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Abstract

The study sought to identify through the action research process what local employers concerns were in relation to the employment of individuals in a phase of recovery from mental illness. The barriers to employment experienced by service users living in a North London Borough were also explored. The study aimed to gain an in-depth understanding of the reluctance by employers to employ individuals with a known mental illness who are in a phase of recovery. It also sought to hear about the lived experiences and perspectives on the barriers experienced to accessing or being in employment from a service user's perspective. There is limited literature examining this area within this North London Borough.

This qualitative study was informed by my professional background where I hold a dual role of managing mental health services in the community and as a lecturer in Cognitive Behavioural Therapy at Middlesex University. Both roles are concerned with promoting the mental health well-being of individuals who experience mental illness. The study adopted an action research design, where six focus groups were held, three with service users and three with employers or employer representatives within a North London Borough.16 employer representatives and 28 service users participated across the six focus groups. The data gathered from each focus group was digitally recorded and transcribed verbatim. Thematic analysis was used to identify the main themes and subsequent sub –themes from the data gathered.

The findings from the research indicate that there are many stakeholders that are involved in supporting individuals back into employment. They also show that mental health and mental ill health are poorly understood in workplace environments. Evidence from this study indicated that while work and employment were thought by both participant types to be important determinants of mental health those individuals with diagnosed mental illnesses remain at a significant disadvantage in the employment market. This points to a need for developments that educate employers, employees and various other stake-holders involved in the employment process on mental health and mental illness in the work- place environment. The main contribution of this research is that of a support and educational package for employers and employees, which has core content but will change in its focus depending on the audience it is being delivered to.

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Glossary of Terms

Absenteeism: This term is used in this study to define an individual who has   not shown up for work.

Advisory, Conciliation and Arbitration Service (ACAS): An independent body that improves organisations and working life through better employment relations. Helps with employment relations by supplying up-to-date information, independent advice and high quality training, and working with employers and employees to solve problems and improve performance.

Affective psychotic disorders: Defined as bipolar I disorder with psychotic features; major depressive disorder with psychotic features.

Antipsychotic drugs: Drugs used to treat psychosis, including schizophrenia and mania. They also have tranquillising effects, reducing agitation.

Anxiety: A mood state in which feelings of fear predominate and where the fear is out of proportion to any threat. Frequently associated with physical symptoms which include fast pulse rate, palpitations, sweating, shaking, 'pins and needles'? Anxiety disorders can include simple phobias, fear of a specific object or situation, generalised anxiety disorder, panic disorder, agoraphobia, obsessive-compulsive disorder, or post-traumatic stress disorder.

Bipolar Disorder: A severe mental illness with a long course usually characterised by episodes of depressed mood alternating with episodes of elated mood and increased activity (mania or hypomania). However, for many people the predominant experience is of low mood. In its more severe forms, bipolar disorder is associated with significant impairment of personal and social functioning.

Chartered Institute of Personnel and Development (CIPD): This is a professional body for human resources and people development. It has over 130,000 members internationally working in human resources, learning and development, people management and consulting across private businesses and organisations in the public and voluntary sectors.

Clinical recovery: This is an idea that has emerged from the expertise of mental health professionals, and involves getting rid of symptoms, restoring social functioning, and in other ways 'getting back to normal'.

Depression: A negative mood state which involves a feeling of sadness. A severe depression can reach the criteria for an affective disorder and require treatment. Depression can frequently coexist with and complicate other physical illnesses. The most frequent disorder found in the 2007 Adult Psychiatric Morbidity Survey was a mixed anxiety-depression (McManus et al. 2009).

Disability: 'A person has a disability if he or she has a physical or *mental* impairment which has substantial and long-term adverse effects on his or her ability to carry out normal day to day activities' (Disability Discrimination Act, 1995).

Dysphoria: (from Greek (dysphoros), from difficult, and to bear) is a state of feeling unwell or unhappy; a feeling of emotional and mental discomfort as a symptom of discontentment, restlessness, dissatisfaction, malaise, depression, anxiety or indifference.

Employment: is defined as being a retainable, paid role within an open, competitive employment market (which includes the option of self-employment), which provides a significant number of hours of employment (often defined as 16 hours per week or more) (Wilkins et al. 2011).

Employment Pathway: There is no definition of this phrase in the Oxford English dictionary except in its separate words employment and pathway. The phrase 'employment pathway' is used to refer to agencies or individuals involved somewhere along the journey to getting individuals in a phase of mental health recovery back into employment and sustaining that.

Employment Support Model: is defined as a 'model' which includes any documented approach, pilot or scheme, relating to supporting people with mental health problems or learning disability in employment, that has been evident in the literature and online material (Wilkins et al. 2011) .

Gross Domestic Product (GDP): Adding up the market values of all the things produced gives a total measure of the size of the economy known as GDP. This

includes an imputed value for publicly provided services, which do not have a market price. But it excludes the value of other important activities, such as unpaid housework. This measure of GDP is called the output measure. GDP can also be calculated by adding up total expenditure on all the goods and service produced (the expenditure measure) or adding the income earned by organisations and individuals in producing goods and services (the income measure).

Health: comprises of physical and mental well-being, and (despite philosophical debate) is usually operationalised in terms of the absence of symptoms, illness and morbidity (WHO 1948; Danna & Griffin, 1999, WHO 2004).

Homogeneous: composed of parts or elements that is all of the same kind; not heterogeneous: a homogeneous population.

Health: Is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2014).

Health inequality: refers to the health differences that are seen in people who occupy unequal positions in society (McCartney et al. 2013).

Human resources (HR): is the set of individuals who make up the workforce of an organization, business sector, or economy. "Human capital" is sometimes used synonymously with human resources, although human capital typically refers to a more narrow view (i.e., the knowledge the individuals embody and can contribute to an organization). Likewise, other terms sometimes used include "manpower", "talent", "labour", or simply "people". The professional discipline and business function that oversees an organization's human resources is called human resource management (HRM, or simply HR).

Inequality in mental health: means the unequal distribution of factors that promote and protect positive mental health and factors that are detrimental to mental health.

Interpretive Paradigm: Over the last half century, a new research paradigm has emerged in the social sciences to break out of the constraints imposed by positivism. With its emphasis on the relationship between socially engendered concept formation and language, it can be referred to as the interpretive paradigm. Containing such qualitative methodological approaches as phenomenology,

ethnography, and hermeneutics, it is characterized by a belief in a socially constructed, subjectively based reality, one that is influenced by culture and history. Nonetheless it still retains the ideals of researcher objectivity, and researcher as passive collector and expert interpreter of data.

Jobcentre Plus: The work and benefit services delivery agency.

Mental Health: 'mental health' is defined as both absence of mental illness, that is, psychological and psychiatric disorders, and mental well-being, which is defined as 'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment' (DoH, 2010: p. 12).

Mental Health Act (1983): The Act concerns 'the reception, care and treatment of mentally disordered patients, the management of their property and other related matters'.

Mental Health Services: For the purpose of this study these are defined as the services commissioned by NHS and local authority commissioners, provided by NHS, independent and voluntary sector services and local authority social services, as a result of a person being assessed and diagnosed as having a mental disorder.

Mental health inequities: these are inequalities in relation to mental health status that can be described as 'morally or ethically' unfair or unjust (Whitehead, 1990).

Mental Illness (MI): This term is used frequently throughout this study. This term will be used to refer to individuals experiencing either 'neurotic' or 'psychotic' symptoms. 'Neurotic' covers those symptoms, which can be regarded as severe forms of 'normal' emotional experiences such as depression, anxiety or panic. Conditions formerly referred to as 'neuroses' are now more frequently called 'common mental health problems.' Less common are 'psychotic' symptoms, which interfere with a person's perception of reality, and may include hallucinations such as seeing, hearing, smelling or feeling things that no one else can.

Mental Ill Health: The term mental ill health covers: harmful levels of stress, depression, anxiety, schizophrenia, bi-polar disorder (manic depression), psychosis, and obsessive compulsive disorder (OCD) and is often associated with

drug and alcohol abuse and eating disorders (e.g. anorexia nervosa and bulimia nervosa), (NHS Employers, 2014).

Mental impairment: in this context refers to a clinically recognised illness such as schizophrenia, bipolar disorder, panic disorder, or a depressive condition, while 'long-term' means having lasted, or likely to last, for at least a year.

Mental wellbeing: is about how feeling positive about ourselves as individuals, our work and our relationships, all interact.

NHS Pathways: NHS Pathways is a suite of clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. It has an integrated directory of services, which identifies appropriate services for the patient's care if an ambulance is not required (Health and Social Care Information Centre, 2014).

Non-affective psychotic disorders: Non-affective psychosis refers to psychosis not related to emotions or moods. Schizophrenia and delusional disorders are examples of non-affective psychosis as opposed to bipolar disorder which is an affective psychosis as it involves emotional and mood abnormalities. Non affective psychotic disorders include Schizophrenia, Schizoaffective disorder, schizophreniform disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, and psychotic disorder.

Organisation for Economic Co-operation and Development (OECD): A multidisciplinary international body made up of 30 member countries that offer a structure/forum for governments to consult and co-operate with each other in order to develop and refine economic and social policy. While the OECD does not set rules and regulations to settle disputes like other international bodies, it encourages the negotiation of agreements and the promotion of legal codes in certain sectors. Its work can lead to binding and non-binding agreements between the member countries to act in a formal way. The OECD is best known for its publications and statistics.

Pathway: could generally be described as being the movement a patient makes from service to service on their way to eventual maximum mental health and social wellbeing (Centre for Mental Health, 2011(a): p35).

Personal recovery ; This is an idea that has emerged from the expertise of people with lived experienced of mental illness, and means something different to clinical recovery. The most widely used definition of personal recovery is from Anthony (1993).

Positivist Paradigm: This paradigm is based on a number of principles, including: a belief in an objective reality, knowledge of which is only gained from sense data that can be directly experienced and verified between independent observers. Phenomena are subject to natural laws that humans discover in a logical manner through empirical testing, using inductive and deductive hypotheses derived from a body of scientific theory. Its methods rely heavily on quantitative measures, with relationships among variables commonly shown by mathematical means. Positivism, used in scientific and applied research, has been considered by many to be the antithesis of the principles of action research (Susman and Evered 1978, Winter 1996).

Positivist tenets - the belief that there are universal and permanent laws or principles that represent unidirectional causal relationships, and the belief that there is only one real "scientific" method to unveil those relationships (Walker, 1993; Guba and Lincoln, 1994).

Presenteeism: is defined as lost productivity that occurs when employees come to work but perform below par due to any kind of illness (Levin-Epstein, 2005).

Psychosis: The term 'psychosis' is used in this study to refer to the group of psychotic disorders that includes schizophrenia, schizophreniform disorder and delusional disorder.

Reasonable adjustment: is an adjustment to the workplace or work practices that is effective for the employee without being too disruptive, costly or impractical for the employer to provide.

Recovery: The process of learning how to live a meaningful and rewarding life, with or without enduring symptoms or vulnerabilities (Slade, 2009). The term has developed a specific meaning in mental health that is not the same as, although is related to, clinical recovery .It has been defined as 'A deeply personal unique process of changing ones attitudes, values, feelings, goals skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations

caused by illness' (Anthony, 1993). Recovery involves development of new meaning and purpose in one's life.

Recovery: The Social Approach: is more focused on enabling a person with a mental health issue to be content and to live a meaningful life with their disorder, rather than working to cure their disorder (Secker et al. 2002).

Schizophrenia: Schizophrenia is a severe psychotic mental illness in which there may be distorted perceptions and thinking, as well as inappropriate or blunted mood. Individuals with this disorder may hold beliefs that seem impossible to others.

Service User: a term that is popular with service providers, particularly within the public sector. It is used as a generic description of the people who use mental health services. Sometimes abbreviated to Users they are most frequently portrayed as patients – as objects of the clinical gaze of mental health professionals (Pilgrim & Rogers, 1999) – and therefore in terms of their illness. However, users can also be seen as consumers, survivors and providers, all of which imply different notions of the roles and responsibilities of people with mental health problems and the relationship between them and mental health services (Tait and Lester, 2005).

Severe (Or serious enduring) Mental Illness (SEMI): More severe and long lasting mental illness associated with functional impairment, someone with a severe mental illness may never the less have long periods where they are well and able to manage their lives.

Stigma: The term stigma conventionally refers to any attribute, trait, or disorder that marks an individual as being unacceptably different from the 'normal' people with whom he or she routinely interacts, and elicits some form of community sanction (Scambler, G. 1998).

Stress: This is generally regarded as a response to an in appropriate level of pressure, which leads to psychological, behavioural and physical symptoms – leading to anxiety (Collins et al. 2010: p963).

The Equality Act (2010) outlines an employer's duty to make reasonable adjustments for people with disabilities in order to ensure that they have the same

access to everything that involves gaining or keeping employment as a non-disabled person. According to the Act a person is defined as disabled if they have a mental or physical impairment that has a substantial long term (i.e. more than 12 months) effect on their normal day-to-day activities. The Act replaces all previous anti-discrimination legislation and includes a public sector equality duty requiring public bodies to have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act provides an important legal framework, aiming to improve the experience of all mental health service users, particularly those from black and minority ethnic communities.

Unemployed: Not employed in a job, wanting and available for work, and actively seeking employment (Barham, 2002). This is often operationalised as being in receipt of unemployment benefits.

Work place adjustment: Is a change or adjustment unique to a person's needs that will enable them to do their job.

Work-related Stress: defined by the Health and Safety Executive (HSE) as the adverse reaction people have to excessive pressures or other types of demand placed on them at work.

Abbreviations

CBI: The Confederation of British Industry

CIPD: The Chartered Institute of Personnel and Development

CQC: The Care Quality Commission

DDA: Disability Discrimination Act

DoH: Department of Health

DWP: Department for Work and Pensions

Emp: Employer

EqA: The Equality Act

FG: Focus group

HR: Human Resources

HSE: Health and Safety Executive

JCP: Job Centre Plus

MI: Mental Illness

NSF: National Service Framework

ODPM: Office of the Deputy Prime Minister

OECD: Organisation for Economic Co-operation and Development Office

ONS: Office for National Statistics

SEMI: Severe and Enduring Mental illness

SU: Service User

WHO: World Health Organisation

Chapter 1: Introduction to the study

There is a longstanding history whereby our understanding of mental illness has been entrenched in a model of illness as opposed to recovery. More recently the objective of traditional health services has shifted to an approach that focuses more on social outcomes, on what an individual with mental illness is able to achieve rather than what they can't. There is a greater emphasis on recovery, society accommodating disability access and its social aspects of management (Boardman, 2003: p327-334). But does that emphasis or way of thinking transfer to the right to employment, when an individual wants to work if they have a known diagnosis of mental illness? There is an assumption that we all have the right to paid employment if we wish to work but for individuals with mental illness there are significant obstacles to be overcome to achieve that right.

For the past eighteen years I have managed a small community mental health service in the private sector based in North London. Over that period of time I have seen a significant shift in the way we understand or treat individuals with mental illness. For example when I first started in 1996, we spoke frequently about a patient's 'mental illnesses' as opposed to these days where we speak about an individual's 'mental health'. There was also very little reference in the past to the notion of recovery from mental illness, whereas these days it is accepted that individuals do have different levels of social recovery.

It is worth considering what mental health recovery as a concept means in context of this study. A research review into the recovery approach in community- based vocational and training adult mental health day services was undertaken by the Social Care Institute for Excellence (SCIE) (Carr and Clapton, 2007). The systematic map was undertaken by SCIE Information managers and research staff, with consultation from the EPPI-Centre at the Social Science Research Unit, Institute of Education and University of London.

The systematic map had a particular focus on areas of vocation, meaningful occupation and training in the reshaping of mental health day services. It reported that only 11 studies (5 of which were from the USA) mentioned the recovery approach, indicating that at that time this concept of recovery was still

considered relatively new (Carr and Clapton, 2007: p15). As far back as 1978 the mental health reform in Italy was influenced by pioneering community mental health work in Trieste which drew attention to the potential for services to focus on user-defined recovery (Cited in Carr and Clapton, 2007). This would imply that whilst the concept of recovery has been around for some time it was still not commonplace in mental health practice in the United Kingdom in 2007.

In the context of this study recovery is considered as a process that is unique to each individual. The definition of recovery that is adopted in this current study has been put forward by the Scottish Recovery Network. They define recovery as:

….. being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process."

(Bradstreet, 2006; The Scottish Recovery Network, cited in The Scottish Government, 2009: P49)

A number of service users with a diagnosis of schizophrenia have lived in community care facilities that I manage. Over my 19 years of management I have developed unique care packages grounded in recovery orientated practice which have helped each individual move from being chronically mentally ill to achieving various levels of social recovery. Schizophrenia is recognised as a severe form of mental illness and it affects 1% of the population of the United Kingdom and is ranked by the World Health Organisation as the ninth leading cause of disability among all illnesses worldwide (World Health Organisation, 2001). Despite the prevalence of mental illness employment for people with mental illness remains consistently low at around 18% (Smith and Twomey, 2002; Social Exclusion Unit, 2004).

Through this research I wanted to explore what are the barriers to achieving employment for individuals with mental illness in a phase of recovery? Why might employers be reluctant to consider employment of such individuals? After all, employers do not advertise a post for individuals with certain ailments such as diabetes, or heart disease. Most advertise for posts that require a set of skills and

expertise. Yet when it comes to an individual with schizophrenia applying for employment they may suddenly be defined by their label. To inform the debate and exploration of perceived barriers to employment for people with mental illness issues, three focus groups were held with employer representatives and three focus groups were held with service users all based in the same North London Borough.

As the researcher I felt that these questions were very important as we know that employment plays a very important role in helping individuals recover from mental illness (Clark et al. 1998, p63-71). Long-term worklessness is proven to have an association with poorer physical and mental health (Department for Work and Pensions (DWP), 2006). Even though this is well documented in the literature research in England shows that individuals with mental health problems have up to a 40% lower chance of obtaining employment compared with other disability groups (Berthoud, 2006). To place this in context it is estimated that there are 11.5 million working-age people in Great Britain with a long-term health condition. Of those more than half (6.5 million) are classified as disabled under the Equality Act (2010), because they have a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities (DWP, 2013(a). Prevalence of mental illness is high and it is estimated that around one in six people will experience a common mental health problem like anxiety or depression at any one time, and a further two in a hundred are affected by severe mental illnesses like schizophrenia (McManus et al. 2009).And one in four will experience mental illness at some point in their life (Lamb, 2014:p1)

It therefore seems imperative to understand this territory if the concept of recovery and employment is to become embedded in the employment world. There were real good reasons why the current was considered worthwhile. The recent report 'Working with Schizophrenia, Pathways to Employment Recovery and Inclusion' (Bevan et al. 2013), shows that those in paid employment are over five times more likely to achieve functional remission than those who are unemployed or in unpaid employment. This in itself points to a huge positive impact as well as having positive implications for the individual and for health and social care budgets. Furthermore the literature suggests that Individuals with psychotic disorders such as schizophrenia and bipolar affective disorder can be valuable and reliable

workers (Bond, Campbell and Drake, 2012). Yet 70% of people with schizophrenia in the United Kingdom have experienced discrimination (Bevan et al. 2013: p8) and there are indications that employment is often not even considered as an outcome by clinicians (Bevan et al. 2013). It has been suggested that employment might be facilitated if clinicians and health care professionals focused more on presenting positive messages about their individuals' abilities and aspirations regarding work (Brown and Kandirikirira, 2007). More recently 'The Disability and Health Employment Strategy' (DWP (a), 2013), adopts the position that employment is good for people's mental health and that it can promote recovery (DWP (a), 2013). While this may signal a shift in thinking it should be noted that the employment rate for all people with mental health problems is 37 per cent – much lower than for people with health conditions in general (58 per cent) of the working-age population as a whole (71 per cent). Considering disabled people who also have a mental illness, employment rates are lower still at just 18 per cent (ONS (b), 2013).

Employment as a long-term intervention a goal for severe mental illness is not something that I have encountered at any mental health review I have attended. The focus is mainly on anti-psychotic medications for the alleviation of active symptoms of mental illness. Yet if employment has such positive impacts on the individual it would seem that this conversation was essential. Whilst this research had a specific focus and was looking at the particular area around barriers to employment of individuals in mental health recovery it is recognised that very low employment rates is not unique to individuals with severe mental illness.

There is no suggestion that employment in itself is a cure or the only factor that enhances good mental health. It is well established that other life influences impact on people's mental health and overall wellbeing. These include the interplay between social and economic pressures faced by individuals, the employment market, psychological and social barriers to working, including stigma (Marwaha and Johnson, 2004). This correlation is captured under the Determinants of Health Model (Dahlgren and Whitehead, 1991). This model postulates that an individual's mental health is greatly influenced by a range of personal, social, economic, and environmental factors. It suggests that determinants include the circumstances into which an individual is born, grows up, lives, works and what age they are. It is proposed that these factors are not

usually the direct causes of illness but are considered as the causes of the causes of illness (British Medical Association, 2011).

Not alone do these social determinants of health correlate to levels of poor mental ill health they are also linked to lower life expectancy. Life and health expectancy has been shown to follow the same gradient as wealth and social class. below illustrates the life expectancy (upper curve) and the disability-free life expectancy (DFLE) (lower curve) of people in different neighbourhoods in England.

Figure 1: Life Expectancy and disability free life expectancy at birth, persons by neighbourhood income level, England 1999- 2003. Source: Marmot et al. 2010, Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England. London, Marmot Review Team.

It is clear that the lower the neighbourhood income level the lower the life expectancy. This highlights that while employment or meaningful activity might contribute to maintaining an individual's mental well-being there are also a number of other factors that society should be aware of. It is suggested that greater understanding of social and structural determinants of life and their impact on lifecycle is needed (Marmot et al. 1991). It has been highlighted that the that lack of control over one's life, the lack of opportunity to participate socially in a

meaningful way, can affect whole societies, not just individuals , depending on where they are within the social gradient within society (Marmot, 2002).

This research focused on engaging two particular types of groups in a local community. It required active participation and collaboration from both: that of employer representatives and service user representatives. Engaging the service user representatives meant that issues relating to levels of participation, empowerment and equality in the research needed to be addressed. Individuals with mental illness whether in a phase or recovery or not are usually described as 'users of services' while non-users of services are engaged or encouraged to participate as 'citizens'.

