to the complexity and depth of human action and social life.

A further source of difficulty lies in the fact that social programmes are not static entities but resemble living organisms. In the course of my research, the Sprout project underwent considerable changes. A second 'tier' was added to it, drawing on a different funding source. Participants who took up employment as this 'tier' was being planned were exposed, albeit indirectly, to an atmosphere of flux and uncertainty among staff. Latterly participants were aware of the newly available opportunity to apply for a second year's employment - an opportunity which modified some of the project's working assumptions. While broad objectives remained relatively unaltered, the arrival of new staff (including 2 changes of manager) together with other developments, led to changes in emphasis and style. The research model assumes that 'inputs' were uniform, but this was not so because of the ways in which the project was changing. One can only speculate on the extent to which this may have a distorting effect on results (Campbell, in Key et al 1976). However the basic elements in the project were unchanged and some change is inevitable in any human institutions.

There are other difficulties related to the fact that I had no control over the direction and extent of changes. The preceding account of the evolution of the research design bears ample witness to how the project imposed parameters on the research. The ways in which the research study was influenced ranged from the very practical to the quasi-philosophical. In practical terms the project's recruiting policy left me little scope to plan or control the inflow of new subjects in line with research priorities. Similarly, given the size and layout of the project, it was not

possible to document in more detail the day-to-day interaction of supervisors and workers 'on the job'.

The Sprout study differs in several important respects from many other hospital-based rehabilitation studies. My unwillingness to employ certain commonly-used research instruments and my decision to use participants themselves as the primary source of data may seem disconcerting to those familiar with clinical hospital research and may lead them to regard the Sprout study as less 'scientific' and 'respectable'. However, the principles which informed practices on the project set boundaries I could not exceed - for instance, it was not acceptable to staff that I should sit in on bi-monthly reviews held with individual participants, since this was felt to breach the confidential and special nature of their relationship with workers; nor was it appropriate for me to use relatives as informants on participants' social functioning. Inevitably one's choice of research method must be consonant with the values of those who are going to give permission. It is only as different possibilities are explored that some must be discarded.

In the next chapter we lay the foundations for the study by describing the sample at point of entry to Sprout.

CHAPTER 5

THE SAMPLE

In this chapter I shall deal with the sample as a whole. Differences between completers and non-completers will be considered in a separate chapter.

To analyse the data I used the SCSS Conversational Statistical System. This is well-suited to studies with a strong qualitative component, in that it allows the researcher to explore relationships suggested by qualitative material with care and speed. Others have found SCSS useful with a small number of cases and relatively large number of variables (Hill, 1983). In this study the statistical operations I used were frequencies and correlations. Given the small numbers, rough fractions and raw figures are generally used in the text, rather than percentages which give findings a spurious precision and mask small numbers. Percentages are given when this is necessary to facilitate comparison. Any statistical relationship between variables will be noted in the text and levels of significance stated.

Direct quotations from participants are used as illustrations. These have been kept anonymous to preserve confidentiality. For the sake of brevity, direct quotes have sometimes been abridged without altering the sense. On the whole, however, participants gave brief responses: this may arise from the fact that interviews followed a semi-structured format.

The chapter consists of background information on Sprout entrants obtained at first interview (Time I) - demographic data, psychiatric and employment histories, social circumstances and the processes which brought people to Sprout.

Certain areas of investigation yielded little of interest or proved to have no direct bearing on the main themes and have therefore not been included in the text. Readers are referred to Appendix A for a full list of the items covered at interview. In this chapter, the results on the Affect Balance and Present Life Satisfaction scales are reported. The others - General Health Questionnaire, Self-Esteem and Social Adjustment scales - were administered to only 10 people at Time I. The small numbers meant that results had to be treated with great caution to avoid spurious comparisons and it was finally decided not to use them.

When analysing the data I looked for possible 'clusterings' in the sample on the basis of age, gender or severity of illness. For example, conceivably, younger participants might have differed sharply from older ones in terms of diagnosis, or employment. However, it did not prove possible to identify categories which did justice to the diversity of participants and in what follows the sample is treated as a whole.

TABLE 5.1 Profile of Sprout Participants

Gender	No.	%
Male	43	81
Female	10	19

Age	No.	%
Less than 25	12	23
26 - 35	27	51
36 or more	14	26
Mean	31 years	
Range	18-54 years	

Marital status	Male		Female	
	No.	%	No.	%
Single	33	62	9	17
Married	3	6	0	-
Divorced	7	13	1	2

Accommodation	No.	%
Parental home	17	32
Supported accommodation	14	26
Shared flat	8	15
Own flat	6	11
Marital home	3	6
Hospital	3	6
Lodgings	2	4
Lives with:		
relatives	23	43
'other'	17	32
alone	10	19
friends	3	6
Length of tenure:		
less than 1 year	18	34
1-2 years	11	21
Over 2 years	24	45

Demographic Data

Table 5.1 gives a profile of Sprout participants. Several points emerge from this. Firstly, the gender ratio is similar to that found among all Community Programme (CP) entrants: men outnumber women by 5 to 1 (Finn, 1986). However, Sprout participants were older than those on other CPs: two-thirds of all CP entrants in the year ending October 1985 were under 25 (op.cit.). Compared with the general population, the number of married people is disproportionately small, while single, divorced and separated people are over-represented. According to the General Household Survey (1983) of those over the age of 16:

24% males and 18% females were single
69% males and 62% females were married
3% males and 6% females were divorced/separated
4% males and 14% females were widowed.

Two sets of explanations can be adduced. Firstly, one of the consequences of CP eligibility criteria is that participants tend to be single. Almost 80% of entrants in 1985 were single (Finn, 1986). Secondly, other studies have found that mentally ill people tend to remain unmarried (Cheadle et al. 1978). Among those who do marry, the rate of divorce and separation is unusually high (Brown et al. 1973).

The low marital rate means that living situations may seem 'unusual', particularly the high proportion living with parents. Unfortunately it is not possible to present figures for the general population as census data use different categorisations: parents and children living together are only recorded when the children are 'dependents', i.e. not adults. Nonetheless, other research has found a similar proportion of mentally ill people living with parents. In their Scottish study of chronic day patients, McCreadie et al (1984b) found over one-quarter lived with parents.

The level of mobility seemed high: over half the sample had moved in the preceding 2 years. People in rented or supported accommodation seemed more likely to move, while those living with parents seemed more settled. Generally participants were satisfied with their accommodation. Ten were dissatisfied and as many were ambivalent. Dissatisfaction had various causes - for example, the isolation of living in lodgings or dilapidated accommodation on deprived estates.

Psychiatric History

It was not possible to gain access to medical records for all the sample, either because permission was not given or because files were unobtainable. The details given below of diagnosis and treatment are therefore based on participants' own accounts. Where medical records were consulted, there was broad agreement between what people told me and what was on record with reference to number and duration of in-patient episodes and diagnosis. It might be assumed therefore that, despite some gaps in knowledge and problems of recall, participants' accounts gave a fair degree of reliability. In any case, using participants as sources was in line with the values of the Sprout project and the research itself. It seemed important not only to look at degree of involvement with psychiatric services, but also to explore how people perceived their illness and the services provided.

Diagnosis

The table below shows the diagnoses participants reported, using their terminology.

TABLE 5.2 Reported Diagnosis

	No	%
Schizophrenia	24	45
Depression	9	17
Nerves	5	9
Manic depression	3	6
Personality disorder	2	4
Anxiety	1	2
Alcohol-related problem	1	2
Don't know/said not ill	8	15

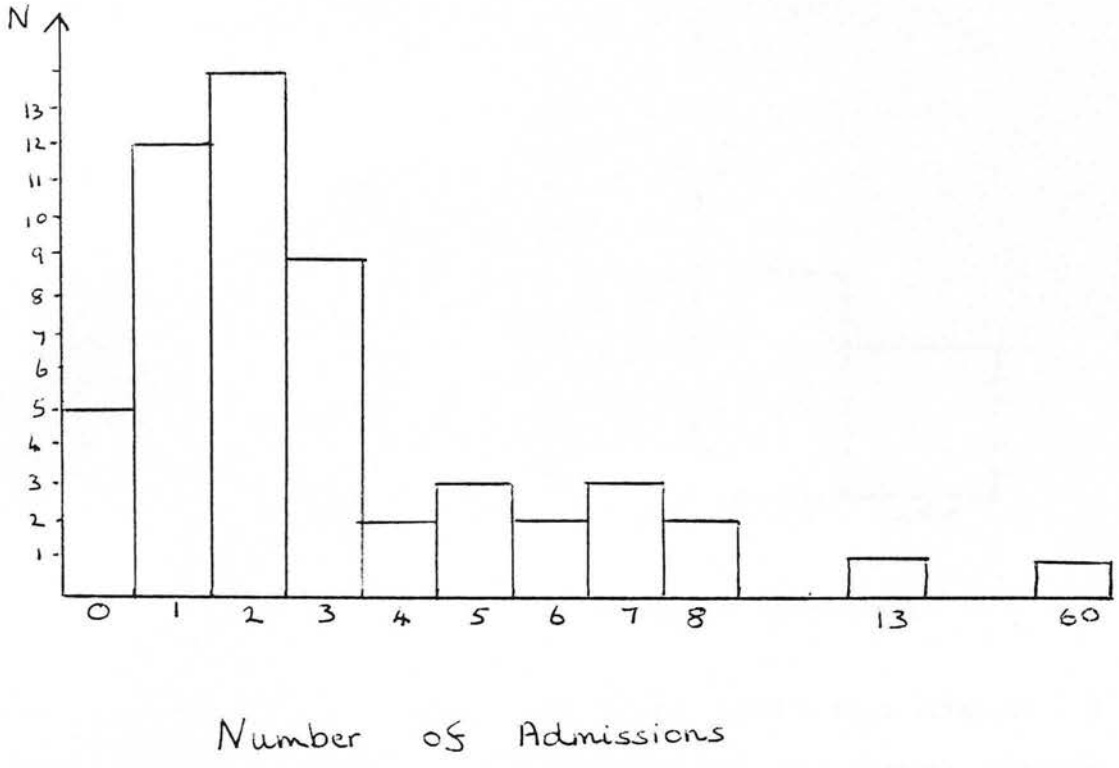
These categories contain certain ambiguities - 'nerves' is a catch-all term, for instance, and depression may be psychotic or neurotic. What is clear is that at least half the sample had suffered from some kind of psychotic disorder. More than one-third (19 people) reported they had had alcohol-related problems in the past, but only 1 in 10 stated this was still a problem. Thus, while only one person reported a diagnosis of alcohol-related problems, many more indicated they had at some time abused alcohol. Drug-related problems were less common, affecting 10 people in the past but no one at time of asking. Possibly respondents felt more able to admit to problems in the past, giving the impression these had been overcome.

In-patient Treatment

There was considerable variation in the amount of psychiatric in-patient care participants had received. Figure 5.1 shows the number of hospital admissions. The mean for all participants was 4 admissions; excluding the exceptional case of the person with 60 admissions, the mean was 3. The number of in-patient episodes was

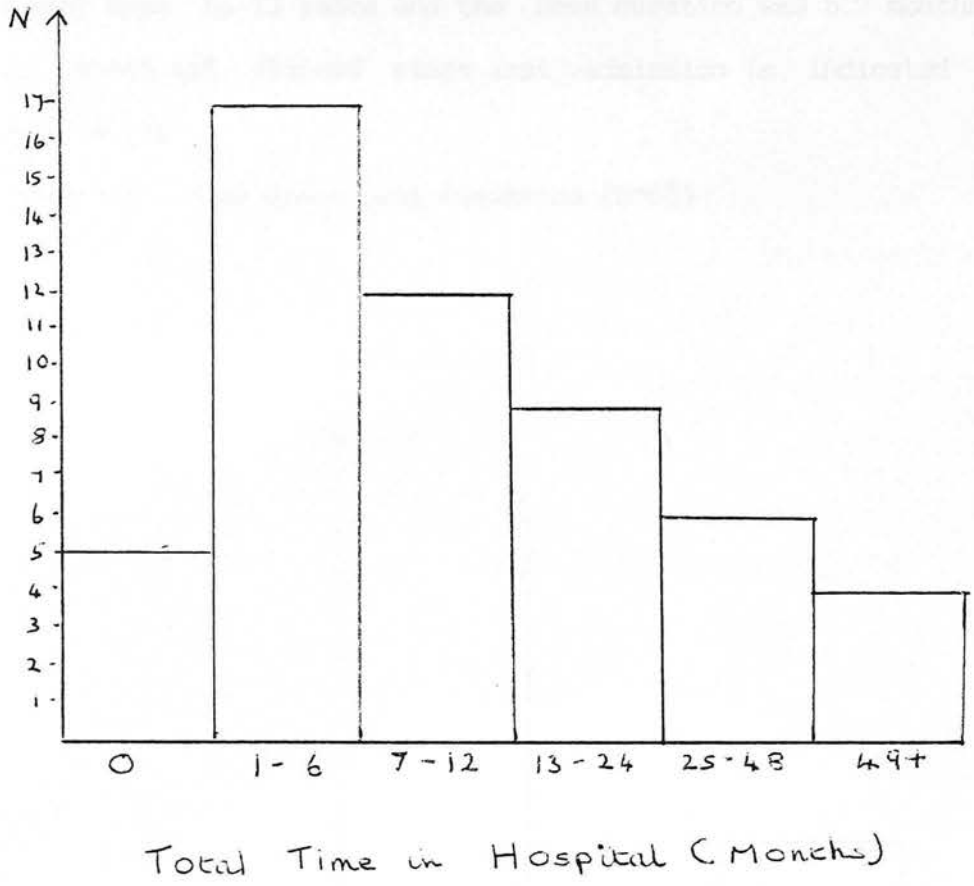
loosely related to age (p = 0.07). Those who had never been in-patients were relatively young - aged 19-27 - but were similar to the sample in other respects.

FIGURE 5.1 Admissions to Psychiatric Hospital (n=53)



The total amount of time spent in psychiatric hospital is shown below.

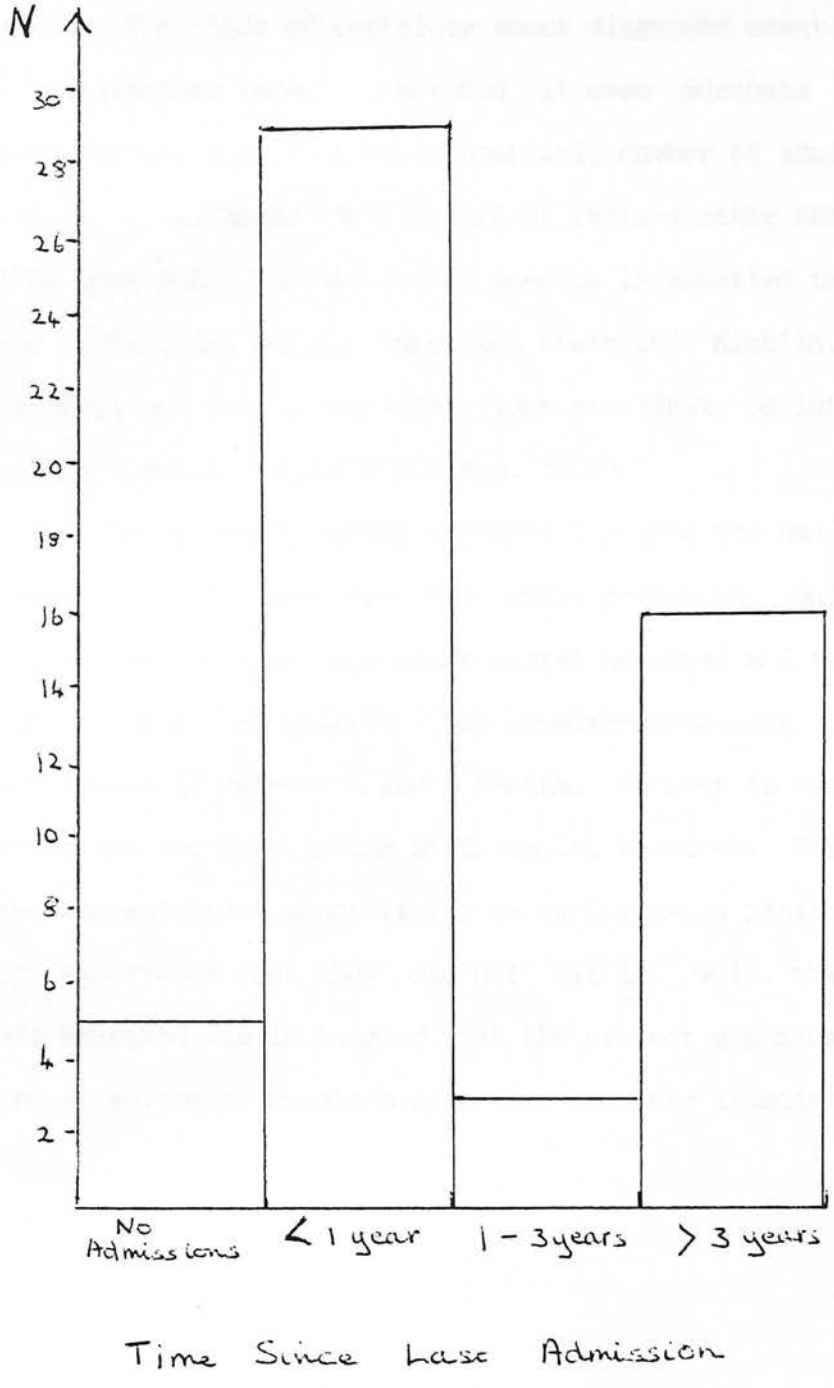
FIGURE 5.2 Time in Psychiatric Hospital (n=53)



The range was wide: from 0 to 26 years, with a mean time of 1.9 years in hospital. The 4 men who had spent the longest time in hospital had all been patients of the state mental hospital at Carstairs. This hospital is used for patients detained under the Mental Health Act who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities. Patients are admitted from the courts following criminal proceedings or transferred from other hospitals which have found them unmanageable.

The length of individual admissions varied enormously from several days to 13 years and the mean duration was 5.7 months. The time which had elapsed since last admission is indicated in the figure below:

FIGURE 5.3 Time Since Last Admission (n=53)



The fact that several years had elapsed since someone was admitted did not necessarily indicate recovery. Some were still out-patients while others seemed to have slipped through the net of services altogether.

It was not possible to rate participants according to 'severity of illness'. The lack of certainty about diagnoses meant these were not a satisfactory index. Nor did it seem adequate to combine several variables, such as time in hospital, number of admissions and so on, since it is known that a range of factors other than severity of illness have a bearing on whether someone is admitted to hospital. Relatives' attitudes may be important (Leon and Micklin, 1978) and administrative and policy considerations are likely to influence how long someone stays in hospital (Grimes, 1978).

In sum, Sprout participants included 5 people who had never been in-patients, 4 (all men) who had spent prolonged, uninterrupted periods as in-patients of the state mental hospital and the majority who tended to have had several - but sometimes numerous - relatively brief admissions of between 2 and 6 months. Comment is needed on the small group who had been in the state mental hospital. While project staff were apprehensive about taking on ex-Carstairs patients, on the basis of experience that they did not 'fit in' well, the fact that they were selected was in keeping with the project's philosophy which paid less attention to people's past than to their immediate need for employment.

Out-patient and Day-patient Treatment

The great majority - 43 people - had been psychiatric out-patients at some time. On starting Sprout, 27 were out-patients. Four others lived in hospital hostels under medical supervision. Fewer - 29- had ever been day-patients. Thirteen of them moved directly from day care, generally in the hospital's occupational therapy department, to Sprout.

The Effects of Mental Illness

The perceptions which mentally ill people have of their illnesses are directly relevant to services designed to meet needs. Users are likely to assess services at least partly in terms of the extent to which their needs are met, as the study by Mayer and Timms (1970) demonstrated. I asked participants about what 'caused' their illness and the table below shows the responses. Where people gave more than one 'cause', I recorded what they indicated was the main one.

TABLE 5.3 Perceived Cause of Mental Illness

	No
Difficulties in relationships	12
Stress at work	8
Childhood experiences	3
Bereavement	3
Drugs	3
Physical ill health	2
Genetic factors	2
Unknown	20

The proportion stating 'stress at work' is striking in view of the fact that Sprout is an employment project. Stress had generally been occasioned by working under pressure in what was seen as an unsympathetic environment.

The extent to which illness affected people's lives was not necessarily related to diagnosis: some of those diagnosed schizophrenic said they were only slightly affected. In all, about half the sample - 25 - felt illness had a substantial effect on their lives and specified ways in which they were restricted. Seventeen were less seriously affected and 11 not at all.

Mental illness had various consequences. Firstly, it introduced an element of unpredictability.

> You think you've got it cracked and then it recurs ... I worry when something good happens if it'll be spoiled by this skeleton in the cupboard.

The possibility that illness might recur seemed to diminish the control several people felt they had over their lives. Secondly, illness could limit capabilities.

> My illness totally dominates my life. It limits what I can do, how I feel, the type of job I could have.

Thirdly, it restricted opportunities. One man who had had his application for jobs turned down explained:

> Being unemployed so long, they say you've no' been trying. You cannae say you've had a problem wi' drinking because they'll no' want to know you.

Illness had often disrupted participants' working lives. Twenty-seven had been in work when they last became ill, but only 3 subsequently returned to their jobs. Ten had been dismissed, 14 left voluntarily, sometimes because they felt too unwell to continue,

sometimes because they could not face colleagues who now 'knew' about them. The Sprout group seemed to have fared worse in this respect than mentally ill people in other studies. Wansbrough and Cooper (1980) found, in 2 separate studies, that between 66% and 80% of those discharged from hospital returned to former jobs. However, these results may not be representative, since the studies looked at a group of employers who were particularly 'sympathetic' and took place at a time when general unemployment rates were lower. Thirty Sprout participants felt their health would have a considerable effect on their ability to work, while 23 felt it would have little effect.

Views on Psychiatric Services

I asked people to describe their most recent admission to hospital. The substance of responses varied greatly: some gave very brief accounts ('It was OK' or 'I didn't like it'), while others described their experiences in detail. A number of themes emerged from these.

For some participants, admission to hospital was a relief - for them and for their relatives.

> I was glad to go in, things were so bad.

About one-third (16) felt that the treatment received helped alleviate their illness. However, a few felt very strongly that they should not have been hospitalised and recalled the experience with bitterness. In all, 10 thought being in hospital did not help, or was actually detrimental.

> Going in had a shattering effect on me.
> It was futile. I was drugged to the extremes
> and that was all they did.

Half of those admitted (23) found it a disagreeable or disturbing experience.

> I didn't want to be there. I didn't like anything about it. I was very unhappy.

Added to that, participants were often acutely aware of the wider social implications of going into a psychiatric hospital.

> Just the thought of being in hospital, you feel everybody kens about it. You feel funny.

Several people interpreted admission as a sign of failure.

> You feel you're letting the side down.

In a study which looked at compulsory admission to the Royal Edinburgh Hospital, patients commenting retrospectively on their experiences had similar ambivalent and sometimes bitter attitudes (McGregor, 1983).

Sprout participants made few comments on out-patient treatment, but had more to say about day treatment. Of the 29 who had received day treatment, 7 indicated it was helpful, providing occupation and social contact. Eleven found it unhelpful, however.

> I was quite optimistic about (weekly group therapy). For a while I was able to talk openly. Then I felt it wasn't going to achieve any revolution in my psyche. It was divorced from reality.

Others who had been in occupational therapy criticised the mundane repetitive work undertaken. The remaining 11 day patients made no comments.

It might be argued that psychiatric services do not need to be 'enjoyable' to benefit patients, that patients do not necessarily know what treatment will best help them. It was evident nevertheless that psychiatric services were not always perceived as helpful. Some people had been disappointed that services were not available when wanted. Others had come to realise that a 'cure' was not attainable:

> I've always had this belief I'd go into hospital and get some sort of miraculous cure. But things've changed ... that's not going to happen. It's just something I've got to cope with now.

Health and Well-being

At the time of starting work at Sprout, 36 participants were on medication of some form. This may not be wholly reliable as an indicator of clinical condition. In a study of 190 people with chronic schizophrenia living in the community, Cheadle and colleagues (1978) found that 80% were on medication. However, they noted that there seemed little consistent association between clinical condition and whether or not subjects were on medication. Participants' descriptions of how they felt provide a subjective measure of health. Over half - 33 - said their health had improved over the preceding year and only 8 felt worse. The majority described themselves as well rather than unwell.

The 2 measures of psychological well-being used at Time I - the Affect Balance and Present Life Satisfaction Scales - afford a means of comparing the Sprout sample with other populations, in addition to monitoring change over time within the sample. Warr (1978) used both scales in his large-scale study of 1,655 redundant workers and his results are cited here for comparison. His sample, which was mostly male, covered a wide range of ages and occupations. They did not have a history of mental illness. The table below shows the scores on the PLS scale.

TABLE 5.4 Present Life Satisfaction Scale : Sprout Sample and Warr's Sample

Sprout Sample	Warr's Sample
47	56

High score = 'good'

This suggests lower levels of well-being among Sprout participants which is further confirmed by the results on the ABS.

TABLE 5.5 Affect Balance Scores : Sprout Sample and Warr's Sample

	Sprout Sample	Warr's Sample
*Positive	2.54	2.69
+Negative	2.62	1.01
*Balance	-0.08	+1.68

*High score = 'good'; +Low score = 'good'

The level of positive affect among the Sprout sample is lower than Warr recorded, while negative affect is considerably higher. Looking at the distribution of total scores (positive and negative combined), positive affect predominated for 21 people (40%) and negative affect for 23 (43%). These figures are quite different from those for the general population. In a large-scale study of a representative sample of the US population, Andrews and Withey (1976) found positive affect was predominant in 70% of cases and negative in only 17%.

The Sprout sample was on the verge of entering employment when the scales were administered and it may be that comparatively low scores reflect the impact of unemployment. Warr noted that unemployed people reported significantly lower well-being than those in work. The results may also be due to the effects of mental illness. Bradburn, creator of the ABS, found that in people with 'long-term psychological disturbances' levels of negative affect tended to be consistently high.

To summarise, there was evidence that Sprout participants were relatively disabled by mental illness. Virtually all had been in psychiatric hospital at least once. While several years had sometimes elapsed since last admission and some people appeared to be recovering from mental illness, others had been ill very recently. There was still considerable involvement with out-patient services and the majority of participants were on medication. Many had experienced alcohol-related problems - although these were mainly said to be a thing of the past.

Mental illness left people vulnerable and uncertain about themselves and the future, although most felt their health was improving. Views about psychiatric services were ambivalent - to an extent they had failed to meet perceived needs and people were thrown on to their own resources to find ways of 'coping with' their illness.

Employment and Unemployment

Education

The table below compares the educational attainment of participants with that of the general population.

TABLE 5.6 Highest Educational Qualification

	Sprout Sample No	Sprout Sample %	General Population* %
University/college	17	32	32
School	16	30	24
None	20	38	42

* Figures are taken from General Household Survey, 1985.

Percentages do not add up to 100 as foreign qualifications are excluded.

The GHS makes a distinction between degree level qualifications, higher education below degree level, commercial qualifications and apprenticeships. Unfortunately data for the Sprout sample did not allow a similarly detailed analysis. Thus, while the figures suggest that the educational level of the sample resembled that of the general population, this is not conclusive.

Previous Occupation

Information on the occupation of participants' fathers was not obtained and therefore classification according to family of origin was not possible. Table 5.7 shows the type of employment participants themselves held previously and compares this with the wider population.

TABLE 5.7 Previous Occupation

	Sprout Sample No	Sprout Sample %	General Population* %
Managerial/professional	2	4	30
Services and other non-manual	17	32	23
Skilled manual	8	15	17
Semi- and unskilled	24	45	29
None	2	4	-

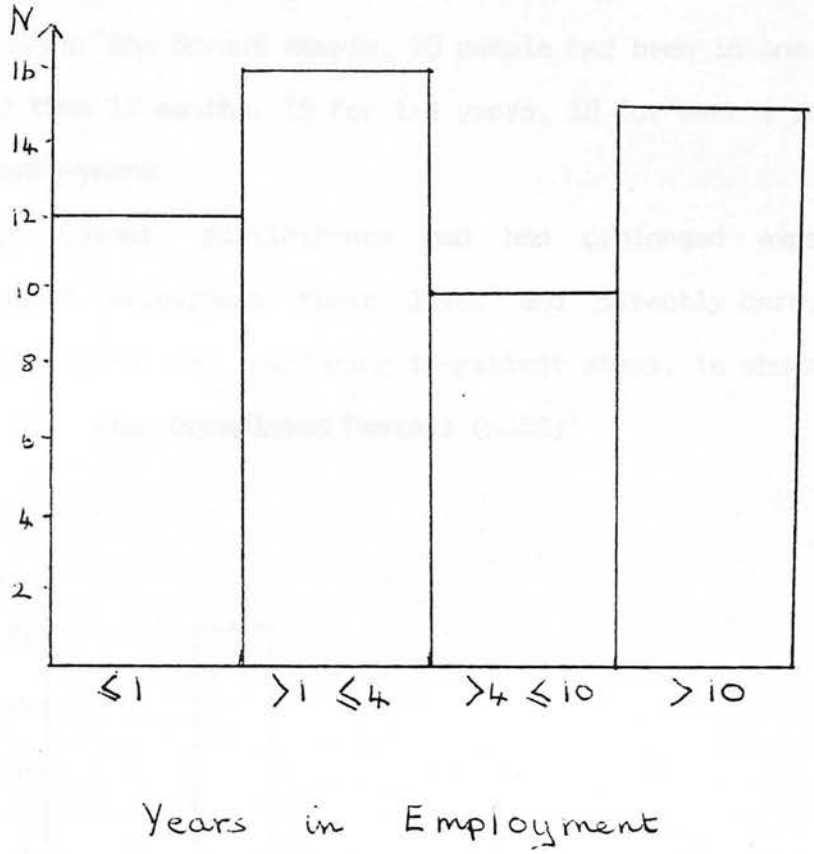
* From Labour Force Survey, 1984.

There was sometimes a disparity between educational level and subsequent occupation, particularly with a small group who had had a schizophrenic breakdown whilst at college or university, managed to gain a qualification but had only done unskilled work - if any - thereafter. This is consistent with the 'social drift' hypothesis: the concentration of mentally ill people in lower occupational groupings is caused by their tendency to be downwardly mobile over a lifetime (Cooper,in Wing, 1978a).

Employment Experience

The wide range of ages and occupations was accompanied by diverse experiences of employment. Figure 5.4 shows time in employment since school, excluding in-patient stays.

FIGURE 5.4 Time in Employment (years) (n=53)



The mean time employed was 7 years. There was a strong association between age and time in employment (p = .003). Those under 25 had not only been on the job market for a shorter time, they also entered it when job opportunities were contracting. In all, 1 in 4 had worked for no more than a year. On the other hand, half the sample (25) had been employed for over 4 years. Time in employment alone gives little indication of job tenure or occupational stability. It was clear that many participants had rarely stayed long in one job: 23 had never spent more than 12 months in a job. At the other extreme were 16 people who had stayed at least 4 years in one job. Moving from job to job may, however, be the norm in some occupations and may reflect the orderly pursuit of a career. Indeed, Watts and

Bennett (1977) found that length of time in one occupation was a better measure of employment capability as indicated by resettlement in work. In the Sprout sample, 20 people had been in one occupation for less than 12 months, 15 for 1-4 years, 18 for over 4 years.

Unemployment

Most Sprout participants had had prolonged experience of unemployment throughout their lives and directly before Sprout. Total time unemployed, excluding in-patient stays, is shown below.

FIGURE 5.5 Time Unemployed Overall (n=53)

Half the sample had spent at least 4 years in all out of work. There was no association between age and unemployment, suggesting that those under 25 were almost as likely as older participants to be unemployed for lengthy periods.

In an analysis of the ways in which unemployment affects different sections of the population, Lonsdale (1985) observes that people disabled from all causes are among several groups particularly vulnerable to unemployment. She notes that disabled people are likely to have been unemployed for longer periods than others. Certainly, compared with other CP entrants, Sprout participants had been unemployed longer directly before joining the project. In 1985, 58% of CP entrants had been unemployed for over a year (Finn, 1986). However, 37 of the 53 Sprout participants (almost 70%) had not worked for over a year. This is despite the fact that eligibility criteria for Sprout are less stringent than for most CPs (see earlier).

Looking at individual patterns of employment, Sprout participants included:

(1) 10 people (7 men and 3 women) who had little work experience apart from Youth Training Schemes or casual work. In their case, unemployment mirrored a lack of opportunity as much as the effects of disability;

(2) 8 men who were older than (a) but who also had little employment experience. In their case, illness had intervened while they were completing their education or training and they had not progressed directly into employment. Several felt they were now recovering, or at least stable, but they lacked both experience and skills;

(3) 17 people, of whom one was female, aged between 30 and 49 who had prolonged stable work experience in a small number of jobs. Their employment had often been interrupted by illness and they found re-entry to the job market difficult. Some were still considerably disabled and could not return to their previous occupation. Others who wished to had difficulty getting a job.
(4) 18 people did not fit neatly into any of these categories but cut across them.

Any work the first 2 groups had previously done tended to be in casual jobs or on other schemes and Sprout was therefore reproducing the pattern of temporary employment. For the third group, Sprout represented a way of regaining access to the employment market from which they had been excluded.

The Effects of Unemployment

The last decade has seen the emergence of a large volume of literature on employment and unemployment. The central thesis of much of this is that individuals derive a number of benefits from paid employment. These have been articulated in different ways (Hill, 1978; Warr, 1982), but are essentially similar. Jahoda (1982) distinguishes between the manifest functions of employment (e.g. financial reward) and the latent functions, which are the unintended consequences of the way employment is organised. Individuals in employment are exposed to 5 categories of experience which are said to have beneficial psychological effects:

1. structured use of time;
2. social experiences;
3. participation in a collective purpose;
4. conferment of status and identity;
5. regular required activity.

Unemployment has deleterious effects by depriving people of these experiences. The unemployed must find for themselves, according to Jahoda, experiences within these categories.

The 'deprivation approach' to unemployment has acquired the status of an orthodoxy; however it is not without its weaknesses. Because it is predicated on the latent functions of employment and their psychological benefits to the individual, the deprivation approach assumes that employment is always beneficial. Yet many jobs are low-paid and insecure (Townsend, 1979) and involve working in unpleasant even dangerous conditions. It also assumes that unemployment is uniformly and inevitably deleterious and tends to treat the unemployed as a homogeneous group. However, Warr (1982) has suggested that a range of factors (such as age and sex) can moderate the impact of unemployment. It is perhaps more helpful to view 'the unemployed' as a population of various subgroups. Preoccupation with the psychological effects of unemployment may lead to an unfortunate neglect of the link between unemployment and poverty. A study of a Scottish mining community where at least 30% of the men were unemployed found that one of the greatest hardships the unemployed faced was shortage of money (Bostyn and Wight, in Fineman, 1987).

The deprivation approach describes unemployment in terms of 'losses'. It seems important , as Hartley and Fryer (1984) point out, to consider the experience of unemployment itself. Warr has developed this aspect by explaining unemployment as **more** than the removal of features associated with employment. It also involves features associated with the unemployed role - such as signing on, looking for a job and these may be threatening or unpleasant (Warr, 1984).

In the context of this debate about employment and unemployment, it is interesting to consider the views of Sprout participants. I

shall look firstly at their views on employment and then describe their reactions to unemployment.

Views on Employment

All participants indicated that working was important for various reasons. These are shown in the table (people could give more than one response).

TABLE 5.8 The Advantages of Working

	No	%
Money	24	45
Status	22	42
Occupation	18	34
Health	13	25
Purpose	5	9
Satisfaction	5	9

Money gave people greater independence.

> You can look after yourself instead of your parents having to keep you.

It also provided a sense of security.

> You feel more secure, you don't have to get into hassles with the DHSS.

Money made it possible to pursue chosen goals in life - several had plans to marry, for example. Earning a wage also meant people could participate socially on an equal footing with others.

> It makes you feel part of society.

Indeed, almost as many participants referred to the status working gave and in many ways money and status seemed inseparable. It was not simply a question of 'looking good' in the eyes of others. In a more subtle way employment affirmed people's 'normality'.

For about one person in 3, work's primary importance was that it provided occupation and structure in what might otherwise have been a disorganised existance.

> It provides routine. On your own it's very hard to stick to something. You say you'll do something, but it's hard to stick to that.

Social aspects of working were mentioned by 1 in 4 and as many referred to the health benefits of working.

> My health's better when I'm working. I'm a different person altogether, mair like masel'.

This man's view - that he felt better when working is borne out by the results of research by Wing and Brown (1970). Not only has research on the effects of unemployment among the general population demonstrated that unemployment leads to a significant deterioration in psychological health (Warr, 1984d), research in the field of mental illness has illustrated that activity, such as work, can bring about a reduction in clinical symptoms.

It seems that the reasons Sprout participants wanted to be employed bear out the thesis of Jahoda and others discussed earlier. However, participants were referring to employment in the abstract, not to specific jobs. From employment histories it seemed participants had often come to a decision to leave a job because they disliked the work or the conditions and therefore specific experiences of employment had often been negative. This theme will be developed in later chapters. Moreover, Sprout participants attached considerable importance to money. The import of this is illustrated further when their experiences of unemployment are considered in detail.

Unemployment : Life on the Dole

Participants were asked to describe how they felt about being unemployed and what were the worst things about it. The majority said that unemployment made them feel depressed. There were several aspects to this. Unemployment made people feel

worthless:

> You feel left out, not worthwhile.
> You´ve nae pride in yoursel´;

purposeless:

> Your life´s not going forward.
> It´s not worth it, what´s the point?;

hopeless:

> I didn´t have any hope of anything coming along.
> I felt I´d just fade away and die.

This closely resembles Beck´s cognitive model of depression (Beck et al. 1979). He states that depression is founded on a set of negative beliefs about oneself, the world and the future.

Several people appeared to have grown accustomed to unemployment. None indicated that they preferred being unemployed, they seemed rather to have entered the ´adaptation´ phase Hill (1978) describes and had become resigned to it. The disadvantages of unemployment are shown below. One answer was recorded per person.

TABLE 5.9 The Disadvantages of Unemployment

	No	%
Boredom	16	30
Poverty	15	28
Isolation	8	15
Stigma	7	13
No response	7	13

The different aspects were often interrelated: lack of money meant people could not go out socially, or, if they did, were conscious of not being able to pay their way. The 2 'worst' features will be discussed in detail to give a picture of what life was like for participants before they joined Sprout.

Time and Unemployment

Filling time was a constant problem.

> I'd do anything I could to keep masel' busy,
> but you feel as though something's missing.

Being unemployed had not spurred people on to develop alternative occupation in leisure pursuits. Other studies have reported similar findings (Economist Intelligence Unit, 1982). While most participants could name at least one hobby, sport or interest, this in itself gave little indication of whether/how often they did these things. Only 1in 5 belonged to any club or organisation. Fifteen people had no interests, or these were only passive, mainly watching television.

A more informative picture of how people used their time is found by looking at a 'typical day'. Participants were asked to describe this and I used their accounts to rate each person's use of time as follows:

(1) good : engages in regular, structured activities;
(2) fair : engages in structured activities occasionally;
(3) poor : little or no structured activity.

Only 3 were rated 'good'. Two of them were attending occupational therapy and therefore had structure imposed on them. Only one man, who was a keen and accomplished musician, seemed able to fill his day constructively. Twenty-one were rated 'fair', 29 'poor'. These ratings proved to be correlated with people's satisfaction with how they spent their time ($p = 0.005$) as shown in the table.

TABLE 5.10 Use of Time and Satisfaction

	Use of Time Rating	
	Good/Fair	Poor
Satisfied	15	6
Dissatisfied	9	23

In all, over half the sample were dissatisfied. Accounts of 'typical days' often conveyed a sense of aimlessness.

> I get up late, lie in bed to get the day over with. Do things round the house and potter about on the back green.

Several people indicated that the long empty hours caused them to dwell on problems:

> If you're just sitting in the hoose, you worry more.

Interestingly, research has shown that unemployed people tend to be anxious (Payne and Hartley, undated). They face an uncertain future and possible financial strain and therefore may have cause to 'worry'; as we have seen here, they also have ample opportunity to 'worry', having few other occupations.