The uses of these terms create a very clear distinction between those who use services and those who do not. The labelling of the service user community of participants introduces different levels of sharing power between service users, the researcher, and employer representatives. Issues relating to power imbalance in the research process are further complicated by the values which are placed on different types of expertise and language and the professional assumptions about decision-making competence (Carr, 2004). In terms of this current study the issues relating to power imbalance were necessary to consider as I have managed community mental health services in the community for over 20 years. It was likely that some service user participants in this current study may know me. They may view me as someone with a senior position or someone 'in charge' of them as frequently happens despite my vehement commitment to fighting against such imbalances and inequalities. However it is necessary to be mindful of these issues as the power imbalance is thought to exist even when the researcher has an intellectual and emotional commitment to the people being studied" (Hammersley et al. 1993: p. 274).

Service user involvement was encouraged by considering the different points at which service users could participate in the research process. Some service users organised the research information packs in advance of the research, others chose to organise the refreshments for the focus group sessions, whilst others were participants in the focus group sessions. This allowed individuals to be in charge of or to choose their level of involvement and participation. There needs to

be a range of models that support or encourage involvement and this should be real and should promote choice (Janzon and Law, 2003).

Alongside promoting choice the level of control the user has is central to both user controlled research and emancipatory disability research approaches (Turner and Beresford, 2005; p2). Although these approaches clearly have different titles they do not necessarily define different research approaches with service user's levels of control central to both. In addition emancipatory disability research aspires to 'liberate' service users'. In this current study service user aspirations and levels of participation were made by them so it could be argued that the research approach cut across both user controlled research and emancipatory disability research. There is no agreement as to whether service user controlled research should be led by a service user researcher or a non-service user researcher due the lack of suitably skilled user researchers (Turner and Beresford, 2005; p9).

However it is acknowledged that techniques by which individuals are encouraged to participate or to share their views are not neutral techniques (Jones and Jones, 2002) and have implications for participants. There are issues around degree and level of participation and whether individuals in a phase of recovery want responsibility or not. According to Arnstein's ladder of citizen participation (1969:p220), most activities taking place under the umbrella of participation are hollow, and that only the top three rungs (partnerships, delegated power and citizen control) involved genuine participation or dialogue with people.

It is proposed though that these relationships are much more complex between service users and service providers than that postulated by Arnstein's ladder of participation (1969), (Small and Rhodes, 2000; Laird et al. 2000). It was therefore important to be aware of how individuals with mental illness were encouraged to participate in this research dialogue bearing in mind Arnstein's argument that consultation was nothing more than tokenism and that partnership would be a better route to citizen empowerment. However user involvement to improve employment possibilities has to be recognised as a huge benefit for both employers and the community at large, where involvement is considered as valuable as participation, and the service user considered 'the expert' (Donaldson, 2001).

It is also worth noting that while social determinants of mental health are important to be mindful of one should also be aware that mental illness is generally more debilitating than most chronic physical conditions (LSE, 2012: p1). On average, a person with depression is at least 50% more disabled than someone with angina, arthritis, asthma or diabetes (The London School of Economic and Political Science, 2012: p1). Therefore participation or empowerment of an individual with mental illness might not be everyone's goal. Mindful of the possibility of such issues arising I worked closely to the values which are associated with user led research; empowerment, emancipation, participation, equality and antidiscrimination (Turner and Beresford, 2005: p3). Service user involvement was critical to the research questions explored, but such involvement and empowerment does not mean that 'professional' researchers are barred from the research process or that service users must undertake every stage of the research (Hanley et al. 2004).

Whilst it is thought that employment can actually contribute to the development of mental illness (Warr, 1987, Warner, 1994) there is a longstanding recognition of the positive role employment can play on improving mental health including the belief that it is as a way of reintegrating individuals into mainstream society (World Health Organisation, 2000).

It was therefore felt necessary to speak to both communities those in positions where they employ people (employers) and individuals with a known diagnosed mental illness (this could be a severe mental illness or a common mental illness), who have been employed in the past or who consider themselves as available for employment to gain a true understanding of the situation. By giving both groups a voice I could then consider what development needed to happen to make it easier for employers to consider or actually employ individuals with mental illness and then consider what support these individuals would need to stay in work.

The conversation with employer representatives and service users seemed pertinent when we look at the employment rates in the United Kingdom (UK) for people with schizophrenia which is considered as a severe mental illness. The unemployment rates for people with severe mental illness are estimated to be between 5% and 15%, with the average rate of only 8%. These statistics present a dim picture when it is placed beside the statistic for the UK wide working age rate

of employment of 71% as of December 2012 (Bevan, 2013: p8). This would suggest that there is as much as 63% negative difference in the opportunity for employment for people with schizophrenia.

This research commenced in 2011 within a North London Borough. The 2011 census figures indicated that the then population of that borough was 312,500. In terms of mental illness in 2011/12, 2,930 of its residents registered with GPs were recorded as suffering from Schizophrenia, Bipolar Affective Disorder or other severe Psychoses, equating to 1.01% of the resident population, which was similar to the London prevalence (1.00%), but above the England prevalence of 0.82%. This was a similar prevalence to that recorded in 2010/11, when 2,805 people or 1.01% of the adult population were identified as suffering from Psychoses including schizophrenia and bi-polar disorder (NLB, Director of Public Health, 2012).

This research was particularly interested in hearing from individuals with severe mental illness although not exclusively so. However much of the research shows that it doesn't matter what the diagnosis is, or severity of impairment and level of social skills when looking at the relationship to employment outcomes (Bond et al. 2001a; MacDonald-Wilson et al. 2001). Having previously had a job, wanting a job and believing that you can work have been shown to be the best predictors of success (Grove and Membrey, 2005).

There have been a number of attempts to place equality and employment on both welfare and social agendas when thinking about employment of individuals with mental illness. These include the introduction of The Disability Discrimination Act (DDA, 2005), with the Disability Equality Duty which came into force in 2006. There was The United Nations (UN) Convention on the Rights of Persons with Disabilities (UN, 2008) which was later ratified by the United Kingdom (UK) Government in 2009. The latter legislation gave individuals the right to complain to the United Nations committee if they believed that their rights had been breached. Although disability and equality for all was firmly on the UK government agendas and influencing policy it was reported that whilst there was awareness by small employers of the DDA (2005) and that negative attitudes to disabled people had reduced, positive attitudes were still far from universal (Kelly et al. 2005). Whilst the DDA made it unlawful to discriminate against disabled people it had not really been successful in getting employers to make reasonable adjustments to remove

disadvantages for those with mental illness disability (Riddell et al. 2005: pp. 27-33). It's worth noting that only 210 individuals out of 31,920 with a mental health condition reported being helped by the Access to Work programme run by the DWP (Perkins et al. 2009). In Wales it was found that one of the underlying factors affecting the success of employment in relation to the DDA (2005) was that employers were not actually fully aware of their responsibilities (Winkler, 2009: p7). Other research suggests that the DDA actually had a negative effect on employment (Bell and Heitmueller, 2005: p465 - 480). More recently the Marmot Review (2010) on health inequalities, fair society and healthy lives in England, specifically addressed equality and employment suggesting   that fair employment and good work should be created for all. This research has aimed to understand and clarify the determinants of access to employment for those with a disability of mental illness and severe enduring mental illness, and how this may be facilitated.

Summary of the chapters

Chapter 1 has included an introduction and brief historical rationale for this study along with consideration of key challenges and sources that will be further explored in chapter two.

Chapter 2 sets out the terms of reference and research questions explored in this thesis. It presents a consideration of the key political drivers and social care models that have influenced or shaped the research questions that were posed.

The primary objectives of the research are stated followed by some additional specific objectives. These specific objectives were a means of seeking to gain knowledge on what I need to know most.

The third chapter offers an introduction to the methodology used in the research from the outset right through to analysis. It sets out the rationale for the research design, a description of methods of enquiry used paying attention to my role as inside researcher (Robson, 2002: p382) and my reflexivity in the research process.

The rationale for using qualitative research design is discussed. Action research is described in terms of its historical background and its appropriateness to this research design.

Thematic analysis as a qualitative analytic method used in this type of research is discussed. It is considered to offer an accessible and theoretically flexible approach to analysing qualitative data (Braun and Clarke, 2006: p77-101). Chapter three also considers the confirmability or explanatory power that the findings of this research may have. The importance of awareness of the ethical and moral issues when conducting research is addressed.

The actual project activity from conception to conclusion is concentrated on in chapter 4. This retraces the various stages in the journey of the enquiry.

Outlined in chapter 5 are the themes as they emerged from the data gathered. Verbatim statements are included to convey how each theme was constructed.

Chapter 6 revisits the themes that were identified in the data with the view to making sense of them in the context of similar enquiries around barriers to employing individuals in a phase of mental health recovery. It also seeks to understand the findings in terms of the local population within a North London Borough.

This final chapter captures the conclusions that I have drawn from my findings .It revisits and summarises the objectives and research questions of this study and considers them individually. It also sets out the recommendations that are thought to be useful as a result of conducting this piece of work. This chapter also includes details of the contribution to practice of this research along with proposed developments, training materials and advisory guidance for different stakeholders including service users, employers, practitioners and policy makers.

Chapter 2: Terms of Reference, Objectives and Literature review

Aims of the study

The aim of this study was twofold. Firstly I wanted to gain an in depth understanding of the reluctance by employers to employ individuals with a known mental illness who are in a phase of recovery. I also wanted to hear about the lived experiences and perspectives on the barriers experienced to accessing or being in employment from a service user's perspective.

A qualitative study was undertaken and it was hoped that this shared narrative would inform future developments that would help bridge the gap of understanding between employer, and employment of an individual with mental illness. Employment of individuals with severe mental illness was not an outcome sought from this research. Increasing understanding of what would make that possible was.

Objectives of the study

The objectives for this study were to:

- Identify through the action research process what local employers concerns were in relation to the employment of individuals in a recovery phase of mental illness.

- To raise consciousness and empower both participant types by encouraging dialogue, the sharing of good practice and coping strategies amongst participants so that appropriate strategies could be developed to challenge misconceptions that are identified.

People with mental illness continue to experience huge obstacles in their daily lives with the opportunity for employment being very limited. The following research questions were posed because I wanted to understand why that might be so. Interest in this as a research topic is influenced by my many years working as a manager of community mental health services. Despite many services users using our services attaining varying levels of recovery they are still not considered for employment. The following research questions were formulated after considerable review of the literature, examining the topic at local level and

identifying that studies so far either examine this topic from a service user's perspective or from an employer's perspective. I wanted to give participants an opportunity to share their experience from both sides of the equation that of a service users experience and that of a potential employers perspective. The research questions posed were:

1. Are employers' reluctant to employ people in the recovery phase of mental illness? If so what are their possible reasons?

2. Do mental health service users who are in a recovery phase experience any barriers to employment in a North London borough?

This research explores anticipated barriers to employing individuals with mental illness from an employer's perspective. It also examines perceived barriers to accessing, securing, or being in employment from a service user's perspective. It is envisaged that any new development implemented out of the data analysis will help to bridge any possible gap in confidence between the employer and the possible employment of an individual in mental health recovery. In order to appreciate the relevance of conducting this research it is worthwhile considering the background within which it took place.

Literature Review

Bibliographic databases, health data bases and social care databases were searched using the key words of employment, mental illness and recovery. A number of research project data bases were also searched using the search terms above. Government agendas and department publications were also searched using a combination of the above search terms. Reports or publications were accessed where the institution or agency were well known to the researcher or considered to be likely to inform the research discussion. This included accessing sites such as Rethink Mental illness, the Mental Health foundation, the Social Care Institute of Excellence (SCIE), the Institute of Psychiatry, Psychology and Neuroscience, and the Centre for Mental Health. Data bases such as The Kings Fund, The Royal College of Psychiatrists, and The Schizophrenia Commission provided rich sources of literature in relation to the research topic. Departments such as The Department for Works and Pensions, The Department of Health, the Social Policy Research Unit were also accessed.

In an effort to access literature and discussion on a broader level the search terms included phrases such as: policy on mental illness and employment, strengths based approaches to mental illness, mental illness and social care, mental illness and models of employment and mental illness in relation to the economic context. A wide range of peer reviewed journals were accessed. These were considered to have articles or publications related to this current research topic. The searches focused on a time frame from 2004 to 2014 and were restricted to English language only publications.

Older references are included in the thesis where the literature was thought to be of particular relevance to the discussion. These have helped to map the historical perspective of this research topic up to and including current thinking. There was a specific focus on the most recent publications as this topic seems to have become very much to the forefront of government thinking and policy drive in 2014. The articles and reports cited in this study map the journey where by individuals with mental illness are now considered as individuals who can recover from mental illness and who can have meaningful occupation. It also marks a significant shift in the language used, moving from an emphasis on illness to mental health recovery. There has been a continued shift in language with initiatives and drives that now focus on strengths based approaches rather than deficits in individuals who experience mental illness.

Employment, Mental illness and Recovery: The Historical Perspective

The population of people with mental illness in the United Kingdom is relatively large. Almost one in four British adults and one in ten children are experiencing a diagnosable mental health problem at any given time, making mental health problems the largest source of disability in the United Kingdom (Centre for Mental Health, 2013(b). From the UK population around five per 1000, or an estimated 210,450 people of the adult population have schizophrenia. This figure is projected to rise to 243,931 by 2026 (McCrone et al. 2008:p51).

Estimates of prevalence of individuals with bipolar disorder vary with a review by Waraich et al (2004) suggesting a 12-month prevalence estimate of 0.72 per cent for Bipolar Type I. Twelve month prevalence rates across European countries are

estimated as ranging from 0.5 per cent to 1.1 percent for Bi-Polar disorder (Pini et al. 2005). In the United States the National Comorbidity Survey Replication (NCS-R) reported twelve-month prevalence rates for Bipolar Type I as 0.6 per cent , 0.8 percent for Bipolar Type II and 1.4 per cent for sub-threshold bipolar disorder (Merikangas et al. 2007).

Individuals with a diagnosis of schizophrenia are more likely to be unemployed (Manning and White, 1995) with only 4% of that population reported as working in 1999 (Perkins and Rinaldi, 2002). The Psychiatric Morbidity Survey (PMS) for psychosis showed that 72 per cent of men and 68 per cent of women were economically inactive (Singleton et al. 2001). Lost employment due to schizophrenia is suggested to occur for 53 per cent of men and 24 per cent of women (Mc Crone et al. 2008:p60).This would suggest that diagnosis and diagnostic classification of mental illness leads to stereotyping and it is thought that this also leads to mental health professionals treating individuals by their attached label and exacerbating the notion that this client group do not recover (Corrigan, 2007).

Whilst health care professionals and the general public may contribute to the stigmatisation of these individuals there is strong evidence that employment of individuals with schizophrenia can have a huge positive impact on their life. It can lead to a reduction in symptoms and fewer hospitalisations (Bell et al. 1996: pp 51-57; Reker and Eikelman, 1997). It also enables the individual to have a better quality of life and greater self-esteem (van Dongen, 1996; Priebe et al.1998), provides financial benefits to the individual and society and also reduces dependency (Cook and Razzano, 2000). These research findings suggest that it would be worth pursuing an initiative making employment of individuals in mental health recovery a priority. There are other indicators, which may well improve if an individual with schizophrenia was to be in employment.

There are a lot of negatives aspects associated with having a diagnosis of mental illness such as stigma, discrimination, loss of self-worth and optimism about the future (Marris 1974; Perkins et al. 2009; DoH 2009b; LSE 2012; Bevan et al. 2013). Individuals with mental illness are considered as being less reliable, less able to perform and more of a risk for employers (RCP, 2003; 'see me' 2004; Perkins and Rinaldi 2002). More significantly having such a condition has serious

implications for life expectancies (Schizophrenia Commission, 2012). People with schizophrenia and bipolar disorder die on average 25 years earlier than the general population, largely because of physical health problems (Parks et al. 2006). Of those living with schizophrenia in the community, men experience 20.5 years' reduced life expectancy and women 16.4 years' reduced life expectancy (Brown et al. 2010; Schizophrenia Commission, 2012). When the above statistics are considered alongside those statistics that show the positive impact of employment for individuals with mental illness is it possible that employment could increase their longevity?

The idea that people with mental illness will still retain 'its residual reminders', such as forgetfulness, inability to concentrate or delirium and are capable of little more than employment at a basic level is an assumption that has been challenged by the South West London and St George's Mental Health NHS Trust (Perkins, Rinaldi, Hardisty, 2008).

Initially the trust established a User Employment Programme (Perkins, Evenson, and Davidson, 1995). This was designed to increase access to sheltered or supported employment within mental health services for people who have themselves experienced mental health problems. Between 1995 and 2007, 142 people were supported in 163 posts within the South West London and St George's Mental Health NHS Trust and on the 1st January 2007, 86% of these people continued to work within or outside the organisation or were engaged in professional training (Perkins, Rinaldi, Hardisty, 2008).This demonstrates the potential for long-term employment and resulting possible health benefits, where positively supported.

In addition, in every year between 1999 and 2006, at least 15% of new recruits within the trust had themselves experienced mental health problems. A more detailed analysis of 2005/6 recruitment data shows that new recruits with mental health problems were more numerous among those recruited to higher grade positions (Rinaldi et al. 2008: p10).

This work is encouraging and suggests that the findings of this current research could contribute to a very positive outcome for service users in terms of promoting recovery, social inclusion, and empowerment of service users by promoting employability. However it is not clear from the study above, to what extent

individuals were retained in employment outside the trust in 2007 and it is likely that there was a greater awareness of the needs of individuals with mental illness entering employment in a mental health service.

The financial burden on business every year as a result of absences due to mental illness is also significant. The Health and Safety Executive reported that the principal causes of absence from work due to mental illness are 55% certified by GPs for the year 2009/10. Following on from that the Confederation of British Industry's (CBI, 2011) report mental health conditions emerge as the single most widespread cause of long-term absence amongst both manual and non-manual workers(CBI, 2011: p20). The total cost to employers due to mental health problems among their staff is estimated at nearly £26 billion each year (Sainsbury Centre for Mental Health, 2007: p1).

Government is actively trying to address the low unemployment rates of this client group with different government initiatives such as their strategy called '*New Horizons: Towards a shared vision for mental health'* (DoH October, 2009(a). As discussed earlier the strategy set out to develop higher quality, more personalised mental health services in England. It was co-produced with people who use services and focuses on improving quality and accessibility of services for including the promotion of equality of access to employment. It also aimed to reduce the employment gap between people with severe and enduring mental health problems and other disabled people. That gap is quite significant with The Labour Force Survey of 2001 finding that 48 per cent of people with disabilities (Smith and Twomey, 2002: p420) are employed and only 18.4per cent of people with a mental illness, compared with a rate of 81 per cent for those without disabilities (Smith and Twomey, 2002: p421). In addition statistics produced by the Department for Work and Pensions survey (2002) showed that only 37 per cent of employers would recruit people with mental health problems compared to 62 per cent being willing to take on people with physical disabilities.

The Sainsbury Centre for Mental Health (2009)have identified a number of challenges to achieving the principles and ideas set out in the government policy *New Horizons* (DH, 2009(a) in particular that there are no drivers for action at local level. This is yet another bridge that needs to be built for employment of individuals with mental illness to become a reality.

Local authorities may not yet have put targets or outcomes in place but individuals with mental illness have identified employment and meaningful occupation as a priority for them (Evans and Ripper, 2000; Blitz and Mechanic, 2006) and they have described how returning to work is one of the most significant milestones in the recovery process (Secker et al. 2002). Despite these clearly established links between mental health and employment, individuals with a diagnosed mental illness continue to be disadvantaged when it comes to employment. There is this ongoing vicious circle with it being suggested that a way of approaching stigma reduction is to offer ways of integration and recovery, e.g. through paid employment, which has been observed to reduce stigma (Perkins et al. 2008).

It is known that paid employment contributes to recovery (Bevan et al. 2013; Knapp et al. 2014) and that employers remain reluctant to employ individuals with a mental illness (Schizophrenia Commission, 2012). What therefore is the way forward? How can this gap be bridged? Achieving change of such magnitude would be almost unimaginable given the well-documented negative attitudes to mental illness held by the population. These attitudes, beliefs and prejudices are important influences on recovery and on achieving respect for diversity of values and lifestyles. Recently the survey '*Attitudes to Mental Illness*' (DoH, 2013) showed that attitudes of the general public towards individuals with mental illness have shifted. It found that the vast majority of the public think that people with mental health problems deserve sympathy and that society needs to be more tolerant towards them (88 per cent respectively, p12). It also found that 77 % of those surveyed in 2012 agreed that people with mental health problems should have the same rights to a job as anyone else - up from 66 per cent in 2003 (p15-16). This huge shift in support for individuals with mental illness to go back into paid employment and this shift in attitude nationally provided it is maintained is encouraging.

While there might be a change in public attitudes there is still the case of engaging the employer. Considering this Irvine (2008) suggested that it is an overall lack of knowledge about mental health problems, rather than stigma or prejudice that constitutes the greater barrier to effective employer engagement. Employers have a poor understanding of mental illness, a finding borne out in this current research.

Lack of knowledge of mental illness on behalf of the employer would seem pertinent to address but the current economic climate must be considered. Public

sector services, including the National Health Services (N.H.S.), are facing huge cuts in their budgets, with an estimated £15 to £20 billion of real-term cuts likely in the 3 years from 2011 (RCP, 2009: p8).

Faced with cuts in NHS budgets there is the additional concern that the costs of mental illness will double in real terms over the next 20 years (Mc Crone et al. 2008) with the demand for health and mental health services increasing as a result of unemployment, personal debt, home repossession, offending and other forms of economic fallout (RCP, 2009). Therefore it is suggested that it is more worthwhile to develop strategies which invest in promotion, prevention and early intervention as not only can these reduce the burden of mental ill health and inequality but they also make sound economic sense (Future Vision Coalition, 2009).

Employment and Mental Illness: The Policy Context

Mental illness and employment was firmly placed in the public arena with the introduction of The Disability Discrimination Act (DDA, 1995). This contributed to the improvement and acceptance of mental health problems in society at large. The Act applied to all employers and explicitly stated that an employer must not treat a disabled person less favourably than another employee because of disability. It made it illegal for an employer to treat an individual less favourably because they think or know that they have a disability. Employers were required to make 'reasonable adjustments' to work practices, and provide other aids and adaptations, for disabled employees. The law covered an individual during recruitment, employment and if they are being dismissed for any reason, including redundancy. Employers are now still not allowed to use pre-employment questionnaires to ask about individuals' health before a job offer is made.