There were 2 main reasons why people who were dissatisfied did not do more with their time. About one-third felt they lacked the confidence or motivation:

> Sometimes I feel like I want to do more, then
> I just seem to draw back from the first step.

A similar proportion said they could not afford to do more. A recent national survey showed that unemployed people spent less than the employed on leisure items and pursuits (such as sports equipment or visits to the cinema) both in absolute terms and as a proportion of their overall expenditure. As unemployment continued, spending on leisure declined (Social Trends, 1987).

Money

Money was one of the main perceived advantages of working. In our consumer society, money has become more than a means of acquiring the necessities of survival. It has assumed symbolic importance as a means of participating in social relationships and culturally valued patterns of consumption (Douglas, in Halsey, 1976). Money also enables people to exercise choice and to act upon their environment.

Income levels and employment status tend to be interrelated so that the unemployed and particularly the long-term unemployed are poor (Townsend, 1979). They therefore face multiple disadvantages, such as restricted choice and low status. Moreover, financial strain is likely to exacerbate the impact of unemployment on psychological ill-health (Warr and Jackson, 1984).

For Sprout participants, the financial implications of unemployment were severe. Most (35) had been claiming supplementary or unemployment benefit, with 18 on sickness or invalidity benefit. They had thus mostly been on consistently low incomes for over a year. Only 18 were satisfied with their standard of living, while most found it difficult to manage on their income. Budgetting required careful planning and constant self-restraint:

> You can't really budget as such, your starting-point's so low it's like trying to create something out of thin air.

Sixteen people were in debt. Several said they were obliged to spend less on food and frequently people said they never bought new clothes, but used secondhand shops. Others had to forego extras - home comforts or a night out. One man explained:

> I go to the pub just to talk to somebody, but I go as late as possible because I can only afford 2 pints.

C M Parkes has observed (in Fagin and Little, 1984) that there are parallels between the effects of institutional neurosis, which can induce apathy and chronic hopelessness, and the effects of unemployment. He states that people need a sense of meaning in life which can only arise out of a reasonable expectation that plans will be fulfilled. For many, unemployment severs the connection between plans and their realisation. As Sprout participants illustrate, unemployment limits choices and the extent to which individuals can take control of their lives.

The Sprout Project

Participants heard about the project from various sources, as shown below:

TABLE 5.11 How Participants Heard about Sprout

	No
Doctor : psychiatrist	15
GP	2
Social worker	9
Occupational therapist	5
Disablement resettlement officer	5
Nursing staff	4
Other participants	4
Don't know	9

The social workers and occupational therapists concerned were nearly all based in the Royal Edinburgh Hospital, thus most referrals were precipitated by hospital staff. Mentally ill people living in the community and not in touch with psychiatric services seemed less likely to apply to Sprout.

The reasons why participants applied were diverse. Participants were asked to select from a list of 7 their 3 main reasons for applying. Responses are shown below:

TABLE 5.12 Participants' Reasons for Applying to Sprout

	No
A stepping stone to other things	30
Occupation	29
Social contact	28
Money	27
To learn skills	17
Interested in gardening	17
A 'second chance'	16

Several people referred to the gap which seemed to separate them from employment.

> I've nae chance o' a job elsewhere. I've bin away for a long time. It's a chance to get masel' back up and tae work again.

Others saw Sprout as an opportunity to overcome some of their difficulties and to prove their worth. One middle-aged man who had worked for many years, but, after suffering from depression, found he could not get a job, said:

> I felt I'd been on top of the scrap heap. Sprout's another chance to work.

A young man who'd never lasted more than 6 weeks in a job and who was made anxious by social situations, said:

> I've had trouble sticking jobs before.
> I thought (Sprout)'d help me.

On the whole participants appeared to appreciate the fact that Sprout was not quite like an ordinary job. Most had found that ordinary employers did not want them anyway. It was encouraging to know that at Sprout they would be treated sympathetically:

> I knew ... the people I'd be working with would understand my problems. They'd not be surprised if I was a bit 'strange'.

Perhaps surprisingly, the majority approached their new job confident they could cope: only 1 in 7 anticipated difficulties, generally in relation to getting to work on time and to physical fitness. Possibly participants were reluctant to admit to any worries at that point.

We saw earlier that some participants had come to believe that the formal psychiatric services could not 'cure' their illness and what was offered was not always helpful. Sprout seemed to appeal because it offered a different approach to participants' problems. It focussed on employment, the lack of which was often a major source of concern. Moreover, the project concentrated on their ability to work, not their needs as patients. It was more in keeping with the way participants perceived themselves - potential workers who unfortunately suffered from a mental illness, rather than one-time mental patients.

The fact that the project was specifically for mentally ill people met with a mixed response. One person in 6 indicated they were unaware of this. It was not clear why they had not absorbed this information as it was always explained at selection interviews.

Five of the 9 concerned were able to name their illness, so it was not a simple case of denial. Participants' main anxiety was that the specialised nature of the project would mark them as 'different'.

> There's a label attached to you once you've been there.

Several people had deliberately concealed details of their new job from friends, describing it as a market garden. One man went so far as to 'alter' its location to an area not associated with the psychiatric hospital. Mixing with other mentally ill people was sometimes seen as a retrograde move by participants who wanted to disassociate themselves from anything connected with mental illness:

> I feel I'm getting involved with people that I've tried to get myself away from.

On the other hand, the common experience of mental illness had advantages. It made it easier to apply to Sprout

> ... knowing the other people there had been through what I've been through.

Furthermore, someone else remarked:

> When you've been through the same things you can talk about it, you understand.

Most people indicated they would have been disappointed had their application to Sprout been unsuccessful:

> I would have come to a crisis in my life, it's **that** important.

It seemed Sprout was the only chance people had of getting work. As one man put it: 'You take Sprout or you get nowt'. Whatever reservations participants might have had about Sprout, there were few alternatives. While 32 people said they would have continued to look for employment if rejected by Sprout, their past experiences did not augur well. Twenty-seven had applied to other jobs before joining

the project, 19 had had at least one interview, but only one job offer ensued (and this was turned down as its legality was dubious). Importantly, only 9 people had been assisted in their job search. Help was given by doctors, social workers and family and in only one instance by a disablement resettlement officer. A third of the sample had no alternative plans, bar continuing on the dole.

> It was either Sprout or do nothing.
> Just sit around the house doing nothing ...
> getting out of bed when you feel like it.

In the earlier discussion of attitudes to employment in general, money, status and occupation were major motivators. These factors carried less weight, however, in relation to Sprout. The project appealed firstly because it offered a means of resolving immediate difficulties - primarily lack of social contacts and occupation. Additionally, there was evidence that participants saw the project as a means to achieving longer-term goals: they hoped to improve their chances of gaining employment in the future. Money and status were not features readily associated with the project and in that sense Sprout was not entirely congruous with the benefits participants expected to derive from employment.

Social Support

Previous sections have focussed on participants' individual histories. The perspective will now be broadened to consider them in their social context with reference to social relationships and social support.

Bennett and Morris have remarked that

> support may seem a simple and commonly
> accepted idea, but closer examination reveals
> unexpected complexities and ambiguities
> (in Watts and Bennett, 1983, p.192).

'Support' emanates from those social relationships which lead someone to believe he is valued, accepted and useful (Cobb, 1976). Support can thus facilitate coping with crisis and adapting to change. It cannot be assumed, however, that relationships are always supportive. In a study of coping behaviour in response to stressful situations, Pearlin and Schooler (1978) found that support was not equally effective in all situations: for example, self-reliance proved 'more effective' in handling 'close interpersonal problems' than seeking help from others. Much may depend on the nature of the relationship. Suls reviews evidence on the health benefits of social support and concludes that the effects of social support may not always be facilitative of prevention, coping and recovery (in Sanders and Suls, 1976).

With reference to mental illness, there is evidence of a connection between inadequate social support and psychiatric illness. The nature and degree of support available have a bearing on someone's vulnerability to illness (Brown and Harris, 1978) and on the course of illness (Vaughn and Leff, 1976).

It was beyond the scope of this study to undertake a detailed analysis of social networks and so I have concentrated on levels of contact with family and friends and on the perceived satisfactoriness of these relationships.

Family

Shepherd found that families played an important role in the social networks of the mentally ill (in Watts and Bennett, 1983). In the Sprout study, most people had frequent and regular contact with parents. Eight people had no living parents, or had never known them. Thirty-two saw their parents at least once a week (17 of them lived with parents). Seven had regular but less frequent contact -

about once a month - and 6 had little or no contact. Over half of those with siblings saw them at least monthly.

Generally, participants were satisfied with levels of contact. Nine would have liked more, 6 less. Four of these 6 lived with parents and found this could create difficulties:

> I've seen my mother for 7 years, sitting in the house together. It gets you down. Getting out takes the depression off you.

Participants expressed varying levels of satisfaction with their family lives. Thirty-one wanted things to change in some way. Several regretted they were still living with parents and did not have a family of their own.

> I'm always sorry I never married, ye ken. All the rest are married - I'm the odd one out.

> If I'd not been ill, I'd probably be married and have children.

Some people regretted they were not closer to their families and blamed this on their illness.

> I'd like to change masel', to be cheerier and mair relaxed when I go round to see my parents.

On the other hand, one-third were satisfied with their family relationships and felt their parents were especially understanding and concerned:

> My mother's good to me, she understands about my illness.

Friends

Unemployment is likely to lead to reduction in social contacts. Hill (1978) notes that unemployed people tend to withdraw from contact with people outside the family. Their breadth of social interaction is therefore reduced, as people lose confidence and feel ashamed. Other research points to the restrictions low income

imposes (Economist Intelligence Unit, 1982). It is likely that the mentally ill are at a particular disadvantage, as unemployment may only compound their lack of social and personal resources. Indeed in an East Lothian survey of 83 people with mental health problems, 90% of whom were unemployed, virtually all said loneliness was a problem to some extent (Amwel, 1985).

However, the area of relationships must be treated with some caution in a consumer study, as it raises the issue of the 'honesty' with which people responded. It is conceivable that people maybe reluctant to admit they have no friends. In addition, responses to questions about relationships are more likely to be coloured by mood or recent experiences than responses about, say, employment. In the Sprout study, 15 people said they had no friends. Most of those who had friends met them weekly, but 10 saw friends only once a month. At least half the sample therefore either had no friends or had infrequent contact with them. Wing and Brown (1970) refer to the dangers of overstimulation for some people with schizophrenia, who may deliberately withdraw from social contact to avoid emotional over-arousal. In view of this, numbers of friends seems less important than satisfaction with friendships.

Thirty people declared themselves satisfied with their friendships; this included 7 who had no friends. On the other hand, 15 of those who had friends were not satisfied and wanted more friendships as did 8 people who were friendless.

While it is commonly acknowledged that mentally ill people face difficulties in social interaction, a lack or shortage of friends may also reflect an absence of opportunity to meet people. There was evidence that this was a real difficulty: 4 out of 5 participants said they had no such opportunities.

In sum the picture is a group of people who were often dissatisfied with their social relationships. There was some evidence that illness had created difficulties in this area, but it was not possible to make judgements about the social competence of individuals on the basis of information available.

Conclusion

This chapter has described the backgrounds of Sprout participants and has sought to convey how they were affected by mental illness and by unemployment. Although no standardised scales were used at this stage to rate participants' functioning, it was evident that they were disadvantaged and disabled. Many had recently been ill and been hospitalised. In addition, most had been unemployed for substantial periods. It is important to bear these facts in mind when we come to consider outcomes.

Unemployment and mental illness seemed to interact in a way which exacerbated difficulties: for example, illness made it hard to find work because of prejudice and lack of confidence, and at the same time unemployment was detrimental to people's well-being. Many participants felt that mental illness set them apart from other people and stigmatised them. Ironically, unemployment only compounded their isolation and denied them opportunities to prove their 'normality' and worth.

The project's appeal lay in the fact that it offered work and the chance for people to depart from the role of patient. It was apparent that some participants had serious misgivings about the nature of the work or about being associated with a project for 'the mentally ill'. Nevertheless, Sprout seemed their only hope of employment at that point.

In subsequent chapters the sample is divided and completers and non-completers are discussed separately, with cross references and comparisons at appropriate junctures. Before proceeding to this, we need to consider possible differences between completers and non-completers. This is the subject of the next chapter.

CHAPTER 6

COMPLETERS AND NON-COMPLETERS

The aim of this chapter is to compare those who completed the year at Sprout and those who left prematurely using information collected at Time I, when people were about to start work on the project. Details of the length of time non-completers worked at Sprout and of why they left are available for the 14 people followed up and discussion is deferred to a later chapter. Suffice it to say here that length of employment at Sprout varied greatly among non-completers, from no time at all to over 6 months and reasons for leaving were diverse.

A comparison of completers and non-completers at Time I is crucial when it comes to interpreting outcomes for the 2 groups. Differences in outcome might, for instance, reflect the fact that the 2 groups were dissimilar at Time I, rather than suggesting that intervening variables, such as participation on Sprout, were responsible. In addition comparing completers and non-completers might indicate that certain individual characteristics were associated with non-completion rather than completion.

The division of the sample into completers and non-completers was of course done retrospectively, i.e. after Time I data had been collected. The discussion which follows is based entirely on this data. The 2 groups are contrasted on the tables below, which contain brief comments on similarities and differences. These are discussed more fully subsequently. In general, differences were not statistically significant and discussion is therefore couched in terms of 'tendencies' and 'trends'. Where differences were significant, this is indicated.

TABLE 6.1 Completers and Non-completers Compared

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Age						
25 or under	7	29	5	17	More were under 25 years	More were 26-35
26-35	10	42	17	59		
36 or over	7	29	7	24		
Sex						
Male	20	83	23	79	Similar	
Female	4	17	6	21		
Marital Status						
Single	17	71	25	86	More were separated/ divorced	More were single
Married	1	4	2	7		
Divorced/separated	6	25	2	7		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Accommodation						
Parental home	11	46	6	21	Twice as many lived with parents. None were in hospital	Those in supported accommodation were mainly in units with resident staff. Included all those who were in-patients. Twice as many in flats alone/with others
Marital home	1	4	2	7		
Supported accomm:						
staffed	3	12	6	21		
unstaffed	3	12	2	7		
Hospital	0	-	3	10		
Lodgings	2	8	0	-		
Shared flat	3	12	5	17		
Own flat	1	4	5	17		
Psychiatric History: Diagnosis						
Schizophrenia	9	38	15	52	Included all those diagnosed manic depressive	More had diagnosis of schizophrenia
Manic depression	3	12	0	-		
Nerves	3	12	2	7		
Depression	4	17	5	17		
Anxiety	0	-	1	3		
Personality disorder	0	-	2	7		
Alcohol problems	1	4	0	-		
None/not known	4	17	4	14		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Number of Admissions to Psychiatric Hospital						
None	3	12	2	7	More had never been in-patients	More had at least 4 admissions
1-3	16	67	18	62		
4 or more	5	21	9	31		
Total Time in Hospital						
0-6 months	13	54	9	31	More had spent a very short time in hospital (≤ 6 mths)	
7-12 months	3	12	9	31		
13-24 months	4	17	5	17		
Over 2 years	4	17	6	21	Similar proportions had been in hospital for a year or more in all	

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Last Admission						
In 12 mths prior to Sprout	14	58	15	52	Similar	
Between 1 and 2 years previously	1	4	3	10		
More than 2 years previously	6	25	9	31		
None	3	12	2	7		
Out-patient Treatment						
Never been an out-patient	3	12	7	24	Twice as many were out-patients when joined Sprout	Twice as many had never been out-patients.
In treatment when began Sprout	18	75	9	31		Four times as many had ceased to be out-patients
No longer in treatment when began Sprout	3	12	13	45		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Day Patients						
Moved from day care directly to Sprout	4	17	9	31		Twice as many were in day care directly before joined Sprout
Medication						
On medication	15	62	21	72		More were on medication
Reported 'Cause' of Illness						
Stress at work	5	21	3	10	Twice as many stated 'stress at work'	Four times as many cited 'relationships'
Relationships	2	8	10	34		
Childhood	2	8	1	3		
Bereavement	2	8	1	3		
Drugs	1	4	2	7		
Genetic	1	4	1	3		
Physical ill health	2	8	0	-		
Not known	9	38	11	38		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Current Health Effects of Health on Work						
Considerable	8	33	14	48	More said work ability was not affected	More said work ability was considerably affected
Limited	4	17	4	14		
None	12	50	11	38		
Changes in Health in Preceding Year						
Improved	15	62	18	62	More said health was unchanged	More said health had deteriorated
Deteriorated	1	4	7	24		
Unchanged	8	33	4	14		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Alcohol Problems						
Had problems in the past						
Yes	10	42	9	31	More had alcohol-related problems in the past	
No	14	58	20	69		
Alcohol Problems						
At time of interview						
Yes	2	8	3	10	Similar	
No	22	92	26	90		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Educational Qualifications						
University	3	12	1	3	More were University graduates.	More had school-level qualifications only.
College	6	25	7	24		
School	6	25	10	34	Similar numbers had no qualifications	
None	9	38	11	38		
Employment History						
Total Time Employed						
A year or less	6	25	6	21	More had been employed over 4 years	More had been employed 1-4 years
> 1-4 years	4	17	12	41		
More than 4 years	14	58	11	38		
Total Time Unemployed						
A year or less	2	8	3	10	More unemployed for 1-4 years	More had been unemployed for over 4 years in all
> 1-4 years	15	62	11	38		
More than 4 years	7	29	15	52		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Time Unemployed Pre-Sprout						
A year or less	5	21	11	38	More were unemployed for 1-4 years before joining Sprout	More were unemployed over 4 years before joining Sprout
>1-4 years	16	67	9	31		
More than 4 years	3	12	9	31		
'Worst thing' about being Unemployed						
Boredom	11	46	5	17	Boredom was most frequently mentioned	Poverty was most frequently mentioned
Poverty	6	25	9	31		
Isolation	2	10	6	21		
Stigma	2	10	5	17		
Don't know	3	12	4	14		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Reasons for Applying to Sprout						
A stepping stone	15	62	15	52	More were keen to learn skills	More were motivated by: (a) money (b) meeting people (c) interest in gardening
Occupation	13	54	16	55		
To meet people	10	42	18	62		
Money	8	33	14	48		
To learn skills	10	42	7	24		
Interested in gardening	6	25	11	38		
A 'second chance'	7	29	9	31		
Alternatives to Sprout						
Had no other plans	5	21	11	38		More had no alternatives

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Attitudes to Sprout						
Would cope well with Sprout	15	62	12	41	More were confident would cope well	More expected difficulty
Would have difficulty	9	38	7	59		
Attitudes to 'life in general'						
Said to cope well	9	38	6	21	More 'coped well'	
Said had difficulty	15	62	23	79		
Use of Time Rating						
Good	2	8	1	3	More were rated 'good' or 'fair'	More were rated 'poor'
Fair	10	42	11	38		
Poor	12	50	17	59		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Satisfaction						
Satisfied with how spent time	11	46	8	28	Significantly more were satisfied ($p<.01$)	
Not satisfied	13	54	21	72		
Family Relationships						
Quantity						
Would like more contact with parents	1	4	8	28	More were content with current levels of contact with parents	More wanted an increase in contact
less	3	12	3	10		
same	18	75	12	41		
Not applicable	2	8	6	21		
Quality						
Wanted family life to:						
change a great deal	2	8	7	24	More wanted limited change	More wanted considerable change
change in some ways	12	50	10	34		
remain unchanged	9	38	12	41		
Not applicable	1	4	0	-		

	Completers		Non-completers		COMMENTS	
					Completers	Non-completers
	No	%	No	%		
Friends						
Has friends	18	75	20	69		More were friendless
Has none	6	25	9	31		
Satisfaction with Friendships						
Satisfied with friends	17	71	13	45	Significantly more satisfied with friends (p=0.05)	
Not satisfied	7	29	16	55		
Living Arrangements						
Living:						
alone	5	21	6	21	Similar numbers lived alone	
with relatives	13	54	9	31	More lived with a relative	More lived with someone other than friend or relative
parents/siblings/ spouse	1	4	2	7		
with others	5	21	12	41		

Discussion

From the data presented in the tables above, a complex pattern emerges. It seems that there were consistent differences between the 2 groups, although these differences were not large enough to be statistically significant. However, the differences were more a question of degree rather than of substance. In no sense was there a sharp dichotomy separating completers and non-completers. The 2 groups seemed rather to occupy different positions on a spectrum. It should also be noted that the range of individual abilities and experiences was great in both groups. It was possible that a wider range among non-completers might have had the effect of improving the mean and blurring the contrast with completers. However, this did not prove to be so; the range was similar in both groups.

The proportion of male and female participants was broadly similar in both groups. However, completers included a larger proportion of people aged 25 or younger. It was suggested earlier that younger participants tended to be less disabled, but had been at a disadvantage in terms of employment because they entered the labour market at a time when opportunities were contracting. Certainly the younger participants seemed more likely than older ones to complete the year.

In terms of psychiatric histories, a number of interesting points emerge. On the whole, reported diagnoses differ only slightly. If the diagnoses of schizophrenia and manic-depression are combined, a similar proportion in both groups reported a psychotic illness (it was not known whether the diagnosis of 'depression' indicated a psychotic or a neurotic condition). In a study which looked at the outcome for psychiatrically disabled people of attendance at employment rehabilitation centres, Wansbrough and

Cooper (1980) found that participants with a 'psychotic illness' had the highest non-completion rates: 21% did not complete, compared with 17% of those with a 'psychoneurotic illness' and 14% of all those with a 'psychiatric disability'. The overall non-completion rate at Sprout was clearly much higher: 29 of the 53 left prematurely. This may reflect the loose selection procedure at Sprout, whereby applicants are rejected only if they seem likely to be disruptive. Furthermore, ERC courses are shorter (several weeks) and drop-out rate is thus likely to be lower. However in the Sprout study, the outcomes for those with different psychotic conditions were not the same. All 3 people diagnosed as manic-depressive completed the year, whereas only 9 of the 24 diagnosed schizophrenic did so. This must, of course, be viewed with caution, as the numbers are small.

More of the non-completers were on medication at Time I. They had also made greater use of psychiatric in-patient services: they were more likely to have been admitted to and have spent longer in hospital. Both factors may suggest they were more seriously ill, although, as mentioned earlier, this cannot be assumed conclusively.

Interestingly, none of those who were in-patients at Time I completed Sprout. This recalls other findings of Wansbrough and Cooper. They noted that people who moved directly into rehabilitation on discharge from hospital tended to drop out.

Completers used out-patient services more than non-completers and twice as many completers as non-completers were under out-patient care on joining Sprout. Out-patient status thus seemed associated with completion: two-thirds of those who were out-patients completed, compared with only one-quarter of those who were not. Not attending as an out-patient may imply that people were not under any

medical supervision, or alternatively that they received care from another source, such as their family doctor or hostel staff. However, it is conceivable that out-patients were more likely to stay at Sprout because:

(1) they were not so ill as to require in-patient care or to be living in staffed accommodation. At Time I 6 non-completers were in staffed accommodation and 3 others were in-patients, whereas only 3 completers were in staffed accommodation and none was an in-patient;
(2) they were nonetheless under regular medical supervision.

Those who came to Sprout directly from day care facilities, on the other hand, tended to leave prematurely. Possibly day patient status is an index of disability, so that these participants began Sprout at a greater disadvantage. In addition, they may have been directed to Sprout by day care workers rather than on their own initiative and may thus have been less motivated. Several participants, for example, had been advised they could no longer stay in occupational therapy. A third possibility is that Sprout was not like day care - it involved hard physical work - and this may have deterred some entrants, or proved too demanding for them.

There were differences too in participants' perceptions of their health. Non-completers were more likely to report a deterioration in their health over the 12 months prior to starting at Sprout and to feel that their lives were considerably impaired by illness. Taking these subjective measures together with usage of services and numbers on medication, it seems that non-completers tended to be more disabled by illness at Time I. Nevertheless, completers had also had serious mental health problems.

The scores on the Affect Balance Scale and the Present Life Satisfaction Scale seem somewhat anomalous, as non-completers recorded higher levels of well-being on both scales, although the differences were small.

TABLE 6.2 Well-being Scores for Completers and Non-completers at Time I

Affect Balance Scale

	Total sample	Completers	Non-completers
*Positive Affect	2.76	2.54	2.93
+Negative Affect	2.68	2.62	2.72
*Balance	+ 0.08	- 0.08	+ 0.21

***Present Life Satisfaction**

Total sample	Completers	Non-completers
47	46	48

*High scores = good; +Low scores = good

Other research has suggested that people with a high commitment to work are more adversely affected by unemployment (Warr, 1982). Possibly work was more important to completers and thus unemployment prior to Sprout diminished their well-being while non-completers were less severely affected. Certainly, by definition, completers displayed greater employment commitment.

It is striking that non-completers had higher levels of negative affect as well as positive. It may be that this reflects the association between high negative affect and long-term psychological disturbance, mentioned in the previous chapter. This would accord with the suggestion that non-completers were more disabled than completers.

Looking at comparisons of employment histories, completers tended to have more extensive experience in employment and to have been unemployed for less time overall. One in 3 of those unemployed for over 4 years in all failed to complete. This raises the question of whether this is because people unemployed for long periods of time have difficulty adjusting to the transition from unemployment into employment, as Hayes and Nutman (1981) suggested, or whether their particular characteristics (such as lack of skills and disability) impede their return to work, as Colledge and Bartholomew (1980) proposed. The 2 sets of factors may of course be interrelated - it seems likely that the non-completers were at a disadvantage because of their greater disability, which in turn made it more difficult for them to adjust to the demands of employment.

Two separate differences were apparent in the time participants were unemployed directly before joining Sprout. Firstly, more non-completers had been out of work for over 4 years: three-quarters of those out of work for that length of time dropped out of the project. Secondly, a greater proportion of non-completers than completers had been out of work for 12 months or less. This seemed to indicate a pattern of intermittent, short-term employment and suggested that these individuals had difficulty retaining a job. Thus, non-completers included a considerable number out of work a very long

time and a similar proportion who were apparently unable to sustain effort in a job.

The 2 groups reacted slightly differently to unemployment. Completers tended to feel boredom was the worst aspect, while non-completers were more likely to mention poverty. Moreover, the latter were more frequently attracted to Sprout by the prospect of financial gain than were completers. Possibly Sprout proved to be a more effective remedy for boredom than for poverty.

Completers appeared to be more future-oriented than non-completers. The former tended to view Sprout as a means to an end and laid greater emphasis than non-completers on skill acquisition. Completers were also more likely than non-completers to have had some alternative in mind if their Sprout application had been unsuccessful. Non-completers, on the other hand, had a greater interest in gardening work per se.

Completers were more confident, on the whole, about their ability to cope with working at Sprout and with 'things in general'. This is in line with the findings of the study by Wing (1966) described earlier, which indicated that the confidence with which people approached rehabilitation had a bearing on outcome.

Turning now to the 2 groups' social circumstances, there was only a slight difference in their 'use of time' ratings. However, completers were significantly more satisfied with how they spent their time ($p < 0.01$). Similarly, while there was only a marginal difference in the proportion of each group which was friendless, completers were significantly more satisfied with their friends. It is possible of course that participants were reluctant to admit to having no friends, but were more 'honest' about their feelings. Interestingly, the association between satisfaction with social

relationships and completion of Sprout is further reflected in the fact that non-completers tended to be less satisfied with their family lives. This applied both to the amount of contact with parents and to the general quality of relationships. Moreover, non-completers were more likely than completers to be attracted to Sprout by the prospect of meeting people. Evidently personal relationships tended to present greater problems to non-completers and noticeably more of them attributed their illness to difficulties in relationships. The overall impression therefore is that there were clear subjective differences between the 2 groups, with reference to relationships and non-completers were less satisfied with this area of their lives. There was some suggestion also that they may have been less competent socially.

Non-completers tended to be less well supported than completers; compared with completers, fewer non-completers lived with a relative/relatives (parent, sibling or spouse) and more of them lived with people other than family or friends (i.e. shared accommodation with other patients or tenants not classed as friends).

In summary, while it was extremely difficult to predict from data obtained at Time I who would complete and who would not, there were observable differences between completers and non-completers on both objective and subjective measures. When looked at together, differences were not merely random but seemed to form a coherent pattern. It is thus possible to identify a constellation of factors which seem associated with completion/non-completion (see table below). Again, it should be stressed that these are suggestive of likely outcome, not predictive.

TABLE 6.3 Factors Associated with Completion and Non-completion

Factors which Suggest an Individual will Complete	Factors which Suggest an Individual will not Complete
Health	
Not on medication	Diagnosis of schizophrenia
Less reliance on in-patient services	On medication
Out-patient status at time of joining Sprout	Greater use of in-patient services
Stability of or improvement in perceived health	Day care attendance immediately before joining Sprout
Limited (self-reported) impairment of functioning	Deterioration in perceived health over time functioning
Employment	
Previous employment experience of more than 4 years	Over 4 years unemployment (a) in total (b) directly prior to entry
Attitude	
Orientation towards the future	Lack of confidence in ability to cope with: (a) working (b) life in general
Confidence in ability to cope with: (a) working (b) life in general	Dissatisfaction with how time was spent
Satisfaction with how time was spent	

Factors which Suggest an Individual will Complete	Factors which Suggest an Individual will not Complete
Social Relationships	
Satisfaction with friendships	Dissatisfaction with friendships
with family life	with family life
	Difficulties in personal relationships
Support	
Living with relatives	Living with people other than relatives or friends

In the chapter on methodology, I indicated that non-completers were of intrinsic interest and merited study in their own right, but that they should not be viewed as a control group. The consistent pattern of differences between completers and non-completers at Time I adds weight to this assertion. Thus, while I intend to trace and contrast the outcomes for the 2 groups, it is not possible to extrapolate from the experiences of one to the other or make causal inferences, for instance that completers were 'better' at follow-up because they stayed at Sprout.

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CHAPTER 7

WORKING AT SPROUT

Of the original 24 completers, 23 were interviewed when they had spent 9 months on the project. This is referred to as Time II and information collected at these interviews is the substance of the next 3 chapters. The aim of this chapter is to describe participants' experiences of working at Sprout. I intend to look at their attitudes to work, their standard of performance, feedback, motivation and relationships at work. The chapter concludes with a summary of the benefits participants felt they derived from working at Sprout and these are compared with supervisors' assessments of what participants had gained.

No comparable information was available for non-completers at Time II. Follow-up interviews with them adhered to a different timescale and consequently discussion of non-completers' views of Sprout will be presented in a later chapter.

An Overview of Sprout

This section presents completers' perceptions of the project as a whole, before we go on to consider specific aspects of their employment at Sprout. Having worked at Sprout for 9 months, most participants (16) said the project had lived up to their expectations, or exceeded them:

> I didn't fancy the job at all because I'd never done anything like it, but if it keeps me occupied for a year, I thought it's maybe a good thing. It's been more than that, it's brought me back to life.

One man was relieved to find Sprout was not like the hospital day centre he had formerly attended:

> I thought it'd be another ... (day centre) where you get bored out of your mind - but I haven't! Sprout's a hundred times better ... you've actually got something constructive to do - working with standards.

The expectations of 7 people had not been met, however. Some found the work was more demanding than anticipated:

> I thought sheltered work would be a lot easier, but it's quite hard.

One woman felt Sprout was less supportive than expected, partly as a result of efforts staff made to reproduce normal working conditions. Two men were disappointed that they had not been able to make as full use of the opportunity Sprout presented as they had hoped:

> I hoped to get better in my social contact with people. I get nervous about speaking to people. I started off well but then I went downhill.

For the 19 completers with previous experience of working, the distinctive features of Sprout compared with other jobs were the relative absence of pressure and the fact that employees were treated with understanding. Twelve people, from various occupations, mentioned that work at Sprout was less pressurised. A man who had been in a highly demanding post as a radar technician said:

> This is the easiest job I've ever had because of the atmosphere, the absolute lack of pressure.

Seven felt the project was sympathetic to workers' needs:

> The management here are not half so oppressive, you feel they do have your interests at heart. They take your personal life into account and how you are. That's all discounted in a conventional job.

It was evidently a relief for some people to stop dissembling and to acknowledge their difficulties:

> They know you've had problems in the past, whereas in most other jobs people haven't known that. So when you have been feeling bad, I've managed to carry on.

Earlier we saw that 1 in 5 completers stated that stress at work had precipitated their illness. It was not that participants believed **work** was intrinsically harmful to them, but certain aspects of the work environment. Sprout represented an opportunity to work, without being exposed to some of the more detrimental aspects of employment.

Overall most completers had enjoyed working at Sprout: 16 a great deal, 5 with reservations and 2 not at all. One of these 2 disliked horticultural work, but persevered nonetheless:

> I'm not the sort of person who starts something and doesn't finish it.

The other found everything in life a struggle:

> If I'd 've felt alright within masel' I'd 've said it's been a good job.

Further investigation suggested that there was a range of attitudes to the project within the completer group. Partipants were asked to identify good and bad things about Sprout and these are shown below. People often gave more than one response.

TABLE 7.1 Aspects of Sprout Completers Liked

	No
Contact with other people	14
Chance to gain work experience	11
Working outdoors	7
Chance to learn new skills	7
Absence of pressure	3

Some of the 'good things' reflected the fact that Sprout offered employment, while others were more bound up with the nature of the project.

TABLE 7.2 Aspects Completers Disliked

	No
Horticultural work	7
Working outdoors	6
Too strict	6
Not strict enough	2
Time-limit of 12 months	2

These tables illustrate the diversity of views - while some liked outdoor work, others hated it; some felt the project was too rule-bound, others that it was too lax.

One in 3 participants disliked the nature of the work and it was impressive that they nonetheless sustained sufficient interest to complete. The reality was that there was little option, as one man explained:

> It's a job I don't enjoy. I've stayed on because you don't have much choice. I'd have a lot of trouble at the unemployment office if I gave up.

Surprisingly, only 2 referred to the time-limit as a negative aspect, although more might have done so if asked directly. These 2 felt that if employment was permanent, both the project and participants would benefit:

> Then people would take more interest - I've got to get rid of these weeds because it's me'll have to deal with them next year.

Work Preferences

The debate about whether or not work still has a place in rehabilitation tends to deflect attention away from the question of what **form** of employment best suits the needs and abilities of the mentally ill. In practice, the work offered in rehabilitation has

tended to be manual. McCreadie et al (1985) found in their survey of psychiatric rehabilitation services in Scotland that industrial therapy units in hospitals tended to provide simple, repetitive, manual work, with few opportunities for clerical work. Employment rehabilitation centres also tend to provide a limited range of repetitive work (Cornes, 1982). Morgan (in Watts and Bennett, 1983) argues that simple repetitive tasks are the most suitable in view of the performance deficits of chronic schizophrenic patients. It is probable, however, that he is referring to those most severely disabled by mental illness.

A different conclusion was reached by Floyd et al. They state:

> We have found little evidence that a diagnosis of schizophrenia should be equated with an inability to do more skilled types of work. We would argue instead that many people with schizophrenia are capable of doing a wide range of jobs **given the right working environment.** (my emphasis) (Floyd et al. 1983, p.71)

The range of disabilities associated with mental illness is great. One experienced practitioner and researcher has emphasised the virtual impossibility of predicting what kind of work is most suitable for an individual and what might constitute 'stress' in an individual case (Hudson, 1981). However, the work of Floyd and colleagues suggests that the nature of the work environment can affect an employee's performance, the stress experienced and ultimately whether he/she remains in the job.

Bearing these issues in mind, we now turn to consider the attitudes of completers to the content and form of their work. I shall attempt to argue from the particular to the general: to identify key features of Sprout which may have relevance to other forms of rehabilitation.

Tasks

Preferences for particular tasks varied enormously and for each task someone disliked, someone else expressed a preference. In the main, people tended to enjoy tasks which gave them a sense of achievement: 10 mentioned this.

> I like propagating plants, I think because you can see the end results. If you sow seeds, hopefully they grow!

> I like it when there's a piece of ground covered with weeds and being left to work it. Starting from nothing right through to the end.

Seven people got satisfaction from hard physical work - 'jobs you put an effort intae' - while 6 preferred small-scale, detailed work. Several specified they liked tasks which involved skills they could deploy in other contexts.

> I liked taking cuttings ... potting up plants ... using machinery. I feel these are all relevant things that can be used again.

The most common dislike, mentioned by 10 people, was of monotonous tasks:

> Weeding seems awfae boring, as if it's no' necessary. It is, but to me it doesnae seem necessary.

Participants also disliked being on the same job for long periods: 'you think you'll never get to the end of it'. While most people (18) had had some experience of working with the general public on the weekly stall or at open days, 5 had deliberately declined such work and 5 others had found it stressful:

> The stall was a bit nerve-racking. There's a lot to pick up in 2 days, getting used to the scales and the prices before the public comes in ... I was glad to get away from it.

Key points for participants seemed to be, therefore, that work should be varied, should give a sense of achievement and provide opportunity to develop useful skills, without entailing too much stress. The importance of matching the requirements of a particular task to the abilities of individuals so that the latter gain an experience of success is a recurring theme in the rehabilitation literature (Goldberg, 1974; Bennett, 1975).

Sprout participants seemed to indicate, however, that the type of work was less important than how the task was structured. Weeding, for example, was disliked because it was tedious and seemed endless. Perhaps we need to rephrase our original question and ask not what type of work is most suitable, but how can different types of work be modified to accord with the needs of those in rehabilitation? This is in line with an earlier argument that rehabilitation involves a mutual accommodation of the disabled person and the social environment (Criswell, 1968). Thus, rehabilitation could include work of varying levels of complexity and sophistication with the stipulation that it should offer variety and that it should be capable of being broken down into discrete tasks so that workers can gauge progress. For some people in particular it seemed useful to have a learning element built into the job. Floyd et al (1983) point out that opportunities for learning may enhance an employee's satisfaction and self-confidence. From the Sprout study it seemed also that if participants could be helped to understand the necessity of a particular task, they might come to value their own contribution more highly.

Responsibility

In rehabilitation, a tension exists between presenting participants with opportunities to use and develop abilities and exposing them to excessive stress. Opinions seem divided as to whether people with mental illness should take on considerable responsibility at work. Wansbrough and Cooper (1980) advise against promoting mentally ill people, while Reinach argues that to make blanket recommendations and confine people to work which may be inappropriate is likely to increase stress (in Lishman, 1981). Floyd and colleagues (1983) noted that people in their study (who all had schizophrenia) frequently expressed a desire to have autonomy in their work but this was often coupled with an inability to cope with a lot of discretion. Floyd contends that the 'ideal' work situation is one where the mentally ill person can operate independently at his/her own pace, within clearly defined boundaries, where the emphasis is on quality not quantity and where good supervision provides feedback.

The Sprout project had deliberately chosen not to use rigorous methods of assessment (such as are employed on some rehabilitation programmes) in its endeavour to simulate a 'normal' work environment. A corollary of this was that staff had little substantive basis on which to assess participants' capacities when they started work and supervisors indicated that an element of risk-taking was involved in encouraging participants to take on responsibilities.

Most participants could identify tasks or areas of the garden for which they were responsible, either individually or as part of a group. Frequently people related with pride how much they had

learned and achieved within their domain. Some felt such opportunities should be developed:

> People should try to keep to one area. It's more beneficial. I feel I'm able to work better if I'm responsible for a certain area.

> I'd give (workers) more responsibility for their immmediate task. They'd be given a job and then, if capable, left to make decisions by themselves so that they felt more in control of the situation.

A possible negative effect of responsibility is that it may induce anxiety. It seemed, however, that most participants - 15 - did not worry about making mistakes. Some of this group indicated there was generally someone they could consult if unsure, others trusted to their own judgement.

> I don't worry ... If somebody asks me to do something, then I've got to do it right. If I don't I'm letting myself down.

The remaining 8 were concerned about making mistakes:

> I feel anxious and tense about getting work done. I feel I'm no' going to dae it right.

Interestingly, it emerged that people who worried about making mistakes did not necessarily prefer to work under close supervision, as the table shows.

TABLE 7.3 Preferred Way of Working (N = 23)

	With a supervisor	Without a supervisor	Either
Anxious	3	3	2
Confident	4	8	3

It appeared that intensive supervision could heighten anxiety. This is in line with research which suggests that people with schizophrenia often feel the need for extra privacy (Brown et al. 1962; Vaughn and Leff, 1976). Participants often indicated they preferred to be given clear instructions and to be left to execute them in the knowledge that help was to hand if needed. Others admitted they had difficulty motivating themselves if left to their own devices.

> I don't think supervisors should shout at you, but in a sense that's the only way to get me moving.

Several points flow from this discussion. Firstly, generalised statements concerning the capacity of mentally ill people to assume responsibility do not seem appropriate. From contact with project staff, I was aware that a minority of participants proved very able and were delegated considerable responsibility. Others were less reliable and less competent. Secondly, it may be that participants' conceptions of the 'ideal' work situation may fail to take account of their own limitations. It is to this we now turn.

Standards of Work

In general, participants were satisfied with their standard of work and were not looking to improve it. As one man said, rather diffidently:

> If it's no' up to their standard I cannae help it. I've done ma best.

Only 5 people felt they could improve on their work performance. Several of them felt they were prevented from working to a higher standard by external factors, such as the poor performance of other participants or organisational matters.

> I feel I'm just wasting my time if I'm very careful and some other people can't be bothered and make a mess of it. That upsets me.
>
> It's sometimes difficult to do a job properly here - you'll either be asked to do something else, or you won't be able to find the materials. I've often felt I can't do things as well as I'd like.

These seem important points in the light of Floyd's observations earlier about quality of work rather than quantity.

Shepherd has suggested that mental illness is often associated with deficits in certain cognitive skills and that consequently sufferers may have difficulty assessing accurately the expectations of others and predicting their reactions (in Watts and Bennett, 1983). To gauge participants' ability to appraise their work and to evaluate their receptiveness to supervisors' judgements, I asked participants what they thought supervisors would change about the way they worked. This elicited the following responses:

4 people referred to the pace at which they worked;
3 to their poor concentration;
2 to their lack of confidence;
2 to their alleged over-confidence;
2 to their poor time-keeping.

Only one person thought supervisors were satisfied with his work, while 9 were aware that supervisors were dissatisfied but could not specify the reasons.

These replies contain several interesting points. There seemed to be a discrepancy between participants' self-asssessments and what they perceived the views of supervisors to be. Most participants (18) were content with their work, yet most (22) also felt supervisors were not entirely satisfied. A similar finding is reported by Griffiths (1973) in his study on the work performance of psychiatric patients in rehabilitation. He used the Work Assessment

schedule and found a lack of relationship between patients' self-assessments and supervisors' assessments. This schedule was also used in the Sprout study, but was completed by supervisors only. Results are described in a later section. There is thus evidence to support Shepherd's suggestion (see above). This would seem to imply that the aspirations of some participants to work relatively autonomously must be viewed with caution, since they may not be able to gauge their abilities accurately. However, it should also be noted that many of the 'weaknesses' in work performance which participants mentioned in this context were seen by them as a consequence of their illness. Participants often felt their motivation, confidence and concentration were affected, as we shall see later, and may have felt unable to improve in the ways they thought supervisors wished. It is conceivable that supervisors and participants had different expectations - participants were resigned to living with their limitations and were less concerned with change or improvement than were supervisors. Finally, responses suggested that almost half the group had no clear idea of what their weaknesses (in terms of work performance) were. Either they had not received adequate feedback, or they had failed to absorb it.

Feedback

The preceding sections on discretion at work and standards highlighted the importance of feedback. The main mechanism for this at Sprout was through supervision. Watts suggests that supervision is likely to be a source of dissatisfaction among employees with a mental illness. He states that anxious people will find the comments and directions of supervisors stressful, while people with paranoid

attitudes are likely to interpret criticism as personal hostility (in Watts and Bennett, 1983).

At Sprout, in addition to on-the-job supervision, participants met with their key supervisor and one other on a two-monthly basis to review progress and discuss any problems. These reviews were seen as helpful by 16 of the 23 completers:

> You get an idea of how supervisors see you, of how you're getting on.
>
> The reviews spurred me on when I seemed to lack motivation. They inspired me to try harder.

In view of Watts' remarks, this seems an achievement. Reviews provided an opportunity for participants and supervisors to make their views explicit and to confront discrepant expectations. However, there was evidence that reviews were not sufficient as a means of providing feedback. Firstly, 6 of the 16 who spoke positively of reviews were nonetheless unable to identify what their supervisors would change in their work. Thus, whatever 'benefit' they derived from reviews, the meetings added little to participants' appraisal of their own performance. In addition, 7 people found reviews of little value, or at worst positively stressful. Part of the difficulty seemed to be that reviews were non-directive and reflected the style of relationship supervisors sought to foster with participants, based on trust and openness. This made the supervisors' role ambiguous: participants indicated that they looked to supervisors for an assessment of their performance, but supervisors were reluctant to stand in judgement.

> It's always the same - 'How do **you** think you're getting on? What do **you** think of your work?' - I struggle like mad to give an answer.

Given that workers were often unsure of their own standard of performance - both strengths and weaknesses - there seems to be a clear need for project staff to devise ways of providing effective feedback. It may be that verbal assurances alone are not sufficient and that ways must be found of building feedback mechanisms into tasks. This might enhance the sense of achievement workers looked for in their work. In the study by Walker (1979), described in Chapter 2, financial incentives, combined with social reinforcement, proved an effective means of improving output. However, this study was set in a rehabilitation workshop and it is probably easier to measure output there than in a market garden, where results are delayed and are affected by many factors other than participants' performance. The fact remains that Sprout is a community programme and this limits its scope to 'reward' participants for their performance. Wages are paid on a flat-rate basis and the number of 4 or 5 day places is not elastic. Thus, the length of someone's working week bears no necessary relationship to his/her ability. Ultimately the desirability of paying differential wages based on performance in rehabilitation needs to be considered. This practice may improve the performance of some participants. It is also 'normal' practice in many areas of open employment. On the other hand, it may act as a disincentive for those who are most disabled. An emphasis on increasing productivity/improving standards assumes that rehabilitation is exclusively about change and overlooks the protective-maintenance function, particularly in respect of the most disabled. There is also the danger that production may become the raison d'être of a rehabilitation project. In her survey of day services for adults in England, Carter (1981) observed that once projects adopted production aims, the significance of participants

altered. Staff defined contact with participants as primarily supervisory and their welfare/caring function diminished. Participants tended to become means to an end and work was carried out in order to produce rather than because it was a useful vehicle for rehabilitation.

The crucial issue seems to be to identify ways of rewarding good performance, based on quality as well as quantity of work, and at the same time to ensure that all participants are made to feel valued and respected, regardless of ability. If financial reward is contingent on performance, there is a risk that the least able will be penalised and denied their right to a reasonable standard of living.

Motivation

Evidence from other research, reviewed earlier, suggests that motivation is unlikely to change in rehabilitation. The motivation scores on the Work Assessment schedules are considered later in relation to the overall impact of the project. At this juncture it is of interest to consider motivation from participants' perspectives, to find out whether they felt it fluctuated over time and to ascertain what factors were associated with different levels of motivation.

Three items were used to define motivation levels:

(1) Did participants ever lose interest in their work? If so, at what stage?
(2) Had they ever considered leaving?
(3) How did they feel about their jobs when on holidays or at weekends?

Twenty-one people said their enthusiasm had waned at some stage. For 3, this was towards the beginning of their year's contract, for 8 around the mid-point and for one as the end approached. Nine people said their interest in work had fluctuated throughout their year at Sprout.

Fourteen had considered handing in their notice: 3 at the beginning, 4 at mid-point, 3 towards the end and 4 at various stages throughout.

Five people found returning to work a real effort after days off, 9 had no difficulty and 8 were glad to return (one person did not answer).

In order to pinpoint those with low motivation, the above 3 items were combined. A score of 1 was given for:

- repeated loss of interest
- recurring thoughts of leaving
- reluctance to resume work.

Each participant was therefore given a motivation score of between 0 and 3:

13 people scored 0
5 people scored 1
3 scored 2
2 scored 3.

Taking 0/1 as a cut-off point created 2 subgroups of comparable size - 10 with lower motivation, 13 with higher motivation. If I had used 1/2 as a cut-off point, further analysis would have been difficult given the small size of the subgroups. All 4 women were among the 10 with lower motivation. In respect of other background variables, such as age, diagnosis and employment history, high and low motivated participants were similar. However, low motivation seemed part of a set of negative attitudes to employment and the future.

Low motivated participants tended to hold pessimistic attitudes towards the future. This group were also less likely to have started looking for work at Time II; 7 of the 13 highly motivated were job-hunting, compared with only 2 of the 10 poorly motivated. As might have been expected, there was an association between motivation and absenteeism. The mean absenteeism rate was 12% (1 day off in every 8 working days) but over half the workforce had an absenteeism rate of only 6%. The relationship between motivation and absenteeism is shown in the table below.

TABLE 7.4 Motivation and Absenteeism (N = 23)

		Absenteeism	
		6% or less	More than 6%
Motivation	Low	3	7
	High	10	3

One of the difficulties in evaluating a rehabilitation programme is that participants are exposed to a multitude of events and influences outside the programme which may affect outcome. It seemed important therefore to attempt to ascertain what difficulties participants encountered during their Sprout career, both at work and beyond. The listing of difficulties has little explanatory power on its own, but it is possible that patterns may emerge, for example, that those who face many problems are less motivated.

Participants were asked if they had encountered any difficulties at work and/or in their personal lives since joining Sprout. Work-related difficulties were more readily mentioned and a series of prompts was used concerning personal or domestic matters. The results were categorised as follows:

TABLE 7.5 Work-related Difficulties

Nature of Difficulty	No
The work itself	4
Discipline	3
Relationships with supervisors	2
Relationships with fellow workers	2
Relationships with project manager	1

TABLE 7.6 Personal or Domestic Difficulties

Nature of Difficulty	No
Sleep problems	10
Personal relationships	7
Accommodation	6
Drugs *	6
Alcohol	4
Diet	3
Mental health	2
Finance	1

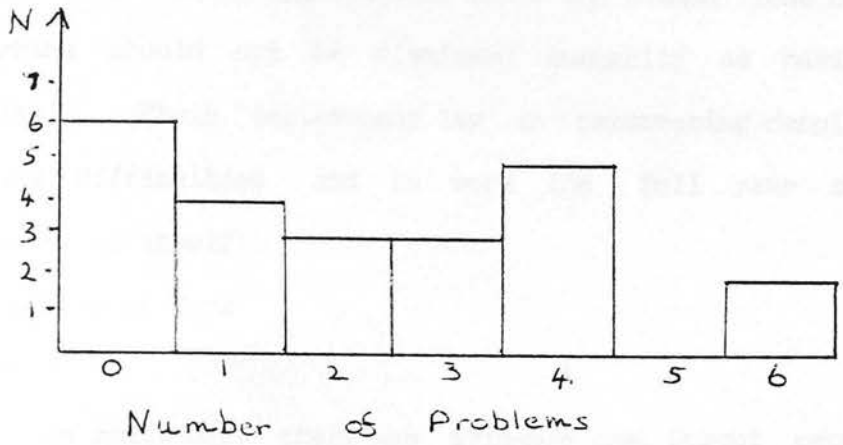
* in 5 cases drugs were prescribed.

It should be stressed that 'problems' were only counted as such if respondents expressed concern about the matter and felt it was interfering with their well-being. In all, 51 'problems' were identified. It was striking that only 12 of these were work-related; most were domestic or personal and in no individual case did the number of work-related problems outweigh personal problems.

Surprisingly perhaps, only 2 participants reported mental health problems, although a large number of problems mentioned were broadly health-related (sleep, diet, drugs, alcohol) and may have been indirect manifestations of mental health problems. It is easy to see how participants' work performance might have been adversely affected by such difficulties.

The distribution of problems is shown in the Figure below:

FIGURE 7.1 Distribution of Problems (N = 23)



Those with low motivation were more likely to face a larger number of difficulties, as shown below:

TABLE 7.7 The Association between Motivation and Problems

		Motivation	
		Low	High
No. of problems	0-2	3	10
	3+	7	3

This discussion of motivation has brought to light 2 important points. Firstly, it was clear that participants often faced considerable difficulties in their non-working lives and this would seem to have far-reaching implications for the project's effectiveness. Secondly, it is likely that the problems people faced had a bearing on their motivation, although evidence does not allow us to draw firm conclusions. It was impressive that participants facing considerable problems nonetheless continued at Sprout.

Presumably the project offered them something useful and stable while their difficulties continued. This seems a very valuable function for Sprout. It also suggests that those who seemed 'less committed' to working should not be dismissed summarily as having 'less potential'. Their achievement lay in persevering despite often disabling difficulties and to work the full year seemed an achievement in itself.

Relationships at Work

Peers

As we shall see, there was evidence that Sprout promoted the development of friendships among participants. It seems important to consider what features of the project may have facilitated or impeded this process. On a general level, it may be that Sprout simply provided a place for people to meet: at Time I, 1 in 5 completers said they applied to Sprout as a way of meeting people. However, from participants' descriptions of how they 'got on with' their fellow workers, it was possible to distil 3 sets of factors which may add to our understanding of the process of friendship development:

(1) participants' social and personal resources;
(2) the nature of the work and organisation of the project;
(3) the fact that Sprout was exclusively for people with mental illness.

1. Firstly, the quality of relationships seemed to be related to the social competence and confidence of individual participants. The majority of participants (20) indicated they got on well with their peers at Sprout:

> Most of the other workers are friendly and accepting of each other. Very little animosity.

Many apparently felt that being in employment enhanced their status and this in turn seemed to give them more confidence both in their own ability to make relationships and in their attractiveness as a friend to others.

> When you're working you feel more proud of yourself.

> (Being in work) ... restores a lot of my self-respect more than anything else. It's also improving my self-confidence.

However, 3 people admitted to difficulties in their relationships with peers and explained this in terms of their own lack of confidence or skills:

> I've never been a talker, I've always been a loner.

> If anything, it's been me that's been the one who couldnae break through the barrier.

Only a small number of people therefore stated they lacked skills to make relationships, but this may well be an underestimate. It is clear nevertheless that individuals' social skills had a bearing on the quality of their relationships with peers, although the extent of the influence cannot be fully assessed, and that those with least personal resources had most difficulty.

2. It seemed from participants' comments that it was often easier to communicate with peers whilst working with them, rather than at break-times. One of those who found relating to others difficult said:

> It's a kind of relaxed atmosphere when you're working in small groups. At break-times everybody's quiet. There's an atmosphere that makes it hard to speak.

Working with others on a common task allowed conversations and relationships to develop in an unforced way. This is substantiated by research by Miles (1972), described in Chapter 2. Interestingly, Floyd and colleagues (1983) found that people in their study were more likely to stay in jobs where they did not work on their own all the time, but with at least one other person, in a fairly small group. At Sprout most of the work was done in small groups. Most participants preferred working with other people and those who preferred to work alone explained they could achieve more in this way.

While the patterns of working may have promoted friendships, the time-limited nature of employment at Sprout had the converse effect. Termination of employment also seemed to imply the severance of friendships.

> Life couldn't be better, but on the other hand you're waiting on the last day coming. I'm not looking forward to it. I've made friendships with workers which'll break up.

Additionally, the constant turnover of participants meant that people had repeatedly to go through the process of making new acquaintances. Conceivably this would have been particularly stressful for those who were less skilled in social relationships.

3. We saw that at Time I, participants were often ambivalent about joining a project specifically for mentally ill people. This ambivalence seemed to have persisted. On the one hand 12 participants said one of the good things about their peers was that the shared experience of mental illness provided a common denominator in social exchanges and made others more understanding:

> If you're not feeling well they are a bit more understanding, because they've had that experience themselves.

Possibly receiving support from peers had particular benefits: in a review of the effectiveness of social support Suls (Sanders and Suls, 1982) notes that support based on reciprocity is less likely to damage one's self-esteem since one is not merely cast as a recipient of help.

On the other hand, mixing with people who were mentally ill was not always a positive experience. Perhaps because mental illness was something participants had in common it was often the main topic of conversation:

> You never seem to get out of yourself, to talk about different things instead of how you feel.

Furthermore, the types of exchanges which took place were described by some participants as 'weird', 'strange' or 'unhealthy' and this could deter even the more confident from joining in conversation.

> It can be very difficult to contribute when conversations sometimes don't make sense.

Some shyer participants felt that other people made little effort to draw them into conversation. Evidently more able participants found it difficult to tolerate the 'failings' of others.

> Some can get on my nerves. Alright, they may be ill, but that doesn't stop them trying.

In sum, it seemed that the various factors discussed had different effects. The patterns of working seemed conducive to the development of relationships among participants and, to an extent, the concentration of mentally ill people created a basis for reciprocal support. Conversely, the lack of continuity caused by the turnover of workers and the fact that participants were exposed

to 'abnormal' forms of social exchange militated against the growth of friendships, particularly in the case of the most withdrawn. The central issue, about which participants were ambivalent, seemed to be the desirability of concentrating mentally ill people in one setting. This theme will be discussed more fully subsequently.

Supervisors

Other research which has looked at how mentally ill people view their helpers have found that clients/patients are often not satisfied with their relationships with helpers. Gordon et al (1979) looked at patients admitted informally and for the first time to a psychiatric hospital in Aberdeenshire. They found that while most patients felt their personal, emotional and physical needs had been met, they were less satisfied with the opportunities to develop relationships with staff. A similar point is made by Kanis (in Drucker, 1987, Vol.II) in writing about the needs of those who suffer from manic depression for long-term support.

It seems that clients/patients attach importance to informal confiding relationships with helpers. Davis (1986) found that day centre users gave highest ratings to staff who were friendly, open and did not seem 'superior'. In a survey of patients attending a psychiatric day hospital, Turner-Smith and Thompson (1979) reported a striking consonance between the popularity of different professionals and the distribution of staff time. Nurses, who were most popular, also spent most time with patients, while social workers, who were least popular, made the least time input. Interestingly, the aspects which clients/patients valued in their helpers in these studies - openness, friendliness, approachability - resemble what are often regarded as the essential ingredients of a therapeutic relationship (Truax and Carkhuff, 1967).

Turning now to the views of Sprout participants, it seemed that supervisors had achieved a successful balance between work and welfare. Most participants said they enjoyed good relationships with supervisors. Only 2 had had difficulties in this area and both were shy people who tended to isolate themselves. While several other participants explained they had no affinity with certain supervisors, they had established good relationships with others. The majority had learned something from supervisors, to do with work in 14 cases, but also more personal matters, such as how to cope with stress, in 4 instances. Supervisors were perceived as approachable: 14 people said they would discuss work-related problems with them and 8 both personal and work matters. In some cases it was evident that this represented a major achievement for both sides.

> I'd try to discuss any problems with a supervisor
> but I'm not very good about trusting people.
> I've come to trust supervisors a wee bit though.

A number of suggestions were made as to how supervisors might do their job differently: 4 people felt supervisors should be less strict (reiterating the complaint about excessive discipline noted earlier); 2 felt supervisors should be more available and spend less time in meetings; one person wanted them to be more consistent in their treatment of individual participants and another said supervisors should teach more rather than issue instructions.

The consensus was that supervisors were the linchpin of the project, without which it would disintegrate. Participants had great admiration for supervisors and appreciated their diverse talents and personalities, since they were thus more likely to find someone to whom they could relate. Unquestionably, supervisors were

a talented and dedicated group of people, but that in itself does not seem sufficient to explain their achievement. Several other explanations seem plausible. Firstly, the non-commercial status of the project may have enabled supervisors and participants to enjoy more open, trusting relationships than if the project's primary concern had been production. This was highlighted by the research of Carter (1981) reported earlier and by a different study of patterns of interaction between staff and users of 4 local authority psychiatric day centres in England. Shepherd and Richardson (1979) found that variations in management and organisational practices were associated with differences in the nature and quality of staff-user interaction. Where management attitudes were 'client-oriented' staff adopted a more personal approach to users' problems and interacted more warmly with them. This has implications for the funding of projects like Sprout. Community Programme status means that Sprout is subsidised and not 'for profit' and is therefore able to pursue its rehabilitative goals. Should the project decide to become self-financing (and this would have the benefit of freeing it from the MSC rules and conditions) its fulcrum would be altered; the basis on which people were recruited would be modified as would the nature of staff-participant relationships.

Secondly, supervisor-participant relationships were based on a different premise to doctor-patient or social worker-client relationships. Receiving psychiatric care is predicated on an assumption of illness or disability, whereas being supervised at Sprout is part of the role of worker and is an index of 'normality' (Shepherd, in Herbst, 1984). Transactions between participants and supervisors were not unidirectional exchanges in which participants

were recipients only, since the latter also assisted supervisors by supplying their labour.

Thirdly, supervisors and participants were working side by side on a shared task and in this respect the nature of their interaction differed from that of social workers and clients. This may be important in view of the point made earlier, that people found it easier to talk to their peers when working with them rather than 'just sitting'.

The Impact of Sprout

Having looked at participants' experiences at Sprout, we now turn to consider the project's impact on participants as perceived by them and by supervisors.

Perceived Gains

Participants were asked what they had gained from working at Sprout. Answers were later coded to yield the following (people could give more than one answer):

TABLE 7.8 Perceived Gains from Working at Sprout

	Number reporting
Work experience	11
Friends	8
Skills	6
Satisfaction	6
Confidence	5
Better mental health	5
Sense of direction for the future	3

The import of these gains is best illustrated by the comments of participants. Work experience would improve participants' chances of securing future employment. It also enhanced participants' self-image:

> At last I know I can stick a job out.
>
> People outside said I wouldnae last, but I have.

These 2 young men had had very little previous work experience. Sprout had given them a firmer sense of their own worth. For others, it confirmed they still had abilities despite having been ill.

> I've learned that I could still do the work after my illness.

On the other hand, 2 people had come to recognise their limitations as a result of working at Sprout:

> I've learned ... maybe I'm no' as tough as I'd like to be.
>
> I've learned I couldn't hold down a full-time job just now.

Sprout had led some participants to realise that work could be enjoyable:

> My attitude to work has changed dramatically. I no longer see it as a series of chores to fill the time.
>
> I've realised I can be happy actually doing something - I'm actually enjoying it! Before I don't think I ever really enjoyed my work.

This last comment was made by a woman who was afflicted periodically by serious bouts of depression. Several participants indicated ways in which their attitudes had altered:

> My mental health has improved, my attitude to life as well, because I'm not lying in bed all the time.
>
> I've learned to push masel' when I'm working on my own.

It was evident from the qualitative data that some participants derived more benefit from Sprout than others. Sprout presented people with various challenges and opportunities, but ultimately it was up to the individual to make what he/she could of them.

> I've learned some things, not an awfae lot, but that depends on the individual, how much you want to learn.

It seems that participants were confirming the importance of motivation, in commonsense terms:

> Regardless of how ill or inept you might consider yourself to be when you come here, the supervisors will coax the best out of you if you're willing to put a little bit of effort in.

Whilst appreciating how they had benefitted from the year's employment, some participants retained a clear sense of proportion.

> It's helped me to be a better person, but it won't help me to get a job in the future. I don't think anybody else'll be as impressed with Sprout as I am.

Sprout was, after all, only a brief episode in participants' lives and gains made could easily be eroded. One young man was ambivalent about Sprout and the future.

> Sprout ... will help me get a job when I leave. If it wasn't for Sprout I'd be permanently unemployed no doubt. You can forget skills, so if I don't work, the skills will be lost, but if I do continue working the skills will be of use.

In general, then, participants could identify various ways in which working at Sprout had benefitted them. Perceived gains were not only work-related, but also spilled over into other areas of their lives; as we shall see in the next chapter, participants were often more active, more confident and in better health than when unemployed. We now need to compare perceived gains with supervisors' assessments of participants.

Supervisors' Assessment of Participants

Supervisors completed the Work Assessment schedule at 2 months and 10 months into completers' careers on the project. Scores are shown in the Table below.

TABLE 7.9 Work Assessment Schedule +

	Time I (N = 24)	Time II (N = 23)
1. Task competence	20.71	22.83
2. Response to supervision	8.88	10.26
3. Social relationships	11.08	10.39
4. Motivation	14.75	17.74
5. Confidence	9.50	9.13
Total score (mean)	62.79	67.78
S.D.	12.76	17.55

+ Low scores indicate better performance.

Participants' scores tended to deteriorate over time, with the exception of 'social relationships' and 'confidence' scores which improved slightly. This downward trend seems disappointing: it also seems at odds with the perceptions of participants themselves. Several points should be noted however. Firstly, the timing of administration may have been influential. The second assessment was carried out 2 months before participants left Sprout and by that stage people may have been less motivated and performed less well.

Secondly, some participants seemed to find that working was stressful and their performance may have consequently deteriorated. Thirdly, the criteria which supervisors used to assess participants may have altered over time. Possibly they were more lenient at first assessment than later. In Chapter 2 I mentioned that Watts (1978) noted a similar tendency for ratings to deteriorate in his study of patients attending a Vocational Resettlement Unit at the Maudsley. He speculates that supervisors may have been more lenient in their first ratings. Fourthly, the overall tendency for scores to deteriorate may disguise variations among individuals. Watts found that changes in work behaviour showed considerable variation among individuals. This was also the case in the Sprout study. While mean scores deteriorated, 1 in 3 participants were given a higher rating at second assessment. However, it proved impossible to explain why certain individuals improved. Analysis by past employment, psychiatric history and age revealed no patterns. The range of total scores widened over time: at first assessment the range was 36-80, at second assessment it was 36-109. It seems therefore that Sprout had a variable impact on the work behaviour of participants on the Work Assessment schedule. Participants started Sprout at very different levels and improved or deteriorated at varying rates.

In addition to the Work Assessment schedule, supervisors made recommendations concerning the future employment of participants. This was part of the evaluation supervisors completed for each participant at the end of the latter's year at Sprout. Recommendations are shown below:

TABLE 7.10 Placement Recommendations (N = 24*)

Open employment	7
Sheltered employment	9
Further rehabilitation	8

*N = 24 here as an evaluation was completed for the man not available for interview at Time II.

Only 1 in 3 participants was thought to be ready for open employment at the end of the year. A further third were said to require sheltered employment and the remainder apparently needed further rehabilitation. Evidently Sprout was a necessary, but not sufficient, preparation for employment for most participants. Some needed long-term placements in a supportive setting, others needed further preparation. Wansbrough, an experienced worker and researcher in the field, stresses that

> rehabilitation and resettlement cannot be hurried. Short cuts do not work. (Wansbrough, 1980, p.32)

The MSC set up Development F projects to provide longer-term rehabilitation than Employment Rehabilitation Centres offered for certain groups, including the mentally ill. It seems that a year may not be long enough.

In sum, participants felt they had gained considerably in diverse ways from working at Sprout. It was disappointing, however, that ratings of work performance showed no improvement for two-thirds of completers. The findings of other research suggest it may be unrealistic to expect such changes. Social intervention programmes have often achieved change in client satisfaction, but rarely in client behaviour, except in relation to very specific aspects of behaviour (Goldberg, 1987). For example, Fenton et al (1982) compared the effectiveness of home and hospital-based

psychiatric treatment for people with schizophrenia. They found that home-based treatment was preferred by mentally ill people and their relatives, but neither mode of treatment diminished the chronic impairment of many patients. In a study of couples with marital difficulties, Mattinson and Sinclair (1979) found that clients were more content following social work intervention, but there was little evidence of attitudinal or behavioural change. On the other hand, it was evident that certain participants did 'improve' while at Sprout and this will be pursued in Chapter 9. Moreover, supervisors indicated, by recommending 1 in 3 for further rehabilitation, that perhaps more could be achieved in the way of change and work preparation.

The impression gained from participants, however, was that they were not concerned with changing their own behaviour: they simply wanted the chance to work, not necessarily to become more 'efficient' workers. They welcomed Sprout because it offered richer, more rewarding experiences than unemployment. Participants saw Sprout as an opportunity to gain work experience and obtain an up-to-date reference and thought these were sufficient to improve their employability.

Looking Ahead

Participants tended to view the termination of their employment at Sprout with mixed feelings. A minority - 4 - seemed relieved they would soon leave, most were concerned about what they would do next. I asked how people thought things would be in the future. Only 6 seemed at all optimistic:

> Sprout will give me confidence, will help me get a job when I leave.

Eleven approached the future with trepidation:

> If I got a job, it'd be OK. If not, it'll be hard.

Six others seemed very pessimistic:

> I dinnae see any future, nothin' at all. I dinnae want to end up in the unemployment thing again.

Employment was at the heart of participants' plans for the future. Eighteen people indicated they hoped to continue working, 12 in full-time work, 3 part-time and 3 on a self-employed basis. Six of the 18 wanted to stay in horticultural work, having enjoyed the work at Sprout. The other 5 people had no clear plans. It is striking that most planned to obtain employment even though supervisors felt only 1 in 3 was capable of open employment. This strengthens the impression that participants were not wholly aware of their own limitations (for example, were not concerned with changing their behaviour or improving skills and tended to perceive their employment difficulties in terms of an absence of opportunities). On the other hand, given that sheltered work was not immediately available, what else could they plan?

Obtaining other employment was treated with varying degrees of urgency. Only 9 people had started to look for work 3 months before leaving Sprout. Even fewer - 5 - said they were getting any help with this, mainly from Sprout staff.

> I've been applying desperately to jobs. If I end up unemployed, it's not through lack of trying and I won't feel so guilty because I did make an effort.

> It's not the financial point of view (that worries me) but that feeling of hopelessness.

Others seemed to defer job hunting as a means of avoiding the thought of the imminent termination of their contract or were so pessimistic that efforts seemed futile. It seemed that during the last few months on the project many participants began to feel dejected and to lose confidence. Ironically, this was the point at which they needed to be most motivated in order to launch themselves into other employment.

The report which discusses the MSC's rehabilitation services and the RER developments observes that the Community Programme offers a means of providing the longer periods of work preparation needed by some people, including those with a mental illness. It goes on to say:

> Experience so far with this approach has pointed up the need for job search training and intensive placing action as projects come to an end. (MSC, 1984b, p.32)

There was little evidence that by 1986/87, when the study was carried out, that the 'need' the MSC identified was being met. Staff at Sprout were aware that they did not have sufficient time to help participants plan for the future, although they sought to do so in final reviews. About halfway through Time II interviews with completers, Sprout appointed a training and development officer. This post was created by using funding from the European Social Fund, not the MSC, although the post covers both parts of the project. One of this worker's responsibilities was to be to prepare people for leaving. However, it transpired that much of his time was taken up with recruitment. The participants interviewed after his appointment gave little indication they had received help from this quarter to look for future employment. It may be that the project needs to review how it deploys its resources (principally staff time) and consider how more intensive assistance might be

given to participants at this crucial stage. An alternative which has been used sometimes at Sprout is to 'buy in' training in job search skills. These different options could be compared in terms of cost and effectiveness.

Conclusion

On the whole, then, completers regarded their time at Sprout as a positive experience from which they had gained. However, it was not simply that this group liked Sprout or found the work easy. Some would have preferred other types of work. In addition, people often faced considerable difficulties, mainly outside work, which may well have made it harder for them to sustain effort and complete their year.

There was little evidence from the rating scales that participants' competence had improved while at Sprout. This seems disappointing, although timing may have been important here. It was noticeable that participants and supervisors had different expectations: the former did not appear to share the latters' concern with personal change and growth, but saw work as an end in itself.

One of the project's main achievements was that it fostered friendships among participants and trusting relationships between staff and participants. Work not only brought people together, it also provided them with a valued role which had positive connotations and which promoted reciprocity rather than dependency. Most participants were sorry their employment at Sprout was drawing to a close. It was clear, however, that the project was only offering people limited preparation for leaving, apparently because it lacked the resources. While the MSC has acknowledged the

importance of assisting participants to plan for the future, the Commission seems to expect projects to use their existing resources to this end. At Sprout it was evident, from interviews with staff and from my observations, that keeping the project running smoothly and attending to participants' immediate needs absorbed most of staff's time and energy at the expense of longer-term concerns. The corollary was that participants did not necessarily receive adequate support at the point they were probably most vulnerable and in need of assistance.

Finally, the views of completers challenged some of the conventional notions about the type and form of work which are best suited to mentally ill people and this theme is discussed more fully in the final chapter of the thesis.

In the next chapter we remain with completers at Time II to consider the extent to which their personal and social circumstances had altered since they began Sprout.

CHAPTER 8

THE SOCIAL SITUATION OF COMPLETERS AT TIME II

This chapter reviews changes which had occurred in the personal, material and social situations of completers since Time I and looks at health and well-being, accommodation, social support, leisure activities and finance.

Health and Well-being

Health

During their 9 months at Sprout, most participants had not been admitted to hospital; 6 people had been admitted. The table below shows how often these 6 were in hospital and how long they spent there.

TABLE 8.1 In-patient Episodes between Times I and II

Case	Number of Admissions	Time in Hospital (weeks)
1	1	1
2	1	1
3	1	1
4	1	7
5	3	8
6	4	2

Despite their admissions, all 6 had managed to resume employment, sometimes working at Sprout during the day while still in-patients.

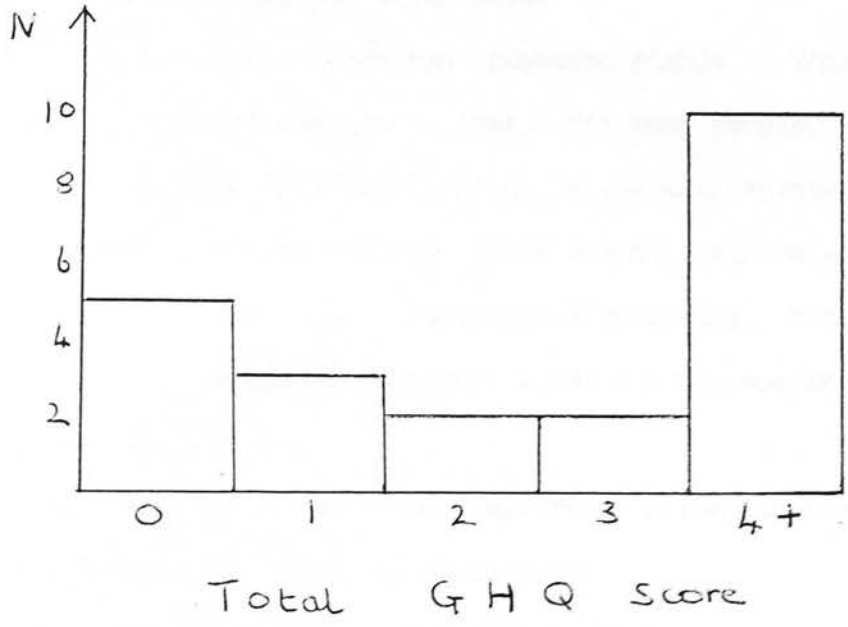
There was little association between whether someone had been admitted to hospital in the 12 months before joining Sprout and whether they were admitted while employed there. Rates of admission seemed to have declined since Time I, although comparisons are difficult given the different time-frames and small numbers.

Fourteen people had been admitted in the 12 months prior to their joining Sprout, while 6 were admitted in the 9 months between Times I and II. An early study by Brown et al (1958) looked at the post-hospital adjustment of ex-patients and found an apparent association between employment status and readmission to hospital. Those who were employed at least 6 months of the 12 months follow-up period, were considerably less likely to be readmitted to hospital. The interesting point in the Sprout study is that the same individuals were monitored both in and out of employment. Discussion about employment and hospital admission has often been confounded by the difficulties of comparing admission rates for an employed sample and an unemployed sample, since being in work may itself indicate better health.

There were few other changes in treatment received. All those attending as out-patients at Time I were still doing so. The proportion on medication remained the same.

The GHQ was administered to 22 completers at Time II (one woman refused to complete the GHQ) and provides a measure of psychological distress. Because reliable scores on the GHQ are not available for Time I, the main interest of Time II scores is as a measure of 'caseness'. It will be recalled that a total score of 4 or more can be taken to indicate caseness. The distribution of scores for the 22 completers is shown below.

FIGURE 8.1 Distribution of GHQ Scores (N=22)



It can be seen that 10 of the 22 completers scored at least 4 and thus qualified as 'cases'. This suggests a high level of psychological ill-health among participants.

It is possible, however, that the timing of administration influenced results on the GHQ As the end of employment approached and anxiety about the future intensified, participants were likely to experience an increase in distress. This possibility becomes more plausible when we consider the findings of a study by Wall and Clegg (1981). They report significantly higher levels of psychological distress on the GHQ in workers employed by companies with financial problems and conclude that insecurity and tension contributed to this distress.

At Time I, completers were likely to report an improvement in their health in the year preceding Sprout. This trend continued at Time II. Eighteen of the 23 declared their health had improved since starting work, compared with 15 out of 24 earlier.

I feel more in control of my life now.

I feel a lot better now. I was just out of hospital then and I could hardly face the world. A bus journey was a big event.

The health of 4 others had remained stable. This recalls an argument put forward earlier: that, for many people, the optimum that can be attained in rehabilitation is the maintenance of a steady state of health and performance. Only one man said he was less well than when he started work. He disliked gardening, but felt that - rather like nasty medicine - it was 'good' for him and had determined to complete the year.

Changes had taken place in completers' perceptions of how their health affected their work, as shown below:

TABLE 8.2 Perceived Effect of Health on Work

	Time I (N=24)		**Time II** (N=23)	
	No	%	No	%
Considerable	8	33	7	30
Limited	4	17	10	43
None	12	50	6	26

Looking at the nature of these changes it emerged that

- 4 people felt their health had less of an effect than they had anticipated at Time I
- 9 people revised their views in the opposite direction and felt their health had a greater impact than anticipated.

Health impinged on participants' work capacity in various ways, affecting motivation, concentration and decision-making powers.

If I'm depressed, I get lethargic.

When I feel bad, I find it hard to make decisions about things. I get really panicky. I feel I never do anything properly.

Several people referred to the effects of their medication and how it damaged their work performance. The most extreme example of this was one man with schizophrenia who said:

> I don't think there'll be any improvement in my work while I'm on injections. They make it harder. They make me shake like anything, especially when I'm trying to dig. I think I'd be working a lot better if it wasn't for modecate.

While participants' health could affect their work performance, being in employment could also have positive effects on their health. For some, this involved an increased sense of well-being.

> I feel happier all the time, livelier because I'm working. Better, brighter in myself.

Working also helped reduce some of the effects of illness. One young man who suffered from anxiety said:

> I dinnae worry so much. I've no got time tae worry. If you're on the dole all you can dae is sit and worry and things get worse and worse.

The social aspects of work were also therapeutic.

> I've realised I need regular contact wit people. I was shutting myself off but it doesn't suit me. It makes my condition worse.

Well-being

The tables below look at changes in levels of well-being among completers since Time I on the Affect Balance and Present Life Satisfaction scales.

TABLE 8.3 **Affect Balance Scale at Times I and II** (Mean scores)

	Time I (N = 24)	**Time II** (N = 23)
*Positive Affect	2.54	2.74
+Negative Affect	2.62	2.87
*Balance	-0.08	-0.13

* High score = 'good'; + Low score = 'good'.

TABLE 8.4 **Present Life Satisfaction Scale at Times I and II** (Mean scores)*

Time I (N = 24)	**Time II** (N = 23)
46	51

* High score = 'good'.

The PLS and the positive affect scores suggest an increase in well-being had occurred, however the negative affect score had also risen. It is possible that 2 separate processes were in operation. Positive affect is associated with exposure to new experiences and with higher levels of social contact (Bradburn, 1968). Conceivably by providing both these aspects, Sprout enhanced positive affect. On the other hand, negative affect is associated with measures of anxiety and concern about one's health.

It is important to note that both scales look at respondents' attitudes to 'life as a whole' not only to their working lives. A vast array of factors outside the work arena might therefore have influenced levels of well-being. However, the scores on the Life Events Inventory were remarkably consistent over time:

TABLE 8.5 Life Events Score at Times I and II

Time I (N = 24)	Time II (N = 23)
197	195

This indicates no change in levels of 'turmoil, disturbance and upheaval' in participants' lives since they started work. On the evidence available, therefore, the increase in negative affect cannot be explained by the occurrence of significant events. Recent research by Brown and his colleagues (1987) has introduced new considerations into the debate about the importance of stressful life events. These researchers looked at the onset of a particular condition - depression - among a specific group - working-class mothers. Nevertheless, their findings may have a wider relevance. They posit that the meaning of an event to the individual concerned, along with the individual's vulnerability, are crucial determinants of whether that person goes on to develop depression. Thus simply measuring events in quantitative terms is not sufficient. Unfortunately, it was beyond the scope of the Sprout study to undertake a qualitative assessment of events and therefore findings must remain inconclusive.