Before the Act individuals with a disability only had recourse to the law if treated unfairly in applying for work, through the main employment legislation (Thornton and Lunt, 1995), which was considered inadequate by people with disabilities. The effectiveness of the DDA legislation in helping individuals with mental illness gain employment is reflected in the government Access to Work initiative (Johnson et al. 2011). That scheme focuses on funding reasonable adjustments in workplace

environments for disabled people, but only 1% of the population who received support cited mental illness as their primary disability. But despite this significant piece of legislation as far back as 1995 individuals with mental illness remained at a significant disadvantage in the labour market some 17 years later (Schizophrenia Commission, 2012).

Nine years prior to this current research it was asked what could be done in the UK to bridge the gap between the disabling effect of mental health problems and gainful employment (DoH, 2003)? It was suggested that Social Inclusion through employment was a more realistic prospect than ever before for people with severe mental health problems. The research findings suggested a number of drivers for change in this area which included the following factors:

a. There was a steady demand for paid work on the part of people with mental health problems (DoH, 2003:p4).

b. That changes in UK legislation then protected the right to work of all disabled people (Ditto).

c. That policy guidelines placed increasing emphasis on the goal of social inclusion which highlighted the importance of employment to all sections of the community, not just the fully able (Ditto).

d. That a more flexible benefits system was improving employment prospects for people with mental health problems (Ditto).

 e. That there was growing bodies of practice knowledge enabling services to help people with mental health problems achieve employment (Ditto).

f. That underpinning all the above points was some sound evidence of the effectiveness of occupational interventions (Ditto).

It could be deduced from the above list that employment of individuals with mental illness was the anticipated norm when this particular research took place over 2011/2012. The drivers were very clear and explicit but the vehicle for achieving these changes was less clear. In the ensuing years there have been more policies aimed at tackling employment of individuals with mental illness. However the statistics continue to indicate that the numbers accessing employment remain significantly low (DoH, 2014).

The DoH research in 2004 saw The Mental Health and Social Exclusion report published by The Office of the Deputy Prime Minister (ODPM), (2004). This report was commissioned in 2003 by the then Prime Minister and the Deputy Prime Minister. It sought to address the social and economic costs of mental health problems and their impact on family well-being and child development. It outlined a detailed action plan aimed at improving access to social participation, employment and services for individuals with mental illness. The report was keen to examine two main questions:

1. What more can be done to enable adults with mental health problems to enter and retain work?

2. How can adults with mental health problems secure the same opportunities for social participation and access to services as the general population?

This topic was very firmly on the government agenda with over 900 responses from a written consultation. In addition 500 people mostly with experience of mental health problems or carers attended 7 consultation events across the country (ODPM, 2004). Prospective employers were not formally represented, which placed the problem and the solution in the locus of the service user. Was this then a one-sided consultation and can the questions outlined above be fully answered if the conversation is between service users carers and government? While 55% of consultation participants suggested that they experienced stigma as a barrier to accessing meaningful employment, the source of this stigma was not identified or the meaning defined in the report.

In 2005 the government issued a response in the form of a joint publication by the Department for Work and Pensions, the Department of Health and the Health and Safety Executive of the strategy known as 'Health, Work and Well-being; Caring for our future' (DWP, DoH, and HSE, 2005). It set out a vision of promoting the health and well-being for all society with an emphasis on creating healthy workplaces. That vision and resulting strategy was influenced by previous research commissioned by the HSE (Institute of Occupational Medicine, 2002: p8) which reported that only 15 per cent of all British firms provided basic occupational health support, and only 3 per cent provided comprehensive support. The emergence of this policy indicates a growing awareness of the importance of good support systems for any individual in employment. One of the main objectives of

the strategy was to ensure that people with health problems or disabilities were able to optimise work opportunities. This initiative was the beginning of the three departments (DWP, DoH, and HSE, 2005) working together to initiate change in the workplace environments. It also stated that they would learn from the successes, and failures, of the past; they would look at local pockets of excellence where barriers had been overcome by people working together at local level (DWP, DoH, and HSE, 2005:p27). Having completed research in this current study in to why employers are reluctant to employ individuals in mental health recovery and into the barriers experienced by individuals in accessing employment who consider themselves in a phase of recovery, it would appear that these promises have not been fulfilled.

The theme of work and its relationship to health was addressed in a publication called: 'Is work good for your health and well–being?' (Waddell and Burton, 2006). This was an independent review commissioned by the DWP which concluded that there is a strong evidence base showing that work is generally good for physical and mental health and well-being. It reported that being unemployed is associated with poorer physical and mental health and well-being. Employment has been found to be therapeutic and to reverse the adverse health effects of unemployment across all populations of working-age people, including those with disabilities and those with common health problems. Waddell and Burton (2006) concluded that work is generally good for health and well-being.

However there appears to be continued discrimination against individuals with mental illness when trying to access employment in the mainstream employment market (Time to Change, 2013).

The Social Policy Research Unit (SPRU) researched the theme of stigma and discrimination of those with mental health disability in accessing employment (Irvine, 2008). It presented a mixed picture and one that did not necessarily agree that stigma and discrimination were the only operant factors to barriers to employment of individuals with mental illness. The study found that when employees disclosed a mental health problem the responses ranged from very positive and supportive to overtly negative or what was perceived as an over-reaction(Irvine, 2008: p3). There were also a number of employees who felt that there had effectively been no response at all to their initial disclosure of mental health problems at work. In some cases, for example where people had attempted

to talk to employers about work-related stress, the lack of response was perceived to have exacerbated mental health problems, eventually resulting in long periods of absence. Conversely 76% of line managers reported having experience of managing at least one person who they knew had a mental health condition but they felt that they lacked the confidence to act and approach an employee who may be showing signs of distress (Great Place to Work, 2009: p6).

It is important to note that the mental illness referred to here is commonly experienced in work situations and not confined to those conditions of a complex nature such as schizophrenia (DoH, 2014). Nevertheless it cannot be ignored that even a common mental health issue, such as workplace stress, can greatly impact on a person's ability to do their job if the individual is not supported properly. Moreover the *Absent Management Survey* (CIPD, 2013), suggests that stress is now the most common cause of long-term sickness absence for both manual and non-manual workers (p6). Unmanageable and high workload is cited as the leading cause of stress related absence, with management style cited as the second leading cause (CIPD, 2013: p25). This indicates that employers need to have a greater understanding of mental health and mental illness so as to support their employees more appropriately.

Other research in to the management of stress or mental health related issues at work varied. They were largely a matter of individual attitude rather than a consistent organisational approach (Irvine, 2008).

There were suggestions that lack of response and engagement in discussion of employees' mental health problems was linked to low levels of knowledge and understanding among some line managers and Occupational Health staff. Overall there was the suggestion that a lack of knowledge about mental health problems, rather than stigma or prejudice, was the greater barrier to effective employer engagement.

What was encouraging about the findings from the SRPU study (Irvine, 2008) was that where people had been open about their mental health difficulties, they had often found that they were not alone in their experience and that at least one person in their acquaintance was able to offer empathy and support. Thus it was suggested that if steps can be taken towards challenging the taboo around mental illness, there might be less distance to travel than anticipated (Irvine, 2008).

This and other studies indicate that there appears to be a subtle shift at least in thinking about how to support individuals with mental illness back into employment. There is a stronger drive to go beyond traditional clinical care and help service users with a known mental illness back into mainstream society. This has contributed to a re-defining of recovery as it has been understood hitherto, now incorporating quality of life, employment, a decent place to live, friends and a social life (Appleby, 2007). The research reports cited in this thesis and different government's initiatives have helped to foster the appetite for this enquiry. They indicate that despite there having been many attempts to understand mental illness, employment, employability and work place environments the rate of unemployment for this client group is very low (Bevan et al. 2013). However, on examining the literature, the topic is usually considered from either a service user's perspective or from an employer's perspective, leaving a need for the topic to be researched from a more inclusive perspective. Therefore this research sought to understand the problem from a shared perspective or through both lenses, the service users' and the employers' with a view to developing appropriate resources and guidance that might bridge this two way gap in knowledge and understanding of people with mental health issues.

Two years prior to this fieldwork there was a government consultation called *New Horizons* (Department of Health, 2009(a). It aimed to create a new cross-government vision for mental health in the United Kingdom for 2010. It was interested in building on what had been learned or developed out of the *National Service Framework* (NSF), (DoH, 1999) for mental health. It set out a vision to create flourishing and connected communities through the promotion of well-being and resilience and the reduction of inequalities. *New Horizons* identified some key themes that needed addressing; prevention of mental ill health and promoting mental health, early intervention, tackling stigma, strengthening transitions, personalised care innovation with the mode for tackling these set there in. This was one of the contributory drivers which led to the development of The Equality Act (2010), anti-discriminatory and equality legislation which brought together a number of former Acts and Regulations.

The *New Horizons* report (DoH, 2009(a), heralded

'*that people with mental health problems are able to run their own lives, participate   in the life of their families and communities, and work productively to*

earn their living and contribute to the economy, to varying degrees – just like people with physical health problems' (p7).

This vision indicated a shift in how individuals were perceived especially around capability. The report included terms such as 'work productively' which is not usually associated with individuals with mental illness. In that vision the workplace was identified as a place for prevention and promotion of good mental health. It suggests that individuals in workplace environments should have mental health awareness training and access to free counselling (DoH, 2009(a): p15).

The essence of this vision pointed to a move in the right direction but it also pointed to a glaring gap between 'the vision' and what is actually the current reality for those with mental illness (Bevan et al. 2013). Clearly it is not enough to have a vision; the processes and mechanisms for making this a reality have yet to be identified. The findings from the current research indicate that the vision has not been effectively disseminated to employers, leaving individuals with mental illness with limited employment opportunities (Organisation for Economic Co-operation and Development (OECD (a), 2014; Bevan et al. 2013; CIPD, 2013).

Building on the vision set out above, the Equality Act (EqA) (2010) replaced a range of anti-discrimination legislation; including the Disability Discrimination Act 1995 (DDA, the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and three major statutory instruments protecting discrimination in employment on grounds of religion or belief, sexual orientation and age. The EqA states that it is unlawful to discriminate against people with a disability. A person will be considered to have a disability if they:

- Have an **impairment** that is either physical or mental; and

- The impairment has **substantial adverse** and **long-term** effects on their ability to carry out normal day-to-day activities.

(The Equality Act (S6) (1), 2010: P7).

Individuals with a mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities are considered disabled under this Act. Within this legislation there is a provision for disability access and reasonable adjustments for individuals with mental illness who are employed. That poses the questions of how will the employers respond to complying with the provision of

disability access? And what constitutes a reasonable adjustment when considering an individual in mental health recovery in the work place environment?

The duty on the employer to make reasonable adjustments arises in three situations. They are where a provision, criterion or practice applied by or on behalf of the employer, places a disabled person at a substantial disadvantage compared with people who are not disabled or where a physical feature of premises occupied by an employer, places a disabled person at a substantial disadvantage compared with people who are not disabled or where the lack of an auxiliary aid places a disabled person at a substantial disadvantage compared with people who are not disabled.

An employer has to take such steps as it is reasonable to take in all the circumstances above to avoid that disadvantage – in other words the employer has to make a 'reasonable adjustment' (Equality Act, 2010). Disability access may involve interpretation in the wider sense. Employers may consider introducing flexi hours to accommodate the effects of anti-psychotic medication on individuals in mental health recovery. This could fall under a reasonable adjustment but may also be considered as enabling access to a position or post of employment. Failure by employers to meet with these requirements could be considered as discrimination. This act protects individuals in mental health recovery, so even if an individual is in a phase of recovery the legal obligations on the employer are still relevant.

Bearing the legal obligations placed on the employer by the EqA 2010, reports in the past indicate that that 55% of individuals with a known mental illness experience stigma as a barrier to accessing meaningful employment (ODPM, 2004) and that employers have a poor understanding of mental illness pointing to this continued gap between the two parties(Irvine, 2008). There needs to a shared narrative between individuals with mental illness who are in a phase of recovery and employers so that a common ground and understanding can be gained about what is contributing to this continued division.

The above legislative requirements were certainly issues that I had to be aware of while conducting this research as participating employers were likely to be worried that there might be legal or reputational risks for them by agreeing to participate in this study. Consequently it was imperative that this was handled with great

sensitivity and that the aim of the study and the importance of confidentiality were stressed. Clearly, if those objectives had been implemented across the country and at local level I would not have had to carry out this research unless of course I wanted to evaluate the achievements. The initiative was yet another drive towards equality and diversity for all regardless of mental illness. The intentions seem well founded but again the vehicle for delivery seems less obvious. It could be argued that this is a pervasive issue for 'hands off' government and therefore could be construed as a means for positively encouraging local solutions.

In addition to the above was the emergence of the policy *No Health without Mental Health* (DoH, 2011). This set out the Governments strategy for England. It identifies a list of key objectives aimed at promoting better mental health care. They are:

1*. More people will have good mental health,*

2. More people with mental health problems will recover,

3. More people with mental health problems will have good physical health,

4. More people will have a positive experience of care and support,

5. Fewer people will suffer avoidable harm and finally

6. Fewer people will suffer stigma and discrimination.

No Health without Mental Health (DoH, 2011, Chapter 3: p19-29).

I have listed the objectives, as they seem to be quite similar to the objectives set out in the government strategy 2005: *Health, Work and Well-being; Caring for our future* (DWP, DH, and HSE, 2005). Objective number 2 above was of particular interest to this research. To achieve this objective it was suggested that individuals with mental illness will have a greater ability to manage their own lives, stronger social relationships, and a greater sense of purpose. They will have the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live (DWP, DH, and HSE, 2005). These objectives appear to be very clear and specific though these targets have not yet been achieved in the community at large.

Noting objectives 1, 2 and 3 above in 2012 the London School of Economics (LSE) report that mental health conditions account for 23% of the burden of disease (LSE, 2012: p2). Discussing the mis-match between burden and expenditure in the National Health Service the LSE note that of those under the age of 65, nearly half of all adults suffering ill health are suffering from mental illness (LSE, 2012: p1). The population of individuals with mental illness is nearly as much as in all physical illnesses put together (LSE, 2012: p1). This would imply that substantial change is needed in order to bridge that gap between understanding the correlation between mental illness, recovery, employment, employers, understanding and support.

Objective 6 set out above is further supported by the Mental Health (Discrimination) Act 2013. Amendments to this Act were put in place in an effort to reduce discrimination against people on the grounds of their mental health.

Specifically there were three provisions in the Act that were repealed or amended:

- Repeal section 141 of the Mental Health Act 1983, under which a Member of the House of Commons, Scottish Parliament, Welsh Assembly or Northern Ireland Assembly automatically loses their seat if they are sectioned under the Mental Health Act for more than six months.

- Amend the Juries Act 1974 to remove the blanket ban on 'mentally disordered persons' undertaking jury service.

- Amend the Companies (Model Articles) Regulations 2008 which states that a person might cease to be a director of a public or private company 'by reason of their mental health'.

These amendments signal a shift strengthening the case for the suitability of employment of an individual who is in a phase of mental health recovery. It also points to the need to understand employer's perspective of mental illness and perception of suitability of this client group to employment. The next stage of mapping the landscape that shaped this research considered some of the thinking around the concept of recovery and the strengths model a model that is mental illness specific (Rapp and Goscha, 2006). It has been clearly established in the literature that models and approaches are more important than client

characteristics in determining whether people with mental health problems are able to work. Studies of employability indicate that client characteristics have very little impact on vocational outcomes (Secker, Grove and Seebohm, 2001). It is also known that the wish to work, and the belief that you can succeed, are the best predictors of work outcomes (Rinaldi and Perkins, 2004: p. 54-56). These are principles that are grounded in the concept of recovery and the Strengths Model (Rapp and Goscha, 2006).

Employment, Mental Illness and Strength Based Approaches

Considering individuals with mental illness as suitable for employment of any sort requires a huge cultural shift in thinking and implementation. However the idea that people can recover and do recover is well documented (Shepherd et al. 2008; Repper and Carter 2010; Andrews et al. 2012; Knapp et al. 2014).

The strengths model (Rapp and Goscha, 2006) is a model which was developed to help people with mental illness tap into their strengths and it is known to be linked to recovery. It sets out six principles proposing firstly that individuals do actually recover from mental illness. It places a strong emphasis on what the individual with mental illness is capable of achieving rather than their inabilities. This model pays less attention to the diagnosis of the individual, which is often associated with absence of skills and ability rather than a presence of these. So this model starts from the position of looking at what the individual has to offer. There is already an acceptance that an individual with mental illness has something to offer. This stance is also adopted under the appreciative method of enquiry (Hubbard, 1998). Within the appreciative method of enquiry(Hubbard, 1998) the social construction of reality is taken to its most positive extreme with an emphasis on seeing the best in one another and in situations. A strengths focused approach is also emphasised in the discipline of 'positive psychology' (WHO, 2005; Barry and Jenkins, 2007; Friedli, 2009). In this discipline there is a focus on "positive mental health", as an empowering resource, broadly inclusive of psychological assets and skills essential to human fulfilment and well-being (WHO, 2005; Barry and Jenkins, 2007; Friedli, 2009). It is seen as complimenting the results emerging from synthesising narratives about recovery from mental illness, which provide naturally valid insights into the processes by which people

experiencing mental illness can develop a purposeful and meaningful life (Slade, 2010). Collated, these models and ways of thinking emphasise strength promotion and a focus on the development of mental health services that are health orientated rather than illness orientated.

I have a strong affiliation with strength-based concepts and the strengths model in particular (Rapp and Goscha, 2006), as these consider the broader picture. Strengths focused approaches like that of Rapp and Goscha seek to establish what the strengths are within the local community that can be tapped into. How can these be utilised to promote recovery? Furthermore the Rapp and Goscha strengths model (2006) looks at resources such as local employers: those that might be willing to employ individuals in mental health recovery, and employers that might be willing to support recovery. Common examples of this kind of employer are large supermarket chains (Asda, Tesco, and Sainsbury's), Do It Yourself (DIY) chains (B&Q, Homebase), employers such as the Richmond Fellowship and Remploy. The government is looking to expand on such employers by developing high quality employment support. Between April and December 2013, the '*Access to Work*' (DWP, 2013(b) and *'Work Choice Scheme'* (DWP, 2013(c) helped 1090 people with a mental health condition back into employment. Looking at improving on this the government published *'Closing the Gap: priorities for essential change in mental health'* (DoH, 2014) which emphasises the strengths based approaches to employment of individuals with mental illness.

The strengths model places the service user at the centre of the recovery journey. The service user is the main player in the process and it is a total person centred unique journey for each individual. In terms of this research this principle is very important as individuals with mental illness place different values on different jobs, different types of employment and different employment sectors. For example some see voluntary work as hugely valuable to their self-worth and recovery whereas other service users would see that as devaluing a person with mental illness. They would see paid employment as the main route to supporting recovery. The same can be said about types of jobs considered as suitable for individuals with mental illness. Some see sweeping the floor as a real valuable meaningful job where as others would view this as demeaning. To address these different aspirations it is suggested that there should be a broad definition of 'work', subsuming a variety of work including paid employment, pre-vocational and

non-vocational options are adopted. This definition might be useful given the differences in interests, skills, talents, physical abilities and limitations of mental illness such as schizophrenia (Bachrach, 2000: p6-10).

An article published in The New York Times (Saks, 2013) captures how one can respond to a diagnosis of schizophrenia either as a positive driving force in one's life or allow it to reinforce one's negative appraisal of one's own ability. The author was advised to take the 'low road' by therapists and doctors, but she went on to become a law professor and a researcher on how others with schizophrenia succeed while managing their illness. She said that

'*an approach that looks for individual strengths, in addition to considering symptoms, could help dispel the pessimism surrounding mental illness'* (Saks, 2013: p1).

The strengths model places emphasis on the importance of the relationship between the individual with mental illness and the person that is supporting their recovery (Rapp and Goscha, 2006). In terms of understanding the pathway to employment this would be very important. It might well be that the employer or fellow employees takes on this role. Recovery champions could be pioneered in different industries and employment sectors. This relationship of trust is then considered to impact positively on the recovery process.

It also places the community as the focus for recovery. It is thought that the skills learned in the community are more likely to be transferable to life in the community at large.

This model was developed in 2006, but it seems that this concept has not been taken on by employers or communities at large. There is still a particular association of illness and inability with a diagnosis of mental illness with the possibility of employment not on many employers radar. It would seem that many employers or those involved in the employment pathway may not be ready to shift to a strengths framework. This may well be because they are not aware of it. Moving to the adaptation of a more overarching strengths model would mean that some well-established cultural and professional traditions, perceived truths and hidden meanings are challenged (Blundo, 2006: p301).

The strengths model (Rapp and Goscha, 2006) goes some way towards stressing the importance of engaging the employer and linking the skills learned in the community as areas that enhance recovery. The focus is entirely on the individual with mental illness, their strengths and their abilities. There is however a limitation in the model in that it focuses on the individual and an employer to be able to support that individual. This model could be enhanced if it were to be adapted to applying the strengths perception to whole work place environments and whole sets of employers and employees as opposed to focusing on the individual. The addition to the model could be around capturing the strengths existing in employee groups, employment sectors, and work place environments that would promote and enable employment of individuals with mental illness. It would be worth testing the idea that such an adaptation could lead to a normalising and acceptance of mental illness and mental well-being in workplace environments.

It may also be worth considering constructing a more encompassing strength based integrated model for all employees, employers and those involved in the employment pathway. Central to the adaptation of a strengths based model is empowerment as a proactive process in which individuals and groups gain power, access to resources, and control over their own lives (Robbins, Chatterjee, and Canda, 2006: p. 94). The promotion of health and well-being is at the heart of the new European health policy framework, Health 2020 (WHO, 2013(a). This policy aims to support action across government and society to:

"*Significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centered health systems that are universal, equitable, and sustainable and of high quality*" (WHO, 2013(a):p11).

This suggests that health and well-being are gaining recognition across Europe with a greater emphasis on wellness models that take account of the individual's overall well-being. This is a huge shift away from the illness models most commonly associated with a diagnosis of mental illness. The next stage of this paper will consider employment of individuals with mental illness in the Social Care context.