A further possible explanation for the increase in negative affect is to view it as an anticipation of future events, rather than (or as well as) a reaction to past events. A similar proposition was suggested earlier with reference to GHQ scores. Conceivably the prospect of imminent unemployment, which clearly aroused anxiety in Sprout participants, may have increased negative affect.

Self-esteem

It was decided not to show results on the self-esteem scale for completers at Time II as no comparative data was available. I could find no normative data using the same scale and same method of scoring. As with the GHQ, scores were only available for small numbers at Time I. However, SES scores are considered in the next chapter which looks at integroup differences.

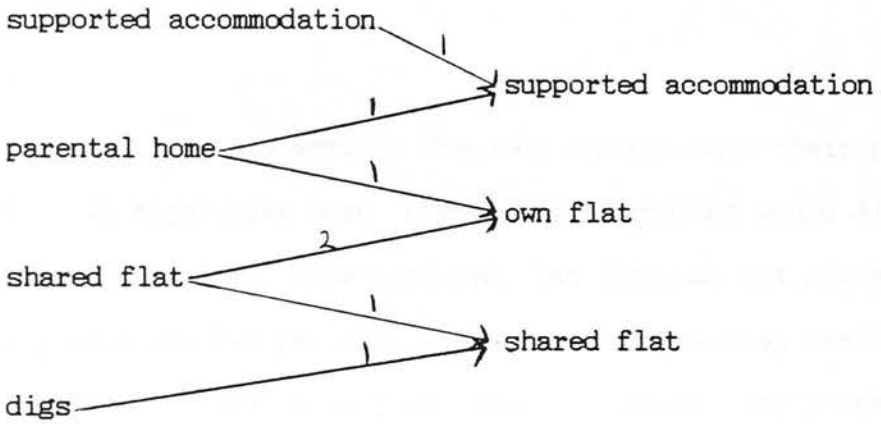
To recapitulate, there was some indication that rates of admission to psychiatric hospital dropped when completers entered employment. Participants often reported improvements in their health since Time I, but this was only borne out to a limited extent by scores on the scales measuring psychological well-being. It was thus unfortunate that GHQ scores were not available for Time I to give an indication of change over time. The experience of working at Sprout had led many participants to re-evaluate the extent to which their health affected their work; it had also brought the realisation that working benefitted their health.

Improvements in health and well-being which might be attributed to being in work seemed to be offset by the detrimental effects of impending unemployment. It is thus interesting to note the conclusions of Kasl et al. who researched the relationship between job loss and changes in physiological and psychological health. They observe that the period of anticipation of the event (i.e. job loss) can be at least as stressful as the event itself (Kasl et al. 1975).

Accommodation

At Time I, we saw that one-third of the total sample had changed accommodation in the preceding year. Between Times I and II, 7 of the 23 completers had moved, suggesting a consistent, relatively high level of mobility. The diagram below indicates the direction of change.

FIGURE 8.2 Changes in Accommodation since Time I



In 3 cases moves seemed to indicate greater independence: 2 people moved into supported accommodation, one of these from his parents' home and one from a staffed hostel into a group home with non-resident staff. A third man moved into his own flat from his parents' home. In the other 4 cases, it was not possible to say whether moves involved an increase in independence.

At Time II, the living arrangements of the 23 completers were as follows:

TABLE 8.6 Accommodation at Times I and II

	Time I (N = 23)	Time II (N = 23)
Parental home	11	9
Supported accommodation	5	6
Own flat	1	4
Shared flat	3	2
Marital home	1	1
Lodgings	2	1

Social Support

Family

Most participants were in frequent contact with their parents at Time I. It might have been expected that contact would diminish to some extent once they were employed, but this was not always so. Of the 20 people who had parents, 4 saw more of them than earlier, 7 saw them as often, 9 saw them less often. Contact had therefore been reduced for about half the group only. Moreover, there was little association between whether someone lived with his parents and whether contact increased or declined over time, as the table illustrates.

TABLE 8.7 Change in Contact with Parents since Time I (N=20)

	Less Contact	Same Contact	More Contact
Lives with parents	4	3	2
Does not live with parents	5	4	2

In general, it seemed most participants were satisfied with the amount of contact with parents. It was not possible to determine exactly how much contact was involved, but available evidence suggested that being employed did not automatically reduce contact with parents. Whether this is a 'good thing' is open to speculation. Research has shown, however, that the amount of face-to-face contact between relatives and sufferers from schizophrenia can have a bearing on prognosis. Vaughn and Leff (1976) found that where patients were on phenothiazine medication and where contact between patients and relatives was restricted to less than 35 hours a week, the risk of relapse was considerably reduced. Clearly, if someone is employed for 3 days a week minimum, for over 7 hours a day, the opportunities for such intensive contact are diminished.

Employment outside the home can provide a welcome respite for relatives and sufferers (Creer and Wing, 1974). In the Sprout study it appeared that, where participants were living with parents, relationships at home had improved since they started work. Six reported that relationships were better. This seemed the result of less contact combined with an increase in respect for participants:

> I'm not lounging about when my father comes in from work. I'm doing something constructive.

It was common for participants to believe their mental illness had disappointed and shamed their families. Employment was a means of redeeming themselves and of assuming a valued role. In 2 instances family relationships within the home remained unchanged. In one case they deteriorated. This was a middle-aged man with schizophrenia who lived with his sister, also schizophrenic, and his mother who had senile dementia. Sprout offered this man a respite from his domestic problems.

Friends

Social isolation had been a major problem when participants were unemployed and one of the attractions of Sprout was the chance to meet people. In interviews at Time II, a distinction was made between work-based friendships and pre-existing friendships with people not at Sprout.

On the whole contact with 'non-Sprout' friends tended to remain the same or decrease when participants entered employment, as the table below shows:

TABLE 8.8 Change in Contact with Friends Since Time I

	No
More	3
Same	7
Less	7
None	6

Participants attributed decreases in contact to the fact that they had less time and energy to meet people after a day's work. In contrast, 20 of the 23 participants had made new friends at Sprout - including 4 of the 6 who were otherwise friendless. Friendships made were not restricted to the work environment, as most people said they met fellow-workers socially outside work. There was strong evidence, then, that Sprout facilitated the development of friendships among participants, even in some instances where they had no other friends and may have been less competent socially. In the previous chapter I discussed various factors which may have helped foster friendships at Sprout. It is worth noting here that in general work contacts are an important source of friendships. In a recent special analysis of data on social networks, collected in 1973, Wilmott (1986) found that 1 in 3 friendships had its origins in work, or a work-related interest.

The formation of friendships with other workers notwithstanding, more participants were dissatisfied with their friendships than at Time I. Eleven of the 23 said they would like more friends compared with 7 (out of 24) previously. It is hard to account for this - possibly entering employment caused participants to re-evaluate their social relationships and raised their expectations.

Social Adjustment

The Social Adjustment Scale was administered to all 23 completers at Time II. These scores allow us to compare completers with other populations, although this entails some difficulties. Weissman et al (1978) provide scores for a normal population, but use the original version of the SAS, as do McCreadie and Barron (1984) in a Scottish study of schizophrenics who were not in-patients. On the other hand, Cooper et al (1982) use the version of the scale employed in the Sprout study, but scores refer to 2 different groups of women: mothers of young children and women undergoing elective sterilisation. Notwithstanding these qualifications, the global scores from the different studies are shown below.

TABLE 8.9 **Comparison of SAS Scores for Completers with other Populations+**

Source	Sample	Number	Global Score
Weissman et al	Normal US sample	482	1.59
McCreadie and Barron	Non-in-patient schizophrenics	67	2.00
Cooper et al	Mothers of young children	130	1.97
	Women about to undergo elective sterilisation	201	1.75
Sprout study	Completers at Time II	23	2.35

+ Low score = 'good'.

The Sprout group seem less well-adjusted socially, even when compared with McCreadie's sample of schizophrenics. Cooper et al (1982) found that SAS scores were associated with subjects' mental state: those who qualified as cases using the GHQ proved to have significantly higher SAS scores than non-cases. This also appeared to be so with completers. The 10 who qualified as 'cases' had a mean global score of 2.77, compared with 2.43 for 'non-cases'.

Use of Leisure Time

It has sometimes been suggested that high unemployment heralds a new 'leisure age' where people are freed from the tyranny of employment to pursue their own goals. It was evident at Time I, however, that Sprout participants did not view unemployment as an opportunity: time, for them, was a burden.

When people were in employment, free time (leisure) assumed different connotations:

> Your leisure time feels different. Time takes on a new meaning, more enjoyable, something to look forward to.

Leisure was a valuable commodity as a contrast to working - the 2 dimensions were complementary rather than interchangeable. Participants seemed to use their free time more constructively when they had employment. Using the same rating system as previously, 12 people were given a better rating than at Time I, one deteriorated and 10 remained unchanged:

TABLE 8.10 Use of Time Rating at Times I and II (N=23)

	Time I	Time II
Good	2	7
Fair	10	12
Poor	11	4

In some instances, participants spent more time on existing hobbies and interests than earlier. In addition, 5 people had taken up new interests - in 3 cases, gardening - and 4 had joined a club or organisation. Thus, for some participants, Sprout seemed to re-charge their energies in non-work areas of life. These were mainly people who had interests previously.

Others found working was draining and had less time and energy for leisure pursuits; 7 people did less in their spare time than when unemployed. A hard core of 4 people still had no hobbies or interests. It seemed, then, that Sprout encouraged more resourceful participants to develop and sustain interests outside work, but the least resourceful were the most resistant to change.

Despite the evidence of improved use of time, more than half the group - 13 people - were still dissatisfied with how they spent their time. This was similar to the proportion dissatisfied at Time I. Money was now less of an obstacle to doing more: only one person mentioned this, compared with 6 earlier. On the other hand, almost the same proportion as previously (1 in 5) felt they were held back by lack of motivation or confidence.

Money

The table below indicates the financial gain which participants derived from working at Sprout by contrasting wages and benefits.

TABLE 8.11 Wage and Benefit Levels Compared (1)

Benefit Levels 1987 (per week)		**Wage Levels 1987** (per week)	
Supplementary Benefit (single person)	£30.40	Gross 3-day week £50.60	Net (2) £45
		4-day week £67.48	£56
		5-day week £84.35	£78
Unemployment Benefit	£31.45		
Invalidity Benefit	£39.50 (3)		

(1) Rates current at time of writing are shown. Increases in both wages and benefits over time have been slight and the contrast between the 2 was similar earlier.
(2) Net wages are approximate, as deductions vary according to individual circumstances.
(3) Additional allowances may be payable, depending on the age at which incapacity began.

Considerable changes had occurred in perceptions of income adequacy. At Time II, 13 people said they 'managed well' on their income, compared with only one at Time I. Ten got by with varying degrees of difficulty compared with 23 earlier. In all, 20 people said their standard of living had improved. These may seem striking changes, given the absolute size of increases involved. It will be recalled that at Time I, 17 people were on supplementary benefit, one on unemployment benefit and 6 on invalidity benefit. Most were therefore on very low incomes prior to joining Sprout and an increase of £15 a week would constitute a 50% increase in basic income. Comparisons are not straightforward, however, since entitlement to other benefits, such as housing benefit, is affected by change in income and employment status.

The fact remained that 12 people - over half - were not satisfied with their standard of living, despite increases in income. It is interesting therefore to recall that one of the worst aspects of unemployment, according to participants, was lack of money. Although entering employment meant most were better off, many were still dissatisfied with their financial situation.

Recent developments in MSC policy and services are predicated on the assumption that the cause of unemployment and its cure lie with the individual and that the employed are reluctant to work (Finn, 1987). Claimants are now required to undergo tests to prove their availability for work and suggestions have been mooted that the unemployed should work for benefit (Loney, 1987). While it is difficult to generalise about the willingness of the unemployed to work, Sprout participants were not of the opinion that unemployment was preferable. They were prepared to take up employment which paid low wages and offered no long-term security for a whole variety of

reasons, other than financial gain. Shepherd relates similar experiences at a sheltered factory employing mentally ill people, run by Camberwell Rehabilitation Association, where patients were apparently prepared to work for wages only slightly above benefit level. He states that this underlines the social and psychological significance of work (in Herbst, 1984).

Conclusion

Participants' lives had altered for the better to some extent whilst they were employed at Sprout. They tended to report better health and were less likely to be admitted to hospital than previously. In several instances, being in employment appeared to ease tensions in family relationships. Most completers gained new friends through work and were better off financially. For some, working seemed to act as a catalyst and encouraged them to develop their leisure interests. A number moved into more independent living arrangements.

Nevertheless it was evident that changes were not always positive. Some people found work very demanding and their contact with 'non-Sprout' friends and involvement in leisure activities diminished. Moreover, completers remained largely dissatisfied with their social lives and with their standard of living.

The rating scales indicated that there was a high level of psychological ill-health among participants and it seemed likely that the prospect of unemployment was at least partly contributory. Compared with other populations, completers were at a clear disadvantage in social relationships and activities.

In considering outcomes it is of interest to ascertain whether there were any differences among completers, for instance, did

Sprout 'achieve more' with some people than with others? It is to this subject we turn in Chapter 9.

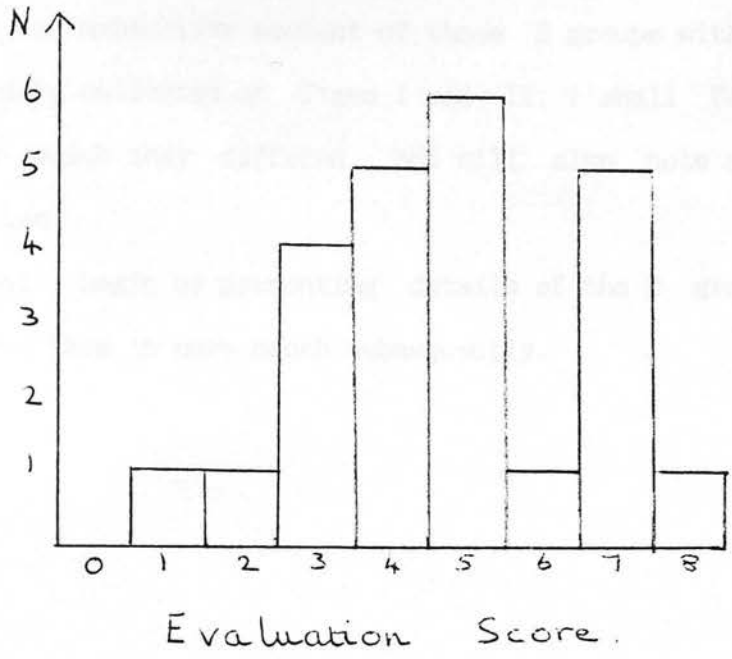
CHAPTER 9

VARIATIONS IN OUTCOME AMONG COMPLETERS

Until now those who completed the year at Sprout have been treated as one group. However, the material from Time II interviews suggested the project had a variable impact on participants. It was of interest to categorise participants relative to some definition of successful outcome at the end of their year at Sprout in order to ascertain the features associated with success and to answer the questions 'who does Sprout best help and why?'

The identification of subgroups among completers was done retrospectively, after completers had left Sprout. I decided not to use the Work Assessment schedule for this purpose, as it rates performance at a particular time rather than change over time. The 2 measures selected to gauge participants' achievements at Sprout were supervisors' end-of-year evaluations and attendance rates. Both measures were described in Chapter 4. To recapitulate briefly, the evaluation required supervisors to answer 8 closed questions for each participants. These covered changes in confidence, motivation, participants' ability to work independently, their ability to relate to others, their understanding of their difficulties, plans for the future, how realistic these seemed to supervisors and supervisors' recommendations concerning participants' future employment. A score of 0-8 was obtained for each person (8 indicating greatest achievement). The distribution of scores is shown below).

FIGURE 9.1 Evaluation Scores for Completers (N = 24)*



* Evaluations were obtained for all 24 completers, including the man not interviewed at Time II.

There was a clustering around the mid-point of the scale with several participants towards both extremes, indicating a considerable range of abilities.

By cross-tabulating evaluation scores and attendance rates, it was possible to identify 2 groups for further consideration. Firstly the 'achievers' were those with evaluation scores of 5 or more and with absenteeism rates of 6% or less. Nine people were in this group. Secondly, there was a group of 6 people with evaluation scores of less than 5 and higher rates of absenteeism (over 6%). I shall refer to this group as 'resolutes', since terms such as 'non-achievers' or 'failures' have pejorative connotations and also seem inappropriate, as I hope to demonstrate.

This categorisation left 8 completers unaccounted for. They were a mixed group, whose characteristics and circumstances were unremarkable and put them at various points on the continuum between achievers and resolutes. In the discussion which follows, I shall

therefore concentrate on comparing achievers and resolutes. Rather than give an exhaustive account of these 2 groups with reference to all the data collected at Times I and II, I shall focus mainly on areas in which they differed, but will also note any important similarities.

I shall begin by presenting details of the 2 groups at Time I and discuss them in more depth subsequently.

TABLE 9.1 Comparison of All Completers, Resolutes and Achievers at Time I

	All Completers (N = 24)	Resolutes (N = 6)	Achievers (N = 9)
Age (mean)	31 years	20 years	28 years
	No.	No.	No.
Gender			
male	20	4	9
female	4	2	0
Accommodation			
parental home	11	3	4
marital home	1	1	0
supported accommodation	6	1	3
own/shared flat	4	1	2
lodgings	2	-	-
Diagnosis			
schizophrenia	9	3	5
manic depression	3	1	1
other	12	2	3
Number of Admissions			
none	3	1	2
1-3	16	3	6
4+	5	2	1
(mean)	5.0 (2.7)(1)	2.5	2.0
Time in Hospital			
none	3	1	2
a year or less	13	4	4
over a year	8	1	3
(mean)	22.2m (9.6)(2)	6.8m	10.7m
Last Admission			
in 12 months pre-Sprout	14	3	5
over a year pre-Sprout	10	3	4
Day Care			
attending day care directly before Sprout	4	2	1
not doing so	20	4	8

	All Completers (N = 24)	Resolutes (N = 6)	Achievers (N = 9)
	No.	No.	No.
Medication			
yes	15	4	4
no	9	2	5
Perceived Health			
reported improvements in health in 12 months pre-Sprout:			
yes	15	4	7
no	9	2	2
Time in Employment (mean)	7.1yrs	6.8yrs	4.8yrs
Longest Time in One Occupation (mean)	4.5yrs	3.6yrs	2.5yrs
Time Unemployed			
overall	4.3yrs	6.2yrs	3.6yrs
immediately pre-Sprout	2.4yrs	3.8yrs	2.0yrs
Seeking Work at Time I			
yes	15	2	6
no	9	4	3
Reported Difficulties in Relationships at Home			
yes	7	3	2
no	17	3	7
Friendships			
has friends	18	3	2
has none	6	3	7
Satisfaction with Friendships			
satisfied	17	1	8
dissatisfied	7	5	1

	All Completers (N = 24)	Resolutes (N = 6)	Achievers (N = 9)
	No.	No.	No.
Use of Time Rating			
good	12	2	6
poor	12	4	3
Satisfied with Use of Time			
satisfied	11	2	4
dissatisfied	13	4	5

(1) The mean number of admissions is high because this includes the case of one man who had an exceptional 60 admissions to hospital. Excluding him, the mean is 2.7

(2) The mean time in hospital is affected by the inclusion of another person who had spent an exceptional 26 years in hospital. Excluding him, the mean is 9.6 months.

TABLE 9.2 **Summary of Scores on Scales Used at Time I : Resolutes and Achievers Compared**

Affect Balance Scale	Completers (N = 24)	Resolutes (N = 6)	Achievers (N = 9)
* Positive	2.54	2.33	1.78
+ Negative	2.62	2.83	2.22
* Balance	-0.08	-0.50	-0.44
Present Life Satisfaction *	46	48	46
Life Events Inventory +	197	300	198

* High score = 'good'
+ Low score = 'good'.

Discussion

Women seemed to do less well at Sprout. Of the 4 female completers, none figured among achievers, but 2 were included in the resolutes.

Looking at the psychiatric histories of the 2 groups, achievers tended to have made greater use of in-patient services in terms of time in hospital, although resolutes had more admissions. The fact that more of the resolutes were on medication and had come from day care suggests they may have been more impaired by illness, but this is far from conclusive.

Patterns of employment and unemployment seem ambiguous. On the one hand, resolutes had been unemployed for longer than achievers; on the other, they also had more extensive experience of employment. With small numbers and considerable variation in individual histories, it is difficult to propose satisfactory explanations.

However, there was found to be a significant relationship between age and time in employment and, as achievers tended to be slightly younger, they were also likely to have worked less. A second explanation of difference in time employed is that achievers had spent more time in hospital than resolutes. Furthermore, achievers had spent longer in education and were therefore likely to come on to the job market later. Resolutes contained 2 distinct groups: 3 people who had worked very little at all, all aged under 30, and 3 others who had worked 8, 11 and 20 years, respectively. This latter group of 3 had been edged out of the employment market after lengthy periods of employment and had remained unemployed for several years. In all, 5 of the 6 resolutes had been out of work for over 2 years prior to joining Sprout. By comparison, the 4 achievers who had worked for substantial periods (at least 6 years overall) had not been unemployed for long continuous spells. Only 2 of the 9 achievers were unemployed for over 2 years prior to Sprout. Whether lengthy periods of unemployment are in some way responsible for resolutes' 'poorer' performance at Sprout is a moot point, as noted earlier. It may be, after all, that lengthy unemployment is simply an index of ill-health.

Looking at the results on the scales used at Time I, several points emerge. The Affect Balance scores are very similar for both groups. However, achievers registered lower levels of both positive and negative affect than resolutes. This may be explained by differing levels of commitment to work and possibly also by greater psychological disturbance among resolutes, as discussed earlier with reference to completers and non-completers.

Resolutes recorded higher scores on the Life Events Inventory

indicating they had undergone greater upheaval in the preceding year. It will be interesting to observe whether this difference persists over time.

At Time I, then, there were a number of differences between achievers and resolutes, but perhaps more marked differences might have been expected. While completers and non-completers appeared to diverge on perceptions of health and confidence about coping with Sprout, this was not the case with resolutes and achievers. Nevertheless, the latter seemed more content with their social lives - both relationships and activities. They also seemed more committed to work.

Differences between the 2 groups at Time II are shown on the tables below:

TABLE 9.3 Comparison of All Completers, Resolutes and Achievers at Time II

	All Completers (N = 23)	Resolutes (N = 6)	Achievers (N = 9)
Admitted to Hospital during Sprout Year			
yes	6	2	1
no	17	4	8
Improvements in Perceived Health Since Time I			
yes	18	3	8
no	5	3	1
Effect of Health On Work			
little/none	16	3	8
considerable	7	3	1
Use of Time Ratings			
good	19	4	8
poor	4	2	1
Satisfaction with Use of Time			
satisfied	10	1	6
dissatisfied	13	5	3
Self-rated Work Performance at Sprout			
above average	13	1	7
average	10	5	2
Preferred Working			
alone	6	0	4
with others	17	6	5

	All Completers (N = 23)	Resolutes (N = 6)	Achievers (N = 9)
Motivation *			
high	13	2	8
low	10	4	1
Number of Problems while Sprout			
0 - 2	13	2	6
3+	10	4	3
Seeking Work at Time II			
yes	9	0	5
no	14	6	4
Attitude towards the Future			
optimistic	6	0	5
ambivalent	11	2	4
pessimistic	6	4	0

* Differences in motivation are to be expected as motivation and absenteeism seemed associated (see earlier)

TABLE 9.4 Scores on Scales at Times II : Completers, Resolutes and Achievers

	Completers (N = 23)	Resolutes (N = 6)	Achievers (N = 9)
Affect Balance Scale			
* ABS Positive	2.74	2.50	3.00
+ Negative	2.87	3.67	2.44
* Balance	-0.13	-1.17	+0.56
* **Present Life Satisfaction**	51	48	52
+ **Life Events**	195	314	157
+ **Self-esteem Scale**	2.3	3.2	1.9
+ **GHQ** (total)	5.59	7.60 (1)	3.78
+ **SAS** (global)	2.35	2.63	2.12
+ **Work Assessment**:			
first	53	50	58
second	68	75	57

* High score = 'good'
+ Low score = 'good' (1) n = 5

Divergences between the achievers and resolutes had become more marked by Time II. Working at Sprout seemed to be accompanied by positive changes in achievers in relation to health and well-being and their social activities, while resolutes appeared to change less or in the opposite direction.

Achievers displayed greater commitment to work in general and to the project itself. They were more confident in their abilities and more optimistic about the future.

It is evident that on each of the scales used, achievers surpassed the mean score for all completers, while resolutes fell below the mean, indicating that achievers were more able, more content and in better health than resolutes at Time II.

Comparing Times I and II, the well-being of achievers had increased (on the ABS and PLS scales). Their positive affect level had increased and, at the same time, negative affect had fallen. For resolutes, positive affect had increased but so also had negative affect, with the result that the gap between the 2 groups had widened by Time II. On the PLS scale, resolutes' satisfaction level remained stable, while it increased for achievers.

It was striking that resolutes continued to register a higher score on the Life Events Inventory: this was also reflected in the tendency for resolutes to report a greater number of problems at interview.

While the mean score for all completers on the Work Assessment schedule showed a deterioration (of 5 points) in work behaviour over time, the degree of deterioration was considerably greater for resolutes (15 points) and achievers' scores actually improved marginally. This is reminiscent of Wing's findings in his early

study, in which those who approached rehabilitation with a constructive approach and with confidence showed most improvement (Wing, 1966).

Conclusion

Thus, while the overall impact of Sprout seemed slight, as measured on the scales used, this disguised a wide range of individual differences. It is evident that certain participants gained considerably, others slightly, while some deteriorated. Nevertheless, from the qualitative material it was clear that, despite the difficulties they faced, resolutes felt Sprout had benefitted them in various ways and their views on this were no different from those of other participants.

Having documented the differences between these 2 groups, how can they be explained? There was some evidence that resolutes were more seriously or more chronically disabled at Time I. More of them were on medication, they had had more psychiatric admissions and were more likely to have been in day care. On the other hand, achievers had spent longer in hospital, overall.

In view of the paths taken by the 2 groups from Time I onwards, it seems plausible to contend that resolutes were more disabled. Certainly qualitative data suggested that although achievers had been seriously ill, they were stable at the point when they started at Sprout and felt their health was improving. They tended to speak of their illness as something in their past and were in the process of reconstructing their lives. At interview, resolutes seemed to me to be more impaired by illness and were, for example, depressed or sometimes apparently hearing voices. This contrast has been discussed by Shepherd (1985) who states that it is not always

helpful to talk about life **after** mental illness, since for many people it is a matter of living **with** mental illness.

The findings that Sprout was of most help to those who seemed least disabled is in line with the findings of other social work research. In a study of the probation service, Davies (1969) showed that probation officers were most 'successful' with clients who had good family relationships and who had fewest problems.

Given that achievers improved dramatically on entering employment, it may be that their major handicap was joblessness. Sprout provided a 'remedy' and enabled them to fulfil their potential. On the other hand, resolutes appeared to face a plethora of other difficulties in addition to unemployment. While Sprout had an important function to perform for them, it did not herald improvements to the same extent. It may therefore be misleading and unhelpful to measure outcome by comparing the 'achievements' of various individuals. Sprout seemed to fulfil a protective/maintenance function for some, as well as acting as a mechanism for change for others, and both functions seem equally valuable.

This also has important implications for how projects like Sprout define their objectives. It was clear from interviews with supervisors that several of them perceived Sprout as a change agent and that the limited evidence of change in participants was a source of disappointment and stress. In writing about the needs of staff employed in therapeutic settings, Menzies (1979) emphasises it is crucial that staff have realistic expectations of what they can achieve and at times they may need support in **not** attempting things which are impossible.

The next chapter describes completers 3 months after leaving Sprout and considers the extent to which differences between achievers and resolutes persist.

CHAPTER 10

FOLLOW-UP INTERVIEWS WITH COMPLETERS

This chapter will discuss what became of completers after they left Sprout, using data collected at follow-up stage (Time III). As I explained earlier, it was decided not to follow-up all completers but to interview the first 16 only, 3 months after they left the project. One person repeatedly broke appointments, leaving 15.

The reduced sample at Time III meant that 5 of the 9 achievers and 4 of the 6 resolutes identified earlier were followed up. In view of the small numbers involved, comparisons necessarily become more tentative. I shall therefore focus primarily on outcomes for the group of 15 as a whole and where there were differences between achievers and resolutes, these will be discussed in the appropriate section. I shall present the results of the scales firstly for the group of 15 as a whole and subsequently for the 2 subgroups.

We begin by looking at completers' experiences of employment and unemployment since leaving Sprout and then go on to consider changes in health, well-being and social circumstances. The chapter concludes with a summary of outcomes: perceived gains, changes on the scales and differences between achievers and resolutes.

It is important to establish at the outset whether or not the sample of 15 was representative of the original group of 24 completers. On examination, there proved to be few differences on the basis of information collected at Time I, as the profile below shows.

TABLE 10.1 Profile of All Completers and Those Followed Up

		All Completers (n=24)		Followed Up (n=15)	
Age (mean)		31 years		30 years	
		n	%	n	%
Gender	male	20	83	11	73
	female	4	17	4	27
Marital Status	single	17	71	12	80
	married	1	4	-	
	divorced/ separated	6	25	3	20
Accommodation	parental home	11	46	9	60
	supported accom.	6	25	4	27
	shared flat	3	12	1	7
	lodgings	2	8	-	
	own flat	1	4	1	7
	marital home	1	4	-	
Diagnosis	schizophrenia	9	38	7	47
	depression	4	17	4	27
	manic depression	3	12	2	13
	nerves	3	12	-	
	alcohol problems	1	4	-	
	unknown	4	17	2	13
Number of psychiatric admissions (mean)		2.6		3.1	
Total time in hospital (mean)		1.8 years		0.9 years	
Time in employment (mean)		7 years		7 years	
Time unemployed					
overall		4 years		4 years	
before joining Sprout		2 years		2 years	

The backgrounds of all completers and those seen at Time III were broadly similar. The difference in time spent in hospital was because one man, who had spent an exceptional 11 years in hospital, was not among those followed up. If he is excluded, the mean for all completers is 0.8 years in hospital. It can be assumed, therefore, that the 15 followed up are representative of the larger group and discussion will proceed on that premise. As a further safeguard, when using numbers or the scores on scales, I shall compare the 15 followed up with themselves at earlier points.

Employment and Unemployment

Employment after Leaving Sprout

The most recent follow-up survey of community programme participants found that fewer than 1 in 4 of the 2,500 found jobs on leaving the programme. Eight months later, 1 in 3 were in employment (Turner, 1985). Even compared with this 'success' rate, Sprout participants had not fared well. Only 3 of the 15 participants seen at Time III had been in employment since Sprout and 2 of them were no longer working. It may be valuable to consider their different experiences. In order to respect confidentiality I decided not to say whether individuals described subsequently were achievers or resolutes.

1. M was in his 30s and had a period of 7 years' unemployment before joining Sprout, but had previously worked for some 8 years as a clerical officer. He found a post as a telephone salesman through the Job Centre immediately after he left Sprout, but stayed in the job for only a week. The wages were very low (£50 per week) and were supplemented by commission on sales, which created a great deal of pressure to perform well. M viewed himself as a conscientious worker and while at Sprout he had immersed himself in his work.

> Your life revolves around your work, you more or less live for your work.

However, he explained he was not prepared to tolerate what he saw as slave labour in order to have a regular earned income. Compared with working at Sprout, selling offered M little intrinsic satisfaction and the job seemed a retrograde step. At Sprout he had come to value regular contact with people, but in the sales job he was working in a competitive atmosphere rather than in co-operation with others.

2. The second man (G) was also in his 30s and had been out of work for 4 years before he came to Sprout. He had previously been a skilled manual worker. G left Sprout several weeks prematurely to take up a job in a garden centre. He acted as nurseryman as well as overseeing 6 apprentices. He had been delighted to find horticultural work as this was where his interests now lay. However, although Sprout staff were pleased for him, they were also apprehensive, knowing that employees in this particular business were often exploited. G worked there for 2 months but left following disagreements with his employer over employment conditions. The work itself had been interesting and G said he was managing it competently. However, no contract of employment was ever given, nor any specification of holiday entitlements, despite frequent requests. G seemed to have been carrying a heavy workload and considerable responsibility with little back-up or reward and a potentially satisfying job was undermined by the lack of support. While it is difficult to say whether others might have stayed in the job, the general feeling among Sprout staff was that he had been unfairly treated and, although disappointed, they felt his resignation was understandable.

3. The third man (W) was aged 26 and had been out of work for 18 months before joining Sprout. He had previously done clerical work for 3 of the 6 years he had been in employment. W was the only person in employment at follow-up. On leaving Sprout he worked initially on a self-employed basis for 6 weeks, doing a range of jobs (gardening, cleaning, temping in offices). His determination to find a job was unrelenting: he visited the Job Centre daily and applied to over 20 vacancies. Two interviews came of these efforts and he was eventually offered a temporary clerical post for 6 months with a possibility of being made permanent. On the whole he enjoyed his job, although it could be demanding if work accumulated. At one point he felt he could no longer cope and feared a recurrence of his schizophrenic illness.

> I considered going to see the doctors at the Royal Edinburgh because the pressure at work was just getting too much for me. I spoke to the boss and realised the pressure I was experiencing was the same as anyone else.

His boss was the only person W told about his illness and her reassurance that he was reacting in an understandable way to the inherent pressures of the job allayed his fears. She also praised his work performance which he had hitherto regarded as mediocre and he seemed to gain greater confidence as a result.

The experiences of these 3 men demonstrate that the types of jobs obtainable were not necessarily suitable for someone who had been mentally ill. In the study by Floyd et al (1983) few of those employed after discharge from hospital were dismissed from their jobs, but many more left voluntarily. On investigation, it emerged that most people had left their jobs in order to withdraw from a situation they found too stressful, not because they lacked motivation. This casts some light on the bemused observations of

Wansbrough and Cooper (1980) who note that sheltered work is often seen as a panacea for mentally ill people and yet many leave it of their own accord. Floyd and colleagues contend that certain characteristics of the work environment play a crucial role and that it is the interaction between the person and his/her environment which determines whether or not someone remains in the job. Their findings suggest that mentally ill people are more likely to remain in jobs which research into job satisfaction among 'normal' people would define as good, satisfying jobs.

Key characteristics include:

- a high objective quality with opportunities for learning, advancement and feedback
- good supervision, particularly knowing help is obtainable when necessary
- a good social climate where colleagues trust one another
- work organised so that the employee does not work alone all the time
- the feeling that work is interesting and that quality takes precedence over quantity.

Comparing this definition of a 'good job' with the jobs the 2 Sprout participants left, there are evident discrepancies. M's sales job was in a competitive social climate, was unrewarding and stressed quantity rather than quality. The garden centre job lacked good supervision and also was little concerned with quality. G remarked of his boss that

> a rose to him was just 30 pence.

The clerical job W obtained appeared to offer good supervision and some hope of advancement (in terms of permanence). This job was not without stress, but, importantly, W had obtained help and learned to cope with the stress.

At a time of high unemployment it is particularly difficult for mentally ill people to find employment. The issue of what type of employment is most suitable tends to be obscured, yet we have seen that it may be crucial in determining whether or not someone stays in a job. Research by Townsend (1978) illustrates that unemployed people, and particularly those who are unskilled, tend to have access to jobs which entail poor working conditions and few or no fringe benefits. Moreover, Lonsdale (1985) argues that disability (from whatever cause) serves to compound these disadvantages and that the choice of jobs is narrowed due to discrimination and to the low priority given to disabled people in the job market. Once in a low paid, low status job, employment options become closed off. In a study of labour market structure, Craig et al. note that the only jobs open to all are those that no-one wants (Craig et al. 1982). Just as the location of mentally ill people in the community offers no assurance they will be accepted and respected as individuals, so too with employment. Employment per se does not guarantee valued participation in society (Liebow, 1970). Much depends on the nature of the job and whether society acknowledges that the contribution made is of value.

Voluntary Work

In addition to the 3 men with experience of paid employment, 2 participants had done voluntary work after leaving Sprout. Both worked with an agency which did conservation work in Edinburgh. In one case, Sprout's training and development officer had arranged for this man to be interviewed at the agency before he left Sprout and he began there immediately his Sprout contract terminated. He worked one day a week throughout the following 3 months and enjoyed the work. He saw this as a means of keeping in touch with the world of

work and as a temporary measure until he could return to Sprout or qualify for other MSC help, such as Job Clubs or Restart (these are available only to those unemployed for 6 months or longer). The other volunteer, a woman, went to the agency after seeing a notice at a drop-in centre. She attended for only a few days and resented the fact that she was not paid for her efforts. She seemed to want voluntary work to serve as an alternative to paid employment, which it cannot do (Weir, 1986).

The Search for Employment

At Time II, most completers said they intended to continue in employment if possible. At follow-up, 11 of the 15 said they were looking for work. Of those who were not, one was already in employment, a second person was attending a hospital day centre and felt too unwell to work, the third was well occupied with various hobbies and interests and was content in the interim to pursue these. The fourth person's reasons were unclear.

The experience of job-hunting proved dispiriting and many participants found it difficult to sustain effort and hope.

> I used to go up to the Job Centre all the time, but now I've no' been up for a while.

> I look in the papers but it's all for experienced (people) or for youngsters who just left school. You get over the enthusiasm after a while.

The man in employment at follow-up, it will be recalled, had made over 20 applications before he was successful. Of the 11 job-seekers, however, only 4 had made any applications and 2 of them were the men who had found, but subsequently left, jobs. Only 2 people said they were getting help with their quest. This was from family and friends, not from professionals, although, as we shall see,

after leaving Sprout 1 in 3 participants saw professionals more than previously. Several people clearly felt they needed help in this area.

> I could do with help for interviews. I'm not very good at reading notice-boards and things like that.

In a study which explored the employment and unemployment experiences of 36 psychiatric patients, Birch (1983) found that the contact the latter had with professionals post-discharge was largely concerned with domestic matters, yet many people were apprehensive about seeking employment and could have benefitted from counselling. Floyd et al. (1982) also observed with regret that few health or welfare workers showed interest in clients' employment.

It was stated earlier that changes in the employment service - the reduction in the number of disablement resettlement officers, making registration for employment voluntary - may mean that those seeking work do not come to the attention of employment services personnel. Sprout participants had other criticisms of employment services. One young man whose only previous work experience, apart from Sprout, had been 6 months on a youth training scheme, did not want more of the same.

> A year's not very long. You need longer than a year. It's not what I'm looking for, I don't want to get passed from scheme to scheme.

M who had left the sales job, would have welcomed help from the employment services, but bitterly resented the fact he was not eligible because he had only recently become unemployed:

> The Job Centre can't help me. They can help youths on the YOP. They can help people unemployed a year or more. But because of the horrible rules I don't qualify for any help. According to them, I've been unemployed for 3 months not 6 years out of the last 7.

Furnham (1973) suggests that employed people and unemployed people are likely to 'explain' unemployment differently: the unemployed tend to lay blame on external, structural factors, rather than on personal factors, such as lack of motivation. Kelvin, on the other hand, argues that as unemployment levels remain high and there is a reasonable probability of knowing someone who is unemployed, responsibility for unemployment will tend to be attributed to the situation rather than the individual (in Gilmour and Duck, 1980). How then did Sprout participants account for their difficulties in finding work?

Three people saw their difficulty as symptomatic of the current economic climate - there were simply not enough jobs to go round. Four others were aware of their lack of experience and skills. One man, who was a graduate, said:

> I feel angry. I haven't been trained for anything useful.

And to those not interested in a career in horticulture, Sprout seemed of little help.

> The problem with working at Sprout is that the working experience isn't really transferable.

Two people were conscious that their history of mental illness and their poor work record interacted and one said:

> For 7 years I've been unemployed ... I've been tackling the problem (i.e. illness) and trying to conquer it ... They think anybody who's been unemployed that length of time is either a hopeless case or doesn't want to work at all.

Several believed their history of mental illness put them at an immediate disadvantage.

> I think it's got something to do with me being in hospital why I don't get a start. It really hurts me, as much as to say 'You're not good enough'.

In fact, further investigation revealed that at least half of those followed up believed they had faced discrimination in relation to employment at some time on account of mental illness. Sometimes this was when applying for a job, or when in post. In other instances it led to people being disqualified from certain occupations. One man applied to a teacher training course and was rejected because of the medication he took. It was not clear whether the effects of the medication itself aroused concern, or the implication that he suffered from a psychotic illness. Another man who had worked as a roofer was paid off because his employer feared his medication posed a safety hazard. No attempt was made to verify this belief with his GP.