Employment, Mental illness and Recovery: The Social Care Context

Consideration of employment as an option for individuals with mental illness availing themselves of social care support has been slowly but steadily gathering pace. The *Attitude to Mental Illness* research report (DoH, 2013) reported that out of approximately 1,700 individuals from the general population 60% agreed with the statement that 'People with severe mental health problems can fully recover' (p24). Health and well-being is also addressed in The Health and Social Care Act (DoH, 2012(a). It places a new duty on (upper tier and unitary) local authorities in England to 'take such steps as it considers appropriate for improving the health of the people in its area' (DoH, 2012(a):p2). Local authorities must take responsibility for improving health and co-ordinating local actions to protect the public's health and well-being, and for ensuring that health services effectively promote population health. However wording such as 'steps as it considers appropriate' (DoH, 2012(a): p2), are nonspecific leaving it open for interpretation at local level. There is no specific mention of employment and how it constitutes better mental health in promotion of the population's health. It has similar non-specificity to The Disability Discrimination Act (DDA, 1995), which suggested that employers should 'make reasonable adjustments' in employing disabled people (DDA, 1995, Section 4A). Yet in the same year as The Health and Social Care Act (DoH, 2012(a) received Royal Assent one third of new jobseekers allowance (JSA) claimants reported that their mental health deteriorated over the period of the four-month study, while those who entered work noted improved mental health (McManus et al. 2012). Also in that year The Care Quality Commission (CQC, 2012) survey of community mental health service users found that 43% of the 2,780 respondents said they would have liked support to find or keep a job but did not receive any (Care Quality Commission, 2012). That suggests that consideration of the suitability of the employability of this client group remains patchy and poor and its link to recovery largely unrecognised. This is despite the continued recognition of the relationship between unemployment and poor mental health (Dorling, 2009).

Employment as a route to recovery is included in the Government mental health strategy, *No Health without Mental Health* (DoH, 2011) where the second objective states that 'more people with mental health problems will recover' (Part 1: p8), with reference to individuals been given the 'skills they need for living and

working' (p 33, p 38) and 'better employment' (DoH, 2011:p33). The concept of recovery is also picked up in the 'Closing the Gap' report (DoH, 2014). There-in it states 'high quality mental health services with an emphasis on recovery should be commissioned in all areas' (DoH, 2014: p10), but does not specifically mention employment. It is accepted that employment may not be possible for everyone with mental illness, though the possibility of employment could benefit from more in-depth assessment to support any meaningful shift in the employer attitude about individuals with mental illness and their suitability to employability.

The importance of employment to recovery has been recognised by mental health service users and practitioners (Highlands Users Group (HUG), 2005; Royal College of Psychiatrists (RCP), 2003; Brown and Kandirikirira, 2007). However recovery from mental illness is not well understood or accepted among employers or the general population despite the evidence base that people who work benefit from better mental health, including a sense of purpose, social contacts, (Warner, 2002), reduced clinical symptoms and positive social functioning (Warr,1987; Bell et al. 1996; Schneider, 1998).

A central tenet of recovery is that it does not necessarily mean cure (clinical recovery). Instead, it emphasises the unique journey of an individual living with mental health problems to build a life for them-selves beyond illness (social recovery). Thus, a person can recover aspects of their life, without necessarily recovering from their illness.

There is no single 'model' of recovery but more an adherence to a particular way of thinking, recovery ideas. One of the most available definitions of recovery is set out by Anthony (1993), who defines it as:

"*a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and a purpose in one's life as one grows beyond the catastrophic effects of mental illness…*" (Anthony, 1993: p11-23).

Employment would therefore seem to go some way to meeting that definition in terms of it being satisfying, purposeful and meaningful. Recovery is also perceived as providing a further step to developing coping strategies a move on from mere survival or life management to an improved and personally defined quality of life (Wallcroft, 2005). Encapsulated in the concept of recovery is a great sense of

hope and possibility, which seems a very long way away from the negative attitudes, associated with diagnostic classification of mental illness (Corrigan, 2007).

The policy paper called 'Making Recovery a Reality' proposes that the recovery approach is an idea whose time has come (Shepherd et al. 2008) while others perceive it as more than an idea and proposes that it also includes a set of values, a policy, and a philosophy (Bonney and Stickley, 2008).

The Scottish Executive has also included the promotion and support of recovery as one of its four key mental health aims and has funded a Scottish Recovery Network to facilitate this (Ramon, Healy, and Renouf, 2007). In addition a 2006 review of nursing in Scotland recommended a recovery approach as the model for mental health nursing care and intervention (NHS Scotland, 2006), while The Mental Health Commission of Ireland (2005) reports that its guiding documents place the service user at the core and emphasises an individual's personal journey towards recovery. So recovery as a reality is becoming more accepted but in order for it to be truly integrated into services there has to be a change in culture and practice at every level of the organisation (Shepherd et al. 2010). This will be a vital concept if employers are to begin to entertain the notion of the possible employment of individuals in a recovery phase from mental illness.

Recovery is about tapping into the individual's strengths and fostering those environments of possibilities. If recovery from mental illness is to be recognised as a possibility, a reality, and that employment of individuals with serious mental illness is possible, does this imply that the term mental illness needs to be rebranded? Is it time to move from defining people by their labels such as schizophrenia to seeing the potential in the person? Are employers ready to change from holding the locus of control to facilitating the employment of the individual with mental illness? Is partnership between health, social services and employers the new way forward? Promoting recovery as part of government policy is certainly indicated in the white paper, *Liberating the NHS, no decision about me without me* (Department of Health, 2010). If recovery and employment are to be truly accepted there is much work to be done to make this cultural shift a reality. Employment as a means to support recovery from mental illness is postulated in this research. Without that knowledge and understanding the various barriers to accessing and maintaining employment when in a phase of mental health

recovery will remain. It should be noted that many workplace factors that would help an employee with schizophrenia stay in work are the same as in any psychologically healthy workplace – creating an environment in which we feel safe and support that is available for all those who need it (Bevan et al. 2013). This principle might cut across employment for all, as we all want to feel safe and supported at work but there may be additional areas identified as promoting the successful employment of individuals in mental health recovery. Strengths based approaches have proven to lead to increases in social harmony, community empowerment and adult employment (Mclean, 2011).

Despite the existence of strength based approaches to support individuals with mental illness in employment the issue of finding the right employment and having appropriate support in maintaining employment continues to be a difficult one. There are a number of supported employment models which have been proven to support individuals with mental illness back into supported employment. The next stage of this thesis will consider how these models are used to engage individuals with mental illness in supported employment.

Employment, Mental Illness and Models of Employment

There have been many supported employment models developed all over the world with the view to supporting individuals with mental illness back into work. To date the main focus of such support packages has been on support for the individual with mental illness, with very little work done on developing support packages, which combine support for the employer and employees of organisations in recognising and managing mental illness in work place environments. Supported employment (SE) models have been around since the late 80s (Becker and Drake, 1993; Bond et al. 2001(b), offering vocational rehabilitation for individuals in mental health recovery. SE initiatives in the United States (US) initially place individuals in employment and then train them (place-train models) as opposed to training first and then finding competitive employment for the individual (train-place models). Interestingly the vocational outcomes for people on supported employment programmes in the US place-train style models tends to be higher than in other parts of the world (Bond et al. 2012).

In Australia they have various models of supported employment for people with

mental illness including the 'open employment' scheme (Australian Government Disability Services Act, 1986). Their SE model offers group based assistance provided by business services, offering sheltered work in modified (not fully competitive) work settings. There has also been an approach adopted in Australia called Mental Health First Aid (MHFA), (Jorm and Kitchener, 2011: p 808–813). It was first pioneered in 2001 (Kitchener and Jorm, 2002) and is used to teach the public about mental illness. The idea is that ordinary lay people undertake the training and learn how to assist someone who is developing a mental illness or in a mental health crisis situation (e.g. the person is suicidal or has had a traumatic experience). This first aid is given until the person receives professional help or until the crisis resolves.

Although not specially targeting individuals in employment this approach could be modified to be used in workplace environments. It has been reported that in 2011 there are over 850 instructors in Australia who have trained over 170,000 adults. The MHFA programme has spread internationally, starting with Scotland in 2004; it then spread to Canada, China, England, Finland, Hong Kong, Japan, Nepal, New Zealand, Northern Ireland, Singapore, South Africa, Sweden, USA and Wales. This approach has been proven to improve mental health literacy and is therefore transferable to people in work place environments.

The most widely used model in the United Kingdom is known as the Individual Placement Support (IPS) model (Rinaldi et al. 2010(b). This model emerged in the US in the 1990's and is now the most widely replicated model in the UK, Norway, Denmark, Hong Kong, Canada New Zealand and Australia (Centre for Mental Health, 2013, (b). This approach aims to get individuals back into work and give them support in the work environment. It is based on a number of principles which are described later in this chapter and although different in name adopts the same principles of SE (Twamley, Jeste and Lehman, 2003: p515-523). Individuals who have availed of this support have proven to have higher rates of competitive employment, duration of employment and hours worked compared to different forms of place and train supports (Kinoshita et al. 2013). Yet today almost half of England's secondary mental health services still have no IPS workers or teams in place (Centre for Mental Health (b), 2013). It is worth noting that rates of employment of individuals with mental illness in the UK remain very low with only 5% to 15% in paid employment (Andrews et al. 2012).

The Centre for Mental Health has developed a centre of excellence project in the UK which will act as exemplars of how IPS can be implemented in localities across England. There is extensive research, which was conducted over 15 years, through 16 randomised controlled trials, which support the superiority of this model over the best available alternative (Bond et al. 2008: pp 280-290). One showed that although high fidelity implementations were difficult to achieve, the IPS approach was consistently more effective in countries with widely differing labour markets, health and welfare systems (Burns et al. 2007: pp 1146- 1152).

They concluded that IPS is more effective for helping people with mental illness achieve competitive employment outcomes than any other psychiatric rehabilitation approach. In fact 16 randomised controlled trials in 16 different countries of 'Individual Placement with Support' (IPS) evidence based supported employment show that an average of 60% of people with more serious mental health conditions can gain and sustain employment if they are given the right support (Bond ,et al. 2012).

The findings are set out in Figure 2 below.
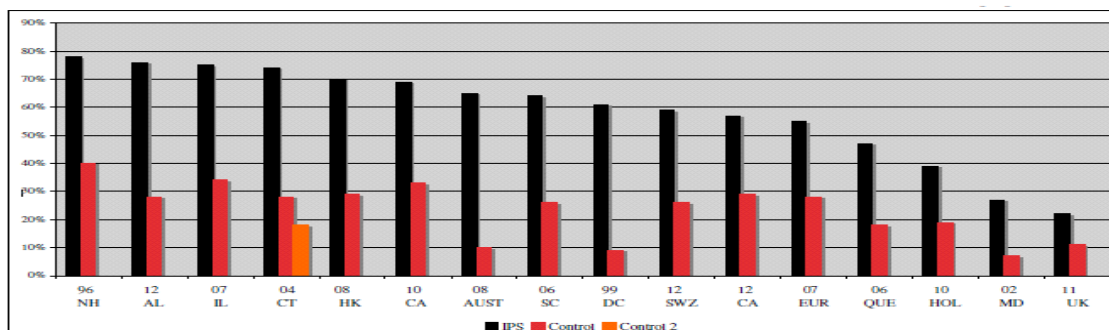
(Bond et al, 2012)

Figure 2: **Competitive Employment Rates in 16 Randomised Controlled Trials of Individual Placement and Support. Sourced: Presentation given in October 2013, at the South West London and St. Georges Trust, Mental Health NHS Trust. Increasing Employment of People with Mental Health Problems (Rinaldi, 2013: Slide 5).**

Better employment outcomes are predicted when using the IPS model once the following essential principles are covered within IPS schemes. These include:

a focus on competitive employment as the primary goal; a rapid job search approach is used; clients are intensively assisted to find jobs of their choice; all assistance is individualised and provided according to client preferences; follow-on supports are maintained indefinitely if required; the supported employment

program is closely integrated with the mental health treatment program; and financial counselling is provided to help overcome the many welfare disincentives associated with returning to work (Bond, 2004: p345-359).

Together these principles serve as a foundation for basic evidence-based practices by effective supported employment services. However it is unclear from studies of the IPS model (Rinaldi et al. 2010(b) undertaken so far what the specific vocational outcomes that have been achieved are.

There is also the Danish Model of Job Rotation referred to as 'the golden egg' of unemployment is used by the Social Democrat led Danish Government's fight against unemployment (Preisler, 2013). In 2012, the national budget earmarked more than €24 million for this initiative. Job Rotation is considered to be a flexible instrument that varies according to the individual needs of workplaces and location. It also aids the professional development of longstanding employees by allowing them to pursue other training opportunities on a temporary basis. In effect it provides a win-win resolution.

There has been a job rotation model developed by nurses in Central and North West London (CNWL) Mental Health Trust and West London Mental Health Trust, (Coyne, 2011). This model is quite different from that of the Danish Model of Job rotation described above. Coyne's job rotation model (2011) aimed to improve job recruitment and retention of nurses working in what was considered 'hard to staff' clinical areas in the Trust. That scheme trained 65 participants over two years to become more experienced practitioners following achieving a qualification as a nurse. This scheme seemed to have the attraction of enrolled individuals being able to achieve a degree through Work Based Learning (WBL) at Middlesex University.

Candidates on the job rotation scheme did a number of months in practice and a number of months at University rotating between different 'difficult to staff' posts in the CNWL and the WLMH Trust. That scheme has proven to improve recruitment and retention in the 'hard to staff' areas within the Trust. As with any scheme it also encountered a number of challenges including what to do when staff requested not to be rotated or was not happy with where they were rotated to. Within that scheme job rotation was defined as:

'*The purposeful and organised movement and education of staff within and across*

organisations to enhance both the success of the organisation and the employability of staff' (Coyne, 2011: p32).

It is possible to use the thinking behind this model to support individuals in mental health recovery back into work. Individuals in mental health recovery could be trained in particular job skills and used as 'bank staff' within organisations to cover annual leave, sickness cover or maternity leave. If they were to be employed in posts that were 17 hour contracts they would be able to retain their current benefit entitlements.

Therefore supported models of employment or job rotation models might be an attractive option for easing individuals in mental health recovery back into work. In 2015 there is a drive to treat mental health disorders on a par with physical health disorders to provide what is being referred to as 'Parity of Esteem' (NHS England, 2015). Part of the rationale for doing this is that it is recognised that despite there being a number of initiatives that support employment of individuals with mental illness back into work the total economic and social cost of mental illness in the UK is over 105bn pounds every year (NHS England, 2015). The next phase of this thesis will consider the economic impact of mental illness and employment.

Employment and Mental Illness: The Economic Context

By 2030 there will be approximately 2 million more adults in the UK with a mental health problem (Mental Health Network, 2014). It is predicted that 900,000 working Londoners (1 in 6 of the current 18-64 year olds population of 5.4 million) will experience mental health problems in the course of each year (ONS, 2013). It is also worth noting the most recent figures around cost. Mental health issues cost the UK around 70 billion pound every year, or roughly 4.5% of gross domestic product (GDP) in lost productivity at work, benefit payments and health care expenditure (OECD, 2014(b).

The cost of mental illness in the UK is estimated as being the highest across the O.E.C.D. countries. The bar chart below highlights the costs of mental disorders to society across eight countries (OECD, 2011).
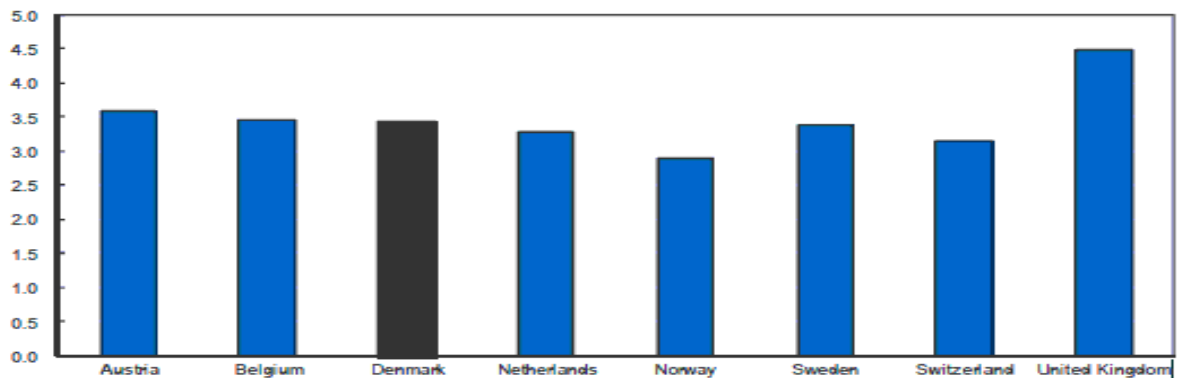
Figure 3: **Costs of mental disorders as a** percentage **of the country's GDP, 2010**. **Source: OECD compilation based on "Cost of disorders of the brain in Europe 2010", European Neuropsychopharmacology (2011) 21, 718–779 for cost estimates and Eurostat for GDP.**

Figure 3 above relates to a study, which covered an estimated population of 514 million people across eight countries (Gustavsson et al. 2011). It is reported that in 2010 out of approximately 45 million cases of brain disorder in the UK people with psychotic disorders were estimated to cost £14 billion. Anxiety was estimated to cost around £10 billion with an estimated total of £112 billion pounds a year spent on brain disorders (Gustavsson et al. 2011: 718-779). During 2010/2011 individuals with a diagnosis of schizophrenia were estimated to cost 11.8 billion pounds (Andrews et al. 2012: p5). Considering the global economic impact of mental illness there is a case to try and understand how employment can be understood as a route to recovery for individuals in a phase of recovery from mental illness at local level. It would also seem equally important to understand why employers remain reluctant to employ individuals in a phase of mental health recovery noting that over 900,000 Londoners will experience mental illness each year (ONS, 2013).

In January 2013, the Joint Chief Commissioning Officer of the North London Borough (NLB) within which this research took place set out its intention to develop a Mental Health Joint Commissioning Strategy (Nagra, 2013). One of its stated intentions is: to commission work opportunities, support and associated employment activity for people with mental health issues. The objectives of the service are to enhance work and life skills and confidence by developing employment opportunities.

With that in mind and taking account of the evidenced based literature, government led initiatives and these current research findings it would seem highly

appropriate to try and establish links with the local Mental Health Joint Commissioning Team in order to develop strategies or resources that may improve employment outcomes for individuals in a phase of mental health recovery.

Chapter 3: Project Design and Methodology

This study commenced in 2011 at a time when the United Kingdom was considered to be in a deep recession with recovery predicted to remain subdued (Organisation for Economic Co-operation and Development, 2011). The office of National Statistics (O.N.S.) released statistics in September 2011, which showed that the unemployment rate was 7.9 per cent and there were 2.51 million unemployed people in the United Kingdom (O.N.S. 2011). Asking employers to participate in such a sensitive discussion at this time was therefore risky.

This chapter will initially describe the theoretical framework that underpinned this naturalistic inquiry. It sets out the study approach that was adopted and describes the methodology and philosophical rationale that underpinned that. Action research (McNiff, 2001) as a systematic approach to research is described in terms of its historical background and relevance to this study. It was considered to be a practical approach to research and sensitive to the research topic and participants involved. Methods for data analysis are described with consideration of the confirmability and explanatory power that focus groups provide. There is also consideration of the role of the researcher as an 'inside researcher' (Robson, 2002: p382) and the influence of reflexivity during the analytic process. Attention is also given to the ethical moral and legal issues arising when conducting research within a social context.

Theoretical Framework- justification of research intentions and design

The researcher adopted what can be described as a phenomenological epistemological approach that had the capacity to capture the rich textured and descriptive experiences of the population participating (Finlay 2009: pp6-25). This stance facilitated the gathering of information that was the individual lived experience of participants. The epistemological position sought to explore

'the *possible ways of gaining knowledge of social reality, whatever it is understood to be. In short, claims about how what is assumed to exist can be known'* (Blaikie, 2000: p 8).

Qualitative methodology pointed to advantages of focusing on the nature and forms of knowledge, which lived in the experiences and social reality of participants (Cohen et al. 2007: p7). The research questions posed required an interpretivist approach that looked at the nature of the relationship between the participants considered to be the 'would-be knower' and what can be known (Guba and Lincoln, 1994: p108).

The phenomenological standpoint aimed to capture participants' perceptions and lived experience in relation to the research topic. In this case it is the lived experience of employers who were in the pathway of employing individuals and of service users who considered themselves to be in a phase of recovery. The participants based on information circulated in advance about the research topic considered themselves to have adequate knowledge around the research question. The process by which participants were invited to participate in the research enquiry will be discussed later. This phenomenological stance was felt to be very suitable as a means of capturing the subjective perceptions and interpretations of the participants.

The theoretical perspective and philosophical stance assumed was one of interpretivism where the researcher and the social world are seen as impacting on each other (Weber, 1895-1994). Within Weber's concept of intrepretivism, 'verstehen' means understanding something in its context (Holloway, 1997). Within this research the researcher was keen to explore how humans construct meaning around the research topic. The researcher accepted that her life experience and values would influence the research. The research topic was explored using both the participants' and the researchers lived experience, understanding their social actions within the material context (Ritchie, 2003).

This approach is sometimes referred to as constructivism because it emphasises the ability of the individual to construct meaning. Constructivists seek to gain understanding of the world in which we live and work (Crotty, 1998). Individuals develop subjective meanings of their experiences and these are linked to things and objects. The relationship between interpretivism and constructivism is described as;

>   '*sensitising concepts that steer researchers towards a particular outlook with proponents of these persuasions sharing the goal of understanding the complex*

world of lived experience from the point of view of those who live it' (Schwandt, 1994: p118).

This study looked at establishing meaning of social behaviour in relation to employer's employing individuals with mental illness who are in a phase of recovery. It is also sought to gain an understanding of the lived experience of service users with a recognised mental illness in relation to barriers they have encountered in accessing or retaining employment. The intrepretivism paradigm posits that research can never be objectively observed from the outside rather it must be observed from the inside through the direct experience of the people involved.

The underlying assumption is that by researching people in their social contexts, there is greater opportunity to understand the perceptions they have of their own activities (Hussey and Hussey, 1997). The primary concern of this current study was to capture and portray the stories and experiences voiced by the participants as accurately and comprehensively as possible. My theoretical position could be described as being 'like a skin not a sweater that cannot be put on or taken off whenever the researcher sees fit*' (Marsh and Furlong 2002: p.17).

Methodology

This section presents a rationale for the approach to research used in this study. It describes the methodology which aims to establish 'how the enquirer can could go about finding out whatever it is they believe can be known' (Guba and Lincoln, 1994: p108). An experimental style of research was ruled out as I was looking at the perceptions, attitudes, behaviours and subjective experience of service users and employers in relation to the research issue. I therefore felt that adopting a Participatory Action Research (PAR) approach was very appropriate. This research was based in 'the real world' and as a 'real world enquirer' the audience targeted was felt to have access to what was needed to be known. It is recognised that there is a symbiotic link between the researcher and the researched when working in this way. This close association has been defined as a partnership (Hall and Hall, 1996: p12) where the relationships are seen as being between equals and that there is no exploitation involved. Participants or organisations are willing participants and are not simply being used for academic achievement. This active

symbiotic link between researcher and researched is expanded on by Carr and Kemmis (1986:165). They postulate that:

> *'Action research aims at improvement in three areas: firstly, the improvement of a practice; secondly, the improvement of the understanding of the practice by its practitioners; and thirdly, the improvement of the situation in which the practice takes place. The aim of involvement stands shoulder to shoulder with the aim of improvement'.* (Carr and Kemmis, 1986: p.165).

Participatory Action Research Paradigm

One of the distinguishing characteristics of action research (AR) is the degree of empowerment given to all participants of the project. Unlike experimental or scientific research action research focuses on specific situations and localised solutions (Stringer, 2007:p1). That would seem a necessary prerequisite for participating in this current research topic. This would provide the opportunity to gain greater insight into the way people interpret events from their own perspective. It would generate interaction, which is likely to provide culturally and contextually appropriate information, which in turn may assist participants to more effectively manage the problems they are confronted with (Stringer, 2004: p.15). This stance provides the chance to capture the story as participants view it from their perspective.

AR is considered as a way of solving a problem whilst doing research into the problem (Cormack and Benton, 1996: p53-63). It is described as proceeding through repeated cycles, in which the researcher has a dual role as participant and observer of the system through the phases of the research cycle, e.g. problem identification, planning of interventions, implementation/action and finally observation as a basis for another round starting with a revised problem description. This research used a number of cycles of Plan - Act -Evaluate - Reflect, sequences throughout with each focus group informing to some extent what might need to change or be added for the next focus group cycle.

The development of Action Research is associated with Kurt Lewin (1948). It is well placed for exploring conditions and effects of various forms of social actions

and individual's subjective experience in relation to that. Lewin's Action Research Cycle is outlined in Diagram 1 below.

Diagram 1

identifying a general or initial idea

reconnaissance or fact finding

take first action step

planning

evaluate

amended plan

take second action step …

Adopting this method Lewin suggested that the first step was to examine the idea carefully in the light of the means available. Frequently more fact-finding about the situation is required. If this first period of planning is successful, two items emerge: namely, an overall plan of how to reach the objective and secondly, a decision in regard to the first step of action. Usually this planning has also somewhat modified the original idea.

The action research process followed in this study incorporated the collecting of, the feeding back of and the reflection on data to effect change (Coughlan and Brannick, 2001). The overall action research method adopted has been described as research that is conducted by, with and for people (Reason and Bradbury, 2001: p2).

McNiff (1988) takes a slightly different stance on how she views the action research process. She suggests that it should offer the capacity to deal with a number of problems at the same time by allowing the spirals to develop spin-off spirals (McNiff, 1988). So initially the researcher follows the tradition cycle of observe, reflect, act, evaluate, modify, and then the researcher should allow for room to move in different directions.

This model is set out in diagram 2 below:

Diagram 2
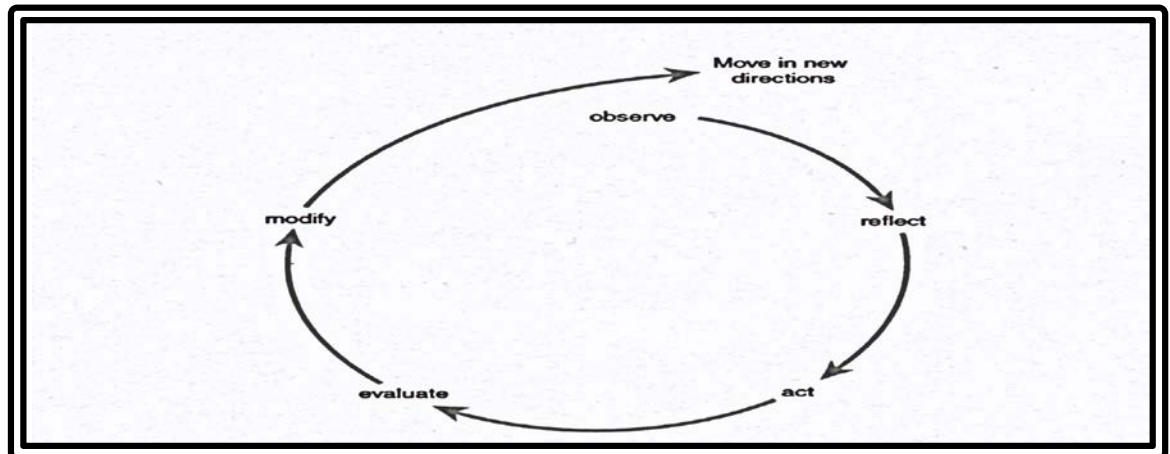
McNiff Model of Action Research (1988)

Sourced: on line at: ineducation.ca/ineducation/article/view/62/308

As the findings from this research emerged, they took on different trajectories spiralling in new directions as alluded to in McNiffs (1988) model in Diagram 2 above. There was a constant challenge to continue to decipher and make sense of the data generated. This required an intense effort to capture the narrative description. There was a continued effort to understand the specific population of service users and employers and situations being studied (Vinten, 1994: p 30-38). Qualitative research is regarded as a way of increasing our understanding of why things are the way they are in our social world and why people act the way they do (Robson, 2002), and its methods, it is argued are well-suited to elicit in-depth information from the perspective of participants (Salvatori, Tremblay and Tryssenaar, 2003: p1-19). AR is considered as a form of reflective practice where the researcher is viewed as being in the middle of the research, continually reflecting on one's own practice with the view to improving it (McNiff, 2002: P6).

Planned Action Research Cycles for this Study

An initial plan of action research cycles was drawn up. Planning in this way meant that the research topic could be shared with a wide audience and that those who would agree to participate would do so because they were interested in the research topic. Long-term it was hoped that this would result in better participant

recruitment. Conducting the enquiry through the process of Planning, taking Action, Evaluating and Reviewing (Lewin, 1946) would provide for the opportunity to introduce new questions or ideas at each stage that I had not been aware of prior to conducting that cycle. The process of reflection would help identify ideas or concerns raised by participants in relation to the research topic which could be introduced in the next cycle of the process.

Cycle One: Refining the research questions and planning the research- The plan as this phase was to work closely with my academic supervisors to finalise and refine the research questions. I or the research assistant would also need to contact a number of agencies such as The Chamber of Commerce, Business Link and Job Centre Plus to try and obtain an up to date list of employers in the North London Borough that the proposed research was to take place. It would also be appropriate to identify local mental health day care facilities, mental health service user organisations, and mangers of supported housing facilities for people in mental health recovery.

Cycle Two: Organising and conducting three employer focus groups: It was envisaged that contact would need to be made with as many employers in the NLB as possible to identify who the relevant person was in their organisation responsible for making decisions on employment of individuals. The research assistant to be engaged to compile a list of who has shown an interest in participating. Service user non-participant volunteers would need to be identified and those willing to help in running the focus groups agreed.

Cycle Three: Organising and conducting three service user focus groups: Contact with various managers of mental health day care facilities, managers of service users led organisations, and managers of supported accommodations for people in mental health recovery would be necessary so that service user participants could be engaged and invited to participate in the enquiry. The identification of an appropriate 'lead' or individual in each service who would explain the research topic to service users was also thought to be necessary during this cycle. Liaison with service users to act as volunteers to help manage the organising and facilitation of focus groups was also considered necessary at this point.

Cycle Four: Review the data set & consider best method of analysis: It was thought that the research assistant would play a key role in reviewing the data set as she was scheduled to be present in all six focus group sessions. Consider involving a selection of participants at this point.

Cycle Five: Set up Participant feedback groups: This phase of the research would need input from the research assistant, and a sample of employer participants and service user participants.

A summary of the initial planned cycles of research is outlined in Figure 4 below.

A Summary of Planned Action Research Cycles

Planned Cycles Of Action Research	Non Participant Stakeholders Involved at each phase	Total Number Of Stakeholders
Cycle1: Refining the research questions and planning the research	2xAcademic Supervisors 1x Research Assistant	3
Cycle 2: Organising and conducting three employer focus groups	1x research assistant Contact/Call 50 employers - identify key contact in their organisation Contact 6-10 service users and invite them to participate in the capacity of volunteers facilitating the running of the employer focus groups	61
Cycle 3: Organising and conducting three service user focus groups.	1 research assistant Contact managers or lead persons of mental health day centres or supported housing facilities x 10 Contact 6-10 service users and invite them to participate in the capacity of volunteers facilitating three service user focus groups	21
Cycle 4: Review the data set & consider best method of analysis.	1x Research Assistant 6 employer participants 6 service user participants Discuss with academic supervisors(x2)	9
Cycle 5: Set up Participant feedback groups.	1x Research Assistant 6 employer participants 6 service user participants 2x academic supervisors	7

Figure 4- A Summary of Planned Action Research Cycles

Figure 4 shows that there was a structured approach to involving participants from various employer back grounds. Similarly mental health organisations to be contacted were considered to have access to a wide audience of individuals in mental health recovery. Planning involvement in this way is supported by the Chief Medical Officer professor Dame Sally Davies. She says that:

"No matter how complicated the research, or how brilliant the researcher, patients and the public always offer unique, invaluable insights. Their advice when designing, implementing and evaluating research invariably makes studies more effective, more credible and often more cost efficient as well."

(Davies Cited in Staley, 2009: p4)

Having developed a plan of the planned cycles of research and a broad outline of who I thought might be involved in each cycle I progressed with the development and design of the study.

Study Approach, Development and Design

This research was conducted with a wide range of service users and a wide range of employer representatives within a North London Borough. Biographical and demographic data was gathered from all participants with a view to establishing the diversity of the individuals participating (Appendices Seven and Eight). Employer representatives were invited from diverse sectors, which covered a range of industries, possible occupations, small and larger organisations and the private and public sector. Employer sectors included large retail employers, a small retail employer, large financial institution employers, a relatively small construction employer, the national health sector, private health sector, and a small employment agency. Out of the 39 employer organisation representatives contacted to participate in the research 16 participated. Out of the 23 who did not participate three had stated they were attending but did not turn up on the day. The other 20 either did not respond or stated that they were not interested. 28 service users participated across three focus groups, with one group of 16, one group of 7 and one group of 6. The focus groups will be discussed later in the data collection section.

It was noted that employers involved in delivering care or who were from the health service sector were much more willing to participate than employers approached from other back grounds such as hair dressers or the retail banking sector. Where possible I asked why and I was given various answers. A barber commented 'I was really interested but I just did not have time'. One Bank Manager said she could not remember receiving the participant information sheet and invitation although I personally delivered it and explained it to her. Representatives from the main post office said they forgot although they had been given the invitation by hand and the research thoroughly explained to them. The manager of a local fast food restaurant also did not turn up and said that despite sharing a strong commitment to participating it clashed with another meeting on the day that he overlooked. The local Metropolitan Police had confirmed attendance but never clarified why they did not send a representative. It was similar with London Transport, and Employment agencies such as Employment Direct. The bakers said they were short of staff on the day and could not release a relevant representative. These reasons were respected.

This study used Action Research (AR) as a means of studying participants' subjective experience and then exploring their perceptions in relation to the research questions posed (Lewin, 1948). This form of transformational learning involves a spiral of steps, each of which is composed of a circle of planning, action and fact-finding about the result of the action (Lewin, 1948). Participants co-operated in a continuous participative and democratic way cognisant with AR. They engaged as knowing subjects and agents co-constructing useful knowledge for social change (Maguire, 2000; Levin and Greenwood, 2001). The participatory and democratic nature of AR involved the full interactive participation of participants. This type of relationship which is the cornerstone of AR is described as a relationship

> *'between equals which is not exploitative: the client organisation is not being 'used' merely to develop academic theories or careers nor is the academic community being 'used' (brains being picked). There is a genuine exchange. The research is negotiated'* (Hall and Hall, 1996: p12).

The philosophical rationale for using this method is discussed later in this chapter.

Cycle one of this study took place in 2010. This involved carefully examining the literature on employment of individuals with mental illness and looking at the population within a North London borough. Once the target audience was identified the researcher visited them all making face to face contact so that the research aims and objectives could be shared. Participants were recruited and focus group dates scheduled.

Cycle two and three of the action research cycle took place between June 2011 and August 2011 when six different focus group sessions were organised, three with employer representatives responsible for employing individuals in their sector and three with service users with a known diagnosis of mental illness who considered themselves as being in a phase of recovery. These focus group sessions were recorded on a digital recorder with permission from the participants. The focus groups provided an opportunity for a free-exchange of ideas, and the chance to ask more complex questions and to get more detailed responses.

Focus groups facilitated the collection of information from a wide range of people who had first-hand knowledge about the community being studied. These community experts (service users and employers), with their particular knowledge and understanding, provided insight into the nature of the problem being explored. During the cycle four of the action research process the focus group recordings were transcribed by the researcher maintaining confidentiality (Krueger and Casey, 2000). This process was undertaken between June 2011 and December 2011.

The researcher then went onto conduct the fourth cycle of the study during June 2012 to December 2012 by carrying out an in-depth thematic analysis of the data gathered (Braun and Clarke, 2006). This analysis was done from an inductive perspective and was not driven by a pre-existing theoretical framework.

Addressing Rigour in this study

Rigour when conducting thematic analysis is considered extremely important. Thematic analysis should not be rushed or treated by giving the text the 'once over' lightly (Braun and Clarke, 2006, p77-101). Braun and Clarke (2006) suggest that the assumptions about and specific approach to thematic analysis should be clearly explicated and that it is evident that there is a good fit between what the

researcher claims to do, and what is shown to have been done and that the researcher is positioned as active in the research process.

In an effort to maintain rigour in this current study the themes as they emerged from the analysis were discussed on an ongoing basis with the research assistant. She was also involved in note taking in the participant feedback sessions. Both these sessions lasted for an hour. She reported that the interpretations made captured what she had experienced in the focus groups. She also reported that the initial and final themes provided a basis for planning some resources to address the problems on which this current research was focused.

Additional rigour and the checking of themes involved bringing together a selection of participants from the employer focus group representatives and the service user focus group representatives. It was considered important that participants or stakeholders of the research process were engaged in the process of analysis so that the end result integrated their perspectives and priorities (Stringer, 2007: p115). Four different attempts were made by the research assistant in the early stages of the analysis (June 2012 to December 2012) to bring a group of employer participants and service user participants together so that initial themes could be shared and discussed. Unfortunately employer representatives cancelled on three different occasions due to various reasons. This meant that some detailed analysis had taken place before these emergent themes were presented to employer representatives in March 2013. Each participant was given a paper copy of the themes that had been identified through the process of thematic analysis. Each theme and sub theme was carefully discussed with three employer representatives (one from each focus group). Employer representative Mark (pseudonym) said that he found participating in the focus group really helpful in making him aware of mental illness in his work workplace environment. Respondents indicated that they were really pleased to be informed how the research was progressing. They felt respected and left knowing that their contribution to the research questions posed were valuable. Mark or the others did not suggest any amendments. They did express an interest to be engaged in any future developments.

Similarly four attempts were made by the research assistant to organise a service user representative group so that their feedback and views could be sought in relation to the emergent themes. It was very important to involve both participant

types in meaning–making discussion and dialogue so that the themes could be considered and mutually agreed as being accurate (Stringer, 2007:p115). This was made possible in April 2013. It is noted that respondent validation is really important as the interpretative nature of qualitative research means that the published results of research are only a version of 'the truth', and the validity of the findings must be judged in relation to the care with which the data were analysed(Richards and Schwartz, 2002).

The three service user representatives were also of the opinion that their views were fairly captured and identified through respondent validation. Having a follow up meeting with both focus group participant types allowed me to share what I considered as significant emergent themes from their groups. In return I was able to receive feedback which gave clarity to my interpretation of the experiences shared in the focus groups thus reducing the risk of misinterpretation of the data on my part or of exploitation of participants.

Sample Frame

The sampling strategy was guided by the researcher's personal and professional contacts and knowledge of the local population. Accordingly purposive non-probability sampling was adopted as clear specific research questions had been formulated. Proportionality was not a primary concern but there was a specific type of participant that I wanted to secure. The purposive sample was made up of 28 service users in total,10 Female,18 Male ; Age Range 20's to 60's ; Ethnicity:16 British, 5 African Caribbean, 3 Black British, 1 English Italian, 1 Asian British, 1 Burindiz, 1 Mixed Race. There were 16 employer participants, 12 Female, 4 Male; Age Range 20's- 50's; Ethnicity: 8 British, 2 Indian, 1 Black African, 1 Bangladeshi, 1 Irish, 2 Asian British, 1 not completed. The researcher's judgement was used to build up a sample which satisfied the needs of the research topic (Robson, 2002: p265).

The intention was to capture the perceptions and experiences of the two different targeted groups: service users and employer representatives. This method was based on considering what the research sought to answer and then identifying specific individuals, who were willing to provide the relevant information by virtue of their knowledge and their experience, a strategy that is supported by Bernard

(2002), and Lewis and Sheppard (2006). It is suggested that with experience of working nineteen years in the local community that the researcher was considered a 'key informant' in identifying the purposive sample (Barany, 2006). This local knowledge and experience helped to identify informants efficiently and wisely, and to choose the level of analysis necessary to answer certain objectives (Bernard, 2002).

It was accepted that this was not necessarily a representative population and that it would not be generalizable. Non probability sampling was recognised as contributing to internal validity of the study with the interpretation of the data generated confined to the actual population partaking in the study .To secure validity, transferability or generalisation or to form the basis for a theory, the study would need to be repeated for confirmation in a different population, still using a non-probability method (Bernard, 2002).

Therefore the transferability of the findings from this study is not truly possible as all observations are defined by the specific contexts in which they occurred (Erlandson et al. 1993). On the other hand it could be equally argued that this research is unique and is an example within a broader context and therefore the prospect of transferability should not be immediately rejected (Stake, 1994; Denscombe, 1998). With these different perspectives and mindful of Lincoln and Guba's (1985) evaluation criteria to establish creditability, transferability, dependability and confirmability this sampling method was considered to be most appropriate for the study undertaken.

Use of Focus Groups

Focus groups were chosen as a data collection method in order to encourage dialogue among participants and offer safety to those who may have found one-to-one interviews too threatening. It is argued that in focus groups 'paradoxically, there is a greater feeling of anonymity in a group than in a personal interview' and that this yields richer data (Folch-Lyon and Trost, 1981: p. 445). This was true for both types of groups as the topic being explored was likely to touch on a number of sensitive areas. A range of pre-selected questions and a prepared interview schedule were used to encourage participants to share their own subjective experiences. These are included at Appendix 1 and 2.

However as with all methods of data collection focus groups have both advantages and disadvantages. They can be very helpful in raising consciousness and empowering participants in relation to the research topic. However they also pose various challenges that need to be considered. These are often related to two influences; that of the facilitator and the basic nature of group discussions (Calder, 1977: p353-364).

It may be difficult to follow up on what each participant has raised or contributed, and there are challenges around managing the bias caused by an individual or individuals dominating the group (Robson, 2002: p285). There is a real risk that the dominant view point influences the resultant analysis. Related to that is the concern that participants' attitudes become more extreme, when they participate in group discussion , which could in turn result in greater unification of group opinions or polarize participants (National Oceanic and Atmospheric Administration's Coastal Services Centre, 2009: p2.).Therefore the researcher ensured that she made herself fully aware of the possible pros and cons of facilitating group discussion.

Two different groups of people participated in this research topic. I wanted to explore what the experiences were of individuals with a mental illness who are in a phase of recovery around accessing employment. I also wanted to capture the experiences from an employer's perspective. Why are employers reluctant to employ individuals with mental illness who are in a phase of recovery? That meant talking to two different audiences, service users and employers in a North London Borough.

Accepting homogeneity as a critical characteristic of focus groups both types of focus group participants were considered to have something in common that I was interested in exploring (Kruger and Casey, 2000).

Service Users Focus Groups

I the researcher have worked 19 years in the community in which the research was supposed to take place. As a manager of community mental health services I had an in-depth knowledge of the local population and community of individuals who use mental health services. Based on that knowledge and drawing on

guidance set out for planning and recruiting of samples for focus groups (MacDougall and Fudge, 2001) , a list of potential service user participant representatives living in a North London Borough was drawn up. The contact stage involved developing a community based recruitment strategy. I communicated with key contacts who could liaise with the type of participant I wanted to recruit. Those key contacts acted in the roles of explaining the research to prospective participants. Key contacts included managers of day centre facilities, and a number of managers of community supported housing facilities spread across the borough. The next stage involved providing participant information documentation, invitations to participate in the research, with a stamped addressed envelope and response sheets to key contacts to circulate amongst prospective participants. Participation information sheets clearly addressed issues around confidentiality and participating in the focus group process.

Participants took part based on willingness to participate and their availability. Lunch and refreshments were provided in all three groups. All willing participants were provided with a participant information sheet and were asked to sign a consent form. Out of 50 information packs sent out there were 28 willing respondents.

The participating service users were individuals who considered themselves to have a diagnosis of mental illness and who considered themselves to be in a phase of recovery. All were living in community-based accommodation as opposed to a hospital based setting. The focus groups were digitally recorded and lasted between one hour and one hour and forty minutes. Information in relation to the research questions posed was gathered while ensuring anonymity and confidentiality were met.

Employer Focus Groups

A number of organisations including Reed Employment Agency, The Chamber of Commerce and Job Centre Plus, were approached to try and secure an up to date list of businesses in the North London Borough within which the research was proposed. Business Link advised me that their list was quite old and that they were not aware where I might access a more recent list. After exhausting a

number of contacts in an effort to secure an existing list I researched and drew up a list of employers based on available contacts and advice from employers in the North London Borough. Employer representatives were targeted based on it being considered by the researcher that they would hold specific knowledge around the research questions posed (See pages p27- 28).

Employer representatives were then invited to participate from a range of sectors in the local borough such as: The Private Sector, Social Services, The Local Council, and Large Supermarkets such as Asda's and Tesco's, Smaller Retail Providers, the Banking Industry, the Construction Industry, and fast food restaurants (See Appendix 7). A total of 45 employers were targeted and invitations were delivered by hand to a designated person. This recruiting strategy was selected as it gave me an opportunity to explain face-to-face the nature of the research. It also provided the opportunity to target as wide an audience as possible.