As a result of previous experiences, most people would not disclose their psychiatric history when applying for a job. This could lead to problems later if they became unwell, were off work and had to produce a sickness certificate. People often felt they would have been received more sympathetically had they been 'physically ill'.

> If they discover you've had a mental illness
> it's as though they start to look for symptoms.

Other research adds weight to these fears of being misunderstood and subject to discrimination. A recent survey of UK employers highlighted their poor knowledge of mental illness and their view that mental illness made employees less suitable for certain types of work, such as managerial or clerical work (Newth et al. 1986).

In sum, difficulty finding employment was construed as a consequence of the interaction between certain personal characteristics, such as a lack of skills and experience, and socio-economic factors, such as the dearth of jobs and prejudice. However, few people were receiving any help to obtain employment. I shall

return to the implications of this for practice in the final chapter.

Unemployment Revisited

Participants reacted in various ways to becoming unemployed again. Some seemed relieved and welcomed a chance, as one man put it,

> to pull myself together and recover from the shock of a year at Sprout.

The initial phase was experienced rather like a holiday: staying in bed late and having more free time. Similar responses have been reported in other studies of people who become unemployed. Hill (1978) suggests that the individual still retains the identity of an employed person and the notion of being on holiday is in keeping and implies the situation is only temporary. However, the holiday feeling soon wore off for most Sprout participants.

> The first 2 months I quite enjoyed, but a couple of weeks ago I began to feel ill again. I've got to the point where I need to be doing something again.

One of the assumptions underlying Sprout was that the project helped participants cope with unemployment - by increasing confidence, developing interests and so on - if they did not find work afterwards. I therefore asked participants how their most recent experience of being unemployed compared with previous experiences.

Six people felt that unemployment was less unpleasant this time. Some explained this was partly because they had only been out of work for 3 months. The man who lived with his mentally ill mother and sister felt the year's respite away from home had helped defuse some of the tension. Several were more optimistic at Time III than previously about their chances of finding employment, having recently

been in work and acquired an up-to-date reference. Moreover, there was always the possibility of returning to Sprout for a further year and the knowledge that a way out was available sustained hope.

One man had learned at Sprout the importance of keeping occupied and now filled his time well.

> I was crawling up the wall then (before Sprout). I'm a lot happier now, doing a lot more. I'm eating better and I'm filling up the time fairly well.

Other participants did not find unemployment any more tolerable and 3 months had been ample to rekindle the feelings of anger, frustration and depression which unemployment generated (as noted at Time I).

> I always think the fit people should work and the unfit shouldnae, so it makes me feel like there's something wrong with me.

> I'm a second-class citizen, not contributing to the community in any way.

> Without a job, it's a bit demoralising. You feel your life's just slipping away because you're not doing anything.

One man felt he was worse off than before he joined Sprout.

> Being unemployed now is worse. Sprout made it worse, by raising my hopes only for them to be dashed. Only **this** time, it seems more final ... Sprout was very enjoyable at the time, but it was a bad thing for me in the long run because it raised my hopes when I didn't have any hopes.

It seemed, then, that some people could get through brief periods of unemployment unscathed, but it was important that a way out was available. On the whole, however, unemployment was frustrating, unpleasant and demoralising. We saw earlier that the worst aspects of unemployment were identified as boredom and poverty.

These will now be considered to ascertain whether any change had occurred by Time III in how participants spent their time and in their financial situation.

Use of Time

There was some evidence that participants made better use of their time than before joining Sprout. At Time III, using the same rating system, 2 people were rated as 'good'. One was in full-time employment and had a variety of spare time interests. The other had developed a routine of structured activity which closely resembled a working day - he attended several classes, did wood carving and made mobiles which he sold to shops. Nine others were rated 'fair' and 4 'poor'.

In 8 cases, ratings had improved over time, 5 stayed the same and 2 deteriorated. Three people had taken up a new interest since leaving Sprout, and one of these had also joined a social club. Five people had started to attend classes ranging from adult literacy and relaxation to Higher-level Biology. This seems impressive, given that in 1983 only 5% of the adult population were attending some sort of leisure class, although this figure excludes classes leading to a qualification (General Household Survey, 1985).

Nevertheless, the account most participants gave of 'a typical day' indicated that they struggled to fill their time and missed the structure and routine of work.

> I often think in bed, what am I going to do tomorrow? I do the everyday things, then it becomes a bit of a problem. It's alright going for walks, but it's always better if you've got company. It comes to be a real problem to keep yourself going.

Proportionately fewer than previously were satisfied with how they spent their time: at Time II, 11 out of 24 (46%) were satisfied, compared with 5 out of 15 (33%) at Time III. Thus, while several

participants had taken up new interests, or developed existing ones, these were generally more resourceful people. There was no change throughout the study in others who did little and who were persistently dissatisfied.

While similar proportions of achievers and resolutes were given 'good' use-of-time ratings (5/5 and 3/4, respectively) other data from interviews indicated achievers were more fully occupied and were more likely to sustain interest in their activities.

In other investigations of how unemployed people use their time, some individuals have proved highly motivated and have succeeded in imposing structure on their lives. Evans (1986) observes, in considering these 'successes' that the key factor seems to be some type of meaningful activity which resembles work. In the Sprout study an example would be the unemployed, but well-occupied man described above who did wood carving and attended classes. Generally research has found that such 'successes' are the exception rather than the rule and that filling time is a major problem (Colledge and Bartholomew, 1980). Indeed, to fill time successfully with leisure activities may be to concede that employment is not attainable. Adapting 'too well' to being unemployed may imply, as Bostyn and Wight observe, that one does not 'need' to work (in Fineman, 1987).

It seems unrealistic in any case to expect leisure pursuits to fill the vacuum work once occupied. Work and leisure pursuits appear to be complementary, not separate. A review of research in the area found that workers' on-the-job experiences tended to carry over into non-work areas and that there was a link between the nature of work and leisure activities and between levels of satisfaction with both (Staines, 1980). As Shepherd remarks:

> social, recreational and leisure pursuits are most valuable when in contrast to work, and by themselves are difficult to stretch out into a meaningful and sustained programme of activities. (Shepherd, in Herbst, 1984, p.23)

Moreover, leisure pursuits differ from work: they often afford only limited social contact and require little co-operative effort (Kelvin, 1982). Work is guided by external demands and standards of performance while in many leisure activities, individuals set their own goals and judge the results themselves (Bennett, 1975).

Money

Just as perceived adequacy of income improved while participants were in employment - at Time II - so it diminished when people became unemployed. The only person who said he managed well on his income at Time III was the man in full-time employment. Six others 'got by' while 8 people 'had difficulty'. As the table below illustrates, this mirrors responses given at Time I.

TABLE 10.2 Change in Perceived Adequacy of Income Over Time

	Time I		Time II		Time III	
	(n=15)	%	(n=14)*	%	(n=15)	%
Managed well	1	7	8	57	1	7
Got by	6	40	2	14	6	40
Had difficulty	8	53	4	29	8	53

* one of the 15 was not seen at Time II.

As at Time I, more than half of those interviewed found their income barely covered their needs. However, a slightly smaller proportion were dissatisfied with their standard of living at Time III compared with Time I(half and two-thirds, respectively). Possibly, being in employment for a year had made it possible for participants to cushion themselves from the economic hardships of unemployment (two-fifths had savings at Time III compared with one-fifth at Time I).

Health and Well-being

Health

At Time II, we saw that the rate of admission to psychiatric hospital appeared to fall while participants were employed at Sprout, but there was no change in the numbers in out-patient treatment or on medication.

In the 3 months since leaving Sprout, only one person had been admitted to psychiatric hospital. This person had not been admitted to hospital while at Sprout. As I noted earlier, it is difficult to compare admission rates over time because of the small sample and the different time spans. The evidence available does not suggest that admission rates increased after participants left Sprout, but a longer follow-up period would be required before any conclusions could be drawn. Again there was little change in out-patient attendance and in the proportion on medication (two-thirds of completers were on medication at each stage).

Three people - all men - reported problems with alcohol at some point since they left Sprout. This seems a high proportion. Two of these lived with their parents and, as described in a later section, domestic relationships had worsened over the preceding 3 months. One of this pair felt that his tendency to drink heavily was exacerbated by having nothing to do.

> I wouldn't mind being unemployed too much if I could control the drinking, but I feel it's dangerous. When I was working, I'd feel tired and didn't need to go out in the evening, so I'd just go to the pub at weekends.

The person not living with parents had undergone several major changes in his life in a short time. In addition to losing employment, he moved into new accommodation - a group home - with

people he did not know. He said that he drank heavily during the transitional period, but then abstained altogether.

Turning now to perceived health, it was noted earlier that participants tended to report improvements in their health while at Sprout. By Time III this was less likely.

TABLE 10.3 Health Trends among the 15 Completers Followed Up

Perceived health	Change in health in 12 months pre-Sprout		Change in health in 9 months at Sprout*		Change in health in 3 months since left Sprout	
	n	%	n	%	n	%
Better	11	73	10	71	6	40
Worse	0	-	1	7	2	13
Same	4	27	3	21	7	47

* one of the 15 was not seen at Time II.

At Time III noticeably fewer stated their health had improved. Those who felt better were apparently still enjoying the beneficial effects of having worked at Sprout. The 2 who felt worse attributed their poorer health to the fact they were unemployed.

The GHQ scores, discussed below, indicated an overall deterioration in health and it may seen surprising that only 2 people stated their health had worsened. However, individual responses were generally in accord with change in their GHQ scores between Times II and III: where scores showed improvement, participants were likely to say they felt better. Moreover, the terms used - better/same/worse - were general and if someone said they felt the same, this might disguise consistent ill-health. Indeed, 2 of the 6 who reported no change were consistently above caseness level on the GHQ.

As at previous stages, resolutes tended to report poorer health than achievers. None of the former described themselves as 'well', while 3 of the 5 achievers did so. Furthermore, achievers were more likely than resolutes to state their health had improved at Time III.

Changes over time in the total scores on the GHQ for the 15 completers followed up are shown below.

TABLE 10.4 Overall GHQ Scores at Times II and III

	Time II (n=13)*	Time III (n=15)
GHQ overall score +	5.92	6.60
Standard deviation	6.70	9.25

\+ low score = 'good'
* one person was not interviewed at Time II and another refused to complete the GHQ

Scores for the 4 subscales showed little change over time. Full details are given in Appendix C.

Overall scores had risen, in line with other research which has found that psychological health tends to deteriorate when people become unemployed (Warr, 1984b). However, the standard deviation was greater at Time III than earlier. It seemed unemployment was associated with greater extremes of health than employment. This is apparent when resolutes and achievers are compared.

TABLE 10.5 Overall GHQ Scores : Resolutes and Achievers

	Time II		Time III	
	n	Score	n	Score
Resolutes	3*	5.70	4	13.00
Achievers	5	3.00	5	0.00

* one person refused to complete the GHQ

There was evidence from the qualitative data that achievers started Sprout in better health. The GHQ scores indicated that their psychological health improved after they left, despite the fact 4 of the 5 were unemployed. On the other hand, resolutes deteriorated abruptly when they became unemployed and the GHQ scores would suggest they were very unwell.

Well-being

The table below shows changes in the well-being of the 15 completers followed up on the Affect Balance and Present Life Satisfaction Scales.

TABLE 10.6 Changes in Well-being among Completers (n = 15)

	Time I	Time II	Time III
Affect Balance Scale			
* Positive	2.67	2.71	2.40
+ Negative	2.73	2.71	2.80
* Balance	- 0.06	0.00	- 0.40
Present Life Satisfaction *	46	52	46

* high scores = 'good', +low scores = 'good'.

Both scales show a decline in well-being since Time II and the ABS suggests that well-being dropped below that registered at Time I. This may be because at Time I participants had the prospect of a year's employment, whereas at Time III most had no such opportunity.

It is interesting to note that negative affect levels varied little with change in employment status. High negative affect may partly reflect anxiety about the future, as mentioned earlier. It was also evident that despite various advantages, being in employment also exposed participants to various risks and stresses. By contrast, positive affect declined considerably when participants became unemployed.

As previously, achievers registered higher levels of well-being than resolutes, as shown below.

TABLE 10.7 Well-being of Resolutes and Achievers at Time III

	Resolutes (n=4)		Achievers (n=5)	
	Time II	Time III	Time II	Time III
ABS * Positive	2.50	1.00	2.80	3.00
+ Negative	2.75	3.00	2.20	2.00
* Balance	- 0.25	- 2.00	0.60	1.00
PLS *	52	38	53	53

* High score = 'good'; low score = 'good'.

Achievers' well-being scores had altered little since Time II, whereas resolutes' scores had deteriorated so that the gap between the 2 groups had widened. It seemed that unemployment was associated with greater extremes of well-being than employment. A similar finding was noted earlier in relation to health.

Self-esteem

Self-esteem scores for the completers followed up were as follows:

TABLE 10.8 Changes over Time in Self-esteem +

	n*	score
Time II	14	2.1
Time III	14	2.2

+ low score = 'good'
* on each occasion 1 person did not complete the SES.

Unfortunately, it was not possible to ascertain whether self-esteem improved when people entered employment. Clearly, however, there was little change when they left employment. The extent to which rehabilitation can affect self-esteem is debatable. In Wing's study of patients in an Industrial Rehabilitation Unit (see Chapter 2) a substantial proportion grew more confident on both objective and subjective measures (Wing, 1966). However, Shepherd argues that increases in the self-confidence of rehabilitees tend to be relatively specific to particular tasks or situations (in Watts and Bennett, 1983).

Others have examined the relationship between employment status and self-esteem among 'normal' populations. Evidence suggests that self-esteem tends to be a fundamental personality feature which remains relatively unaffected by change in employment status (Warr, 1982). In a large-scale Israeli study by Shamir (1986) the self-esteem of employed and unemployed adults was examined cross-sectionally and longitudinally. Self-esteem proved to have an independent moderating effect on the relationship between unemployment and other aspects of psychological well-being. That is, self-esteem was not related to employment status and was unaffected by change in employment status. Thus people with low self-esteem were more vulnerable to the adverse effects of unemployment than people with high self-esteem.

This seems extremely important for a project such as Sprout. It implies that its rehabilitative function is less to increase participants' self-esteem (a desirable but possibly unrealistic aim) than to protect them from the damaging effects of unemployment to which they may be highly vulnerable.

At Time III, as earlier, resolutes recorded lower levels of self-esteem than achievers: the respective scores were 2.7 and 1.4. Shamir's study would suggest that resolutes are likely to be particularly vulnerable to the effects of unemployment and this is borne out by their well-being scores presented in the previous section.

In sum, 3 months after leaving Sprout participants were less likely to report improvements in their health than previously. However, 2 different patterns could be discerned. Firstly, those who were in better health and more content while at Sprout appeared to retain and - to an extent - increase their relative advantage after leaving, as indicated on the health and well-being scales and by comments at interviews. By contrast, although the well-being of resolutes improved while they were at Sprout, health and well-being deteriorated when they left.

Use of Services

It was of interest to discover whether participants' usage of health/welfare services changed after leaving Sprout. Research on long-stay patients discharged from an English psychiatric hospital suggested **patterns** of dependency on services altered rather than **levels** of dependency. Discharged patients relied heavily on social workers, community psychiatric nurses and day-care services (Howat and Kotny, 1982). Moreover, studies of the unemployed have found that the latter tend to make greater demands on GP and out-patient

services than employed people (Beale and Nethercott, 1985). However, other research has shown that services are often either not available or not used. In their follow-up of long-stay psychiatric patients in Scottish hospitals, McCreadie et al (1985b) found that after 2 years, two-fifths of those discharged were receiving no after-care.

Participants were asked (1) whether they were in contact with various professionals (GP, social worker, psychiatrist, community psychiatric nurse) and (2) whether they had seen that worker more/less/the same amount since they left Sprout. Responses are shown below.

TABLE 10.9 Change in Contact with Various Professionals since Left Sprout (n=15)

	More	Less	Same	None
GP	2	2	7	4
Psychiatrist	3	1	4	7
Social worker	2	2	0	11
Community psychiatric nurse	0	0	2	13
Other	2*	0	0	13

* In one case : nursing staff at hospital day unit,
in the other : support worker to a group home.

Five people had more contact with at least one professional since leaving. Three of these 5 were women. Two people had less contact than previously and one person had no contact with any professional at follow-up. Evidence suggested that participants relied on GPs more than on any other professional. It is perhaps striking that 11 people had no contact with a social worker. This reflects the

findings of McGregor's study of 89 patients admitted compulsorily to the Royal Edinburgh Hospital (the hospital Sprout participants attended) (McGregor, 1983). Of the 39 patients she followed up after discharge, less than one-third were in touch with a social worker.

While about 1 in 3 increased their contact with professionals after leaving Sprout, achievers were less likely, resolutes more likely to do so: 3 achievers saw less of professionals and in 2 cases contact was unchanged, whereas for 2 resolutes contact increased and for the 2 others remained unchanged.

The increased use of services has considerable implications for resources in that participants often seemed to need long-term support, not just time-limited rehabilitation. There were indications, furthermore, that perceived needs were not fully met. Participants were asked what kind of rehabilitation services - apart from Sprout - would be of help to people like themselves. Nine had suggestions. One person felt Sprout was limited in what it could achieve and that its welfare function should be developed:

> All you really learn at Sprout is the work ethic. To work for a supervisor, be a good boy. They'd need specialised people to take it further, a social worker or something like that.

Another person wanted some form of social club or centre where people could meet after work and a third felt she herself needed advice on budgetting.

Three people argued for a wider range of employment opportunities - more projects like Sprout plus others offering different types of work. Two individuals felt they needed help to secure employment as they were acutely aware of their lack of qualifications and discontinuous work record.

One man had less to say about the type of services wanted than their character:

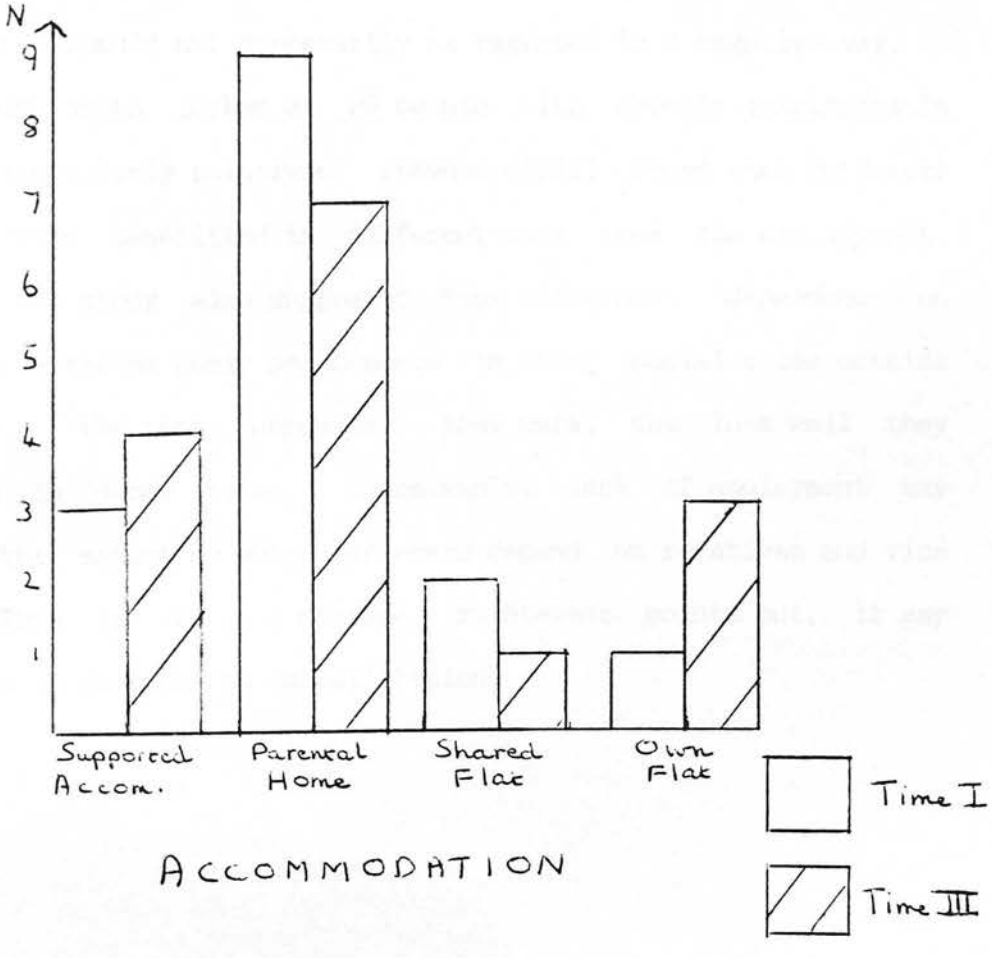
> One thing I enjoyed about Sprout was that it wasn't connected with the Royal Edinburgh directly. Some people wish to be out of that - hospitals and so on.

Accommodation

Little change had taken place in participants' living arrangements since they left Sprout. Two people had moved since Time II from one type of supported accommodation to another, more independent type.

Figure 10.1 shows how the living arrangements of the 15 completers had changed since Time I.

FIGURE 10.1 Accommodation of Completers at Times I and III
(n=15)



While moves which completers made during the study tended to indicate increasing independence, the outcome was not always satisfactory. For example, one man who had been given a council flat of his own whilst at Sprout and was greatly relieved to leave his parents' home, was extremely unhappy with his accommodation when seen at follow-up. His flat and those around it had been repeatedly vandalised and he kept his lights off after dark for fear of becoming a target for stone-throwers. The depressing nature of his surroundings exacerbated his despair at being unemployed.

> I can cope - eventually - with living in a very rough area. It annoys me, but I can live with it. I just think it's a waste that I'm stuck here doing nothing. You get selfish, you wish someone else had to deal with the problem instead of you.

Over half the group were still living with parents at Time III. Living together may be of some benefit to both parties and 'dependence' should not necessarily be regarded in a negative way. In a study which looked at 29 people with chronic schizophrenia living with elderly relatives, Stevens (1972) found that sufferers and relatives benefitted in different ways from the arrangement. However, the study also suggested that sufferers' 'dependence' on relatives affected their performance in other social roles outside the home. The more 'dependent' they were, the less well they performed in other roles. Conceivably, lack of employment may increase the extent to which sufferers depend on relatives and vice versa. This is worrying because, as Stevens points out, it may constitute an obstacle to rehabilitation.

Social Support

Family

It seemed that unemployment was associated with an increase in contact with parents. When participants were in employment - at Time II - contact tended to decline although this was not always so. By Time III, however, this trend had been reversed and contact tended to increase.

TABLE 10.10 Change in Contact with Parents

	Time I - Time II		Time II - Time III	
	n*	%	n*	%
Increase	3	24	7	54
Same	5	38	5	38
Decrease	5	38	1	8

* Others had no parents living.

After leaving Sprout, 1 in 2 participants reported that they saw more of parents than earlier, compared with 1 in 4 at Time II. Conversely, 5 out of 13 participants stated at Time II that contact had decreased since previous interview, compared to only 1 out of 13 at Time III.

Five of the 7 reporting increased contact lived with their parents. Earlier, reference was made to research by Vaughn and Leff (1976) which highlighted the potentially deleterious effects of high levels of contact between relatives and people with schizophrenic or depressive illnesses.

It was alarming, therefore, that 3 of these 5 participants indicated that relationships within the home had deteriorated since leaving Sprout. In one case a woman reported that she and her parents had a number of 'small tiffs':

> My parents would like me to get a job again. Tempers get frayed a wee bit with me ... still being at home. They'd prefer it if I was out working.

The second case - a man who lived with his sister who was also schizophrenic and an elderly mother with dementia - was described earlier. By follow-up the situation had deteriorated further. The mother could not be left alone and the sister had recently had a schizophrenic breakdown during which she became violent.

The third man lived with both parents. The father had been seriously incapacitated by a stroke and the mother was under great strain caring for him. The tense atmosphere at home was one of the reasons this participant started to drink heavily. He admitted that this only made him aggressive, which in turn led to confrontations at home and heightened the tension.

The other 4 people living with parents said relationships at home had not changed regardless of levels of contact.

Friends

Other research suggests that contact with people outside the family tends to decrease when someone becomes unemployed (Hill, 1978). This did not seem to be the case with Sprout participants, however. As noted earlier, while working at Sprout 1 in 3 people saw less of their friends than when unemployed. This was mainly because they had less time and energy. At Time III, on the other hand, 4 people saw friends more often than previously and 10 saw them as frequently as before (one had no friends). This may indicate that being in employment was quite stressful for participants.

It was disappointing that while 13 of the 15 said they had made friends at Sprout (including one who had no other friends), at follow-up 7 were no longer in touch with other participants. After leaving Sprout much evidently depended on the individual's motivation and ability to sustain relationships as there was no longer a fixed

meeting place. Moreover, there were practical difficulties of money and distance which impeded contact.

On the other hand, 6 participants did keep in touch with people they had met at Sprout. In 2 instances the men concerned lived in the same locality, while others had interests in common and tended to be active socially in any case.

Wilmott (1986) notes in his review of social networks that we tend to choose friends from those who share the same milieux and experience. It may be that the shared experience of working at Sprout was not in itself sufficient to cement friendships unless supplemented by other common interests and unless opportunities were available for participants to meet.

Finally, half of those interviewed at Time III were not satisfied with their friendships. Thus the level of dissatisfaction rose initially from 1 in 3 at Time I to 1 in 2 at Time II and stayed stable thereafter. Sprout had provided participants with opportunities for social contact, but many people remained dissatisfied with their social relationships.

We noted earlier that achievers seemed better supported than resolutes and were more satisfied with their friendships. This pattern was still evident at Time III. Four out of 5 achievers were satisfied, compared with only 1 of the 4 resolutes.

To sum up this section on social support, it seems that for a number of people living with parents, loss of employment was accompanied by a deterioration in relationships at home. This seemed alarming in view of the fact that the proportion of completers living with parents remained unaltered throughout the study. Regardless of living arrangements, family generally constituted the main source of support. Although many participants had made new friendships at

Sprout most were forfeited when they left the project and a high proportion continued to be dissatisfied with their friendships. In particular, the circumstances of those who began Sprout with few or no friends changed little.

Social Adjustment

Global scores on the Social Adjustment Scale for those followed up remained stable over time.

TABLE 10.11 Change in SAS Scores Over Time+

	Time II n=14*	Time III n=14*
Mean score	2.39	2.37

+ low score = 'good'
* on both occasions, 1 person did not complete the SAS.

While the scores for separate role areas (work/housework, social and leisure activities, family relationships) followed slightly different patterns, changes were small. Details are shown in Appendix C. The results seem to affirm the conclusion reached by Watts in a review of research on social integration that:

> the gain or loss of a single social role (e.g. employment) has relatively little impact on social integration compared with the greater impact of life-long patterns of social adjustment. (in Watts and Bennett, 1983, p.301)

Looking at differences between achievers and resolutes, it emerged that those who appeared relatively well adjusted whilst at Sprout retained their advantage subsequently, while those who were less well adjusted in employment deteriorated when they left.

TABLE 10.12 SAS Scores for Resolutes and Achievers

	Time II		Time III	
	n	Score+	n	Score+
Resolutes	4	2.53	4	3.06
Achievers	5	2.05	5	1.86

+ low score = 'good'.

While an individual's performance in social roles may change to some extent, long-term patterns of social adjustment are prepotent.

Summary of Outcomes

The generalisation of gains is an issue which has much exercised rehabilitation practitioners. Studies such as those by Wing and Freudenberg (1966) and Wing and Brown (1970) reviewed in Chapter 2 suggest that gains are often situation-specific and short-lived. Goldstein and Kanfer (1979) state that success has only been achieved when end-of-treatment therapeutic gains show both response maintenance and transfer to contexts other than the therapy setting per se. They are referring to psychotherapy, but the same also holds for rehabilitation.

A previous chapter described the benefits which Sprout participants believed they derived from the project. For various reasons discussed earlier, perceived benefits were not always reflected in changes on the scales used. However, the scales demonstrated that certain individuals 'did better' than others.

This final section draws together material collected at follow-up in order to assess outcomes for participants 3 months after they had left Sprout. I shall begin by considering perceived gains and then go on to look at the results of the scales and differences between resolutes and achievers.

Perceived Gains

As at Time II, participants were asked what they had gained from working at Sprout. Three of the 15 participants could not say what they had derived from the experience, although they had been able to name various benefits at Time II. They seemed to view their employment at Sprout as a discrete episode which had no further effects once concluded. Other responses were very similar to those elicited at Time II and detailed in Chapter 7. Participants referred to skills learnt, experience gained, improvements in their health and feeling more confident. However, it seemed that the maintenance of perceived gains was often contingent on being in employment.

> Sprout gave me more enthusiasm, brightened me up. That's what I needed at the time. That's what I'm needing now.

Others who had come to realise that they were capable of working and that work could be enjoyable, were frustrated by the lack of opportunities to continue in employment at all, let alone the type of work they preferred.

> A year seemed a long stretch. Until then (i.e. Sprout) I'd always preferred unemployment to work. Now that I've had 3 months unemployment I'd go back to work anywhere.

Irrespective of the fact that they had demonstrated their ability to work by completing Sprout, jobs were not available.

> I expected to find it easier to get a job. I might as well have been walking the streets for a year for all the good it's done. (I've) ... a good reference and in a normal world it'd be OK, but nobody's even asked to see it.

It was not enough for participants to know they could work and had done so quite recently: increases in confidence tend to be often relatively specific to particular tasks or situations and it is much harder to attain a generalised improvement in confidence (Watts in Watts and Bennett, 1983). Unemployment, as research has demonstrated, offers few opportunities for people to use skills and to feel in control of their lives and futures (Warr, 1987). The model of rehabilitation elaborated earlier involved a process of accommodation between the individual and the environment; it also implied that the person/environment 'fit' was important in ensuring that opportunity and incentives existed for people to use their skills and abilities. There was little indication that this was so for Sprout participants after they left the project.

Changes on the Rating Scales

Table 10.13 presents the results of the scales at all 3 stages for completers and contrasts resolutes and achievers.

It has been noted that the data collected at interview was broadly in accord with the outcome on scales when the achiever/resolute distinction was made. Taking both sets of data together, it seems that Sprout had a variable impact while participants were on the project and also after they left. The nature of the impact has already been described in detail. I shall therefore summarise only.

The striking characteristic of achievers was their stability. At follow-up their scores on the scales had changed little since Time II and any changes were in a positive direction. Scores on the scales were substantiated by comments at interview at Time III, suggesting that for this group the effects of employment were relatively durable. Resolutes on the other hand were more changeable

TABLE 10.13 Summary of Scales for Completers, Resolutes and Achievers

	Completers Followed Up*			Resolutes Followed Up			Achievers Followed Up		
	Time I (n=15)	Time II (n=14)	Time III (n=15)	Time I (n=4)	Time II (n=4)	Time III (n=4)	Time I (n=5)	Time II (n=5)	Time III (n=5)
ABS Positive*	2.67	2.71	2.40	1.75	2.50	1.00	2.00	2.80	3.00
Negative+	2.73	2.71	2.80	3.50	2.75	3.00	2.00	2.20	2.00
Balance*	-0.06	0.00	-0.40	-1.75	-0.25	-2.00	0.00	0.60	1.00
Present Life Satisfaction*	46	52	46	32	52	38	52	53	53
Life Events Inventory+	200	197	178	282	260	213	158	147	155
Self-esteem Scale+	-	2.1	2.2	-	2.5	2.7	-	1.0	1.4
Social Adjustment Scale+	-	2.39	2.37	-	2.53	3.06	-	2.05	1.86
General Health Questionnaire+	-	5.9	6.6	-	5.7 (n=3)	13.0	-	3.0	0.0
Work Assessment Schedule+	63	65	-	64	70	-	56	58	-

* high score = good; + low score = good.
* scores for the entire group of completers at Times I and II are presented in earlier chapters

I have argued that this group were more disabled and less competent from the outset. On entering employment, their well-being, as shown on the ABS and PLS scales, improved. However, loss of employment was accompanied by an abrupt deterioration in health and well-being both on the scales and from comments at interview.

Conclusion

Three months after leaving Sprout, almost all completers were unemployed once again. Little help seemed on hand to assist people to find suitable work and their experiences since leaving Sprout had often been discouraging. At follow-up, participants only found unemployment more tolerable than previously because it was a relatively new state. Although several people had developed more active social lives, the majority were dissatisfied and had found no adequate substitute for employment.

Loss of employment was accompanied by a drop in income and, in some instances, by a deterioration in family relationships.

It was impressive, however, that achievers retained and indeed increased their relative advantage in terms of health, well-being, social activities and support. This confirms the findings of other research, such as the study by Griffiths (1974) which indicated that pre-rehabilitation attitudes and competence were important determinants of outcome. Those who started out from a relatively favourable position appeared to 'do best'. It would seem that a time-limited programme like Sprout may be of considerable benefit to those who are less disabled and whose main difficulty is joblessness, although it is not possible to say how long these beneficial effects would last if this group did not find other employment. Resolutes, on the other hand, showed fewer improvements while employed at Sprout and after they left their health, well-being and social adjustment

deteriorated. For this group a time-limited programme was not sufficient. I shall return to the theme of needs and service patterns in the concluding chapter.

In the next chapter, however, we move on to consider what became of those who dropped out of Sprout and how their experiences compared with those who completed.

CHAPTER 11

FOLLOW-UP INTERVIEWS WITH NON-COMPLETERS

My intention in this chapter is to describe what became of non-completers after they left Sprout, using data collected at interview 12 months after first contact. This is referred to as Time IIb. The chapter contains comparisons on several different planes and it is helpful to make these explicit at the outset. Firstly, longitudinal comparisons are made contrasting non-completers at Time I and Time IIb. Secondly, non-completers at Time IIb are compared cross-sectionally with completers at Time III. Thirdly, it will become apparent that non-completers followed different paths after leaving Sprout. Once their varied experiences of employment and unemployment have been described, non-completers are subdivided on the basis of time in employment since first interview. In subsequent discussion of non-completers' social circumstances at Time IIb, these 2 subgroups are compared.

A comment is required about the qualitative material obtained in Time IIb interviews. This proved briefer and less rich than that from other interviews. Non-completers seemed less interested in talking to me than completers, probably because they had less investment in Sprout. Moreover, I was 'familiar' to completers who had seen me around the project and they may consequently have talked more freely. In several instances, non-completers were unwell at the time of interview and less communicative as a result. Others had done little in the intervening year and had little to say. The discussion which follows consequently contains fewer direct quotations from participants.

Of the 29 non-completers seen at Time I, 14 were followed up.

Numbers diminished for 3 reasons:

1. because of the time pressure, no attempt was made to re-contact 5 people who had been interviewed late in the study
2. 7 people either declined to see me or repeatedly broke appointments
3. 3 were untraceable, having left their previous addresses.

In view of this reduction in numbers by some 50%, it is important to establish whether those re-interviewed were representative of the whole non-completer group. The following paragraphs present details from data collected at Time I, comparing all non-completers with the 14 re-interviewed.

It is apparent from Table 11.1 that those followed up differed only marginally from the entire group of non-completers. The 2 groups were of comparable age and sex and had similar histories of psychiatric treatment. There was some difference in living arrangements, but this seemed unlikely to affect outcome. The only noticeable difference in employment patterns was that those followed up had less overall experience of employment. This may be partly attributable to age, as the group followed up were younger. We can now proceed on the basis that the 14 can be compared legitimately with the whole group of non-completers at Time I. As in the previous chapter when presenting numbers and scores, I shall compare the 14 seen at Time IIb with themselves at Time I.

TABLE 11.1 Profile of All Non-completers and Those Followed Up

		All Non-completers (n=29)		Followed Up (n=14)	
Age (mean)		31 years		29 years	
		n	%	n	%
Gender	male	23	79	11	79
	female	6	21	3	21
Marital Status	single	25	86	12	86
	married	2	7	2	14
	divorced/ separated	2	7	-	
Accommodation	supported accom.	8	28	4	29
	parental home	6	21	4	29
	shared flat	5	17	-	
	own flat	5	17	2	14
	hospital	3	10	2	14
	marital home	2	7	2	14
Diagnosis	schizophrenia	15	52	9	64
	depression	5	17	1	7
	pers. disorder	2	7	-	
	nerves	2	7	1	7
	anxiety	1	3	1	7
	unknown	4	14	2	14
Number of admissions (mean)		3.1		3.6	
Total time in hospital		1.9 years		1.8 years	
Time in employment (mean)		6.7 years		5.1 years	
Time unemployed					
overall mean		5.4 years		4.7 years	
pre-Sprout mean		3.0 years		2.5 years	

Why People Left Sprout

Thirteen of the non-completers followed up began work at Sprout. The exception was a man who was an in-patient at Time I. On discharge from hospital, he moved to London where he believed employment opportunities would be better. Ten months later he returned to Edinburgh and I re-contacted him there. The length of time each of the 14 worked at Sprout is shown below, together with their main reasons for leaving.

TABLE 11.2 Time at Sprout and Main Reason for Leaving

Main Reason for Leaving	Time at Sprout
One person had family problems	1 month
Two people had problems with staff	1 month 7 months
Three people became unwell	1 month 3 months 4 months
Four people disliked the work	1 day 4 months 6 months 6 months
Four people found another job	Did not start 4 months 6 months 7 months

Evidently there was a great range from just one day on the project to 7 months. However, few gave up after a few days or even weeks. While the table shows the main reason people left, they sometimes gave more than one answer. In all, 7 people stated they disliked the work or found it too demanding physically:

> It was coming to winter-time, and I didn't fancy working there in winter.

Interestingly it seemed from the drop-out rates (see Table 4.3, Chapter 4) that participants were more likely to leave the project at certain times of the year: one was during the winter when conditions were harsh, the other was in the summer months when the workload was heaviest harvesting produce. These sorts of pressures are inherent in horticultural work and cannot be totally eliminated. Although staff on the project endeavoured to ensure participants were not exposed to intolerable stress, their task was difficult: in winter facilities for indoor-work were limited and, in summer, harvesting had to be done when produce was ripe. There was a constant tension between the demands of the garden and the needs of participants.

Four people said their health was not good and they could not cope with a job. One man said he was having 'too many thoughts', another suffered from panic attacks. Someone else explained:

> There's nothing wrong with the way Sprout was run. The way I was feeling I just couldn't cope with it.

Two people had difficulties in their relationships with supervisors and left as a result.

> I wasn't very happy. I had an argument with one of the supervisors over skiving the gardening.

Two others were under pressure from family or personal relationships. One of the married men felt obliged to leave to take care of his wife, who was mentally ill herself, and their young daughter. The other, a young woman, had begun a relationship with a man who also worked at Sprout. After a number of incidents he became involved with the police and was eventually imprisoned. His girlfriend said:

> That really brought me down. I just couldn't cope. I was a wee bit ill myself at the time.

One woman left partly because of the other participants. She did not classify herself as 'mentally ill' and found associating with other workers uncomfortable.

> Some of them I found a bit upsetting. I didn't have much in common with them.

Finally, 4 participants had more hopeful reasons for leaving Sprout. They had found other jobs which promised greater security or were more appealing than Sprout.

In view of the reasons participants gave for leaving the project, it is difficult to see how Sprout could have retained them. I shall discuss the implications of this in the next chapter. Reasons often lay in participants' domestic or social circumstances and the project had no control over such matters. Interestingly, the views of non-completers about Sprout were similar in substance to those of completers. The reasons the former left resembled many of the criticisms completers made of the project. The difference between the 2 groups appeared more a question of degree than substance.

The decision to leave seemed to constitute a deliberate choice whereby participants weighed up the costs and benefits of continuing and of resigning. We saw earlier that completers enjoyed and benefitted from Sprout to varying degrees, but that on the whole the advantages of working at Sprout were more attractive than the alternatives. Non-completers tended to leave either because the attractions of employment elsewhere were greater (see below) or because the costs of working at Sprout were too high - in terms of health or family pressures for example. A similar finding emerged from a study by Buckland and MacGregor (in Fineman (ed) 1981). They looked at the reasons why long-term unemployed men refused places at a DHSS re-establishment centre and discovered that take-up of places

hinged on whether the men believed attendance would benefit them in the long run. Those who declined a place thought they were unlikely to get a job after the course and were critical of the type of work offered on the course.