Face-to-face contact improved the possibility of securing interested parties as I was able to convey the potential value of partaking in the research. I was also conscious that given the then current economic downturn (Barr et al. 2012; Evans-Lacko et al. 2013) that willingness to participate might be very low, and that once employers understood that there was no pressure to employ individuals in a phase of recovery from mental illness they might be more willing to participate.

16 employers actually participated across the three focus groups. Employer participants were allocated to focus groups based on their availability and willingness to participate. Invitation packs were distributed to each employer representative visited, which contained a participation information sheet, a consent form, a biographical data form, a letter of invitation outlining suggested date for the focus group sessions, identifying three different time slots and a response section, alongside a prepaid stamped addressed reply envelope . All willing participants were asked to sign a consent form.

Prospective participants were given a choice of three different times of focus groups scheduled for the 28/06/2011 that they might attend. Participants elected which focus group they would or could attend by completing the confirmation of attendance sheet, which set out the time, date and location of the focus group and was received by return post. It was hoped to have a least five employer

participants in each focus group. Nine confirmed attendance for the morning session, but five actually turned up. Seven confirmed attendance for the 1pm session and seven turned up. Six confirmed attendance for the third session and five turned up.

The organisation of groups in this manner was justified as an effective method by the researcher because I felt that interviewing individuals would be more time-consuming and that a diversity of opinion was important in addressing the research topic (Munday, 2006). It is also the case that the focus group interaction process stimulates memories, discussion, debate and disclosure in a way that is less likely in a one-to-one interview (Wilkinson, 2003). Information in relation to the research questions posed was gathered while ensuring anonymity and confidentiality were met.

Data Analysis

This research involved holding six focus groups, three with service users with a diagnosed mental illness and three with employer representatives in a North London Borough. This meant the generation of a considerable amount of data so consideration had to be given as to the most effective data analysis method to use. This involved working with organising it, breaking it into manageable units, synthesizing it, searching for patterns, trying to discover what was important, what was there in to be learned and then deciding what to tell others (Bogdan and Biklen, 1982).

This process involved transcribing verbatim the content of six focus groups. Transcription occurred over a number of weeks. The method for data reduction and for capturing the complexities of meaning within the data employed was that of thematic analysis. The approach involves the adoption of an analytic general inductive approach (Strauss and Corbin, 1998:24), which has its origins in grounded theory (Glaser and Strauss, 1967). It is designed to identify categories and concepts within the transcribed texts (Lingard et al, 2008).

Thematic analysis is used to find or condense the data, but not necessarily with the aim of developing a particular theory to explain it. I wanted to understand the phenomenon being studied but not necessarily generate a theory about it.

Thematic analysis is considered to offer a theoretically flexible approach (Braun and Clarke, 2006:p2) using a combination of grounded theory, positivism, interpretivism and phenomenology, blended into one methodological framework (Guest, McQueen and Namey, 2012: p15). The analysis conducted in this study involved moving beyond counting explicit words or phrases to focusing on and describing ideas that are both explicit and implicit in the data, which are known as themes (Guest, McQueen and Namey, 2012: p10). Once themes were identified codes were assigned supported by or linked to raw data for later analysis. This method was interpretive and inductive whilst also posing the challenge of trying to capture the complexities of meaning that was within the textual data.

When working in this way it is suggested by Charmaz (2003) that the researcher should ask themselves:

What is going on? What are people doing? What is the person saying? What do these actions and statements take for granted? How do structure and context serve to support, maintain, impede or change these actions and statements? (Charmaz, 2003: p94–5: Cited in Gibbs, 2007).

Having these sorts of questions in mind enabled me to; detect themes, patterns, and relationships between the language around the research topic of what are the barriers to employment experienced by service users in a recovery phase of mental illness, and what are the reasons for employers' reluctance to employ people in the recovery phase of mental illness. Engaging with the text intensely allowed for the development of a framework of thematic ideas about the research questions posed (Gibbs, 2007).

I felt that it would be important to move beyond giving the focus group participants just 'a voice' (Fine, 2002) that is heard. Therefore data was selected that I the researcher wanted to know.

When considering how I intended to identify particular themes, or how certain statements captured my attention and when worrying if my analytic process would somehow be flawed and biased I was comforted by the advice given in a research book on qualitative data analysis that one should "*Trust their 'plausibility' intuitions, but don't fall in love with them*" (Miles, Huberman, Saldana, 2014: p 278). These themes and sub–themes are set out in Chapter 5 of this paper.

Isolating Themes

Thematic analysis requires the researcher to be clear and explicit about what one is   doing whilst not being over rigid. There is a responsibility on the researcher to demonstrate how they came to identify the themes in their research. Researchers need a way to argue what we know based on the process by which we came to know it" (Agar, 1996, p. 13). In order to achieve this Braun and Clarke (2006:p35) suggest 6 phases that should be followed when conducting thematic analysis. These are set out as follows:

1. Becoming familiar with the data,

2. Generating initial codes

3. Searching for themes

4. Reviewing themes

5. Defining and naming themes, and

6. Producing the report.

Phase 3 raises the question of what constitutes a theme. How did I identify or construct a theme from the data generated in this study? A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set (Braun and Clarke, 2006, p.82). Themes are further described as patterns in the information that at a minimum describes and organises the possible observations and at a maximum interprets aspects of the phenomenon (Boyatzis, 1998: p161). The themes that have been identified in this study have been supported by verbatim extracts from the data generated.

Initially in phase one of Braun and Clarke's model (2006) I listened to each audio recording from start to finish acquainting myself with the content. I then listened to each one again in an effort to become more familiar with the stories or dialogue within. I felt very engaged and involved with the different recordings. Mentally I was transported back in the focus group when I read each transcript.

I then transcribed the content of each audio recording. This was a very slow process. Often parts of each recording had to be played over and over again so

that the accuracy of the conversations was caught. Transcription took place over a number of weeks. Once transcription of all six focus group was complete I continued with phase one of Braun and Clarkes model (2006). This exploratory approach involved reading and rereading of transcripts until I felt completely familiar with all six transcripts. The process although lengthy allowed me to re-immerse myself in the participant's shared narratives and lived experiences. It brought the focus group sessions to life again. I found myself visualising the faces of participants, their expressions and sensing the atmosphere in the room as I read the content of each transcription. I was taken aback by the emotional impact some of the content and whole experience had on me. I proceeded to access the field notes that were recorded by the research assistant during each focus group recording. Each set of field notes were matched to the relevant focus group transcription.

Moving from phase one towards phase two of analysis I began to highlight particular words, phrases or statements in each transcript that seemed central to the experiences of the participants. This is described in the literature as a selective or highlighting approach (van Manen, 2007). With this interpretative focus I made comments in relation to the verbatim content recording my interpretation of what I thought was being communicated (As demonstrated in appendix 11). In addition I also read and reviewed the reflective field notes relevant to each focus group which had been documented by the research assistant. This enabled me to reflect on each focus group session and consider the overall messages that were being communicated capturing both a semantic and conceptual reading of the data (Braun and Clarke, 2006). This was done initially throughout one transcript and then across all six transcripts. Each set of selected dialogue alongside my interpretations of the dialogue was assigned a code. This strategy was not used simply as a method of data reduction but as part of the analytic process using Carmaz's (2003) questions to aid the process. All codes and relevant data extracts were then collated with codes of similarity collated together.

The daunting phase three of analysis commenced when I used the sets of data collated to search for themes within it. Those that held the same or similar codes were compiled together. Braun and Clarke (2006) use the analogy of a house to capture this stage of moving from phase two to phase three. If it can be imagined

the assigning codes or labels to important features of the text as the 'bricks and tiles' in a brick and tile house then searching for themes could be visualised as the 'walls and roof panels'. They also suggest that this aspect of analysis is like coding your codes. Searching for themes within the data required me to continue to engage intensely with the data and the lists that I collated. I again used Cramaz's (2003) questions to help me to isolate what I thought to be an emergent theme. When faced with such a huge amount of data I think that it is essential to have some kind of template or guide, otherwise the process can seem overwhelming.

It became apparent that whilst different phrases and terminology was used it seemed to point to similar patterns or connections in the transcriptions. For example in employer focus group one the mental image shared by a participant that she associated with the word schizophrenia was that of a killer, someone who kills you.

Q: What image comes into your mind when I say the word schizophrenia?
Gemma (Pseudonym): Paranoia, I am <u>scared</u> of that word, honestly I <u>instantly</u> think it's someone that might <u>kill</u>

This perception could be interpreted as this employer participant being ignorant when it comes to knowledge of mental illness or that people are frightened of individuals with mental illness. However in context of the research questions posed and my reflection on the participant, the emotion with which it was shared I interpreted this shared narrative as contributing to a sub theme that employers view individuals with mental illness as being dangerous. It could be argued that in this extract the theme is very obvious, but I found the association made by this participant with the word schizophrenia very powerful. Coming from a background where I work with individuals with chronic schizophrenia amongst other complex mental illness every day that is not an association that comes easily to me. I therefore had these tensions to manage, that of being an objective observer verses my own perceptions and beliefs.

When I initially coded the above extract it was coded as 'mental illness is associated with fear and danger'. However one of the challenges that I

encountered in conducting the analysis was in developing codes that captured both the topic and content of the narrative as well as the associated emotion. A code is considered to be a good code when it captures the qualitative richness of the phenomenon (Boyatzis, 1998:p.1). Reflecting on the above participant's narrative, she was quite animated when she shared this perception and she actually seemed frightened even as she spoke about her association with schizophrenia. It is well recognised in the literature that qualitative data analysis is the most difficult and most crucial aspect of qualitative research (Basit, 2003:p. 143)

In employer focus group 3 the mental image associated with Bi-Polar disorder was the image of a polar bear. This participant was commenting on labels of mental illness. Talking about Bi-Polar disorder he said:

Mark (Pseudonym): It's like hmm, in words like bipolar; it sounds like to the old man in the street its sounds like polar bear.)

Although the verbatim narrative is very different in each extract above in my analysis of searching for connections and possible themes I interpreted this as this employer participant thinking of individuals with mental illness as being dangerous. Others might interpret this differently depending on the association with polar bears. Considering this shared narrative in context of the research questions posed this contribution was also considered to contribute to the formulation of the sub theme (3.1) from the employer focus groups that people with mental illness are dangerous. This sub theme contributed to the overarching theme that there is still great stigma associated with labels of mental illness from the employer focus group analysis.

Considering the extract from focus group 1(included in appendix 11) the following data extract was searched for interpretation and meaning.

Geraldine (Pseudonym) - I think depression and schizophrenia – depression would be more manageable than someone with schizophrenia. I think it's the milder of the two.

Pam (Pseudonym) - Well it depends, people <u>swing</u> the word depression around a lot, and you can <u>get a girl on her period</u> saying oh I am depressed <u>compared to somebody who cannot get out of bed for months on end</u>
Geraldine - It's very hard to <u>classify</u> it depression it <u>could be anything</u> it's very hard to define it.

There are a number of interpretations that could be made in relation to this extract outlined above. There is a perception that depression might be more manageable than schizophrenia. What does that mean? What is this participant trying to communicate? What does this statement take for granted? People with mental illness need to be managed? People with mental illness will need management in work place environments? They cannot manage themselves? Or this participant sees one type of mental illness not as difficult to experience or manage as the other.

It was my view that when examining the verbatim content from this transcript and placing the phrase or statement in context of what was being discussed, that something important and essential was being communicated in relation to the research questions posed. The participants contributing to the extract above were unsure what having either depression or schizophrenia meant. Evident in the extract there is a comparison of that of a girl having her period saying she has depression and that of someone who can't get out of bed because of depression. What does that mean? Can they be compared? What is this person trying to communicate in the discussion? I thought that this captured participants struggle with understanding and lack of knowledge in relation to depression.

And finally in the extract above there is the worry when the participant can't 'classify' mental illness. Mental illness doesn't fit into any neat pigeon hole. Considering all the questions suggested by Charmaz (2003) I made the interpretation that there were issues in relation to understanding and knowledge of mental illness resident in the above shared narrative. I also felt that there seemed to be greater familiarity with depression even if this still was associated with confusion of definition. It should be noted that prevalence of theme was not considered. Themes were identified based on my interpretation of how they informed the research question posed. Having reviewed all coded data and spent hours days and weeks reviewing the contents of the coded data, I completed this phase of my analysis by assigning coded data to themes that I had identified.

That felt like I was almost there, but as there was such a huge amount of data to be considered, I then implemented phase four of the thematic analysis. This aspect of the research analysis involved taking each theme identified from phase three and checking it out. I went back to particular transcriptions to check and double check that that really felt like the sentiment being conveyed. I did this first with the employer focus group coded data, and again with the service user group coded data. At this stage some themes were collapsed into a more major theme or in some cases I identified some significant sub themes that needed to be isolated in their own right.

Stage five of my analysis was around finalising and naming my final themes and subthemes. A summary of the overarching themes and subthemes have been clearly identified and collated later in this thesis. Each major theme and sub theme has been taken and its relevance considered in context of this study.

In stage six of the analysis I have pulled together what has been essentially my analysis of the data generated. I have attempted to capture the interwoven links in the shared lived experiences of participants across the six transcripts. These have been contextualised and interpreted in a systematic way which is consistent with the data collected.

Throughout the analytic process I was guided by the six stepped approach suggested by Braun and Clarke (2006) and the questions suggested by Charmaz's (2003). Accepting that all analysis is based on interpretation every attempt was made to capture themes that was representative of the participants experience and perspective.

Analysis of each participant group (employer participants and service user participants) was conducted separately. Iteratively conducted particular paragraphs, phrases or sentences were selected and interpretations of these made. The 'verbatim principle' (Stringer, 2007: p99) was followed ensuring that only terms and phrases shared by participants were selected. I am conscious of the debate relating to the concept of themes emerging from data with it being suggested this could be misinterpreted to mean that themes 'reside' in the data, and if we just look hard enough they will 'emerge' like Venus on the half shell. Therefore it is worth being mindful of the notion that 'If themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we

understand them' (Ely et al. 1997: p205-6). Consequently the importance of maintaining reflexivity in the research process was ever present and is discussed later in this chapter.

Conducting thematic analysis manually in this way allowed me the researcher to be 'close to the material' (Creswell, 2005: p.234), but this method is 'not considered easy as it typically takes more time and energy than quantitative techniques (Boyatzis, 1998: p161). Examples of two final pieces of analysed data from focus groups 1 and 2 have been placed in Appendix 11.

Reflexivity during the analytic process

Phenomenological approaches to qualitative research stress the importance to reflexivity in the research process. Within that concept the researcher is considered to be simultaneously reporting on the world at the same time as they are constructing it and that the two are inseparable. It suggests that one cannot report on the world without having constructed it. The researcher is encouraged to 'critically examine their own assumptions and actions through being self-conscious and self-aware about the research process' (Holloway, 1997: 135-6).

Crotty (1998) makes sense of this as the researcher having an awareness of the ways in which he or she has a particular social identity and background which have a particular impact on the research process. Being alert to the implications of the role of inside researcher (Robson, 2002: p382) and truly not able to escape that consciousness was very important , as it is known that subjects of research are eager to comply with the wishes of the researcher and to provide the type of responses that the researcher is looking for. If the researcher implicitly communicates that narrative responses are not what is wanted, by interrupting the interviewee's stories for example, this in some senses 'trains' the respondent to provide a different type of information (Elliott, 2005:p31).

The tensions that come with the role of inside researcher (Robson, 2002: p382) were accepted as being part and parcel of the research process. It was not as if they could be escaped from. It did bring up different issues in each focus group type. For example participants from the employer focus groups were likely to see me as holding a bias position as a manager of community mental health services. I was probably seen as holding a dual position of being an employer and a person

who works closely with people with mental illness every day and would therefore have a very different view of employing an individual with mental illness than that of a bank manager or a construction site foreman or the local hairdresser. I noticed that employer participants were initially very guarded about what they said. There was a sense of nervousness that had to be overcome in each employer focus group before participants became relaxed and felt on an equal playing ground. I remember the need to communicate quite clearly that there was no expectation that employers would be expected to employ an individual with mental illness as a result of participating in the focus group. I was also very aware of having a strong empathy towards individuals with mental illness and that participants were likely to sense this despite my best attempts to stay neutral (Robson, 2002: p382).

In the service user participant focus groups I felt a greater sense of closeness and understanding of experiences shared. Again I really tried to 'bracket' this so as not to influence participants' responses. This idea of 'bracketing' (Spinelli, 1994) harks back to my counselling training completed in the late 90's. This is an existential phenomenological stance, which suggests that in order to achieve the technique of 'bracketing' that the individual has to bracket one's own ideas, assumptions and prejudices so that you can hear the description of the client's experience from the first person point of view. This was a tough thing to do consistently and Spinelli (1994) acknowledges this and points out that this can only be an aspiration rather than something that can be fully achieved. I adopted a style of facilitating that is also closely linked to my counselling back ground which was person centred in style (Rogers, 1967). A non-judgemental position, employing empathic listening skills, paraphrasing, reflecting back responses was adopted. Efforts were made not to confirm or repudiate the participants' subjective experiences, but instead consciously staying with them which enabled further illumination of experiences and exploration of what was being shared.

Confirmability and Explanatory Power

It is well established that the use of focus groups in research provides a rich source of data but that this also limits its generalizability. However there is an argument that that this critique simply does not apply to qualitative methods: 'the

notions of reliability and validity are inextricably linked to quantitative methods and so are irrelevant to qualitative work' (Lunt and Livingstone, 1996: p79-98). Conversely it is suggested that qualitative researchers should reclaim responsibility for reliability and validity by implementing verification strategies such as the process of checking, confirming, and making sure, and being certain integral and self-correcting during the conduct of inquiry itself (Morse et al. 2002:p9).

Trustworthiness and veracity (which are considered alternatives to validity and reliability) of the outcomes of the research were based on the verification process suggested by Morse et al. (2002: p12-13). As the principal researcher I aimed to ensure methodological coherence and sampling sufficiency. I worked at developing a dynamic relationship between sampling, the data collection and analysis, thinking theoretically, as I progressed. It is suggested that when used collectively these checks are conducive to demonstrating reliability and validity of the information and analyses that has emerged from the data gathered (Morse et al. 2002: p11-13).

Emergent themes have been supported by direct quotes from focus group participants to enable readers to evaluate the interpretations. These are documented in Chapter 5 of this thesis.

Credibility of the study was further enhanced through the use of methodical 'triangulation' (Mason, 1996: p253-274) including triangulation sources that had different foci and different strengths. These included the data source where participants attended particular focus groups at a particular time and location .I also used audio methods, which included digitally recording each focus group session. The audio recordings were then transcribed verbatim and field notes observations of the interactions between participants were taken. Theoretical triangulation was conducted by reviewing the literature on various other researches that had been conducted in relation to this subject area. Methodological triangulation was further achieved by accessing books, the internet resources, and attending various consultations and conferences in relation to the research topic.

As with all methodical approaches there are also some complications when employing multiple method analysis and therefore one should err on the side of

caution. I concur with the notion that triangulation is not the combination of different kinds of data *per se*, but rather an attempt to relate different sorts of data in such a way as to counteract various possible threats to the validity of (their) analysis (Hammersley and Atkinson, 1983: p.199).

Ethical, Moral and Legal issues

Ethical consideration is an important aspect of any research. This research took place in real world circumstances face-to-face with participants with real time dialogue. It was therefore essential that consideration be given to ethical and moral issues arising. Ethics is described by Reynold (1979) as rules of conduct, typically, to conformity to a code or set of principles. While both ethics and morals deal with issues around right and wrong, ethics deals more specifically with the principles of what one ought to do.

Ethical considerations were deliberated across two different types of participant groups, those who were employer representatives and those who were service users with a diagnosis of mental illness. As a mental health practitioner I was aware that there might be greater pressure on me to establish an ethical and moral position due the fluctuating nature of mental illness. Once participants with mental illness are introduced into the research equation the notion of autonomy disappears and all sorts of issues around capacity, ability to participate of participants pop up .I was very conscious of being true to my professional integrity with this cohort of participants and I made every effort to promote and maintain respect, beneficence and justice for participants (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). However I was also acutely aware of my deliberate intention to see participants as individuals who have the right to choose to participate and make their own decision about that based on having adequate information around the proposed research topic. In fact research has shown that people with serious mental illnesses retain substantial decisional capacities and that in many cases of impaired capacity, targeted intensive educational interventions can improve the ability to make an informed decision (Dunn et al. 2002; Kim, Karlawish and Caine, 2002).

Before data collection began ethics approval was sought from Middlesex University Health and Social Sciences Ethics Sub-Committee. Approval was obtained in April 2010 and is included at Appendix 3. Once this approval was obtained the participants were recruited and dates for the focus groups scheduled. The researcher visited each organisation in person to explain the research and to make invitation packs available ensuring that those who elected to participate were fully informed as to the nature of the research.

The first of the service user focus groups was held at in a community mental health day centre facility. This was set up by service user volunteers at the centre. Promoting a user controlled led approach has many advantages and has close links with emancipatory disability research and survivor research (Turner and Beresford, 2005: p2). Promoting such user control also had its disadvantages as there seemed to be an over enthusiastic response in wanting to participate in the research. I was really concerned by the large group that turned up for the focus group. There were 17 participants eager to participate. I considered breaking the group in to two groups and seeing the other group at another time. There was concern that with such a large group that each participant may not get their fair chance to participate. There was a risk that others would talk over others and or not feel listened to. As the focus group was about capturing lived experiences I had a real concern that this would be compromised. However having experienced that atmosphere of excitement and willingness to participate in the room I made a decision to progress with the focus group as I was really aware of the ethical cost of turning individuals away.

Confidentiality and anonymity with regard to the participants' identity and the information shared was also considered. Assurances of confidentiality and anonymity were addressed via a statement included in the consent form. Participants were assured that their identity would remain anonymous and that any data collection or dissemination of findings would protect their identities.

Other areas that were given consideration was the safety of the environment in which the focus groups were held, the possible increased levels of anxiety experienced by the participants and the perceived pressure to do well. Informed consent was gained by providing participants with clear information on the purpose, aims, use of results and likely consequences of the study. Participants were also required to provide written acknowledgement of their willingness to

participate in the research. Informed consent was considered imperative to the study as in action research participants are considered as having much more control and are considered to be engaging in a mutual agreement about the conduct of the study (Stringer, 2007: p 55). Copies of the two differing Participant Information Sheets (PIS) are included at Appendices four and five; one for the employer participants and one for the individuals in a phase of recovery from mental illness.

Due to the participatory nature of action research there were a number of principles that needed to be considered as part of the duty of care on my part. These included making sure that the relevant persons, committees and authorities had been consulted and that the principles guiding the work were accepted in advance by all.

This included securing ethics approval, liaising with existing contacts and champions in the community, such as managers of supported housing facilities, individuals in positions of employing people in their company, organisation or sector, and leads and managers of day care facilities. All participants were allowed to influence the work, and the wishes of those who did not wish to participate were respected. Transparency was important and participants were made fully aware of what was happening before during and after each focus group. Permission was obtained before making any observations or examining documents produced for other purposes. And finally due the research being carried in the real world with open discussion on what could be perceived as a sensitive subject I the researcher accepted responsibility for maintaining confidentiality and protecting anonymity of all data generated during the research process (Winter, 1996).

Chapter 4: Project Activity

This research took place in a North London Borough where the researcher has managed mental health services for 18 years. My colleague, a supported housing project manager, whom I have worked with for sixteen years, agreed to work alongside me in the capacity of research assistant. She has a keen interest in the research topic. She agreed to do this in a voluntary capacity.

The role of the research assistant was to work alongside the researcher and service users involved in the research by providing support in planning and recruiting research participants. She was also enrolled to act as observer in each focus group session, sitting in a non-intrusive position and taking notes based on her observations of what was going on in the focus group environment. She also fed into the 'action' element of the action research process by making suggestions with regard improvements that would facilitate the effective running of each session. Her notes and observations were accessed as part of the triangulation of data, ensuring that the emotion and behavioural elements were considered alongside the verbatim contents during the analytic process.

The North London Borough within which the research took place was formed in 1965 by an amalgamation of three former boroughs. It is located on the northern edge of greater London, bordering a number of other London boroughs (Improving Health and Well-being in NLB, 2012:p30).

Prior to conducting this research the researcher sought to understand the local population in terms of its population of mentally ill people. The researcher noted that in the North London Borough within which the research took place that the population was significant. The Mental Health Observatory (MHO), additional data publication "*Estimating the prevalence of common mental health conditions in England*" (Glover, 2008), gave the following estimates for prevalence in three North London boroughs. See Table 1 on the next page.

Table 1

Estimated Cases Adults 16- 74								
	Total population sizes all ages	Any neurotic disorder	All Phobias	Depressive Episode	GAD	Mixed Anxiety Depression	OCD	Panic Disorder
NLB 1	32,6000	39761	4745	7718	11644	18395	3348	1868
NLB 2	**28,5000**	**35258**	**4208**	**6891**	**10404**	**16256**	**2985**	**1637**
NLB 3	22,8000	34493	4161	6669	10074	15966	2942	1594

Estimating the prevalence of common mental health conditions in England

Sourced: The Mental Health Observatory (M.H.O), Glover (2008) Additional Data Excel Sheet.

It is noted that in 2008, The NLB 2 above falls somewhere in between NLB 1 and NLB 3 in terms of population of individuals of people with mental illness.

The local population of employers

The researcher also looked at the population of local employers and found that this NLB is home to London's second largest industrial and logistical parks, with over 200 companies. The borough hosts over 10,000 businesses employing nearly 90,000 people with over 58% of jobs filled by local residents (Improving NLB, 2013).

Major employers in the NLB include Coca Cola, the Local Authority, The Local NHS Trust and Hospital, TNT, Iceland, Warburton's, IKEA and a large ASDA store and ASDA on Line Distribution Centre (Agency Central, 2013).

The largest employment sectors are Wholesale and Retail (27%), Health and Education (27%), Business Services (20%), Manufacturing (15%) and Transport and Communications (11%), (Agency Central, 2013).

The local population

It is reported that since the published statistics of 2008 that the population of this NLB has increased from 273,559 to 312,466 (15%) between 2010 and 2012. In 2012 this had increased again with 317,287 people reported as living in this NLB. It is projected that this will increase further to 330,000 (4%) by 2022 and to 340,000 (7%) by 2032. Adults aged between the ages of 18-64 will increase by 3.6% over the 7 years to 2020. It is also suggested that it is likely that there will be a greater increase in the population of mental illness than that projected because the incidence of mental health problems is known to increase in times of significant economic pressure (NLB Joint Strategic Needs Assessment and the Mental Health Needs Assessment 2012, 2013).

The overall rate of population growth in this NLB is outstripping both the rate of population growth for London (4.5%) and the UK (1.5%) (NOMIS, 2013: ONS Census, 2011).

This study was concerned with the population of individuals experiencing mental illness in a NLB in 2011/2012. At that time it was estimated that there were 37,294 adults with a neurotic disorder. This was forecast to increase by 1,273 to 38,567 by 2020 (ONS, 2013(a) .There is between 4,003 and 8,006 adults living in the borough with a serious mental illness. This is likely to increase by a range of possibly 143 to 285 to 4,146 and 8,291 by 2020 (NLB Joint Strategic Needs Assessment and the Mental Health Needs Assessment, 2013).

Only 4% of adults in contact with secondary mental health services were recorded as being in paid employment in 2012/2013 (60 out of 1,485 people) (NLB Joint Strategic Needs Assessment and the Mental Health Needs Assessment 2012, 2013).

In addition to high levels of unemployment, the North London Borough has the third lowest spend per head allocated to public health, which inevitably impacts on health inequality and the wellbeing of its 313,900 population (The Joint Needs Assessment (JNA), 2012). This indicates that there is poor attention to the social and structural determinants of health and an avoidance of Asset Based Approaches (Mc Clean, 2011: p2).

The North London Borough's position in relation to spending on public health per person is captured in Figure 5 below.
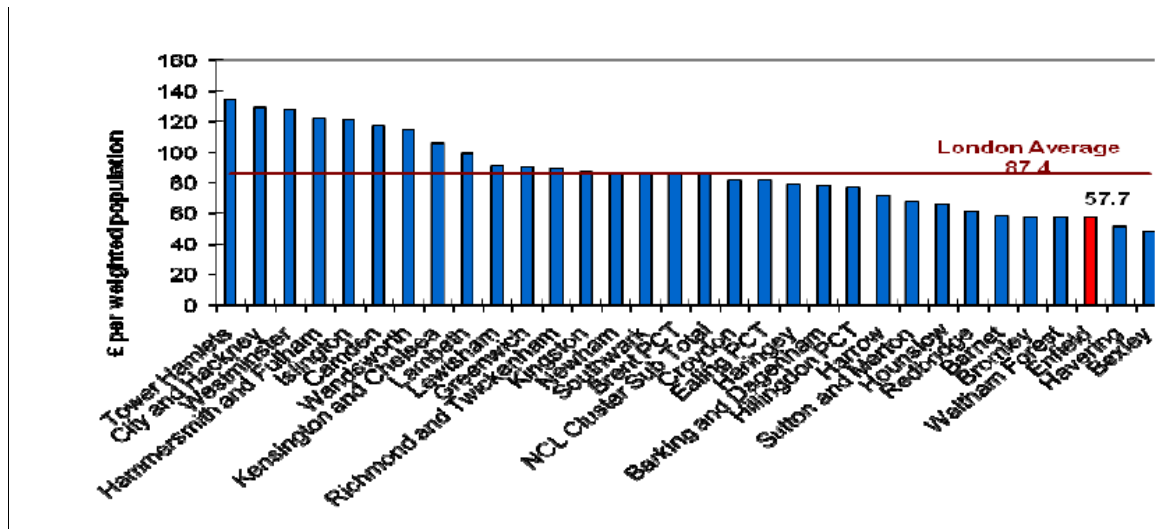
Figure 5: Public Health Spend per Head across London2010- 2011, Sourced NLB **Joint Needs Assessment (JSA, 2012: p5).**

When considered alongside these current research findings the above bar chart clearly indicates a need to attend to developments, which support mental health and wellbeing in the work place.

With that context in mind the researcher working closely with service users and with the help of a research assistant went onto try and find answers to the research questions: Are employers' reluctant to employ people in the recovery phase of mental illness? If so what are their possible reasons? And do mental health service users experience any barriers to employment in a recovery phase in this North London borough?

Research Location

All three-employer focus groups were held separately on the same day in a community mental health setting. Service users were involved in setting up the focus groups and organising the room for all focus group types. This involved replenishing refreshments, organising seating, and making extra copies of consent forms and biographical data sheets available in case individuals had not returned

these or forgotten to bring these with them. Two service users took charge of meeting and greeting participants as they arrived.

One of the venues was located in a relatively rural area of North London and was and still is the home to 16 individuals with mental illness living in supported accommodation. This setting was identified as appropriate as it had reasonable space to accommodate the groups. It was also easily accessible by public transport.

Three other service user focus groups were set up following completion of the employer representative groups. All three groups took place on different dates to accommodate individuals participating in the sessions. One group took place at an existing day centre facility and two took place at the community mental health setting described above.

Participant Information Sheets

Two different Participant Information Sheet (PIS) were drawn up in advance of the research enquiry proceeding. One for service user participation and another for employer participation. These had been approved by Middlesex University Ethics Committee in April 2010. A copy of each PIS is included in Appendices Four and Five.

All prospective participants had been given PIS in advance of agreeing to take part in the research. This provided clear information on the intended nature of the research. It also provided information relevant to subjects to make an informed decision whether to participate in the research or not. The PIS also documented the contact details of the lead researcher in the event they had any additional questions that they wished to pose. Those who elected to participate were aware that they could withdraw from the study at any time without prejudice.

All prospective participants were also given a consent form to sign in advance of participating in any focus group to ensure that participation was voluntary. A blank copy of this document is included at Appendix 6.

Reflection on the Focus Group Process

A clear framework was established at the beginning of each focus group. I started each focus group by introducing myself, my research assistant and any other helpers in the room. Some ground rules were agreed, which I expected to be respected such as ensuring that each participant gave each other the opportunity to describe their experience and perception in relation to the topic being discussed. Participants were reminded that they should be respectful and non-judgemental of each other. The purpose and background of the study was restated prior to the commencement of each focus group. This helped to contextualise the focus of the questions and responses given. Checks were made to ensure that each participant had received the PIS and signed and returned the consent form. Participants were also reassured that their identity would be protected and anything that might identify them would be removed.

The participants were advised that the focus groups would be recorded for the purposes of transcribing later. Details on confidentiality were also reiterated about the anonymity of information and sensitivity concerning its later usage. Participants were advised that they could contact me the researcher at any time in the future if they wished to review the transcriptions for accuracy of content. No participant has taken up this offer to date.

The six focus groups were facilitated by the lead researcher ensuring that all participants understood the nature of the groups and that they felt able to express themselves freely. The researcher was helped throughout the action research process by a longstanding work colleague acting in the capacity of research assistant who also took field notes during the focus group sessions. In addition to taking field notes the research assistant offered prompts relating to the focus groups sessions. These included the suggestion of relocating the digital recorder after focus group one to ensure that participants voices were clearly recorded. She also prompted me to wait for all participants to choose their seating before I sat down so that I did not hold a dominant position. In service user focus group two she suggested that I walk around the room in a facilitative style carrying the recorder with me to ensure all experiences shared were captured.

Service users were involved in greeting participants, showing them to the allocated room, setting up the room for focus group sessions and ensuring refreshments were kept freshly available. Different challenges were encountered within each focus group type and within each individual focus group. Employer focus groups seemed much easier to facilitate partly because of their homogenous nature. Participants seemed to already have a good understanding of the purpose and nature of the research topic. They also seemed to have a greater appreciation of the importance of not speaking over each other. There was a greater sense of fluidity in these sessions and whilst I had to work on teasing out what were likely to have been uncomfortable issues, as opposed to individuals telling me what they really thought I'd like to hear, participants seemed thoroughly engaged. There was an enormous amount of trust evident within each group. This was marked by some of the deeply personal disclosures made which added to the rich source of data gathered.

Conversely in the service user focus group session's participants frequently broke off into having their own separate conversations even in the smaller focus group of the three held. Facilitator involvement was more marked and this required extra effort to keep the sessions focused and giving the quieter participants a chance to express themselves so that data generated was not influenced heavily by with what could be considered 'the dominant voice' view. This concept is an opinion or viewpoint, which emerges from the group discussion, which can, but which does not necessarily; originate from an individual (Smithson and Diaz, 1996: p251-268). This is related to the notion that those who shout the loudest get heard.

While each separate service user group was considered homogenous in that they all had a mental illness and considered themselves to be in a phase of recovery and were able to contribute to the research topic, they were not homogenous in terms of age, gender, previous employment status or educational achievements. Higher levels of participant homogeneity were difficult to attain due to trying to organise times and dates that suited all participants. I was happy with the levels of homogeneity as participants had freely elected to participate in these focus groups. There is a strong argument that greater levels of homogeneity can lead to; an avoidance of disagreement, less use of unique information, overconfidence about performance, more social focus, and less sensitivity to relationship conflict than might be warranted (Phillips and Apfelbaum, 2012). The limited levels of

homogeneity are considered to have contributed to greater diversity and stimulation in the focus group process.

Individuals in all three-service user groups showed poor awareness of listening until the other person had finished sharing. There was also a regular coming together of voices heckling when service users discussed issues, which were emotionally charged. This resulted in making a transcription of verbatim content laborious, as I had to repeatedly play and replay sections of the recording to capture one word. This also meant that when I finally got the word or words that the whole context of the sentence or content changed. Attention spans also seemed lower in service user focus groups. There was however a real sense of wanting to contribute in a meaningful way.

Two predetermined interview schedules were used to facilitate each focus group. The interview schedules were different for the employer representative groups and the service user's groups as each sought to tease out different attitudes and perceptions from different perspectives. Both these schedules were developed by looking at other studies that had been done in this area. The lead researcher was particularly drawn to the work done by the Scottish Recovery Network (Brown and Kandirikirira, 2007; Coutts, 2007). The interview schedule content were also influenced by a number of studies which I had read around barriers to employment for individuals with mental illness (Perkins and Rinaldi, 2002; Smith and Twomey, 2002; Rinaldi et al. 2008; Bevan et al. 2013).

Questions devised were kept short and simple to aid understanding. I avoided the use of negative or loaded questions which might contribute to leading the respondents' answers. I also ensured that only one question was asked at a time so as to avoid confusion and to get as comprehensive an answer as possible from participants. Questions which might warrant interpretation of meaning were also avoided (Adams and Cox, 2008: p20). In addition when I devised these initial schedules they were sent to my then academic advisor Dr. Mary Tilki for her consideration .She suggested some tweaking of certain questions with the view to my being able to get to the real issues that might be underlying the research questions posed. I tried not to be too rigid when facilitating the focus groups using the semi structured questionnaires as a guide. Adopting flexibility and a conversational style in my approach allowed for the emergence of new information

and issues not identified prior to the focus group sessions. Both interview schedules are included at Appendices One and Two.

Whilst every attempt was made to remain objective I was very conscious of being the inside researcher (Robson, 2002: p382) and the bias that, that was likely to bring to the groups. The research assistant who agreed to work with me took field notes and documented non-verbal communications in each group. These notes were used later for the purposes of triangulation.

It is accepted that a huge limitation of using a predesigned interview schedule is that the responses rely on the range of questions posed. Consequently it is possible that if one misses out on an important issue in the questionnaire design this area will be missing from the analysis (Adams and Cox, 2008: p33). Therefore adopting a flexible, participatory enhancing facilitative style which contextualised participants' experiences was necessary to compliment the use of the interview schedules. This included making changes to the planned cycles of research. In the planning phase for this study it was envisaged that the research enquiry could be completed fully in five cycles. However as the findings emerged it became apparent that the study would benefit from adding a sixth cycle. The six multiple cycles of action research followed in this study are outlined below.

Summary of the Action Research Cycles in this study

Cycle One – Planning and recruiting participants

Having formulated the research questions that I wanted answers to I undertook some fact finding and exploration of literature in order to develop an overall plan of initial action (stage 1). Some of this is captured in chapters one and two of this thesis. In the second stage and assisted by the research assistant, I visited all potential employer participants in person so that the nature of the research could be explained fully. This involved visiting as many employers in the North London Borough as possible.

This stance was adopted having previously in stage 1 exhausted the possibility of getting a comprehensive up to date list of employers in that North London

Borough. These initial visits were made over two days with the view to enrolling as many employer participants as possible in the idea. This face to face contact time was used to explain the exact nature of the research. I was keen to let possible employer participants know that there was no pressure on them to actually employ a service user in a phase of recovery from mental illness. I then reflected on this as a method for recruiting participants for the study and felt that the exercise had gone very well.

Still in the second stage the researcher accompanied by the research assistant visited six different community facilities that either accommodate or provide support to individuals in mental health recovery. Again the nature of the research was explained to managers of supported housing projects and community project managers. They in turn explained the nature of the research to each service user..

The second stage of action in cycle one involved three service users who were non-participants in the focus groups, assisted by the research assistant compiling 60 employer research information packs and 50 service user research information packs .This was done following the initial visits to potential participants discussed above. Each pack contained a letter of invitation to participate in the research with suggested dates, a participant information sheet, a consent form and a stamped addressed envelope for replies. Separate packs were prepared for possible employer participants and possible service user participants. The researcher accompanied by the research assistant then visited all potential employer participants and all service user facilities previously contacted to distribute these information packs. Those employers or service user participants who chose to participate in the study completed and returned signed consent forms indicating time and dates that they wished to attend. Evaluation of this first action stage indicated that the exercise had gone well (Stage 3). The face to face contact had enhanced possible participation in the research enquiry. We had been received well by all potential participants visited. No amendments were made to engaging potential participants at this stage (Stage 4). Following the evaluation and reflection stages this completed cycle one.

The various action research stages followed in cycle one provided a sound and systematic framework for progressing to organise the focus group sessions.

Cycle Two - Organising and facilitating employer focus groups

This involved considering where the best room in the community facility to hold the focus group sessions for employers. Conscious that the facility was not a neutral place for employers to come to, the sitting room nearest the front door was considered the best location. Service users living at the facility thought that this would be ideal as participants would have easy access. It would also allow easy access for the provision of refreshments (stage1). Having examined the idea of holding the employer participant focus groups at the supported housing community care facility, and looked at the pros and cons for this the second stage of cycle two involved the actual holding of each focus group. In the second stage three non-participant service users actively helped to set up the room for the employer focus groups. They placed the chairs in a circular set up. They also ensured that refreshments were made available and replenished if they were getting low. They offered a meet and greet service by meeting employer participants as they arrived at the facility and then showed them into the room where the focus groups was taking place.

Still in the second stage of cycle two each focus group was facilitated and digitally recorded by the researcher. The research assistant placed herself in a non-intrusive position in the room. She observed and kept notes on her observations.

This system for planning and organising the focus group sessions was reviewed (stage 3) and evaluated (stage 4) after focus group one. It was considered to work well. We agreed that one service user would remain in the meet and greet area while the focus group was in session so that any late arrivals could be shown to the room where the focus group was taking place.

On further review and evaluation of the very first employer focus group the research assistant suggested that it would be better to let participants to choose their seats before the researcher sits down (stages 3 and 4). The research assistant thought that the most dominant participants in the first group tended to sit directly opposite me the researcher and at times this had to be managed(Stage 3). Krueger and Casey (2000) suggest that placing the least talkative individuals directly across from the moderator and the most talkative respondents and experts

to the sides of the interviewer. This tends to increase the frequency of comments of the least talkative individuals and reduce the frequency of comments by the most talkative participants, providing greater balance for the discussion. This action was taken but there was no way of knowing in advance who would be most talkative in any of the focus groups.

On completion of employer focus group one, a new question was added to my interview schedule (Stage 3 & 4). This question was: How would employer participants accommodate an individual in mental health recovery in the workplace environment who was experiencing side effects from their medication?

On completion of employer focus group two I added a second hand written question to my interview schedule (Stage 3 & 4). This was in relation to GP records of individuals with a diagnosed mental illness in mental health recovery. The question added was: Would employer participants feel reassured if there was a GP report or a psychiatrist report saying the individual with a diagnosed mental illness had recovered?

Both these questions were added after these topics had come to the surface in the focus group conversations. They were considered relevant to the research questions posed. In this sense each focus group informed the shaping of the next focus group sessions.

Cycle two of the action research process had highlighted that some areas might be introduced into the discussion that the interview schedule did not cover. It was considered important to note the occurrences or topics so that probing questions can be introduced if this was felt appropriate. The above review and evaluation stages completed cycle two.

Cycle Three – Organising and facilitating service user focus groups

Each of the three service user focus groups involved having dialogue with participants about a suitable location for the focus group sessions. Participant's preferences were sought. For example one cohort requested that I facilitate their focus group at a day centre where they attend regularly. They said that it made it easier to get people together at once. The other two service user focus groups

were held at the supported housing community facility. Each session was carefully planned (Stage 1).

Sill in stage 1 of cycle three participant service users were involved in setting up the venues for each service user focus group as part of the first action in cycle three. This involved setting out refreshments in an appealing manner and placing the chairs in a circular shape to encourage engagement. Two service users offered to do this at the community setting where two of the service user focus groups took place. There were three service user participants who helped with this where the focus group was held at a day care facility.

The second stage of cycle three involved facilitating each focus group so that it ran smoothly. The research assistant sat in as an observer and made field notes which later formed part of the overall analysis. As service user focus group 4 was very large with 16 participants I carried one of the digital recorders around in my hand to ensure that all contributions were captured. The other digital recorder was placed in the center of the oval seating arrangement During the focus group at the day care community facility I asked for a volunteer to sit outside the room so that people who were unaware the focus group was occurring did not barge in. This worked well, as they also ensure that there was no door banging where individuals went in and out for to smoke (Stage 2).

Review and evaluation followed the completion of each service user focus group. Review of service user group one pointed to the need to be aware of the need to place digital recorders in an appropriate position so that participants input is captured clearly. It also highlighted the importance of having a manageable sized focus group. Service user group two pointed to the need to ensure the groups were facilitated in a way that individuals did not talk over each other. Service user focus group three it was decided that a service user who wished to smoke could do so in session, beside an open window (Stage 3). Overall the researcher evaluated all three sessions as having gone well (Stage 4).

Cycle three highlighted that the flexibility that the action research process affords the researcher can be very useful. This seemed much more important when facilitating the service user focus groups. It felt extremely important to find a way of capturing that when moving to the transcription and analysis of data.