The fact that 7 of the 14 non-completers stated they disliked the work or found it too demanding physically, points up the need for alternative forms of employment.

> I'm not a keen gardener. I would have preferred working with people.
>
> I went for it (Sprout) as a job. It wasn't what I wanted to do. If you want to do gardening you're alright, but I wasn't wanting to do anything like that.

It is acknowledged that mental illness is often accompanied by low motivation and it would therefore seem all the more important to ensure that a range of work is available so that individual's aptitudes and interests can be exploited.

It was alarming that 7 people said they regretted leaving Sprout and while they were contemplating re-applying, they were uncertain and hesitant. It might have been helpful for these people to discuss their concerns with a sympathetic party. However, although 12 of the 14 non-completers were in contact with formal services, these were primarily medical: GPs, or hospital staff. As noted earlier, health professionals are not always interested in or informed about employment matters.

Employment and Unemployment

Employment

Since leaving Sprout, 5 people had been in other employment for some of the time. Four had held one job, one person had had 2 jobs. The length of time in employment varied from one month to 6 months. At interview, however, only one person was still in employment. It

is worth looking at the employment experiences of these 5 people in the light of earlier discussion concerning the types of jobs suited to mentally ill people.

The man still in employment, R, transferred from Sprout to an MSC-funded clerical post with a mental health agency. This post offered work more in line with his preferences and previous experience. From the limited information available, the job seemed to meet many of Floyd et al's criteria for 'a good job'. R worked in a small group in a social environment he found supportive and was well supervised. However, this post was also temporary, being MSC-funded, and thus no matter how well R performed his duties, he had no long-term security.

The experiences of the 4 others were less agreeable. The man who failed to take up his job at Sprout found part-time employment in London as a factory worker. He seemed content with the job but was made redundant after 3 months. It was not clear if this was for economic reasons or because he had been unsatisfactory. However, this brief time in a job continued a pattern of short, intermittent employment, which had started after the onset of his illness.

One woman with previous experience of shop work left Sprout for what seemed a permanent job in a video shop. She worked long, unsociable hours, the job was boring and she spent much time alone. On returning to work after having been off sick, she found the business had collapsed and she no longer had a job. This was an evident disappointment, however she was also relieved to have escaped the tedium and isolation of a job which offered few benefits or satisfactions. It was questionable whether she would have tolerated the job much longer. Another woman found work as a 'Girl Friday' in return for her keep and pocket money. She was employed in an

isolated location and disliked the lack of privacy the job entailed and always being required to do what others wanted. Consequently she decided to leave. Again this reproduced a pattern of casual work: this woman had had about 10 jobs in all, but never spent more than 6 months in one.

The final individual - a skilled worker with a solid history of employment - obtained a job in his former trade and left Sprout. He had hoped this would be an opportunity to re-establish himself after illness had interrupted his career. However, he found he was expected to operate complicated machinery with which he was not familiar and was unable to cope. His health broke down and he left. Although this man did not describe his job in great detail, it appeared that little effort had gone into adapting the work to his needs and when he could no longer meet the job's requirements he was obliged to leave. Floyd et al (1983) argue that it is possible to devise ways, if not of reducing stress, of helping employees cope with it and conceivably such assistance might have enabled this man to retain his job.

The various experiences of these 5 non-completers demonstrate further that the types of jobs available are often unsatisfying and offer little security. Obtaining a job was seen by these individuals as a considerable achievement and yet ensuing experiences were often disappointing and at times damaging. Research on 'fear of failure' suggests that it is likely to reduce people's willingness to take risks and to engage in tasks (reported by Watts, in Watts and Bennett, 1983). After repeated experiences such as these, it is conceivable that individuals might lose their motivation to seek work at all.

As with completers who found employment, there was apparently no-one to whom these individuals could turn for help with difficulties they encountered when in work.

Employment Rehabilitation Centres

Two people had begun courses at Employment Rehabilitation Centres (ERCs) after leaving Sprout. The first man was referred to his local ERC after moving from hospital to a hostel. He left after the first day as he had done at Sprout and said he felt too unwell to attend. The second man had found the work at Sprout too demanding. With the help of staff at the hospital day unit he attended, he applied to the ERC and completed 4 weeks of an 8-week course. However, he suffered from panic attacks, as he had done at Sprout, and withdrew. It is interesting that both men came to ERCs following contact with hospital staff. This raises the question of whether those not in contact with hospital workers did not know about ERCs, or chose not to attend. Certainly, it is clear that in these 2 cases further rehabilitative efforts after Sprout met with the same unsuccessful results.

Day Care

Two of the 14 non-completers had received day care in the intervening 12 months. Both had been in day care directly before joining Sprout. One was the second ERC attender mentioned above. He returned to the hospital day unit after leaving the course and had been attending 5 days a week for 7 months. He seemed content to have occupation and social contact without the demands employment entailed. Presumably the gap between the day unit, which provided social and recreational activities, and employment rehabilitation was too great for him to bridge at that stage.

By contrast, the second day patient would have preferred to be working. She had left Sprout following difficulties with another participant and had been attending a different hospital unit 2 days a week for 6 months. She found the other patients 'a bit frightening' and felt there was not enough to do:

> We just sit around there all day and watch the 4 walls.

The Search for Employment

Seven of the 14 followed up said they were looking for work. Unlike completers, who were acutely aware of the difficulties they faced finding work, the non-completers seeking employment seemed optimistic that 'something would turn up'. In part this may reflect the fact that 5 of them had been 'successful' in finding work after Sprout, although, as we have seen, they had not stayed in their jobs. It also suggests that, unlike completers, they did not perceive themselves as particularly disadvantaged in competing for work, although it is not clear why this should be so. Five of these 7 had applied to vacancies, but only one person had been interviewed and no job offers had been received. Once again, most were relying on their own efforts to find work since only 2 received help - one from his wife and one from job centre staff.

Unemployment

Apart from the one man in employment and the 2 people receiving day care, the other 11 had been unemployed at least part of the year. The mean time unemployed after leaving Sprout was 5 months and 6 people had been unemployed at least 8 months of the year. The reactions of non-completers to unemployment differed slightly from completers. A small group of the former - 4 people - appeared to feel that they preferred unemployment at that point, mainly because of ill-health. All 4 were diagnosed schizophrenics.

> Within the limits of my illness I have to be happy with that (i.e. being unemployed). I don't want it to be anything more stressful. It's a different kind of burden, but one I can handle. I can't handle the burden of working.

> I feel relaxed, at ease (when I'm not working). If I'm employed, I'm under stress and strain all the time and I find it impossible to cope. I don't see anything good about working.

Both these men were in their early 30s. One had worked very little in his life, while the other had been in employment for 12 years in all. Wing notes that for some people with schizophrenia

> social withdrawal is a technique that can be consciously manipulated ... and used in a specific way to avoid situations they find painful. (in Watts and Bennett, 1983, p.58)

It seems that this principle could be applied to employment as well as to social interaction. I have argued that greater attention to the nature of the environment in which people work might make it possible to reduce the stress experienced. However, it may be that for some individuals employment is not appropriate and their preferences should be respected.

None of these 4 individuals was seeking a job when interviewed and nor were 2 other men who were in hospital at that time. In contrast to this group, with a relatively low commitment to working, were the 7 others seeking employment. Their reactions to unemployment were similar to those of completers. Those out of work longest found unemployment difficult to tolerate. A man unemployed for 11 months said:

> Boredom is the worst thing. It drove me very low. For a while I was crying every morning.

Another, unemployed 9 months, said:

> Since leaving Sprout I've been trying to keep sane. That's literally it. It's been murder.

The other 5 job-seekers were less desperate: 3 had been unemployed for less than a month, the fourth had a range of interests he pursued, and the fifth was the woman attending a day unit 2 days a week.

As with completers, it appears that unemployment can be bearable for a brief period and if some form of occupation is available to provide structure, variety and social contact. However, unemployment was only **preferred** by those who felt unable to work because of ill-health.

Differences in Outcomes among Non-completers

As noted in Chapter 4, it proved necessary to reconsider the original assumption that non-completers would afford a useful comparison with completers. Preceding sections have shown that the experiences of the 14 non-completers after leaving Sprout were diverse and details of individual cases are given in Table 11.3.

TABLE 11.3 How Non-completers Spent the Year since First Interview (in months)

Case	At Sprout	In other employment	Day Care	ERC	In-patient	Unemployed
1	7	-	-	-	1	4
2	1	-	-	-	3	8
3	3	-	-	-	-	9
4	4	6	-	-	1	1
5	6	1	-	-	2	3
6	-	3	-	-	1	8
7	1	-	-	-	-	11
8	7	5	-	-	-	-
9	4	-	6	-	-	2
10	6	-	-	-	-	6
11	*	-	-	*	2	10
12	3	-	-	-	1	8
13	6	5	-	-	-	1
14	4	-	7	1	-	-

* 1 day only.

It is evidently an oversimplification to regard non-completers as people who were not exposed to Sprout, or as people who spent most of the year out of work.

It seemed important to take account of variations in experiences when considering outcomes. Non-completers were therefore divided into 2 subgroups comprising:

1. 6 people who worked at least 6 months of the year at Sprout and/or elsewhere whom I shall call 'actives'
2. 6 people who worked 3 months or less in all, whom I shall call 'inactives'.

This categorisation excludes the 2 day care attenders who fell into neither category. They are included in discussion as part of the entire non-completer group at Time IIb.

Subdividing non-completers in this way allowed me to analyse outcomes in more detail and investigate factors possibly associated with employment. In the ensuing discussion, outcomes for actives and inactives are contrasted. However, comparisons between completers and non-completers will still be made between the 2 main groups - the 15 completers and 14 non-completers followed up - rather than among the 4 subgroups - achievers, resolutes, actives and inactives - as the subgroups were formed according to different criteria. Achievers and resolutes were defined in terms of performance in rehabilitation, actives and inactives in terms of time in employment.

Before we consider outcomes for actives and inactives at follow-up, we need to establish to what extent the 2 groups differed at Time I.

TABLE 11.4 Actives and Inactives Compared at Time I

		All Non-completers (n=29)	Actives (n=6)	Inactives (n=6)
Age (mean)		31 years	28 years	31 years
		n	n	n
Gender	male	23	4	6
	female	6	2	-
Marital status	single	25	6	4
	married	2	-	2
	divorced	2	-	-
Accommodation	parental home	6	2	1
	supported accom.	8	2	1
	shared flat	5	-	-
	own flat	5	1	1
	marital home	2	-	2
	hospital	3	1	1
Diagnosis	schizophrenia	15	4	4
	depression	5	1	1
	other	9	1	1
Number of admissions	none	2	1	-
	1-3	18	3	3
	4+	9	2	3
	mean	3.1	3.3	4.7
Total time in hospital				
	none	2	1	-
	year or less	16	3	3
	over a year	11	2	3
	mean	1.9yrs	0.9yrs	2.75yrs
Last admission				
in 12 months pre-Sprout		15	4	2
over a year pre-Sprout		14	2	4
Medication	yes	21	4	5
	no	8	2	1
Perceived health				
reported improvement in health in year pre-Sprout				
	yes	18	3	4
	no	11	3	2

	All Non-completers	Actives	Inactives
Time in employment (mean)	6.7yrs	4.6yrs	7.3yrs
Longest time in one occupation (mean)	4.6yrs	3.4yrs	5.2yrs
Time unemployed (mean)			
overall	5.4yrs	4.8yrs	4.8yrs
pre-Sprout	3.0yrs	2.0yrs	2.7yrs
Seeking work at Time I			
yes	17	4	3
no	12	2	3
Relationships			
has friends	20	5	4
none	9	1	2
Social activities			
use of time rating: good	12	3	1
poor	17	3	5
satisfied with how spent time	8	1	2
dissatisfied with how spent time	21	5	4

TABLE 11.5 Scores on Scales at Time I : All Non-completers, Actives and Inactives

	All (n=29)	Actives (n=6)	Inactives (n=6)
Affect Balance Scale			
* Positive	2.93	2.17	3.67
+ Negative	2.72	3.00	3.17
* Balance	0.21	-0.83	0.50
Present Life Satisfaction*	48	44	50
Life Events Inventory+	222	236	138

* high score = 'good'
+ low score = good.

Discussion

It seemed that inactives had spent considerably longer in hospital than actives. This is partly explained by the fact that 2 inactives had spent 9.5 years and 4 years in hospital. There was little additional evidence that inactives were more seriously ill than actives at Time I: actives were more likely to have had a recent admission and were just as likely to be on medication. Moreover, the diagnoses of the 2 groups were remarkably similar as was perceived health. Actives, surprisingly, had spent less time in employment than inactives. Age may partly explain this as time employed and age were significantly related.

Few differences were discernible between the 2 groups in terms of their social relationships and activities.

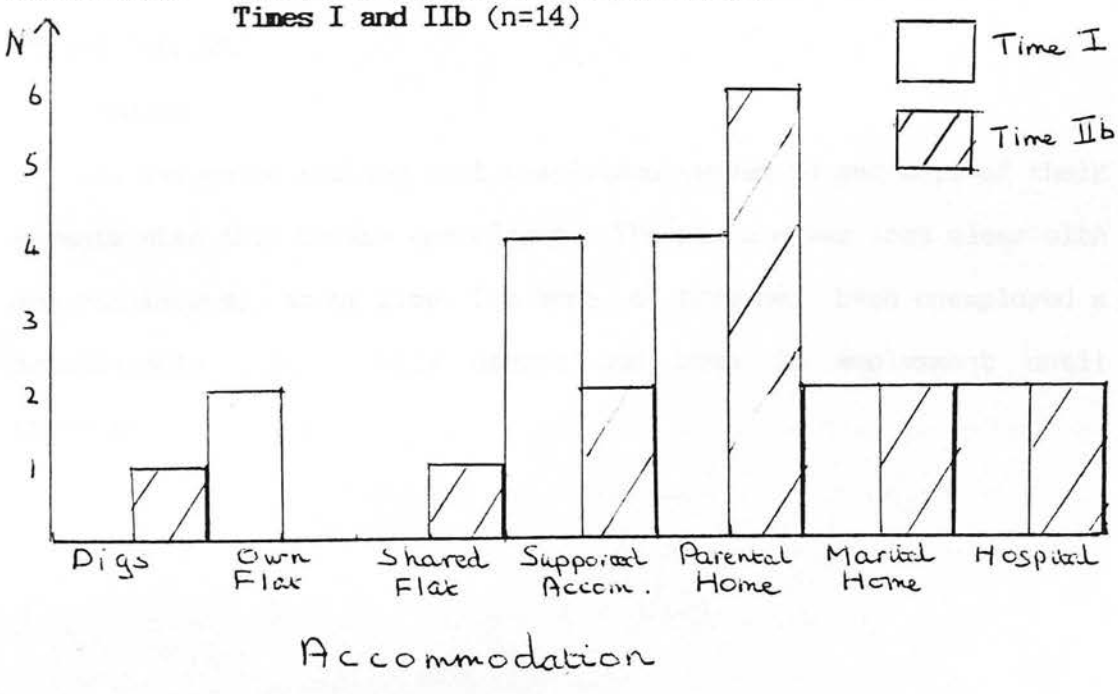
On the scales measuring well-being, (see Table 11.5) inactives registered higher overall levels of well-being than actives. At the same time inactives also scored higher levels of negative affect than actives. This pattern is consonant with the explanations suggested earlier: that high negative affect reflects greater psychological disturbance and that low well-being scores at Time I may indicate greater commitment to work since the well-being of people with a stronger work commitment is more adversely affected by unemployment.

We now turn to look at the personal and social circumstances of non-completers at Time IIb. In each section, I shall discuss the outcome for all 14 followed up and compare this with the outcome for completers. Where differences were apparent between actives and inactives, I shall then present these.

Accommodation

Since Time I, 6 non-completers had changed accommodation. Figure 11.1 illustrates the living arrangements of the 14 non-completers at Time I and IIb.

FIGURE 11.1 Accommodation of Non-completers at Times I and IIb (n=14)



In one instance the move was prompted by a deterioration in health, but in the 5 others, accommodation was provided on a time-limited basis and residents were obliged to move on. As with completers, non-completers in supported accommodation were particularly likely to move: 3 of the 4 living there at Time I moved during the year. In a recent review of supported accommodation in Scotland, Cunningham notes that the facilities provided by health boards and social work departments often operate on a policy of time-limited residence and are therefore ill-suited to those who need permanent accommodation with continuing support (in Drucker, 1987, Vol.1).

A considerable proportion of non-completers - about half - were still living with parents at Time IIb. This had also been the case with completers at follow-up.

Turning to actives and inactives, 2 of the former and 3 of the latter had moved since Time I. For actives, moves represented an increase in independence - for example, moving out of supported accommodation into digs - whereas the converse was true of inactives.

Social Support

Family

It was noted earlier that completers tended to see more of their parents when they became unemployed. The picture was less clear with non-completers, as by Time IIb some of them had been unemployed a considerable time, while others had been in employment until recently.

Of the 13 non-completers with parents alive, 4 reported an increase in contact over the year of whom 2 had moved to live with parents. Eight saw their parents as often as previously, one man saw his ageing infirm father less often.

Interestingly, the only non-completers to report a deterioration in relationships at home were 2 inactives. These were the 2 married men whose wives were also mentally ill. In both cases the wives had been under psychiatric care in the foregoing 12 months.

In sum, non-completers were less likely than completers to report an increase in contact with parents. They were also less likely to report a deterioration in family relationships. This is in line with the earlier suggestion that the 2 factors - level of contact and quality of relationships - are related.

Friends

Sprout seemed to have promoted friendships among completers, although contact often ceased when people left. It was of interest to ascertain in the case of non-completers whether other forms of occupation - either employment elsewhere, or attending a day unit - had similar results.

It emerged that the 2 non-completers attending a day unit had made friends through that experience. Attendance seemed to provide their main social outlet and was valued as such. Other research has confirmed that the social aspects of day units are very important to users (Davis, 1986). Of the 5 who had been employed apart from at Sprout, 3 made friends at work. However, the maintenance of friendships again seemed dependent on continuation of employment. Those who had left jobs no longer saw these friends.

Inactives seemed to fare less well with friendships than

actives. Two inactives were without friends at both stages of the research - these were the 2 married men. Three other inactives saw less of their friends at Time IIb than earlier. On the other hand, only one active was friendless at Time I, all 6 had friends at Time IIb and 5 of them saw friends as often or more often than before. However, similar numbers in both groups were dissatisfied with their friendships and this had not altered over time.

Social Adjustment

The global Social Adjustment Scale scores for non-completers at Time IIb indicated that this group was less well adjusted than completers. Scores for both groups in the individual role areas follow a similar pattern - full details are given in Appendix C.

TABLE 11.6 Social Adjustment Scores for Non-completers and Completers at Follow-up

	Non-completers (Time IIb) (n=14)	Completers (Time III) (n=14)
Global score+	2.46	2.37

+low score = 'good'.

The difference is slight, but is in line with data from Time I interviews which suggested that non-completers tended to have greater problems with personal relationships and with occupying their time satisfactorily. Unfortunately, it is not possible to say whether the adjustment of non-completers had altered over time. Evidence from completers suggested that change was unlikely to have occurred.

Looking at scores for actives and inactives, as might have been anticipated, actives were better adjusted than inactives. The mean global scores were 2.28 and 2.82, respectively.

Use of Time

As with completers at Time III, non-completers seemed to make better use of their time than earlier. Two people were rated 'good': one was the person in employment who also had a number of hobbies, the other was the man who attended a hospital day unit 5 days a week. He was also a regular attender at a patients' social club on the hospital premises.

Five were rated 'fair' and 7 'poor'. Compared with completers, more non-completers were rated 'poor' continuing the trend observed at Time I.

TABLE 11.7 Use of Time Rating for Completers and Non-completers at Final Contact

	Non-completers (Time IIb)		Completers (Time III)	
	n	%	n	%
Good	2	14	2	13
Fair	5	36	9	60
Poor	7	50	4	27

The ratings of 6 non-completers improved over time, 2 deteriorated and 6 stayed the same. Nevertheless, over two-thirds (11) were dissatisfied with how they spent their time, which was very similar to the level of dissatisfaction among non-completers at Time I. It is interesting that completers and non-completers converge on this issue: at Time I there was a significant difference between the 2 groups but after completers left Sprout more of them - 10 out of 15 - were dissatisfied. Possibly continuous employment for 12 months had raised the expectations of completers so that the absence of alternative employment

subsequently caused them to be dissatisfied, whereas non-completers had more intermittent experience of employment, often with long spells of unemployment. Moreover, several non-completers indicated they were not well enough to work and were content to be unemployed at that stage.

Turning now to actives and inactives, the tendency for actives to be given a better use of time rating continued at Time IIb: 4 actives were rated 'good' compared with only one inactive. Additionally, 4 of the 6 actives said they had taken up a new interest or joined a club since Time I, while only one inactive had done so. However, actives continued to be as dissatisfied as inactives with how time was spent.

Overall, it seemed that although some more resourceful individuals developed new interests - and did so without the stimulus of Sprout - this was insufficient to compensate for the absence of employment in the long term.

Money

We saw in the previous chapter that perceived adequacy of income seemed related to employment status for completers and that the majority found it difficult to manage on benefits at Time III. However, the situation of non-completers was slightly different: at Time IIb, when they too were mostly unwaged, the majority said they could manage well or adequately on benefits. This denoted a considerable change in attitude over time as the table below indicates.

TABLE 11.8 Change over Time in Perceived Adequacy of Income

	Time I		Time IIb	
	n	%	n	%
Managed well	-		6	43
Got by	6	43	3	21
Had difficulty	8	57	5	35

It is hard to explain why non-completers apparently faced less difficulty than completers in meeting their needs. There was no evidence that non-completers were on higher rates of benefit at Time IIb, compared with Time I, or with completers at follow-up. Moreover, similar proportions of both groups (two-fifths) reported they had savings. What was clear was that actives tended to be more satisfied than inactives with their standard of living: 5 actives and 3 inactives indicated they were satisfied.

Health and Well-being

Health

In the year preceding entry to Sprout, over half of non-completers had been admitted to psychiatric hospital. Those admitted between Times I and IIb tended to have been in-patients in the year prior to Sprout. Seven of the 14 followed up went into hospital between Times I and IIb, of whom 5 had been in-patients in the 12 months before Sprout. The other 2 admitted had also been in hospital previously. Table 11.9 shows how often these 7 were admitted to hospital and how long they stayed in.

TABLE 11.9 In-patient Episodes between Times I and IIb

Case	Number of Admissions	Time in Hospital (months)
1	1	1
2	1	1
3	1	1
4	1	2
5	2	1
6	2	2
7	2	3

All the admissions which occurred lasted at least 1 month. This is striking, as statistics show that in 1984 in Scotland, half of those admitted to psychiatric hospital were discharged within 3 weeks (SHHD, 1985), and may give some indication of the severity of illness.

It is difficult to compare this admission rate of 50% over a year for non-completers with the rate for completers as the time spans between interviews with the 2 groups varied. However, during the 9 months between Times I and II when completers were employed at Sprout, only 1 in 4 was re-admitted to hospital, suggesting that the rate for non-completers was higher.

Non-completers had spent more time in hospital compared with completers at Time II and Time III. The 7 non-completers admitted by Time IIb were in hospital for a total of 11 months, whereas the 6 completers admitted by Time II plus the one admitted by Time III spent a total of 4 months in hospital and only one completer was in hospital for over a month at a time. Thus, despite the discrepancies in time between interviews, evidence suggests that non-completers were more likely to become in-patients than completers and to spend longer in hospital. This continues the tendency observed at Time I for non-completers to have spent more

time in hospital than completers prior to joining Sprout. It is also in line with the study by Brown (1958), mentioned earlier, which found an association between employment status and re-admission rates.

However this association (between employment status and re-admission) was not a straightforward one in the Sprout study as is evident when we look at actives and inactives. Both groups were equally likely to have been re-admitted and spent similar periods in hospital during the year. Thus actives had been employed a substantial time **and** been in hospital. Their individual case histories indicated that actives went into hospital after lengthy spells in employment and that following discharge they ceased to be employed. It was not that they succeeded in retaining employment despite illness. In this respect it is interesting to recall that several completers continued or returned to work at Sprout despite hospitalisation. Conceivably the supportive environment at the project may have made this possible.

Among completers there was a noticeable consistency with regards out-patient care. In contrast, the proportion of non-completers who were out-patients increased from 1 in 3 at Time I to 1 in 2 (7 people) at Time IIb. The proportion on medication also rose in that one man who had come off anti-psychotic medication not long before Time I was taking it again at Time IIb. Non-completers were more likely to be on medication at Time I than completers and this pattern was still apparent at follow-up, when 12 out of 14 non-completers and 10 out of 15 completers were on medication.

The overall GHQ scores for non-completers at Time IIb are shown below and compared with scores for completers at follow-up.

TABLE 11.10 GHQ Scores for Non-completers and Completers at Follow-up

	Non-completers Time IIb (n=14)	Completers Time III (n=14)
Overall score+	4.43	6.60
Standard deviation	3.92	9.25

+ low score = 'good'.

Non-completers at Time IIb registered better psychological health than completers at follow-up. The scores on 3 of the 4 subscales reproduced this pattern, with the exception of the 'social dysfunction' subscale on which completers recorded less dysfunction than non-completers. Details are shown in Appendix C. In view of the findings reported above on re-admission rates, medication and out-patient care, it may seem surprising that the scale showed non-completers in better health. However, the GHQ is designed to detect recent changes in psychological health and is less sensitive as a measure of prolonged ill-health (Stanley and Gibson, 1985). Conceivably the health of non-completers was less changeable than that of completers and scores may mask consistently poor health among non-completers. It is apparent that the range of scores among completers was greater than among non-completers, but a similar proportion of both groups scored above the clinical caseness level (6 people in both). Thus, although the mean scores for completers were higher, completers were no more likely than non-completers to qualify as 'cases'. Completers included greater extremes of health and their health seemed to undergo greater changes over time on entering and leaving employment.

Turning now to actives and inactives, the mean total GHQ score for actives at Time IIb was 3.00, compared with 7.00 for inactives. Those employed longer were thus in better health. Moreover only 2 of the 6 actives were above caseness level on the GHQ compared with 4 of the 6 inactives.

The perceived health of completers tended to improve whilst at Sprout, but this upward trend slowed when participants left. Non-completers' perceptions of their health did not alter over time to the same extent, as Table 11.11 shows, in line with the proposition made earlier that their health was more consistent, though not necessarily better, than the health of completers.

TABLE 11.11 Changes in the Perceived Health of Non-completers

	In year prior to Time I		Between Times I and IIb	
	n	%	n	%
Better	9	64	7	50
Worse	4	29	4	29
Same	1	7	3	21

The pattern evident at Time I persisted with only slight variation at Time IIb. A slightly smaller proportion noticed an improvement in their health at Time II and almost 1 in 3 indicated their health had deteriorated. This rate of deterioration was higher than that among completers at Time III, when only 2 of the 15 said their health had worsened.

In accord with the discrepancies between actives and inactives on the GHQ, the perceived health of inactives was more likely to have deteriorated than that of actives. At Time II, 4 actives felt better, 2 the same, while only one inactive felt better, one the same and 4 worse.

Well-being

The well-being scores on the Affect Balance and Present Life Satisfaction scales are shown below, comparing non-completers and completers.

TABLE 11.12 Well-being Scores for Non-completers and Completers

	Non-completers (Time I) n=14	Non-completers (Time IIb) n=14	Completers (Time III) n=15
Affect Balance Scale			
* Positive	2.86	2.64	2.40
+ Negative	3.00	2.86	2.80
* Balance	-0.14	-0.22	-0.40
Present Life Satisfaction*	48	49	46

* high score = 'good'; +low score = 'good'.

It can be seen that the well-being of non-completers has remained relatively consistent.

As at Time I, non-completers registered slightly higher levels of well-being than completers at follow-up. It was suggested earlier that the well-being of non-completers was higher at Time I because they may have attached less value to employment and therefore been less adversely affected by unemployment. Certainly compared with completers, fewer non-completers were looking for work at follow-up. The scores for actives and inactives may cast further light on this discussion.

TABLE 11.13 Well-being Scores of Actives and Inactives

	Actives (n=6)		Inactives (n=6)	
	Time I	Time IIb	Time I	Time IIb
ABS* Positive	2.17	2.83	3.67	1.83
+ Negative	3.00	2.83	3.17	3.33
* Balance	-0.83	0.00	0.50	-1.50
PLS*	44	50	50	42

* High score = 'good', + low score = 'good'.

Two separate processes seemed to have been operating between Times I and IIb: scores for actives indicate that well-being has increased while scores for inactives show a decrease in well-being. The differences between the 2 groups at Time IIb can be explained in a number of ways. Actives were in better health and made better use of their time than inactives and both these factors have been found to be associated with well-being (Hepworth, 1980; Bradburn, 1968). Moreover, inactives had more difficulties in their social relationships which may well have affected overall levels of contentment.

However, it is harder to account for the increase in the well-being of actives over time. It might have been anticipated that change would occur in the opposite direction, as actives were more committed to employment than inactives and might therefore have been more adversely affected by unemployment. With the exception of the one man in employment at Time II, the circumstances of actives seemed no more favourable at Time IIb than at Time I, when they had the possibility of a year's employment before them. So why should actives appear more content at Time IIb than when unemployed previously?

Part of the explanation may be that 2 of the 6 actives had been unemployed for less than a month when interviewed at Time IIb and, as noted earlier, brief spells of unemployment seemed tolerable. This may have had the effect of improving the overall well-being scores of actives. We saw in previous chapters that the well-being of achievers followed a similar upward trend, despite the fact that most were unemployed at follow-up. In their cases, it seemed they had gained confidence and a sense of their own worth from working at Sprout and were able to cope more resourcefully with unemployment subsequently. The 3 actives who had been unemployed for longer periods were still keen to find work, but appeared to have adapted to unemployment and devised alternative goals for themselves in the absence of employment.

The decline in well-being among inactives may have been a function of their poorer health. In addition, those who were eager to work were less successful than actives in finding alternative means of occupation.

Self-esteem

Self-esteem scores are shown below.

TABLE 11.14 Self-esteem Scores of Non-completers and Completers

	Non-completers (Time IIb) n=14	Completers (Time III) n=15
Mean score+	2.8	2.2

+ low scores = 'good'.

It was argued earlier that there was little indication that self-esteem changed over time in the Sprout study and also in other research. Unfortunately there is no basis for comparison over time in respect of non-completers' scores. However, there was evidence from Time I interviews that completers were more confident about their ability to cope in general and with working at Sprout. The SES scores obtained subsequently bear this out.

As expected, actives had higher self-esteem then inactives: their respective scores were 2.7 and 3.5.

To sum up this section on health and well-being: there was evidence that non-completers were in poorer health than completers. More of the former were re-admitted to hospital and they tended to stay longer. Additionally, several non-completers entered out-patient treatment between Times I and IIb and the proportion of non-completers on medication was not only higher than the proportion of completers, it had also increased slightly over time. The GHQ scores and measures of perceived health suggested that the health of non-completers had not fluctuated to the same extent as the health of completers.

There proved to be differences between actives and inactives on both objective and subjective measures of health, although little evidence of such difference was apparent at Time I. While those employed longer seemed in better health at Time IIb, they had nonetheless experienced periods of ill-health in the preceding 12 months. From the qualitative data, it seemed that actives were more resilient and tended to recover more fully from episodes of illness than did inactives, whose illnesses seemed more chronic. It is known that the course mental illness takes can vary greatly. Fowlie states, for example, that a third of those who suffer from

schizophrenia will recover completely, a third will experience a chronic illness and the middle third will have varying disabilities (in Drucker, 1987, Vol.1).

Conclusion

Table 11.15 summarises the scores on the scales for non-completers followed up. In conclusion we need to consider what non-completers tell us about the effectiveness of the Sprout project and about the needs of mentally ill people in general. Firstly, it is evident that Sprout did not match the needs and preferences of everyone. Some disliked the type of work; others found they could not cope with employment. Secondly, the experiences of non-completers in the year since first contact reinforced many of the points which emerged from follow-up interviews with completers. Non-completers also had little help with obtaining employment and those who did find work did not necessarily retain it. I suggested in Chapter 4 that non-completers might give an indication of what became of people after they left Sprout over a longer period than was possible with completers. The situation was alarming in that most non-completers seemed to have been cast adrift and left to fend for themselves. While several had been hospitalised, psychiatric services appeared to be concentrated on in-patient episodes and to fade out when people were discharged. This is in line with the survey of Scottish mental health services presented in Chapter 1, which pointed to the heavy concentration of resources in the hospital sector.

TABLE 11.15 Summary of Scales for Non-completers* Actives and Inactives

Scales	Non-completers Followed Up		Actives		Inactives	
	Time I (n=14)	Time IIb (n=14)	Time I (n=6)	Time IIb (n=6)	Time I (n=6)	Time IIb (n=6)
ABS *Positive	2.86	2.64	2.17	2.83	3.67	1.83
+Negative	3.00	2.86	3.00	2.83	3.17	3.33
*Balance	-0.14	-0.22	-0.83	0.00	0.50	-1.50
Present Life Satisfaction*	48	49	44	50	50	42
Life Events+	184	251	236	244	138	304
Self-esteem Scale+	-	2.8	-	2.7	-	3.5
Social Adjustment Scale+	-	2.46	-	2.28	-	2.82
General Health Questionnaire+	-	4.43	-	3.00	-	7.00

* High score = good; + low score = good
* Scores for all non-completers at Time I are given in Chapter 6, Table 6.2

Thirdly, non-completers highlighted that there were few alternative forms of day care for those not ready for the rehabilitation that Sprout offered, but who nonetheless lacked social contact and occupation. This is alarming as Lothian is well-off compared with other regions in terms of day care places (McKay, 1985b). Thus, although one of the findings which emerges most distinctly from this study is the importance many mentally ill people attached to employment, it is crucial not to overlook the fact that not all were able to work and this group were particularly likely to lack the personal and social resources to find satisfactory alternatives to employment.

There were only slight differences between actives and inactives at Time I, but by follow-up there were consistent indications that actives were more competent socially, in better psychological health and more content with their lives. Clearly actives had not been free of illness: they were as likely as inactives to have been admitted to hospital in the year since Time I. However, it seemed that actives were more resilient than inactives, as I indicated earlier, and recovered relatively well from bouts of illness while inactives were held back by chronic ill-health. Research into the effects of mental illness indicates that those most adversely affected tend to have had poor 'pre-morbid' functioning (Wing, in Watts and Bennett, 1983) and this may have been the case with inactives. Quite different forms of intervention would then be required for these 2 groups. On the one hand, actives needed help to gain access to suitable employment and to ensure that bouts of illness did not lead to loss of employment. On the other hand, inactives needed fairly intensive long-term support to offset their shortage of personal skills and resources. In their case

intervention would aim to create acceptable and rewarding occupation and social contact.

Turning now to consider both completers and non-completers, we need to be mindful of the reservations expressed in Chapter 4. Given that the groups were not randomly allocated and that many non-completers did work at Sprout for quite some time, comparisons between the 2 groups must be descriptive and eschew spurious assumptions of causality.

At Time I, on aggregate, non-completers were more disadvantaged than completers in terms of health, social relationships and previous employment. By follow-up, completers had - in some respects - retained their position of relative advantage: they were less likely than non-completers to have been admitted to hospital in the course of the research and were more likely to have developed new friendships and interests. Nevertheless, neither group fared well in obtaining employment and on the whole employment at Sprout did not appear to benefit completers after they left, with the notable exception of achievers.

In any case, the wide range of experiences within both groups means that generalised comparisons are of doubtful value. For example, there was evidence that those who dropped out were not necessarily less able than those who completed. Actives, after all, had worked much of the year and interestingly inactives, who had worked least of all participants, registered better health on the GHQ compared with resolutes, both when the latter were employed and unemployed.

On the whole completers included greater extremes of ability and health. This group seemed to undergo more change in attitude and in social circumstances than non-completers - perhaps because

the former were interviewed on 3 occasions rather than on 2 and more change was detected. This may also reflect the fact completers were more committed to working than non-completers. We saw, for instance, that not all completers enjoyed Sprout, but they nevertheless mustered sufficient motivation to continue. Moreover, completers were more likely to be looking for work at follow-up. If we accept that completers **were** more work-oriented, then it is to be expected that they should have been adversely affected by involuntary unemployment. Non-completers, by definition, had left employment at Sprout (and sometimes elsewhere) of their own volition.

Both groups illustrated the importance of considering the social context in rehabilitation, as noted in Chapter 2. In the first place, participants' performance at Sprout and continuation on the project were often affected by factors which lay beyond the project's control - health or personal relationships. In assessing Sprout's effectiveness in meeting its objectives, these factors should be taken into account. Additionally, it was evident that outcomes were affected by the dearth of other provision, both in terms of employment and of welfare services. I shall elaborate on this theme more fully in the next chapter and discuss the importance of having a comprehensive range of services to cater for varying needs and preferences.

CHAPTER 12

SUMMARY OF FINDINGS AND DISCUSSION

This chapter has several aims:

to draw together the main findings of the study;
to discuss Sprout's effectiveness; and
to consider the implications of the findings for policy and practice.

Summary of Findings

I shall begin by reviewing the extent to which the project attained its goals, with reference to the statement of short- and long-term goals presented in Chapter 2. The review of goal-attainment is concerned with completers. The findings relating to non-completers will be discussed in a subsequent section. It was anticipated that participation on the project would be accompanied by certain changes in participants, both while at Sprout and after leaving. These changes will be considered in turn.

Short-term Goals

1. **Performance**

At work there was little indication from the Work Assessment Schedule that participants' work performance improved substantially whilst at Sprout. However, participants were generally satisfied with their own standard of work and did not seek to improve it. It was evident that performance was sometimes affected by ill-health or by the poor standard of work of other participants.

The project retained in its employ a group of seriously disabled participants and this seemed an impressive achievement. These people faced considerable problems in their personal lives which made it difficult to sustain interest. However, Sprout seemed to offer them something stable in an unsettled existence.

Rates of absenteeism varied greatly, but over half of those who completed were off work less than 6% of the time.

By the end of the year, supervisors considered that one-third of participants were ready for open employment, one-third needed a sheltered post and one-third would benefit from further rehabilitation.

In relationships. Working at Sprout appeared to foster friendships among participants and this spilled over into encounters outside the workplace. Participants also developed trusting relationships with supervisors.

To some extent relationships at home improved while people were in employment as a result of reduced contact with relatives and of participants' enhanced status. However, the Social Adjustment Scale indicated that participants had relatively poor levels of social adjustment compared with other populations.

In social activities. Several participants used their leisure time more fully than when unemployed. These people tended to be more resourceful and competent from the outset. Others who set out at a relative disadvantage changed little.

2. **Quality of Life**

At work. On the whole, participants considered Sprout was worthwhile as an experience in itself. They appreciated the chance to work in a supportive setting, where difficulties could be acknowledged openly and where they were treated as workers not patients. Sprout provided an opportunity for them to re-evaluate their capabilities and limitations.

However, the type of work was not to everyone's taste. Additionally the benefits of working at Sprout were partially offset by the fact that it was time-limited. Relationships with peers were

often severed and participants had less investment in the project than if employment had been permanent. Some participants had strong reservations about being associated with a project for the mentally ill.

In relationships. While at Sprout, participants remained largely dissatisfied with their social lives, both with friendships and activities.

Finance. Participants tended to be better off financially and felt they could manage better than when unemployed, but many were still dissatisfied with their standard of living.

Health and well-being. Most reported improvements in their health since starting work. A considerable number felt better about themselves and being employed gave them more confidence in their relationships with family and friends. Rates of admission to hospital decreased, although reliance on medication and out-patient care did not change. Moreover, GHQ scores suggested a high level of psychological ill-health among participants. Well-being scores increased only marginally and were possibly affected by the prospect of losing employment.

Long-term Goals

1. **Employment Opportunities**

Three months after leaving, the employment situation of most participants seemed little better than before they joined Sprout. Recent employment experience and an up-to-date reference were not sufficient to counteract participants' lack of skills, prejudice and the shortage of suitable jobs.

Participants received little professional help in their search for employment, although 1 in 3 had increased contact with welfare/

health workers after they left Sprout. Employment services were generally perceived as unhelpful and inaccessible.

2. **Independence**

There was little evidence that people became more independent. Firstly, use of welfare services had increased by follow-up. There were indications that needs for support were not always met, as services were not available or not perceived as appropriate. Secondly, unemployment led to a fall in income and reduced the choices open to people. Thirdly, while a number of participants moved into more independent accommodation during the study, this could entail high costs in terms of isolation and vulnerability. Half the group were still living with parents at follow-up.

3. **Integration into the Community**

Several participants developed interests or hobbies, joined classes or did voluntary work. However, most remained under-occupied and found no adequate substitute for employment. Many who made friends at Sprout lost contact with them after leaving.

4. **Quality of Life**

To the extent that Sprout strengthened people's commitment to work and impressed on them the advantages of working, unemployment was harder to bear than previously. Although a minority devised various means of occupying themselves, this was not seen as a viable long-term solution to unemployment.

In several cases relationships at home deteriorated. Increased contact with relatives and tensions in the home sometimes precipitated excessive drinking.

Health and well-being frequently deteriorated abruptly when people left Sprout. This emerged from participants' own accounts at interview and from the scales. In a minority of cases, however,

improvements occurring at Sprout were still in evidence at follow-up.

Variations in Outcome

Outcomes were diverse. Some of those who completed the year gained considerably from the experience and were subsequently able to withstand the adversities of unemployment, at least in the short-term. They seemed more able from the outset, in terms of health and of social and personal resources. Other completers struggled through the year despite substantial problems in their personal lives and this was in itself a remarkable achievement. They deteriorated abruptly on leaving employment and at follow-up were worse off than at first contact.

The findings reported so far refer to completers. Over half of those who started Sprout failed to complete. Despite this, many of them valued Sprout and thought it was worthwhile. Various reasons were given for dropping out: some found they were too unwell to cope with working at that time, others left to go to jobs elsewhere. The outcomes for non-completers demonstrated the lack of alternatives to Sprout. Few of those unable to work were attending day care. People who took other jobs generally soon found themselves unemployed again. As with completers, non-completers received little help with employment from professionals.

In view of the wide range of experiences within the completer and non-completer groups, it is difficult to arrive at definitive conclusions about comparative outcomes. Furthermore, such comparisons must be viewed cautiously, as mentioned earlier, given that the 2 groups were not randomly formed. Keeping these reservations in mind, there was evidence that non-completers began Sprout at a relative disadvantage and, as far as inactives were

concerned, this was still the case at follow-up. Interestingly, however, actives, who did not work the full year at Sprout, seemed in better health and more content at follow-up than resolutes, who had completed Sprout. Completers included a wider range of ability and health and appeared to change more in the course of the study than non-completers. However, neither group fared well in obtaining employment. With the notable exception of achievers, employment on the project did not appear to benefit participants after the left.

The Project's Effectiveness

The main achievement of the Sprout project was that it gave a group of disabled people the opportunity to enjoy the benefits of employment when it was unlikely that they would have found or coped with open employment. They welcomed the social contact, occupation and sense of satisfaction work afforded. They also had a very high regard for supervisors which suggested that the project staff were often managing to balance the demands of work and welfare and create a good working atmosphere and ethos.

Nonetheless, despite the hopes and intentions of those who founded Sprout and of its staff, the project did not achieve major change. It did not help people into employment, nor, on the whole, did it help them cope better with unemployment. Several reasons for this may be adduced.

It is conceivable that the study's findings were influenced by the methods used. The timing of interviews, for instance, may have affected participants' responses. At the first interview the latter were looking forward to employment, whereas at Time II they faced the prospect of imminent unemployment. This may have influenced their perceptions, as I have indicated in the text.

The late introduction of 3 of the scales meant that full baseline data were not available for all participants. As a result, the scales had limited worth as a means of gauging change over time. Nonetheless, they were valuable in that it was possible to assess participants' relative to normative data on GHQ and SAS, but not SES. In addition, the results of the scales for subgroups such as resolutes and achievers were informative in that they confirmed the differences in competence between the groups in the expected direction.

The use of both qualitative and quantitative methods was justified earlier on the grounds that they provide different perspectives on issues (Wallace and Rees, 1982). While participants believed Sprout was of benefit to them, the scales substantiate this to a limited extent only. It might be argued that the scales were not sufficiently sensitive to register change. However, the results of other studies which have used the same scales would refute this. Moreover, the scales did pick up intra-group variations and thus mean scores for the whole group masked a considerable range of scores.

There seems little evidence therefore that the methods used in the study simply failed to measure change. We now need to consider whether the Sprout findings seem surprising in the light of the results of other research. In the first place, the conclusions of the 2 previous pieces of research on Sprout are in line with the findings of this study. The MSC's Development F evaluation suggested that, while participants appeared to benefit whilst employed on projects, these benefits were short-lived and faded if people did not move on to other employment (MSC, 1984b). The pilot study found that a minority of participants - those who were more resourceful -

continued to thrive after leaving, but most gained little in the long-run from their Sprout experiences (Prentice, 1984).

Secondly, the studies on rehabilitation reviewed in Chapter 2 indicated that rehabilitation can rarely bring about lasting, generalised change in behaviour. Changes which do occur tend to be highly situation-specific, as in the study by Wing and Freudenberg (1966). In this, improvements in patients' workshop output and decreases in their symptoms were dependent on encouragement by staff and ceased when encouragement was withdrawn. The pattern of a stimulus-response effect rather than a learning effect also emerges in other research (Wing and Brown, 1970). I have argued, moreover, that it is erroneous to regard rehabilitation as a process of change in competence. Rehabilitation can provide opportunities for people to deploy existing skills as in the study by Miles (1972), but performance in rehabilitation and subsequently is largely determined by the attitudes and abilities people possess before they enter rehabilitation (Griffiths, 1974). Thus in the Sprout study, achievers, who set out from a more favourable position, retained their advantage, while those who were more disabled at the outset were the most resistant to change.

Thirdly, looking at what is known about the effectiveness of social work in general for all client groups, research evidence and practice experience both suggest that human behaviour is highly resistant to change (Sheldon, 1987). Programmes which have effected change have tended to be narrow in focus - concentrating, for example, on social skills - and to use specific techniques - such as behavioural methods. By contrast, Sprout had far-reaching, highly

ambitious goals and sought to achieve these by creating a normal working atmosphere.

The resistance of human behaviour to change assumes particular importance in rehabilitation: as noted earlier, the disabilities associated with mental illness are often chronic and, in such instances, rehabilitation is concerned with preventing deterioration and maintaining abilities. If evaluation gauges effectiveness in terms of improvement in competence, then protective functions may be regarded as of secondary importance. It is extremely difficult to evaluate the effectiveness of preventive efforts. The use of a control group becomes particularly valuable here in that it would indicate whether users of a service would have deteriorated had that service been withheld.

In the Sprout study it is important to look very carefully at outcomes. An undue concern with change would overlook the valuable protective role the project played for resolutes. Furthermore, a research approach which simply considered the 'effects' of a service might fail to recognise that the project contributed in important ways to non-completers, who were not exposed to the full 'dose' of 12 months at Sprout. There is also a risk that outcome research, which investigates the relationship between inputs and outcomes, might discount the quality of the experience itself. To avoid this, I have dealt at some length with participants' perceptions of the Sprout project and have drawn on the accounts of participants and, to a lesser extent, staff, to investigate Sprout's day-to-day operation.

In assessing the project's success, it seems necessary to take cognisance of the many difficulties that participants faced - such as family problems and recurrent episodes of mental illness - over

which the project had little or no influence. There were few non-hospital services to which people could turn for help and contacts with social work services were rare. These factors may well have affected outcome.

To conclude this review of the effectiveness of Sprout, a brief note is required on the question of causality. While it is reasonable to assert on the basis of evidence available that participants tended to experience an increase in well-being whilst at Sprout, we may not infer that working at Sprout caused this change. The absence of a control group precludes such assumptions since we do not know whether well-being did not simply improve fortuitously. In any case, even with a control group, it would be difficult to rule out the possibility that unknown variables unrelated to Sprout had 'caused' the observed changes. It seems particularly apposite to be cautious in view of the mental illness variable in the study as an uncontrollable factor which may have affected outcome. It may be that achievers who did well at Sprout were experiencing a natural remission in their illness and that their situations would have improved without access to Sprout.

The Implications for Policy and Practice

The final section deals with the implications of the Sprout study for policy and practice and considers 3 main areas: selection; rehabilitation and the Community Programme; and needs and services.

Selection

The study raises several issues concerning the selection of participants. It seems important to consider whether the project was using its resources optimally given:

(1) that Sprout appeared to have a greater impact on some than others;
(2) that over half of those recruited left prematurely.

Firstly, it might be contended that Sprout should give priority to those likely to derive most benefit (such as achievers). This matter arose in interviews with project staff who thought that some participants gained little from their year, mainly because they lacked motivation to use the opportunity. To be more selective in recruiting presupposes that potential achievers could be recognised and given priority. However, at the point of entry to Sprout, there were few characteristics which differentiated achievers sharply from other applicants. The 9 achievers came from varied backgrounds in terms of age, employment and psychiatric history. It was difficult to find a satisfactory explanation for their achievement which allowed for this diversity and yet which might have indicated how potential achievers could be identified among applicants. There was some suggestion that achievers had more positive attitudes and stronger commitment to work than other participants, but this was not conclusive. It is possible that the research methods used did not register differentiating factors.

Even if ways were found to select applicants more rigorously, this presupposes that potential achievers are more 'deserving' of the service than, say, resolutes, and overlooks the important function the project played in supporting more disabled participants.

At present, there are few alternative services available to Sprout participants. For the project to decide to specialise and concentrate on achievers, would only seem justifiable if alternatives were provided for applicants who were turned away.

Specialisation of function is likely to lead to neglect of certain potential participants, unless a full range of services exists, each with a specific function.

Secondly, it would be difficult to identify applicants who were unlikely to stay the course. While the comparison of completers and non-completers at Time I suggested that, as a group, non-completers tended to be more disabled, it was not possible to predict on an individual level who would stay and who would not. Completion/non-completion was not a straightforward matter of level of disability: non-completers were a heterogeneous group and some seemed as able and as motivated to work as some of the completers. Conversely, some of those who completed appeared less able than some who did not complete.

It was evident that participants were often uncertain about how their health would affect their ability to work. Sprout provided an opportunity to explore their capabilities and their limitations and it was only after a period in employment that some people realised they were too unwell to work. This self-assessment seems an important process for people to go through, although the cost to the project in terms of time and money is high. It may be that participants should undergo a short assessment course as a preliminary to employment at Sprout.

An undue concern with matching applicants to the project might imply that the project is immutable and overlook ways in which the project could be modified in line with changing needs. Mental health pressure groups suggest that one of the principles on which provision should be built is that services should be tailored to individual needs (SAMH, 1983; MIND, 1983b).

Since the research was carried out, Sprout has modified its criteria for selection. As a result of problems with filling places, the project decided to offer employment to unemployed people who had experienced 'emotional difficulties' rather than 'mental illness', as formerly. This move has drawn into the project's ambit people who have suffered from symptoms of mental illness, but have not necessarily undergone psychiatric treatment. It has attracted participants who, according to staff, are often just as disabled as previous participants. Thus, in practice, Sprout is becoming less specialised, retaining its rehabilitative function but extending the service offered to people not labelled 'mentally ill', who might be reluctant to use formal psychiatric services.

This denotes an important departure from the 'traditional' pattern of mental health provision focussed on patients and ex-patients. It has considerable implications for resources, since the number of people in the community who suffer from symptoms of mental illness but who are not in touch with psychiatric services is substantially greater than the number of identified psychiatric patients (Goldberg and Huxley, 1980).

Rehabilitation and the Community Programme

There were several ways in which Sprout's effectiveness as a rehabilitative project was affected by the conditions and rules of the Community Programme.

1. **Filling Places**

The turnover of participants at Sprout is faster than on most CPs. In Turner's study, 1 in 6 of CP participants left within 6 months, 1 in 3 within 10 months (Turner, 1984). At Sprout, 1 in 2 participants left prematurely. As a consequence, considerable time and effort had to be devoted to recruitment or the project lost

financially. The MSC makes no special allowances for the fact that projects such as Sprout might face particular difficulty in keeping places filled. The project is caught in a dilemma since it wants to appear efficient by having a high occupancy rate, but has to expend considerable efforts to achieve that.

2. **Eligibility Criteria**

The CP eligibility rules exclude certain categories of the population, such as most married women. In addition, the conditions of employment, such as the wage levels, are likely to deter other groups. Sprout is therefore not universally available or attractive to those who might benefit from participation. CP rules are said to reflect the government's concern to reduce the unemployment statistics. Without entering into that particular debate, the rules seem difficult to justify in relation to rehabilitation for the mentally ill: they appear to suggest that certain groups are more 'deserving' of rehabilitation and make questionable assumptions about the rights of different groups to receive employment assistance. The Sprout study has indicated that whether or not participants go on to employment subsequently, the year's experience has various social and health-related benefits and thus it seems unjust that access to such benefits should not be available to all who are mentally ill.

3. **Low Pay**

Financial gain was only one of the reasons why Sprout participants wanted to work. Indeed, some were prepared to work although they were scarcely better off than when on benefit. However, it does not follow that the low level of remuneration is justifiable. In practical terms, low wages impose a further constraint on people who already face numerous difficulties. In

social terms, low pay reinforces the inferior social status of mentally ill people and seems a further demonstration of their value in society's eyes.

4. **Staff Turnover**

It was difficult for the project to develop cohesion and expertise among staff when most were on short-term contracts. Sprout demanded perhaps more of its staff than 'ordinary' CP projects might, since staff required practical expertise in horticulture, an understanding of the effects of mental illness and human relationship skills. Staff indicated that it took considerable time to become familiar with the job and to feel they were fulfilling their role satisfactorily. The loss of experienced staff, who often did not choose to leave but were obliged to, seemed a waste of valuable resources.

5. **Part-time Work**

One of the features of the CP which was useful at Sprout was the availability of part-time employment. Participants could be introduced gradually to the demands of working and some continued on a 3 or 4 day week throughout their contract. However, the number of 3, 4 and 5-day places was fixed and it was not always possible to accommodate individual needs. Thus, someone whom staff believed could cope with working a 5-day week could only do so if a 5-day place was vacant. The MSC is proposing to make all CP places full-time. This is likely to make it difficult for many Sprout participants to continue and would prevent the project responding to individual needs.

6. **Time-limit**

The 12 month time-limit had far-reaching implications for the project and is worth discussing in detail. On the one hand, the

time-limit had certain advantages. Those who completed the year despite personal difficulties might not have persevered to the same extent if their contract had been open-ended. Certainly some participants derived a great sense of achievement from fulfilling their contract. In addition, a manager of the project observed that the time-limit relieved staff of the responsibility of deciding who to retain and who to dismiss. It was possible to retain participants who were unmotivated or disruptive in the knowledge that they would inevitably leave after 12 months. The enforced turnover also meant that the project did not become 'silted up' by more able participants leaving to work elsewhere and the less able having nowhere else to go. Other members of staff felt that the supportive environment at Sprout might encourage participants to remain dependent if they were able to stay indefinitely.

On the other hand, the time-limit had several adverse consequences. The constant turnover of participants disrupted relationships and meant people had to adjust continually to new faces. The fact that employment was temporary seemed in certain respects to diminish participants' interest and motivation. Some felt there was little point in putting effort into the work since they would not be around to see the results. Indeed, leaving seemed particularly painful for those who had invested most in the project. Participants and supervisors both felt that the expectations created during the year only led to disappointment subsequently. It may be that for a small number of people, participation on the project was actually harmful - it raised their hopes only to dash them again. This may be a particular cause for concern with people suffering from an illness such as manic-depression, whose moods are highly susceptible to change in any case.

At a more fundamental level, providing a service for a fixed period assumes a uniformity of need among participants. Evidently people could leave Sprout before 12 months, but there was no flexibility at the upper end to allow for the fact that some might require longer rehabilitation. If we assume that services are provided to meet identified needs (although need can be defined variously by different parties) then the provision of short-term services would seem to imply that the needs being addressed can be satisfied and are temporary. To meet more lasting needs, 2 different patterns of provision are conceivable.

1. A series or network of time-limited programmes forming a co-ordinated system so that participants leaving one programme can enter another;
2. Open-ended programmes provided indefinitely while need exists.

This may cast some light on the problems Sprout faces. Evidence suggested that most participants still required a supportive work environment at the end of their year. Yet the project was unable to offer them permanent sheltered employment; nor was it able to refer participants on to other programmes.

The 2 options - long-term, continuous programmes and short-term, linked programmes - are not exclusive, but complementary. The first option might be best-suited, for instance, to individuals who despite chronic disability could work in a sheltered setting. The second option might suit people whose needs are evolving and who require increasing or decreasing levels of support. Problems arise when one option is over-emphasised at the expense of the other. In the 1960s and 1970s it was found that movement through transitional accommodation, such as half-way hostels, became blocked because an unexpected number of residents proved incapable of greater independence. It seems important that provision should allow for

evolving needs and that the support provided should be the minimum necessary (MIND, 1983b). But on the other hand, to impose a nomadic way of life on often seriously disabled people, whereby they are passed from one programme to another, seems only to exacerbate the disruption associated with illness itself and may be positively damaging.

To conclude this section on rehabilitation and the Community Programme, the availability of funding through the CP enabled SAMH to provide short-term rehabilitative employment to a group who were unlikely to find work elsewhere. As argued earlier, the non-commercial status of Sprout may enable it to pursue its rehabilitative functions more fully than if it were self-financing. However, the sponsoring body, SAMH, is obliged to conform to the conditions and rules attached to the CP which are often at odds with Sprout's rehabilitative objectives. Maguire has remarked that the MSC has overwhelming power in its relationship with sponsors and has the potential to subvert the purposes of the latter (Maguire, 1986). The Sprout project seems to illustrate the tensions arising between the funding body, whose main concern would seem to be with filling places and reducing unemployment statistics (Finn, 1986) and the sponsoring agency concerned with developing services for, and improving the quality of life of the mentally ill. Thus, while it is encouraging to see the proliferation of projects like Sprout across Scotland, the 'strings' attached and the compromises entailed should not be overlooked. It seems quite unreasonable that the rules governing a rehabilitative project should be determined by a programme set up for an entirely different purpsoe. It is justifiable opportunism on the part of SAMH to use the Community Programme for rehabilitation - however, this is far from ideal and

at times hampers rehabilitative efforts. Perhaps the one characteristic of the CP which makes it ill-suited for rehabilitation purposes is its inflexibility. Rehabilitation is concerned with adjustment, adaptation and individualised services; the CP is in many respects a method of processing unemployed people in a uniform way.

Services and Needs

This section sets out to review current employment rehabilitation services in the light of the Sprout study and addresses 3 main issues in turn.

1. The extent to which services meet the needs of the mentally ill;
2. The legitimacy of special employment rehabilitation for mentally ill people;
3. The moral basis of employment for mentally ill people.

1. **The Extent to which Services Meet Needs**

(a) The Place of Work

The summary of outcomes at the beginning of this chapter illustrates that work can be very valuable in rehabilitation as an end in itself. The study highlighted that many mentally ill people want to work and, given the 'right' circumstances, are capable of working. Yet the dearth of employment opportunities means that the needs and wishes of many people who have been mentally ill are not being met. The research also called into question some of the more conventional assumptions about the type of work and work-setting best suited to mentally ill people and suggested that blanket recommendations are out of place.

The fact that the longer term outcomes, after Sprout, were not encouraging does not in itself justify abandoning work in rehabilitation. Similarly, to cite high unemployment as a reason for dropping work activities from the rehabilitation agenda appears

unsatisfactory, for while a return to **full** employment seems unlikely, forecasters indicate that unemployment will nonetheless fall. Thus, unless continued efforts are made to help mentally ill people gain skills and experience, they are likely to be excluded from jobs which become available.

It was evident in the study that the majority of participants lacked the personal and material resources to lead satisfying lives when unemployed. Indeed, many were discontented with their social lives whilst in employment. This seems to suggest that it is not helpful to polarise discussion and to debate whether rehabilitation should aim to equip mentally ill people for employment **or** for 'enhanced leisure'. The 2 seem complementary rather than exclusive. In general, leisure activities cannot substitute satisfactorily for employment, but are most rewarding as a contrast to work. A further argument for providing both work- and leisure-oriented rehabilitation is that, as we have seen, some people are not able to work and need alternative forms of rewarding activity and social contact. Ideally, rehabilitation seeks to assist people to attain their own social goals:

> It is not part of the legitimate aims of a rehabilitation service to impose particular objectives on people against their wishes. It is for the person concerned to decide which social positions are his or her priority.
> (Watts and Bennett, 1983, p.7)

(b) The Nature of Work Available

There has been a tendency for rehabilitation to emphasise manual work and this was one of the criticisms levelled against ERCs by clients in Cornes' study (Cornes, 1982). A substantial number of Sprout participants also disliked the nature of the work available. Given the importance of involving participants in their own

rehabilitation, it seems necessary to offer a range of work to engage interest. The staff at Sprout believed that the project provided basic experience of the disciplines of work in general, which was beneficial irrespective of whether someone wanted a career in horticulture. However, participants who dislike the work may not see any purpose in continuing. And even for those interested in horticulture, experience at Sprout may not be transferable. Not only is agriculture/horticulture a contracting employment sector, the methods used in most businesses are far removed from the relatively small-scale organic production undertaken at Sprout.

It is interesting to note therefore that SAMH is currently setting up an employment project offering training in office technology. This has the advantage of equipping people with marketable skills. At the same time, there also seems some merit in giving people experience of different types of work. It was striking in several cases at Sprout that people who had previously done quite different work - from engineering to translating - discovered they enjoyed gardening immensely. It might be possible to devise a system of linked projects offering varied types of work, which allowed participants to move among them and identify where their interests lay.

Earlier, I questioned the received wisdom concerning the work of which mentally ill people may be capable, suggesting that it is misleading to generalise about whether or not they should be encouraged to take on low-key, 'unpressurised' jobs. In this vein, it is rare to hear of a rehabilitation programme which builds in opportunities for participants to exercise increasing levels of responsibility for example. While Sprout did so, by offering more able participants 5 days work a week and by devolving tasks, the

project's scope was limited, mainly by CP rules on wages. If employment for the mentally ill is to be more than tokenism, then people need assistance not simply to obtain a job but to obtain a job of reasonable quality. Exercising responsibility is a prospect which may arouse considerable anxiety in people vulnerable to stress. However, one of the lessons of the Sprout study was that participants often discovered unexpected abilities in themselves, given appropriate opportunities. There is a strong argument for this sort of 'testing out' - exposing people to new demands - in a supportive situation where difficulties can be reviewed as a matter of course.

(c) Help with Transitions

The Sprout study highlighted that at certain points participants faced major transitions and had to make decisions with little guidance or support. Firstly, those who left the project prematurely often appeared to do so abruptly without discussion. Completers also frequently thought of resigning and it was not clear that they discussed their reasons with project staff. This seems surprising perhaps, given that completers appeared to enjoy close and trusting relationships with supervisors. However, participants may have found it difficult, understandably, to discuss their intentions with staff as this might suggest they were not keen to work. In addition, if people dropped out soon after starting, supervisors had limited opportunity to build up a relationship with them.

Supervisors expressed concern that participants tended to interpret feelings of anxiety or depression as symptoms of their illness, rather than as normal reactions to a stressful situation. The stress associated with starting a new job may therefore have

seemed especially alarming to new participants. Although staff endeavoured to reduce the stress of 'being new' and to discuss these matters with recruits, much also depended on participants' willingness to acknowledge problems. The tension between creating a 'normal' work environment and being supportive and sympathetic to participants was difficult for supervisors to work with at times and participants may also have found it disconcerting.

Secondly, those who dropped out were often unsure about their decision and yet apparently had no one to turn to for advice. The project generally intimated that they could re-contact staff there if they wished to re-apply, but lacked the manpower to offer more proactive follow-up. The prospect of further 'failure' meant non-completers were reluctant to try again, yet there were several instances in the project's history of people returning to complete their contracts satisfactorily.

Thirdly, when people completed their year they were largely thrown back on their own efforts to find employment. Contact with formal services tended to be restricted to health services and not related to employment or training. It seemed that participants were prepared to accept any job offered to them, although this could lead to distress and eventual disappointment. There was little indication that participants had the opportunity to discuss in advance the suitability of a particular job. Finally, those who did find other jobs were given little or no support to help them settle in and retain the job.

The overall significance of this evidence is alarming. We saw earlier that participants found it difficult to judge their own abilities accurately while at Sprout. Floyd et al (1983) observed in their study that very few people they talked to had received

vocational guidance which took individual abilities and interests into account. That is not to say that guidance/counselling would prevent people leaving Sprout or job placements breaking down. It would, however, enable people to make more informed choices.

Taken together, these factors would seem to suggest a need for help to be offered on a systematic basis to participants during and after their time at Sprout. The task of helping people to recognise both abilities and limitations has inherent difficulties since eagerness to find work and to impress may lead people to disguise problems. It seems important therefore that vocational guidance should be offered by a disinterested 'third party' who is not affiliated with any particular employing agency, such as Sprout or with the formal employment services, but who is conversant with employment, training and educational opportunities in the area. This might be provided by a voluntary body in the way that some associations for mental health currently offer a counselling service to assist with a range of personal and practical difficulties.

At present, employment services are moving in the opposite direction. There is no arrangement for Disablement Resettlement Officers to 'pick up' participants leaving Sprout. Facilities such as Job Clubs and Restart are not immediately available to CP leavers, who have officially just become unemployed. While it is encouraging that the MSC's most recent policy review places a strong emphasis on training (MSC, 1988), it remains unclear to what extent proposed changes will take cognisance of the particular needs of disabled people and the mentally ill among them.

Existing employment services emphasise placing people in employment and pay much less attention to how long placements last. Studies such as those by Floyd et al (1983) and Wansbrough and

Cooper (1980) demonstrate that for the mentally ill, finding employment is only half the battle and the second crucial stage is retaining it. Wansbrough's action-research project illustrated the value of an intermediary agent liaising between employer and employee. Thirteen people were placed in sheltered positions in open employment, using several different employers. A special supervisor was appointed for the project and acted as an advocate for the employee in liaising with the employer. This proved to be the sine qua non for successful placements. The model might also be applied to assist mentally ill people in open employment and might help bridge the gap between rehabilitation and open employment (Wansbrough, 1980).

(d) The Lack of Employment

Perhaps the biggest gap in provision which directly affected Sprout participants was the absence of long-term sheltered employment. There is currently no reliable measure of the need for sheltered employment among the disabled in general, in view of the incomplete state of the register of disabled people (National Audit Office, 1987). However, the results of the Development F project suggested that sheltered employment could have a place in relation to the mentally ill: many of those leaving projects were not considered capable of open employment and the benefits of working on the projects faded when no alternative occupation was forthcoming. At Sprout, 1 in 3 participants was considered by supervisors to need sheltered employment. Some of the general issues relating to sheltered employment were mentioned earlier in Chapter 3. Wansbrough has observed that it is mistaken to regard sheltered work for the mentally ill as transitional to open employment, since many people - but by no means all - require long-term placements in a sheltered

setting (Wansbrough, in Herbst, 1984). One of the major difficulties in establishing sheltered workshops, groups or placements, is the lack of lead from government departments and local authorities. Workshops have difficulty obtaining contracts and outlets for their goods and receive little support from the public sector (see Lonsdale, 1985, Chapter 8, for a fuller discussion). The action research project mentioned above found public sector employers were more reluctant than private employers to provide suitable vacancies (Wansbrough, 1980). While 13 people were placed in work for the duration of this project, no vacancies could be identified for 11 other people deemed ready for work. Unless sheltered employment provision is made available to the mentally ill in Scotland, employment rehabilitation services will remain incomplete and the dearth of sheltered facilities is likely to negate the value of projects such as Sprout for many people. Active encouragement by government departments would seem a crucial step in this direction.

There was also a dearth of opportunities in open employment. Demand for the labour which most Sprout participants could offer did not exist. Thus, while we should not underestimate the disabilities of Sprout participants, their lack of success in the employment market was a failure of demand as well as of supply. It is perhaps illustrative of the employment situation in Edinburgh that Sprout could recruit supervisors to do a highly demanding job which offered no long-term security and was poorly remunerated. The government's recent proposals to give more emphasis to training in its special employment measures (MSC, 1988) imply that what is required is an improvement in supply when equal if not greater attention may be needed to improving demand.

Having looked at the extent to which existing services meet the needs of mentally ill people, we turn now to consider the legitimacy of special services for this group.

2. The Legitimacy of Special Rehabilitation Services for Mentally Ill People

Services to rectify the disadvantaged labour market position of this group are likely to reflect underlying assumptions about the causes of disadvantage. The rationale behind current policy and provision appears to be that disability (either mental or physical) is the cause of employment difficulties and that the effects of disability constitute 'special needs' which differentiate the disabled from other unemployed people and thus legitimate the provision of special services.

Proceeding on this basis, 'mental illness' may be a relevant category in policy terms insofar as people with various mental disorders might be said to have needs in common which are not the same as the needs of, for example, blind people. However, existing provision is not logically consistent with this premise. In the first place, services do not recognise that different disabilities generate different needs. The review of employment rehabilitation services in Chapter 3 suggested that provision designed for people with physical disabilities is often ill-suited to mentally ill people. Secondly, the ends and means of policy are contradictory in that the MSC aims to integrate disabled people into mainstream employment, but in doing so it segregates them both conceptually and practically (Mair et al. 1981).

To construe disability as a fixed characteristic of an individual is to overlook the influence of contextual factors. As I have argued, a central tenet of rehabilitation theory is that a

person's ability to perform roles is a function not only of capability, but also of the environment. For example, the fact that someone bears the label 'mentally ill' may affect their life chances by eliciting negative responses from others. The Sprout project recognised this by providing leavers with references which omitted any allusion to the fact that participants had a mental illness. Moreover, the difficulty mentally ill people encounter finding employment may, as I have suggested earlier, have as much to do with the way employment is organised and with the types of jobs available as with individual capability. Analysing employment difficulties in terms of social structures and processes has substantially different implications for policy and provision. It is not sufficient to target services on disabled individuals without also acting on the wider social factors involved.

Possibly a more convincing argument for special services for the mentally ill is as a means of promoting the interests of this disadvantaged group. This leads us into the third issue for consideration: the moral basis of employment for mentally ill people.

3. The Moral Right to Work

The relationship between the employment situation of the disabled and the overall level of demand for labour was recognised some 40 years ago by Beveridge.

> The state of the labour market has a direct bearing on the rehabilitation and recovery of injured and sick persons and upon the possibility of giving to those suffering from partial infirmities ... the chances of a happy and useful career. In time of mass unemployment, (they) feel no urge to get well for idleness. On the other hand, in time of active demand for labour as in war, the sick and the maimed are encouraged to recover so that they may be useful.
> (Beveridge Report, 1942, para. 440)

The fact that the labour market position of the disabled is not fixed, but varies according to the overall employment situation is a further indication that employment disadvantage is not simply a matter of individual disability. It would seem that the mentally ill have little claim to employment as an inalienable right, but are granted access to work when 'extra' labour is required. The Department of Employment has chosen a 'softly-softly' approach and has shown itself reluctant to impose sanctions to enforce compliance with the quota system. Such tactics are in line with the current administration's policy of non-interference with market forces. However, it is far from clear that the interests of mentally ill people are furthered in this way.

It might be argued that using mental illness as a basis for positive discrimination only emphasises sufferers 'undesirable difference'. Since employment is a role we tend to associate with normality, it may seem anomalous to allocate places on an employment project on criteria related to mental health/illness, rather than exclusively to employability. However, those who feared the stigma of being associated with special projects like Sprout, could apply to regular CP projects. It was not clear how many Sprout participants had done so, although it was evident that many regarded Sprout as their only chance of employment. A project specifically for mentally ill people offered them an employment opportunity they would not otherwise have had and this seems to be an important argument in favour of special provision. At the same time, the Sprout study indicated that the common denominator of mental illness disguised a diversity of educational levels and employment backgrounds. Abilities varied greatly from those incapable of working to those regarded as ready for open employment. It would thus be erroneous to

assume that mentally ill people have homogeneous needs and special provision would have to take cognisance of variations by offering a range of services.

Concluding Comments

To conclude this final section, we need to draw together the practical implications of the above discussions. I have argued that existing services do not engage directly with the difficulties mentally ill people face. Nor is it simply a matter of extending current provision since there would seem to be a case for reviewing the underlying rationale.

Firstly, a comprehensive range of employment rehabilitation services is required which takes account of the diverse needs of mentally ill people. Projects like Sprout have a very broad function at present as few alternative services exist. The separate elements of an 'ideal' service would include:

- flexible rehabilitation facilities of varying duration and offering work of different types and levels of complexity;
- long-term sheltered employment;
- support to people moving into open employment.

In parallel, mentally ill people would benefit from vocational counselling and from assistance to look for work. The current tendency to offer time-limited and discontinuous help to the unemployed is particularly ill-suited to people with a mental illness.

Secondly, action is required on a wider social level to counteract the prejudice this group face in finding employment. Changing public attitudes is notoriously difficult. However, small-scale projects - such as that researched by Wansbrough (1980) - which place people with ordinary employers and provide special back-up, might have a ripple effect. Such practices could be encouraged if

the government were to take a lead by promoting sheltered placements within its own departments and by offering incentives to other employers to do so. Additionally, it seems important to consider ways in which the structure and content of jobs might be modified so that they accord more satisfactorily with the needs and abilities of mentally ill people.

Finally, employment rehabilitation is only one part of a comprehensive rehabilitation service. We saw that the effectiveness of the Sprout project was limited by the fact that many participants faced considerable difficulties outside work and, in many cases, were receiving little support from health and welfare agencies. The dearth of other resources meant that, at times, the project's boundaries as an employment rehabilitation programme became blurred and staff were overwhelmed by the demands of participants. Ideally rehabilitation needs to proceed on numerous fronts and to include assistance with accommodation, social activities and relationships, as well as employment, if those involved are to be enabled to lead satisfying lives.

Yet, despite Sprout's limitation, one observation must be made. Given the present under-developed state of community mental health services in Scotland, Sprout participants might be regarded as fortunate to have had access to any form of community-based rehabilitation. One man described the project's importance thus:

> Before Sprout ... I didn't have any hope of anything coming along. I felt I'd just fade away and die. You just think that once you could get a break.

APPENDIX A

TIME I. INTERVIEW SCHEDULE (All participants)

Starting on Sprout

1. How did you come to hear about Sprout?

2. What have you been told about the scheme?

3. Did you know that Sprout is for people who suffer from their nerves?

4. **IF YES** Did that make it harder or easier for you to apply?

5. **IF NO** What do you think about that now?

6. What made you decide to apply?

7. Here are some different reasons for joining Sprout. Which are the three most important reasons for you?

   to occupy my time
   money
   to learn new skills
   to pursue an interest in gardening
   status
   to meet new people
   as a stepping-stone
   a second chance

8. How do you feel about starting now?

Views of significant others

9. What do your family say about your joining Sprout?

10. And your friends?

11. Do you have any worries about starting?

Self assessment

12. How do you think you will cope with working on Sprout?

    very well
    quite well
    alright
    with some difficulty
    with a lot of difficulty

13. Is that how things generally tend to be? (Probe: they work out well/OK/badly?)

Alternatives to Sprout

14. What would you have done if it had not been possible for you to join Sprout?

15. How would you have felt?

16. Have you been looking for other work?

17. Has anyone been helping?

18. If so, who?

19. How did you get on?

20. Did you have any interviews?

21. Were you hopeful that something would come your way?

22. What sort of job were you looking for?

NOW I'D LIKE TO ASK A FEW THINGS ABOUT WHAT YOU'VE BEEN DOING IN THE PAST YEAR

23. Are you employed or unemployed just now?

24. If unemployed, how long have you been out of work?

25. When you think about being unemployed, how does it make you feel?

26. Is that how you tend to feel about things generally?

27. What is the worst thing about being unemployed?

28. Would you say that having a job is important to you? Why?

Past employment

29. What kind of work have you done in the past?

Type of work	Time in job	Reasons for leaving

30. Do you think any of the things you did in that job/these jobs will be of use to you on Sprout?

31. What is the longest time you've been in one job?

Hospital treatment in last year

32. Have you been admitted to psychiatric hospital over the past year? YES NO

33. How long were you in for?

34. Have you been treated as an out-patient? YES NO

35. As a day patient? YES NO

36. For how long?

37. Is your doctor treating you with any drugs at present?

38. Do you take them?

39. Are you having any other treatment?

Life events

40. Have there been any major worries or upsets in your life this last year?

41. Has anything good happened?
Any changes which made you feel happy?

42. What has this year been like for you?

(Present Life Events Inventory)

NOW SOME QUESTIONS ABOUT WHERE YOU LIVE AND ABOUT YOUR FAMILY

43. What age are you?

44. What is your marital status?

45. How long have you been married/separated/divorced?

46. Do you have any dependents?

47. What age were you when you left school?

48. Do you have any qualifications?

49. What type of accommodation do you live in?

50. What are the best things about living there?

51. And the worst things?

52. How long have you lived there?

53. Where did you live before that?

54. For how long?

55. How satisfied are you with your present living situation?

very satisfied
satisfied
half and half
dissatisfied
very dissatisfied

56. Do you live alone?
IF YES Proceed
IF NO Go to Question 60

For people living alone

57. Is there anyone you spend a lot of time with?
Who?

58. How do you get on with them?

59. What is it like for you living alone?

Others

60. With whom do you live?

husband/wife	(Proceed to Question 67)
parents	(Proceed to Question 61)
relatives - specify	" " " "
friends	" " " "
share flat/house with others	" " " "

Those living with relatives/friends/other

61. Specify who else lives in same accommodation

62. Are they employed?

63. What is good about living with ...?

64. What is bad about living with ...?

65. What's it like at home/the hostel?
(What's the atmosphere like?)
Why?

66. How do you get on with each person?

Those living with spouse

67. Does your husband/wife work?

68. What is it like at home?
Atmosphere?
Why?

69. How do you get on with your husband/wife?

70. How would you describe your relationship?

good
satisfactory
poor

71. Can you see this changing in any way?

Those with children

72. Do you have any difficulties with your children?

For all respondents

73. How much contact do you have with your parents?
How frequently?

74. Do you do things together?

75. Are you happy with this?

76. Would you like to see them more/less/the same amount?

77. When you're with your mother or father, do you ever feel like you're really on your own?

For all

78. How much contact do you have with brothers and sisters?

79. To whom are you closest in your family?

80. Is there anyone you can confide in?

81. Is there anyone you can turn to in a crisis?

82. All things considered, would you like your family life to

continue much the same?
change in some ways - which?
change in many ways - which?

83. What was it like at home when you were a child?

84. With whom did you live?

natural parents
foster parents
adoptive parents
in an institution
other (please specify)

85. Brief history of sequence of events if childhood was disrupted

86. Were your parents separated/divorced? YES NO

87. **IF YES** What age were you when this took place?

88. To whom did you feel close - if to anyone - when you were a child?
Expand

I'D LIKE TO ASK ABOUT HOW YOU SPEND YOUR TIME AND ABOUT WHAT INTERESTS YOU HAVE

89. What is a typical day like for you?

90. Are you happy with how you spend your time?

91. Was it different before you became ill?

92. Where do you spend your time?

93. With whom?

Activities

94. Do you enjoy any particular hobbies or sports?

95. How much time do you spend on these?

96. Have your interests changed over the years?
(Probe : different interests,
change in time spent on hobbies?)

97. Why do you think this is?

98. Do you belong to any clubs or organisations?

99. Would you like to do more?

100. What stops you?

Friendships

101. How many good friends would you say you have?

102. Are you happy/worried about this?

103. How often do you see them?

frequency
regularity

104. Did you talk to anyone yesterday?
Whom?

day before
day before that

105. Is that usual?

106. Do you like meeting new people?

107. Do you go to places where you can meet new people?

108. Would you say you make friends

with difficulty?
quite easily?
easily?

109. What kind of a mixer are you?

good
poor

110. Do you get on better with

people of your own sex?
people of the opposite sex?
no difference?

111. How do you get on with boyfriends/girlfriends?

112. What kind of a temperament would you say you have?

113. How do you get on with your neighbours?

NOW SOME THINGS ABOUT YOUR FINANCIAL SITUATION. ANYTHING YOU TELL ME IS STRICTLY CONFIDENTIAL AND WILL NOT BE USED TO AFFECT ANY CLAIMS YOU MAKE WITH THE DHSS

114. How do you manage on the income you have?

with great difficulty
with some difficulty
alright
quite well
very well

115. What do you usually spend your money on?

116. How good are you at budgeting?

117. How do you go about this?

118. Are you short of money just now?

119. Do you ever have to go without things you need because you haven't enough money?

food
fuel
heat
light
clothes
presents etc.

120. What do you do if you run out?

121. Do you have any debts?

(As appropriate)

122. Does your partner?

123. Do you have any savings?

124. Do you tend to worry about getting into debt?

(As appropriate)

125. Does your partner?

126. How would you describe your standard of living?

very satisfactory
satisfactory
so-so
unsatisfactory
very unsatisfactory

127. Are you claiming any benefits?
If so, which?

128. Are you better/worse off than a year ago?

129. Can you say why?

FINALLY SOME QUESTIONS TO DO WITH YOUR HEALTH

130. How would you describe your general state of health now?

Let´s go back into the past briefly

131. Have you had any serious accidents since you were young?

Age Nature of accident

132. Were you admitted to hospital as a result? YES NO

Length of stay

133. Apart from the usual childhood illnesses, have you had any serious illnesses since you were young?

Age Nature of illness

134. Were you admitted to hospital as a result? YES NO

135. Did this happen more than once?

136. What sort of hospital?

general
psychiatric
don´t know

If psychiatric

137. Can you tell me if you were

a voluntary patient?
a compulsory patient?
don't know?

138. How long were you in?

Admission (year)	Type of hospital	Length of stay	Compulsory/ voluntary

139. Were you ever treated as a day patient?
out patient?

140. Did this happen on more than one occasion?

141. What sort of hospital?

general
psychiatric

142. How long did your treatment last?

LET'S TURN NOW TO MORE RECENT EVENTS

For those who have been in-patients

You were last admitted to hospital in .....

143. What effects did this have on you?

144. Your family?

145. Your friends?

For those who have been out-patients/day patients

When you were being seen as an out-patient/day patient in .....

146. What effect did this have on you?

147. Your family?

148. Your friends?

All respondents

149. Were you working when you became ill?

150. What happened to your job?

151. Was a name given to your illness?

152. Can you say why you became ill?

153. How much would you say your illness affects your life now?

154. In what ways?

155. Would you say your health affects your work?

156. In what ways?

157. Have you ever had problems with?

drink
drugs
gambling

158. Have you ever been in trouble with the police because of

drink?
drugs/glue sniffing?

159. When?

160. What was that like for you?

161. Has

drinking
taking drugs
sniffing glue
gambling

ever brought you into contact with a social worker?

162. When?

163. What was that like for you?

164. Is this still a problem for you?

165. Would you say you were

well?
unwell?
on the mend?

166. How do you feel compared with a year ago?

167. How do you think things will be in the future?

168. Is there anything else you'd like to add, or any questions you'd like to ask me?

(Present Scales)

TIME II. INTERVIEW SCHEDULE (Completers only)

Experiences at Sprout

1. You're coming to the end of your time at Sprout.
   What does that feel like?

2. Looking back over your time here,
   what's it been like?

3. How much have you enjoyed working here?

   a great deal
   quite a lot
   half and half
   not really
   not at all

4. What are the good things about working here?

5. What are the bad things?

6. What sorts of things have you been doing here?

7. Was this new work for you?

8. What tasks have you especially liked?
   Why?

9. What tasks have you disliked?
   Why?

10. Have you had specific responsibility for a particular
    task or part of the garden?

11. Were you happy with that or not?

12. Did the work you were doing ever bring you into contact
    with the public?
    How was that?

Work programme

13. What has your work been like?
    How well do you manage to do the work?

    very good
    good
    average
    not so good
    poor

14. Are you satisfied with your own standard of work?

15. Do you worry about doing things wrong?
    What sort of things?

16. Do you prefer to work with a supervisor close to hand or not?

17. Can you say why?

18. If your supervisor could change one thing about your work, what would it be?

19. Have you learned any new skills here? (Specify)

Commitment to work

20. What, for you, are the good things about working, rather than being unemployed?

21. What, on the other hand, are the good things about being unemployed?

Expectations

22. Can you tell me what made you want to work here? (Prompt: what you hoped for?)

23. Has it worked out like that?

IF NO Why not?

24. What have you got out of working here?

25. Has Sprout been as you expected? In what ways?

26. How does it compare with other jobs you've done?

27. Would you consider applying for a second year here? Why?

Relationships with peers

28. What's it been like for you working with the other people here?

29. How do you get on with the other workers?

30. What are the good things about the workers here?

31. What are the bad things?

32. What's the atmosphere like among you all? Why?

33. Do you prefer to work on your own or with others?

34. Do you find it easy to join in conversations?
Why?

Relationships with supervisors

35. What are the supervisors like here?

36. How do you get on with them?

37. Have you learned anything from them?

38. Do you feel you can ask them things?

39. If you were worried about something, would you feel able to discuss it with a supervisor?

40. How important are the supervisors to the project?

41. Do you think they should do their job differently?
In what ways?

42. How have you found the assessments with supervisors?

43. Have they been useful?
Why?

44. What do the supervisors think about your work?
Do you agree?

Management

45. How do you get on with the manager?

46. Do workers have a say in how the project is run?

47. What do you think about the way the project is run?

48. Are there any changes you'd like to make?

Motivation

49. Have there been times when you've felt less interested in Sprout?
At what stage?

50. Have there been times when you've felt like quitting?
At what stage?

51. Do you think you have achieved anything by being here?

52. What does your family think about you being here?

53. And your friends?

54. How do you feel about your job here when you're on holiday/days off?

55. Have you had any major difficulties here?
If so, what?

56. Any major difficulties at home?

57. Do any of the following make it difficult for you to work?

drink
drugs
tobacco
sleep
food

IF YES

58. How often?

59. How difficult?

Overall

60. What are the best things about Sprout?

61. What are the worst things?

62. How would you say Sprout has been?

very satisfactory
satisfactory
half and half
unsatisfactory
very unsatisfactory

63. Has your life changed at all since you started here?
In what ways?

64. Have you learned anything new about yourself since working here?

Person and setting

Accommodation

65. Have you moved to different accommodation since you started at Sprout?

IF YES

66. Can you say why?

67. If so, where do you live now?

privately rented house/flat
local authority house/flat
hostel
own flat/house
other

68. How satisfied are you with your accommodation?

very satisfied
satisfied
so-so
dissatisfied
very dissatisfied

69. Who are you living with?

parents
partner
friends
other

70. What's the atmosphere like at home?

IF NO

71. You live with .....
(parents/partner/friends/other)
Have things at home been different since you started at Sprout?
In what ways?

72 Do you have any difficulty doing any of the following things around the house, or in your daily life, without help?

shopping
cooking
laundry
housework
keeping yourself clean and tidy
household repairs
going out
understanding and handling bills
dealing with maintenance people

73. Do you get enough help with these?

74. If help is given, by whom?

75. Was it different before you began work at Sprout?
(Specify for each)

Before Now

76. Where do you have your main meal?

home
cafe etc.
work
relatives, friends
other

77. When you eat at home, do you usually prepare your own meals?

    never
    sometimes
    always

78. What is the reason for this?

Family and personal relationships

79. How do you get on with people at home?
    (Ask re each in turn)

80. Since starting at Sprout, do you see your parents

    more?
    less?
    the same?

81. Since starting at Sprout, do you see your brothers/sisters

    more?
    less?
    the same?

82. How would you describe your family life now?

83. Who would you say you're closest to?

84. Is there anyone you can confide in?

85. Is there anyone to help you on a day-to-day basis if you need it?

86. Is there anyone you can turn to in a crisis?

87. Do you see your good friends more/less/same since you started work?

88. How many good friends did you see last week?

89. Have you made any new friends at Sprout?

90. Do you see them outside work?
    How often?

91. Have you started seeing a new boy/girlfriend since you began work here?

92. If so, how are things going between you?

93. Are you content with the friends you have just now?

Hobbies and interests

94. How do you spend your time when you're not working?

95. Do you spend more time or less time on hobbies now that you're employed?

96. Have you taken up any new hobbies or interests?

97. Have you joined any clubs or organisations?

98. Would you like to do more?

99. What stops you?

Finance

100. What has it meant for you having a wage packet?

101. How do you manage on the income you get?

great difficulty
some difficulty
alright
quite well
very well

102. Are you short of money just now?

103. Do you have any debts?

104. Do you have any savings?

105. Would you say you're better/worse off now than when you were unemployed?

106. How would you describe your standard of living?

very satisfactory
satisfactory
so-so
unsatisfactory
very unsatisfactory

Health

Since starting at Sprout

107. Have you been admitted to hospital as an in-patient?

Instance	Hospital	Length of stay	Voluntary/ compulsory

108. Have you been treated as an out-patient? YES NO

For how long?

109. Are you receiving treatment from your doctor just now?

drugs
other

110. Have there been any major worries or upsets in your life since you started here?

(Present Life Events Inventory)

111. How would you describe your general state of health now?

well
unwell
on the mend

112. Does your health affect the way you work?
In what ways?

113. How do you feel compared with before you started work here?

Future

114. What plans have you got for when you leave Sprout?

115. Have you done anything about getting another job?

116. Has anyone been helping?

117. Do you think working at Sprout will help you get a job in future?

118. How do you think things will be in the future?

119. How do you see yourself coping?

very well
well
alright
with some difficulty
with a lot of difficulty

120. Do you think anything you've gained here will be of use in the future?

(Present Scales)

TIME IIb. INTERVIEW SCHEDULE (Non-completers only)

1. Did you work at Sprout at all?

IF NO

2. Can you say why you did not take up the place offered you?

IF YES

3. How long did you work there?

4. Can you say why you left?

All

5. Are you working at present?

IF YES Continue at 7

6. **IF NO** Have you worked at all since Sprout?

IF YES Continue

IF NO Proceed to Question 20

Previous jobs

7. How many jobs have you had?

8. How long were you in each?

9. Why did you leave?

Most recent/current job

10. Nature of job?

11. When did you get this job?

12. Can you tell me how you got this job?

13. Why did you take it?

14. What are/were the best things about the job?

15. The worst things?

16. Have you had/did you have any major difficulties at work?

17. How do/did you get on with the other people there?

18. How do/did you manage the work?

19. How does/did this job compare with working at Sprout?

20. What are the good things about working rather than being unemployed?

21. What are the good things about being unemployed rather than working?

22. When you think about being unemployed, how does it make you feel?

Those currently unemployed

23. Since your contact with Sprout, have you been looking for a job?

IF NO Proceed to 31

IF YES

24. What sort of work?

25. What have you been doing to find a job?

26. How did you get on? (Number)

Applications	YES	NO
Interviews	YES	NO
Job offers	YES	NO

27. Job offers - what did you do about this/these? Why?

28. Has anyone been helping you get work? Who?

29. Would you say you were having difficulty getting a job?

30. Why do you think this is?

Accommodation

31. Have you moved to different accommodation since you applied to Sprout/since we last met?

32. **IF YES** Can you say why?

33. Where do you live now?

34. How satisfied are you with your accommodation?

satisfied
so-so
unsatisfied

35. Who are you living with?

parents
partner
friends
others
alone

36. What's the atmosphere like at home?

IF NO

37. You're still living with (parents, partner, friends, other) Have things been different at home in any way since I last saw you? (about a year ago)

38. Do you have difficulty doing any of the following things around the house or in your daily life?

shopping
cooking
washing/laundry
housework
keeping yourself clean and tidy
going out
household repairs
understanding and handling bills
dealing with maintenance people

39. Do you get enough help with these? (specify each one)

40. If help is given, by whom?

41. Do you manage these things

better than when I saw you last?
not so well as?
about the same?

42. Where do you have your main meal?

home
cafe or pub
work
relatives or friends
other

43. When you eat at home, do you usually prepare your own meals?

    never
    sometimes
    always

44. What is the reason for this?

Family and personal relationships

45. How do you get on with people at home?

46. Compared to when I saw you a year ago, do you see your parents more/less/the same?

47. Your brothers/sisters?
    Your good friends?

48. How would you describe your family life now?

49. Who would you say you're closest to?

50. Is there anyone you can confide in?

51. Is there anyone to help you out on a day-to-day basis if need be?

52. Is there anyone you can turn to in a crisis?

53. How many good friends would you say you have?

54. How many did you see last week?

55. What sort of things do you do together?

56. Are you content with the friends you have just now?

    (Where appropriate)

57. Have you made any new friends at work/place of occupation?

58. Do you see them outside work?
    How often?

59. Have you started seeing a new boy/girlfriend since this time last year?

60. If so, how are things going between you?

Leisure activities and interests

Those in work

61. How do you spend your time when not at work?

62. Do you spend more or less time on hobbies now that you're employed?

Those not in work

63. How do you spend your time?
What's a typical day like for you?

64. Are you happy with that or would you like things to be different?

65. Have you taken up any new hobbies or interests?

66. Have you joined any clubs or organisations?

67. Would you like to do more?

68. What stops you?

Finance

Those in work

69. What has it meant for you having a wage packet?

All

70. How do you manage on the income you're getting?

great difficulty
some difficulty
alright
quite well
very well

71. Are you short of money just now?

72. Do you have any debts?
Do you have any savings?

73. How would you describe your standard of living?

very satisfactory
satisfactory
so-so
unsatisfactory
very unsatisfactory

Health

74. Since I last say you have you been admitted to hospital as an in-patient?

Instance	Length of stay	Voluntary/ compulsory

75. Have you been treated as an out-patient?

76. For how long?

77. As a day patient?
For how long?

78. Are you receiving treatment from your doctor just now?

drugs
other

79. Have there been any major worries or upsets in your life over the last twelve months?

(Present Life Events Inventory)

80. How would you describe your general state of health now?

well
unwell
on the mend

81. How do you feel compared with a year ago?

Future

82. Have you got any plans for the future?

83. Would you need any help to achieve these?
What sort of help?

84. How do you think things will be in the future?

85. How do you see yourself coping?

well
alright
with difficulty

Overview of Sprout

86. Looking back, do you regret not having worked at Sprout for a year?

87. Would you consider applying there again?

88. If you could change things at Sprout, what would you do?

89. Do you think you gained anything from working there?

90. What would you say to someone who was thinking about going to work at Sprout?

General

SPROUT IS MEANT TO BE A REHABILITATION PROJECT TO HELP PEOPLE WHO HAVE HAD PROBLEMS WITH THEIR NERVES OR WHO HAVE HAD A MENTAL ILLNESS

91. Given that you decided to leave the project, what sort of help might have been more useful for you?

92. In general, what kind of help or support do you think people like yourself might like?

93. When you've been applying for jobs, have you ever been discriminated against because you've had problems with your nerves or had a mental illness?
Can you tell me what happened?

94. Have you ever been discriminated against when actually in a job for the same sort of reasons?

(Present Scales)

TIME III. INTERVIEW SCHEDULE (Completers only)

Experiences since Sprout

1. It's been about three months now since you left Sprout.
   What has that time been like for you?

2. How have you coped since you left?

   very well
   well
   alright
   with some difficulty
   with a lot of difficulty

3. Since leaving, have you felt in need of help
   of any kind? YES NO

   If so, what kind of help?
   Why was this?

4. Did you get this help?

5. From whom?
   For how long?

6. What did you do in the first few weeks after you finished
   working at Sprout?

7. How do you spend your time now?

8. Can you think back to when you were at Sprout?
   What plans did you have for when you left there?

9. Have things worked out as you planned?
   For what reason?

10. At present are you working?

    IF YES Proceed to Question 11

    Have you worked at all since Sprout?

    IF YES Proceed to Question 11

    IF NO Proceed to Question 29

    Those with employment experience

11. How many jobs have you had since Sprout?

12. Previous jobs : How long were you in each?
    Why did you leave?

    Job Time in job Reason for leaving

13. Most recent/current job : Nature of job?

14. When did you get this job?

15. Can you tell me how you got this job?

16. Why did you take this job?

17. What was/is it like to be working?

18. What were/are the best things about your job?

19. What were/are the worst things?

20. Have you had any major difficulties at work?

21. How did/do you get on with the other people at work?

22. How did/do you manage the work?

23. How does this job compare with working at Sprout?

24. Do you think the experience of working at Sprout helped you at all in getting this job?

25. Has anything you might have learned at Sprout proved useful in this job?

26. All in all, what are the good things about working rather than being unemployed?

27. All in all, what are the good things about being unemployed rather than working?

28. Have you had a period of unemployment since leaving Sprout? For how long?

IF YES continue to Question 29

IF NO proceed to Question 42

Those with experience of unemployment

29. What was/is it like for you being unemployed?

30. How did/does it compare with the period you were unemployed before Sprout?

31. When you think about being unemployed, how does it make you feel?

32. Have you found anything you learned at Sprout has been of use to you since you left?
If so, what?

Those unemployed throughout

33. What are the good things about being unemployed rather than working?

34. What are the good things about working rather than being unemployed?

Those currently unemployed

35. Since leaving the project have you been looking for a job?

IF NO Proceed to Question 42

IF YES What sort of work?

36. What have you been doing towards finding one?

37. How did you get on? (Number)

Applications	YES	NO
Interviews	YES	NO
Job offers	YES	NO

38. If has had job offer(s) : What did you do about this?
Why?

All

39. Has anyone been helping you get work?
Who?

40. Would you say you were having difficulty getting work?

41. Why do you think this is?

Accommodation

42. Have you moved to different accommodation since I last saw you? YES NO

IF YES

43. Can you say why?

44. What type of accommodation are you in now?

45. What are the good things about living there?

46. What are the bad things?

All

47. With whom are you living?

48. How satisfied are you with where you're living?

very satisfied
satisfied
so-so
dissatisfied
very dissatisfied

49. Do you have any difficulty doing any of the following things?

shopping
cooking
laundry
housework
household repairs
understanding and dealing with bills
dealing with maintenance people

If has difficulty

50. Do you get enough help with each of these?

51. From whom?

52. Where do you eat your main meal of the day?

53. When you eat at home do you prepare your own meals?

always
sometimes
never

54. Why is this?

Family and personal relationships

55. What have been the reactions of people you know now that you are not working at Sprout? (family, friends, others)

56. How have you been getting on at home with .....? (parents/partner/flatmates)

57. Have things at home changed in this respect since you left Sprout?
In what ways?

58. Have there been any major difficulties at home in the last three months?

59. Do you see your

partner	more/less/same
parents	more/less/same
siblings	more/less/same

since you left Sprout?

60. Are you content with this? (Ask for each)
If not, why not?

61. Who would you say you are closest to?

62. Is there anyone you can confide in?

63. Is there anyone you can turn to in a crisis?

64. Is there anyone you can turn to for help on a day-to-day basis, if need be?

65. How many good friends would you say you have?

66. Are you happy/worried about that?

(Where appropriate)

67. What sort of things do you and your friends do together?

68. How often do you see your friends?

69. How many did you see to talk to last week for example?

70. Did you make any new friends at Sprout?

71. Do you continue to see them?
How often?

72. Have you made any new friends since leaving?
Where did you meet?

73. Have you started seeing a new boy/girlfriend since last time we met?

74. **IF YES** How are things going between you?

75. Has your marital status changed in the last six months?

Leisure activities and spare time interests

Those in work

76. How do you spend your free time?

Those unemployed

77. Can you tell me what a typical day is like for you - what do you do?

All

78. Are you happy with spending your time in that way?

79. Have you taken up any new hobbies or interests since you left Sprout?

80. Have you joined any clubs or organisations?

81. Have you started attending any classes or courses?

82. Would you like to do more?

83. Can you say what stops you?

Finances

Unemployed only

84. What benefits are you claiming?

85. What is it like for you to be on benefit and not on wages?

All

86. Are you better/worse off than when at Sprout?

87. How do you manage on the income you're getting?

very well
quite well
alright
with some difficulty
with a lot of difficulty

88. What do you spend your money on?

89. Are you short of money just now?

90. Do you have any debts?

91. Do you have any savings?

92. Do you worry about getting into debt?

93. How would you describe your standard of living?

satisfactory
so-so
unsatisfactory

Health

94. Since you left Sprout, have you been admitted to hospital?

Instance	Length of stay	Voluntary/ compulsory

95. Can you say what for?
What brought this on?

96. Have you been treated as an out-patient? YES NO
For how long?

97. Have you been treated as a day patient? YES NO
For how long?

98. Are you having any treatment from your doctor?

drugs
other

99. Can you say how long you've been having this treatment?

100. Have there been any major worries or upsets in your life over the past three months?

(Present Life Events Inventory)

101. Would you say you were

well?
unwell?
on the mend?

102. How do you feel compared with when you were at Sprout? (Say, six months ago?)

103. Over the past three months, have you had problems with
alcohol
drugs

104. Since you left Sprout, do you have more contact/less contact/ same amount of contact with

your GP?
a psychiatrist?
a social worker?
a CPN?
any other 'helping' person?

Future

105. Do you have any particular plans for the future?

106. Would you need any help to achieve these?
What sort of help?

107. How do you think things will be in the future?

108. How do you see yourself coping?

Overview of Sprout

109. Looking back, what do you think about Sprout now?

110. Do you think you've gained anything from working at Sprout for a year?

111. What do you most value about your time there?
(if anything)

112. Do you miss anything about Sprout?
What?
Why?

113. If you could make some changes at Sprout, what would you change?

114. Would you have stayed on there if it had been possible to work for more than a year?
Why?

115. Would you consider applying for a second year?
Why?

116. What would you say to someone who was thinking about going to work at Sprout?

General

SPROUT IS MEANT TO BE A REHABILITATION PROJECT TO HELP PEOPLE WHO HAVE HAD PROBLEMS WITH THEIR NERVES OR WHO HAVE HAD A MENTAL ILLNESS

117. Do you think anything else should be done to help people like yourself?
What sort of things?

118. When you've been applying for jobs, have you ever been discriminated against because you've had problems with your nerves/a mental illness?
What happened?

119. Have you ever been discriminated against when in a job because of that?

(Present Scales)

INTERVIEW SCHEDULE USED WITH PROJECT SUPERVISORS

I'D LIKE TO BEGIN BY ASKING A FEW THINGS ABOUT YOUR OWN EXPERIENCES OF WORKING AT SPROUT

1. What form of education have you had?

   college
   university
   vocational training

2. What work have you done previously?

3. How long have you been at Sprout now?

4. Is your post time-limited?

5. **IF YES** Does this affect the way you approach your job?

6. What do you see yourself doing in the future?

7. What attracted you to this job?

8. What are, for you, the good things about working here?

9. What are the bad things?

10. What do you see as your own contribution to Sprout?

11. Can you say what you are getting out of the project?

12. How do you maintain an interest in your work?

13. What do you understand a supervisor's role to be at Sprout?

14. Would you say it differs from that of a supervisor in an 'ordinary' workplace?
    In what ways?

15. How do you try to achieve this?

16. How do you try to help new workers settle in?

17. How do you try to maintain their interest?

18. How do you prepare people for leaving?

19. How do you deal with problems which arise?

    poor motivation
    lateness
    difficulties between workers
    any others

20. What do you spend most time on?

21. Would you like this to change?
In what ways?

22. Do you have an opportunity to spend time with each member of the workforce?
To get to know them?

23. Would you like this to change?
Can you say why?

24. How can you evaluate a person's progress here?

25. Are there specific activities/areas for which you have particular responsibility?

26. Are you happy with this?

27. Do you feel you have enough say in planning your work?

28. What sort of freedom or scope for initiative do you have here?
Are there limits to it?

29. How does this compare with other employment?

30. What sort of authority do you have here?

31. Do you feel you have a say in how Sprout is run?
How satisfied are you with this?

32. What is stressful about this job?

33. What do you find supportive?

34. How do you feel about the level of support available?
What would you like to change, if anything?

35. Are there changes which could be made to make the supervisor's role easier?

36. How do you judge whether you're doing your job well?
Observable effects?
Feedback from others?

37. Would you say your job was worthwhile?
In what ways?

THE LAST SECTION IS CONCERNED WITH THE PROJECT'S AIMS AND WITH BROADER ISSUES

38. What do you see as the aims of Sprout?
(Prompt: An end in itself?
A means to an end?)

39. How do you set about achieving these aims?

40. How successful would you say you are?
Can you give examples of 'successes'?

41. What are the difficulties of running a project like Sprout?

42. Would you say the project is worthwhile?

43. People who come to Sprout have experienced some form of mental illness. What do you understand that to mean?

44. What sort of help might they need as a result?

45. What can Sprout offer?

46. Could it do more?

47. What kind of person is best helped by Sprout?

48. Finally, the term 'rehabilitation' is used in relation to Sprout. What do you take it to mean?

PROMPT SHEET USED WITH PROJECT MANAGER AND TRAINING DEVELOPMENT OFFICER

1. **Role**
   - How has it evolved?
   - How is time spent?
   - What is manager's/training and development officer's role,
     - vis à vis participants
     - supervisors
     - management committee?
   - To whom accountable?

2. **Job satisfaction**
   - What is stressful?
   - What is supportive?
   - 'Good' things?
   - 'Bad' things?

3. **Aims and values**
   - Objectives of Sprout?
   - What means are employed?
   - How successfully?
   - What does 'rehabilitation' entail?
   - What might mentally ill people need?
   - What can Sprout offer?

APPENDIX B

Affect Balance Scale

PLEASE ANSWER 'YES' OR 'NO' TO THE FOLLOWING QUESTIONS

During the past few weeks, did you ever feel

1. Pleased about having accomplished something?
2. That things were going your way?
3. So restless you couldn't sit long in a chair?
4. Proud because someone complimented you on something?
5. Bored?
6. Depressed or very unhappy?
7. Particularly excited or interested in something?
8. Very lonely or remote from other people?
9. Upset because someone criticised you?
10. On top of the world?

Present Life Satisfaction Scale

THINK ABOUT YOUR PRESENT LIFE AND HOW YOU WOULD DESCRIBE IT

interesting	-	-	-	-	-	-	-	boring
miserable	-	-	-	-	-	-	-	enjoyable
rewarding	-	-	-	-	-	-	-	disappointing
hopeful	-	-	-	-	-	-	-	discouraging
doesn't give me a chance	-	-	-	-	-	-	-	brings out the best in me
full	-	-	-	-	-	-	-	empty
hard	-	-	-	-	-	-	-	easy
fulfilling	-	-	-	-	-	-	-	frustrating
controlled by others	-	-	-	-	-	-	-	under my control
successful	-	-	-	-	-	-	-	unsuccessful
unhappy	-	-	-	-	-	-	-	happy

Life Events Inventory (for all respondents)

PLEASE PUT A TICK BY EACH EVENT WHICH HAS HAPPENED TO YOU DURING THE PAST YEAR

--- 1. Unemployment (of head of household)
--- 2. Trouble with superiors at work
--- 3. New job in same line of work
--- 4. New job in new line of work
--- 5. Change in hours or conditions in present job
--- 6. Promotion or change of responsibilities at work
--- 7. Retirement
--- 8. Moving house
--- 9. Purchasing own house (taking out mortgage)
--- 10. New neighbours
--- 11. Quarrel with neighbours
--- 12. Income increased substantially (25%)
--- 13. Income decreased substantially (25%)
--- 14. Getting into debt beyond means of repayment
--- 15. Going on holiday
--- 16. Conviction for minor violation (e.g. speeding or drunkenness)
--- 17. Jail sentence
--- 18. Involvement in fight
--- 19. Immediate family member starts drinking heavily
--- 20. Immediate family member attempts suicide
--- 21. Immediate family member sent to prison
--- 22. Death of immediate family member
--- 23. Death of close friend
--- 24. Immediate family member seriously ill
--- 25. Gain of new family member (immediate)
--- 26. Problems related to alcohol or drugs
--- 27. Serious restriction to social life
--- 28. Period of homelessness (hostel or sleeping rough)
--- 29. Serious physical illness or injury requiring hospital treatment
--- 30. Prolonged ill health requiring treatment by own doctor
--- 31. Sudden and serious impairment of vision or hearing
--- 32. Unwanted pregnancy
--- 33. Miscarriage
--- 34. Abortion
--- 35. Sex difficulties

Life Events Inventory (for two-parent families)

--- 36. Marriage
--- 37. Pregnancy (or of wife)
--- 38. Increase in number of arguments with spouse
--- 39. Increase in number of arguments with other immediate family members (e.g. children)
--- 40. Trouble with other relatives (e.g. in-laws)
--- 41. Son or daughter left home
--- 42. Children in care of others
--- 43. Trouble or behaviour problems in own children
--- 44. Death of a spouse

--- 45. Divorce
--- 46. Marital separation
--- 47. Extra-marital sexual affair
--- 48. Break-up of affair
--- 49. Infidelity of spouse
--- 50. Marital reconciliation
--- 51. Wife begins or stops work

Life Events Inventory (for those never married)

--- 52. Break-up with steady boy or girlfriend
--- 53. Problems related to sexual relationship
--- 54. Increase in number of family arguments
(e.g. with parents)

Social Adjustment Scale

I AM INTERESTED IN HOW YOU HAVE BEEN IN THE PAST TWO WEEKS. I WOULD LIKE YOU TO ANSWER SOME QUESTIONS ABOUT YOUR WORK, SPARE TIME ACTIVITIES AND YOUR FAMILY LIFE

(Reply:
A = all the time
B = most of the time
C = about half the time
D = occasionally
E = not at all)

Work outside the home

THE FOLLOWING QUESTIONS ARE ABOUT HOW THINGS HAVE BEEN IN YOUR JOB (FULL OR PART-TIME). IF YOU DO NOT HAVE A JOB, GO STRAIGHT ON TO THE NEXT SECTION

Over the past few weeks have you

1. Missed any time from work?
2. Been doing your job well?
3. Felt ashamed of how you have been doing your work?
4. Got angry or argued with people at work?
5. Felt upset, worried or uncomfortable at work?
6. Been finding your work interesting?

Housework

THE FOLLOWING QUESTIONS ARE ABOUT HOW THE HOUSEWORK HAS BEEN

Over the past few weeks have you

7. Done the necessary housework each day?
8. Been doing the housework well?
9. Felt ashamed of how you have been doing the housework?
10. Got angry or argued with salespeople, tradesmen or neighbours?
11. Felt upset, worried or uncomfortable while doing the housework?
12. Found the work boring, unpleasant or a drudge?

Social and leisure activities

THE FOLLOWING QUESTIONS ARE ABOUT YOUR FRIENDS, AND WHAT YOU HAVE BEEN DOING IN YOUR SPARE TIME

Over the past few weeks have you

13. Been in touch with any of your friends?
14. Been able to talk about your feelings openly with your friends?
15. Done things socially with your friends (e.g. visiting, entertaining, going out together)?
16. Spent your available time on hobbies or spare time interests?

17. Got angry or argued with your friends?
18. Been offended or had your feelings hurt by your friends?
19. Felt ill at ease, tense or shy when with people?
20. Felt lonely and wished for companionship?
21. Felt bored in your free time?

Extended family

THE FOLLOWING QUESTIONS ARE ABOUT YOUR EXTENDED FAMILY, i.e. YOUR PARENTS, BROTHERS, SISTERS, IN-LAWS AND CHILDREN NOT LIVING AT HOME

(Please do NOT include your partner or children living at home)

Over the past few weeks have you

22. Got angry or argued with any relatives?
23. Made an effort to keep in touch with your relatives?
24. Been able to talk about your feelings openly with your relatives?
25. Depended on your relatives for help, advice or friendship?
26. Worried more than necessary about things happening to your relatives?
27. Been feeling that you have let your relatives down at any time?
28. Been feeling that your relatives have let you down at any time?

Marital

THE FOLLOWING QUESTIONS ARE ABOUT HOW THINGS HAVE BEEN BETWEEN YOU AND YOUR PARTNER. IF YOU ARE NOT LIVING WITH YOUR PARTNER, OR LIVING WITH A PERSON IN A STEADY RELATIONSHIP, GO STRAIGHT ON TO THE NEXT SECTION

Over the past two weeks have you

29. Got angry with each other or argued with one another?
30. Been able to talk about your feelings and problems with your partner?
31. Been making most of the decisions at home yourself?
32. Tended to give in to your partner to let him/her have his/her own way when there was a disagreement?
33. Have you and your partner shared the responsibility for practical matters that have arisen?
34. Had to depend on your partner to help you?
35. Been feeling affectionate towards your partner?
36. Have you and your partner had sexual relations? About how many times?
37. Had any problems during sexual intercourse? (e.g. pain or difficulty reaching climax)
38. Enjoyed your sexual relationships with your partner?

Parental

THE FOLLOWING QUESTIONS ARE ABOUT HOW THINGS HAVE BEEN WITH YOUR CHILDREN. IF YOU DO NOT HAVE ANY CHILDREN LIVING AT HOME, GO STRAIGHT TO THE NEXT SECTION

Over the past few weeks have you

39. Been interested in your children's activities, e.g. school, friends etc.?
40. Been able to talk to and listen to your children?
41. Been shouting at or arguing with your children?
42. Been affectionate towards your children?

Family unit

THE FOLLOWING QUESTIONS ARE ABOUT HOW THINGS HAVE BEEN WITH YOUR IMMEDIATE FAMILY, THAT IS YOUR PARTNER AND CHILDREN AT HOME. IF YOU DO NOT HAVE AN IMMEDIATE FAMILY, PLEASE IGNORE THIS SECTION

Over the past few weeks have you

43. Been worrying more than necessary about things happening to your family?
44. Been feeling you have let your immediate family down at any time?
45. Been feeling that your immediate family has let you down at any time?

Self Esteem Scale

PLEASE INDICATE WHETHER YOU

(a) strongly agree
(b) agree
(c) disagree
(d) strongly disagree

WITH THE FOLLOWING STATEMENTS

1. On the whole I´m satisfied with myself
2. At times I think I´m no good at all
3. I feel that I have a number of good qualities
4. I am able to do things as well as most other people
5. I feel I do not have much to be proud of
6. I certainly feel useless at times
7. I feel that I am a person of worth, at least on an equal plane with others
8. I wish I could have more respect for myself
9. All in all, I´m inclined to feel I´m a failure
10. I take a positive attitude towards myself

GENERAL HEALTH QUESTIONNAIRE

How has your health been over the past few weeks? Please underline your answer

A1.	Been feeling perfectly well and in good health	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2.	Been feeling in need of a good tonic	Not at all	No more than usual	Rather more than usual	Much more than usual
A3.	Been feeling run down and out of sorts	Not at all	No more than usual	Rather more than usual	Much more than usual
A4.	Felt that you are ill	Not at all	No more than usual	Rather more than usual	Much more than usual
A5.	Been getting any pains in your head	Not at all	No more than usual	Rather more than usual	Much more than usual
A6.	Been getting a feeling of tightness or pressure in your head	Not at all	No more than usual	Rather more than usual	Much more than usual
A7.	Been having hot or cold spells	Not at all	No more than usual	Rather more than usual	Much more than usual

B1.	Lost much sleep over worry	Not at all	No more than usual	Rather more than usual	Much more than usual
B2.	Had difficulty in staying asleep once you were off	Not at all	No more than usual	Rather more than usual	Much more than usual
B3.	Felt constantly under strain	Not at all	No more than usual	Rather more than usual	Much more than usual
B4.	Been getting edgy and bad tempered	Not at all	No more than usual	Rather more than usual	Much more than usual
B5.	Been getting scared or panicky for no good reason	Not at all	No more than usual	Rather more than usual	Much more than usual
B6.	Found everything getting on top of you	Not at all	No more than usual	Rather more than usual	Much more than usual
B7.	Been feeling nervous and strung up all the time	Not at all	No more than usual	Rather more than usual	Much more than usual

C1.	Been managing to keep yourself busy and occupied	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2.	Been taking longer over the things you do	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3.	Felt on the whole you were doing things well	Better than usual	About the same	Less well than usual	Much less well
C4.	Been satisfied with the way you carried out your task	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5.	Felt you were playing a useful part in things	More so than usual	Same as usual	Less useful than usual	Much less useful
C6.	Felt capable of making decisions about things	More so than usual	Same as usual	Less so than usual	Much less capable
C7.	Been able to enjoy your normal day-to-day activities	More so than usual	Same as usual	Less so than usual	Much less than usual

D1.	Been thinking of yourself as a worthless person	Not at all	No more than usual	Rather more than usual	Much more than usual
D2.	Felt that life is entirely hopeless	Not at all	No more than usual	Rather more than usual	Much more than usual
D3.	Felt that life is not worth living	Not at all	No more than usual	Rather more than usual	Much more than usual
D4.	Thought of the possibility that you might make away with yourself	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5.	Found at times that you couldn't do anything because your nerves were too bad	Not at all	No more than usual	Rather more than usual	Much more than usual
D6.	Found yourself wishing you were dead and away from it all	Not at all	No more than usual	Rather more than usual	Much more than usual
D7.	Found that the idea of taking your own life kept coming into your mind	Definitely not	I don't think so	Has crossed my mind	Definitely has

Work Assessment Scale (completed by supervisors)

PLEASE INDICATE IN RESPONSE TO THE FOLLOWING PAIRS OF STATEMENTS WHETHER

(1) A applies
(2) this participant inclines to A
(3) this participant is about average
(4) this participant inclines to B
(5) B applies

A	B
Does complicated jobs	Can only do simple jobs
Grasps instructions quickly	Cannot grasp instructions
Works very quickly	Works very slowly
Works continuously	Works for short periods only
Eager to work	Avoids work
Welcomes supervision	Resents supervision
Needs no supervision of his/her work	Needs constant supervision of his/her work
Willing to change jobs	Refuses to change jobs
Looks for more work	Waits to be given work
Always uses good judgement	Never uses good judgement
Excellent standard of work	Bad standard of work
Manual dexterity is good	Clumsy with hands
Uses tools/equipment well	Cannot use tools/equipment
Gets on well with other people	Gets on badly with other people
Communicates spontaneously	Does not communicate
A good timekeeper	A bad timekeeper
Always finishes his/her work	Leaves work half done
The others took to him/her quickly	Doesn't fit in easily
Takes a prominent part in things	Hangs back and lets others take the lead
Has a sensible attitude to authority	Is a bit of a troublemaker
Were I an employer, I would be very willing to take him/her on	Were I an employer, I would prefer not to employ him/her
Is markedly over-confident	Is markedly under-confident
Accepts criticism of work readily	Cannot accept criticism
Accepts responsibility readily	Cannot really accept any responsibility
Shows a great deal of initiative (makes own decisions etc.)	Shows no initiative (has to be told what to do)

Review of Participant's Progress at Sprout
(completed by supervisor)

PLEASE CIRCLE YOUR RESPONSE

1. Is this worker capable of making decisions without prompting? YES NO

2. Does s/he have plans about what to do after leaving Sprout? YES NO

3. Do these plans seem realistic to you in view of the worker's capabilities and limitations? YES NO

4. Does s/he have a better understanding of his/her difficulties than when s/he started? YES NO

5. How does s/he get on with others?
   A = fits well into the group
   B = tends to be isolated

6. Has this worker become more confident while at Sprout? YES NO

7. Has s/he maintained an interest in work (or some aspect of it) throughout the year? YES NO

8. Has this worker been able to put forward opinions and criticisms even if it meant disagreeing with a supervisor? YES NO

9. If a choice of employment and alternatives were available, which of the following is most suitable for this worker after Sprout?
   (a) open employment
   (b) sheltered employment
   (c) further rehabilitation
   (d) occupational therapy
   (e) attendance at a day centre

APPENDIX C

TABLE C.1 Details of Scores on the General Health Questionnaire

		COMPLETERS		NON-COMPLETERS
		Time II (n=22)	Time III (n=15)	Time IIb (n=14)
A.	Somatic symptoms	1.46	2.00	1.43
B.	Anxiety	1.63	1.80	1.57
C.	Social dysfunction	1.23	1.00	1.20
D.	Severe depression	1.27	1.80	0.36
	Overall score	5.59	6.60	4.43
	S D	6.46	9.25	3.92

TABLE C.2 Details of Scores on the Social Adjustment Scale

ROLE AREA		COMPLETERS				NON-COMPLETERS	
		Time II		Time III		Time IIb	
		no.	score	no.	score	no.	score
1.	Work	23	1.95	1	1.67	1	1.50
2.	Housework	-	-	11	1.67	10	2.10
3.	Social and leisure	23	2.49	14	2.35	14	2.59
4.	Extended family	23	2.52	13	2.27	14	2.60
5.	Global	23	2.35	14	2.37	14	2.46

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