Cycle Four – Transcription and analysis of data

The first stage of cycle four involved transcribing verbatim each of the six audio recordings. Transcription was given order and structure with each transcription checked and rechecked for accuracy. Some transcriptions had to have words amended as they were not quite right and when the recordings were replayed these errors were addressed (stage 1). Once the researcher was satisfied that each transcription was accurate the stage 1 of cycle four continued. This involved the reading and rereading of each transcription. Once the researcher was familiar with the content of each focus group transcription thematic analysis was conducted using the model set out by Braun and Clarke (2006)(Stage 2). This is discussed later in this chapter.

Review of cycle four pointed to the need to check the interpretations and ideas that were emerging from the data with a sample of participants from service user and employer focus groups. Whilst these has been shared on a continuous basis with the research assistant and all the data had been searched and revisited to ensure that interpretations were not just made up from the research questions asked, it felt really important to arrange to hear from a sample of participants how they viewed these interpretations (stage 3). Evaluation of their comments and feedback and of the overall cycle completed stage 4 of cycle four.

Cycle Five – Addressing rigor in research

Three employer focus group participants were invited to a meeting in March 2013 where they were given printed copies of provisional themes generated from the analysis so far. The same process was conducted with three service user focus group participants (April 2013). The researcher was supported by the research assistant in both these sessions. The research assistant took notes on the general feedback received. One service user conveyed dissatisfaction with the theme that being on long-term benefits contribute to keeping individuals in a phase of mental illness unemployed. She said that I would not get that theme if I was to conduct my research now. However she accepted that this was due to ongoing recent changes that are being implemented in benefit legislation. The outcome of both these sessions was that the themes were agreed as an accurate interpretation of what was discussed and therefore as being final themes. Cycle five of the action research process provided the opportunity to check out the accuracy of the

researchers interpretations. It also indicated that the findings from the study could be of greater use if they could influence or affect change even if this was only within a local North London borough. Action research is considered as being useful in this way so the researcher took the opportunity to present the research findings to date to a wider audience at two public consultations events held in the North London Borough within which the current study took place.

Cycle Six – Public consultation events

On evaluating and reviewing cycle five of the research I formed the view that the emergent findings from the study were worth sharing with a wider audience in the NLB where the study took place. In line with the cyclical nature of action research a sixth cycle was added to the research process. The emerging findings from this current study were presented at two public consultations in January 2014. These consultations were held with the view to getting further feedback on the barriers to employment of individuals in a phase of mental health recovery that were identified in this study, so that these could be addressed in the development of the local mental health employment strategy. Feedback from attendees was recorded on dedicated feedback sheets and on both occasions indicated the need to develop resources that educate people about mental illness. During the public consultation breakaway discussions seeking feedback on the themes presented I was supported by the research assistant and a contracts and commissioning officer from that North London Borough. The completed feedback sheets containing feedback from the attendees in relation to the emergent themes from this study were given by me to the lead commissioning officer.

Presenting the themes from this study at this event promoted discussion and interaction about mental illness and employment amongst a diverse audience. It is argued that action research is about bringing about social change, therefore generating debate and interaction on employment and mental illness at this public event may contribute to that process. It is difficult to measure the overall impact of presenting to this wider audience but it did confirm that the themes identified in this current study are not unique to the focus group participants in this study. In the weeks following the researcher I met with the research assistant to review and reflect on all six cycles of the research. The six cycles of action research are mapped in figure 6 on the next page.

Mapping of the Iterative Action Research Cycles

Cycle One	
Non Participant Stakeholders involved: 2 x Academic Supervisors, 1x Research Assistant, 3 service user volunteers: 6 in total.	
Plan	Planning of research -process of refining of research questions. Formulating research questions- finalising questions Conducted an exhaustive desk search of local employers Literature search and fact finding in relation to employment, recovery and mental illness
Act	Identify lead contact in employer organisations in the local area to explain the proposed research to them. Identify lead person or manager of services that either accommodate or support individuals in mental health recovery. 3 non participant service users accompanied by the research assistant compiled research information packs for possible employer participants and possible service user participants. These were delivered by hand to over a two day period.
Evaluate	Face to face meetings were considered as an effective method to adopt for the recruitment of participants in the study. Personal delivery of participation information packs was found to be a way of ensuring the right individual/s received them and a wide audience were reached.
Reflect	Reflection indicated that the face to face contact with potential participants had enhanced possible participation in the research enquiry. It also indicated that this had provided an effective framework for moving to cycle two.

Cycle Two	
Non Participant Stakeholders involved: 1x research assistant, 39 employers contacted - lead contact identified in their organisation,3 service users to participate in the capacity of volunteers facilitating the running of the employer focus groups : 43 in total	
Plan	Organise and facilitate employer focus groups x3 Identify an appropriate facility for to hold the focus groups in.
Act	Facilitate focus groups. Service users at the community facility to organise seating lay out, refreshments. Service user to 'meet and greet' employer participants as they arrived at the setting. Facilitating of and digitally recorded focus group sessions. Research assistant to take field notes in each FG session sitting in an non-intrusive position.
Evaluate	Evaluation of the session took place after each Employer FG. Following employer focus group one the positioning of the researcher in the group was reviewed on the suggestion of the research assistant. At this point a new question was added to the researcher interview schedule around employers managing the side effects of medication of an individual in mental health recovery in work place environments. Following focus group two a second question was added to the focus group schedule probing the issue of reassurance- would employers feel more reassured if they had a GP or psychiatrist report saying an individual was in recovery? It was considered helpful to request that a service user volunteer remain in the front hall area so that the arrival of any late comers could be handled with minimum interruption to the focus group.
Reflect	Reflection took place after each focus group. Adding the additional questions as prompts for the researcher and making these slight adjustments following each focus group ensured the smooth and more effective running of the ensuing sessions. Plan next round of service user focus groups.

Cycle Three	
Non Participant Stakeholders involved: 1 research assistant, 10 managers or lead persons of mental health day centres or supported housing facilities contacted. 3 service users identified to participate in the capacity of volunteers facilitating three service user focus groups : 14 in total	
Plan	Organising and facilitating service user focus groups x 3 Enrolling service user/s to organise the seating arrangements for each session. Enrolling service users to manage the refreshments provided ensuring they were replenished as necessary. Agreeing suitable location for each of the three SU focus groups.
Act	Facilitating and digitally recording of the focus group sessions.
Evaluate	Some adjustments were necessary as we progressed with each focus group. In service user focus group 4, there was a risk that individuals would walk in during the focus group session. One of the service users who were staff at the facility opted to sit outside the door so that this could be managed. Also in focus group 4 due the high level of participants the researcher carried one of the digital recorders around in her hand to ensure each participants contribution was captured. In focus group six it was agreed that service user participants were allowed to stop for a cigarette as two felt that they really wanted to smoke.
Reflect	Greater flexibility in managing and facilitating service user focus groups was required. Adopting such flexibility promoted greater service user involvement across all three sessions.

Cycle Four	
Non Participant Stakeholders involved: 1x Research Assistant, Discuss with academic supervisors(x2): 3 in total.	
Plan	Review of data set. Deciding if it's sufficient. Working out how I am going to go about analysing it, and who I may involve in this cycle.
Act	Transcribing verbatim each of the six digitally recorded focus group sessions. Replaying each recording alongside transcriptions and adjusting words or errors in content Reading and rereading of transcriptions until the researcher had gained an intimate knowledge of the content of each. Accessing the field notes taken by research assistant- matching these to each focus group-considering their contribution to the overall analysis. Conducting thematic analysis using Braun and Clarke's model (2006).
Evaluate	Revisiting and evaluation of the themes and patterns emerging in context of the research questions. Checking that patterns and coding made sense in light of the research questions posed. The process used to conduct the thematic analysis was considered to be effective.
Reflect	Taking time to correct small words was very important as it gave greater clarity to what participants were trying to convey

Cycle Five	
Non Participant Stakeholders involved:1x Research Assistant, 3 employer participants,3 service user participants, 2x academic supervisors : 9 in total	
Plan	Address rigour aspects of the research by organising participant feedback groups Agreeing with the research assistant that she would be available to take notes from employer and service user participant feedback sessions.
Act	Facilitation of feedback sessions from a sample of participants from employer focus groups - reviewing the provisional themes emerging from the data. Facilitation of feedback sessions from a sample of participants from service user focus groups - reviewing the provisional themes emerging from the data. Submit emergent themes to academic supervisors for critical scrutiny.
Evaluate	Giving participants a hard copy of the provisional themes worked well. We were able to go through these one by one.
Reflect	These sessions were very useful in adding validity and reliability including rigour to the resulting final themes. They also confirmed my view that the results to date were worth sharing with a wider group of stakeholders.

Cycle Six	
Non Participant Stakeholders involved:1 x research assistant, 1 x Commissioning Manager, 3 x contracts managers,3 x employment and commissioning managers,1 x head of mental health managers : 9 in total	
Plan	Public Consultation Events- Liaise and work with the Commissioning Manager of mental health locally. Liaise with other agencies involved in the consultation including contracts and quality managers, employment and skills commissioning managers and the head of Mental Health Services. Check out who my audience will be. Consider how best to influence local agencies and local authority. Plan how to use emergent themes to affect change.
Act	Attending two public consultation events and presenting the themes from this current study to a mixed audience of service users, carers, employers, and commissioners. Facilitating breakout sessions where I facilitated the discussion around the emergent themes presented.
Evaluate	Attendees at these events evaluated these public consultation events as being useful exercises in stimulating awareness of the subject area. All attendees expressed a wish to have more of these types of events related mental health and employment. Attending both these public consultation events allowed for the themes to be presented to a wider mixed audience. It allowed for the opportunity to receive 'authentic feedback'. It highlighted that the barriers to employment of individuals in mental health recovery were not unique to the participants in this study. It confirmed that mental illness is poorly understood in other professions and sectors of employment at least at local level.
Reflect	This was use a useful experience. In terms of action research it influenced the outcome by confirming the need to develop an educational programme around mental illness and well-being in work place environments. Integrate how this event influenced overall analysis. Meet with research assistant, review and reflect on this cycle and the six cycles of research overall.

Figure 6: Mapping of the Iterative Action Research Cycles

The six cycles of AR outlined above provide a schematic outline of the project as a whole. Action Research has provided the opportunity for the collection of data in a systematic collaborative manner. Figure 6 captures how the initial planned cycles changed in later iterations of the Action Research Cycles. Five cycles of AR was originally planned in the early phase of planning the study. However a sixth cycle has been added based on critical reflection and evaluation of the emergent findings at cycle five of the research.

Presenting the emergent themes from the current study to a wider audience was seen as an opportunity to stimulate meaningful conversations that may contribute to affecting change. It brought together a community of people from different backgrounds and different contexts that had a shared interest in mental health wellbeing and employment. It was considered that policies and practices in mental health services would be more likely to be opened up to change when such changes are brought about through group processes and collective pressures (Burns, 1999: p.13).

Writing on achieving change through AR it is suggested that change begins in individuals' minds; it develops by individuals talking with one another and taking action as a result of their collective decisions(McNiff, and Whitehead, 2002: p86). These six cycles of action research detailed in Figure 6 above map the processes of action and reflection and identifies the different stakeholders involved at different cycles of the research journey. It captures the collaborative nature of action research always a process that is done with the people not on the people (Rowan and Reason, 1981). At a public level it made the research topic less of a mystery whilst at a research level it showed that my research was rooted in an ethic of respect for others opinions (McNiff, and Whitehead, 2002: p87).

Having mapped the action research process used in this study the following chapter will consider the project findings and analysis.

Chapter 5: Project Findings and Analysis

This chapter will outline the findings from the six focus groups held. Three of these focus groups were held with employer representatives in a North London Borough and involved 16 employer participant representatives. Another three focus groups took place with service user's participants and included 26 participants.

The themes identified below involved initial coding of ideas iteratively conducted, which allowed for the emergence of major themes and additional sub themes. The themes that emerged from the three employer representative focus groups will be discussed first. The themes that were identified from the service user focus groups will then be considered.

The analysis of data from both focus group types will consider the emergent major themes followed by any sub themes considered. The themes and sub themes will be supported by quotes taken directly from participants. All participants have been given pseudonyms to protect their identity. These pseudonyms are given with the view to maintaining anonymity of participants as well as aiming to capture the human element of the stories told. A list of participant demographic details from both employer and service user's focus groups are included at Appendices 7 and 8.

Themes that were identified from the employer representative focus groups

The employer representative focus group participants were made up of twelve females and four males aged between their mid-20s and mid-50s. The analysis and interpretation from this set of data allows insight into the research question posed from an employer's perspective.

There were four major themes identified in the employer representative data set. Each theme also contained a number of sub themes as shown in table 2 (p129). These are supported by verbatim accounts from individual participants. These will be discussed in more depth within this chapter. Consideration will be given as to how these themes inform future developments both locally and nationally.

1. Employers are reluctant to employ individuals with Mental Illness

Employer participants were asked what they thought prevented employers from employing individuals with a known mental illness. It was quite apparent from the end of focus group one right through to the end of focus group three that employers are reluctant to employ individuals with mental illness who are in a phase of recovery. This was an overarching theme which spanned all three employer focus groups. There were many reasons as to why this is the case and the sub-themes underpinning this main theme are considered below.

1.1 Employers view employing individuals with Mental illness as a burden and added cost

One of the issues that arose in each of the three focus groups was the added hassle of employing individuals in mental health recovery. This research has taken place in a climate of deep recession. Therefore the notion of even considering the employment of individuals with a mental illness seemed so far off the spectrum. Pam an employer commenting that if someone was gone off sick with mental illness responded:

"There would still be 2 issues, yes I would be understanding but we are not meant to go off sick because we have got work to do so excuse me while you have been lying on the sofa for 3 weeks but the work has got to be done and who is going to do it, so I would be thinking when are you coming back…when is this going to stop"

Individuals with mental illness in employment were seen as a hindrance rather than a help and participants feared that they would end up with a greater workload as a result. Feeling let down by a colleague who had gone off sick because of mental illness Ash commented:

"I think people can be very judgemental of them, I might myself be judgemental, and there is that inner voice in you thinking you really left me in the lurch".

It was felt that business is concerned about profit and making money so individuals with mental illness regardless of recovery are considered as affecting profits and success of the business. Jaz a participant from the banking industry commented:

"We are not asked how much money did you generate today and how many people did you ease back into the workplace, our business is very caring about people that work for them but in a lot of companies they're not going to be interested in the fact that I spent 2 hours or 2 days integrating somebody back into the team – but sorry my shop didn't turn over any profit for you today".

This point was further laboured and stressed by participant Gemma an Employer Participant.

"It would be lovely if you can find the time but the fact they gone off in the first place has increased our stress levels by however much percent – because there a percentage of our team missing then they come back – outside of work I would love to spend my time sitting with you and talking to you but in that environment you just increase my load. On the face of it I would be supportive but inside I wouldn't".

Pam was very clear that in their industry it was simply a step too far. She said:

"I have enough trouble managing the well never mind anybody else".

This idea that working with individuals who have mental health problems is simply too much hassle and added to the workload was also aired by another participant. Jaz stated:

"But it's still extra work for you with adaptations that your day at a time when there is cuts".

Employers seemed to believe that if they took on an individual in recovery from mental illness that this would have some extra issues attached to it, around employment law, resources and output leading to the researchers' interpretation that employers see this group as just too much hassle. Gemma said:

"But if we employ her we'd have to take on all the legal employment things that come with it as well so immediately there are issues of confidentiality, this that and the other for her".

There was also a strong theme of employing individuals being an added cost or something that employers had no resources to cover. Not alone was it considered as an added cost but it seemed as though employment of an individual in mental health recovery was difficult to perceive. There was poor association between employee mental health and employer. Once I had introduced the idea of employment of an individual with mental illness, cost implications seemed to jump up forcibly in this participant group.

Mark an employer participant in focus group 3 simply said:

"We're all full on now we have no spare capacity".

He went onto say:

"We feel that if you employ somebody it's a great responsibility nowadays it's a huge responsibility just employing our able body person let alone a disabled person".

This was similar to the sentiment shared by Paul a participant in focus group three.

Talking of spare capacity another employer Sharon categorically stated that:

"I I think from my point view as an employer of mentally ill people is, we do not have the spare capacity to, have somebody mentoring that person".

"We don't have the spare the spare manpower".

And again reiterated by Mark *"we can't afford the spare man power you literally the fine line down where the business which is making money and the business that is losing money is so fine nowadays".*

So whilst there might be empathy towards an individual developing mental illness whilst in employment or returning to work following a bout of mental illness employers felt that realistically there are limitations to what they can do in this climate. Discussing this Sharon said:

"But then you find that there are only so much that people really are able to do because we are all pressured…."

Talking on the added pressures employing an individual with MI on your team Karen a participant working in health care stresses:

"Profits, in the health system it can be just the same because the budget can be quiet finite budgets and the work the perception of work has to be done in a rapid phase if people are having time off".

Paul added *"for this kind of thing they're slowing down the operation so I think there is this tension and am mostly in mental health we are used to analysing people's motive and it's being bit suspicious as well all of that comes in you know, the person trying to work the system too much".*

It is seen as an added burden on the 'well 'person at work. Mark whilst sympathetic says that as a human being:

"There comes the point where everybody's patience wears thin and I think that's where you really start to get into a really grey area".

1.2 People in a phase of mental health recovery are seen as less able or less competent

When participants were asked about jobs that they would consider as suitable for individuals in mental health recovery, a range of jobs were put forward from the low skilled or unpaid voluntary sector. Individuals in recovery were considered vulnerable to relapse. Whilst there was some empathy towards such an employee they were generally thought of as less able or less competent as a result of schizophrenia. This participant felt that full time work might be too much. Ash said:

"So for me it is something around the amount of time they spend in their work environment because we know that 9 to 5 is a long span of duty. So it is about tailoring it to meet their needs so it's less time in the work place, so part time work and and the stress level there and pitching it at a level where the stress levels are not as high. So we wouldn't throw them in the front desk in to certain death. What you would do is make sure that it is somewhere where you know they feel less stressed but enjoy what they are doing because I think that work gives people a sense of independence".

As a result of being less able and less competent individuals with MI are also considered a greater health and safety risk. Health and Safety were seen as impeding people with a MH problem. Geraldine clearly felt this and stated that:

"We would say two people come for a job and then and they are virtually the same and you have this one question mark I hate to put it like that but you have this one question mark go over you know the suitability because the safety issue mainly and the supervision issue ham…"

A personal narrative from a significant employer within the borough captured why individuals might be seen as less able or less competent having been diagnosed with depression in the past Mark stated that:

"I press myself I'm not being big headed but I do test myself with inspiration, I get fantastic ideas and when I was on the tablets I pretty well lost that for 3 years or 4 years, but the tablets do de-synthesize your brain".

Whilst the above was the actual employer another participant who was an employee at the time but is now in an employer role had to leave their job in the past as they were seen as not being able to do the job as a result of a diagnosis of depression. Somehow they were viewed as less competent. This is what Valerie shared:

"Because I was working for a company, a care company but the care didn't extend to the staff and I found it really bizarre, you know I actually needed a bit of support, you know need to go back to work probably a couple of days a week it was like what if you can't do the job then you're no good to us".

Some small employer representatives felt that rather than think about employing the individual with mental illness in a state of recovery it is easier just not to bother. Participant Mark an employer participant said that in his opinion:

"A small business employer would want to kind of like to get rid of the problem…..probably I'm not being nasty…."

And a participant from a large retail company viewed individuals with mental illness as more needy.

Sharon said:

"Yeah I think I agree with you about being more vulnerable and requiring more support so that am they are able to access the same you know they need that extra".

1.3 Employers fear that employment will cause stress, which will have a negative impact on mental health and vice se versa

I was keen to explore employer's reason for being reluctant to employ individuals in mental health recovery further. To uncover some of those beliefs and perceptions participants were asked how having mental illness would interfere with their ability to do their current jobs or some other responsible reasonable job.

Employer participants felt that work contributes to raised stress levels and that the coping levels for individuals in mental health recovery is greatly weakened by their mental illness. So employers felt that this was a particular consideration when considering this client group. One participant shared that in her career in The National Health Service that they have employed individuals with Mental Illness but great consideration was given to the post and likely stress levels the person was exposed to. Mary said:

"I have been on panels where you have to think also about stress levels – but you have to think are they going to be able to manage at the levels but we have people who work in areas that are less stressful and where they can cope with the work".

Relapse rates were considered to have a negative impact on employment but there were some employers were more geared up for employing individuals in mental health recovery.

Valerie a participant in employer focus group three describes the huge negative impact that being diagnosed with a mental illness had on her professional life which in some ways might explain why there is a notion that stress can lead to triggering the active symptoms of mental illness. Valerie said that once diagnosed with severe depression in this case that:

"You now I lost everything I lost my whole confidence, everything went so I thought I can do this this, I was running a big day centre at the time and I thought why can't I do it, I always do it, I couldn't function properly and I didn't realise until that happened to me that actually I probably was unwell".

Where an employer actually works in securing employment for individuals in mental health recovery Karen found that whilst the individual might wish to work when actually given the responsibility and tasks that they are unable to cope. She describes one such case:

"I have had one (referring to an individual with mental illness) who achieved employment, but it didn't last because he wasn't able to cope with that pressure you know, great he went to two lots of interviews you know, 50 candidates which we supported him to do that, but obviously the pressure then the reality is actually no you're not a child anymore".

2. Understanding and Knowledge of mental illness

It became clear as the focus groups progressed that depending on the employer type there was a poor understanding of the different mental illnesses that exist. Talking about knowledge about mental illness Geraldine an employer representative from a large retail provider commented:

"Personally I don't know alot about lot about mental health issues I I am aware that there's a different level of mental health issues, there's different range of mental health issues but that's about it. I'm not an expert on it, I haven't, and you know I know it exists. There is I know that it's there but I don't know anything about it you know and ah the argument is I'm not a professional so it's not my responsibility to know what level of mental health is or acceptable quote unquote for want of a better word" .

So the idea of employing an individual with mental illness is someone else's profession. This large retail employer representative felt that it was separate from her role, someone else's responsibility and profession.

Participating employer representatives felt that training would improve their understanding of the differing mental illness. Many employer representatives felt

they knew depression and anxiety but others really did not know or understand schizophrenia. These employer representatives repeatedly suggested training in mental health and differing mental illness. This participant likened it to education about Aids awareness. Mary said:

"I'm just going to back up a bit, it's all about training again I mean I remember aids when aids first and then domestic violence and then am family values they are all being trained at schools now, so because of lack of knowledge on mental health, maybe it is about time but they also brought that to the and training children to school".

Another employer from a private retail sector felt that mental illness was poorly understood. Mark felt that the reason was:

That that is something that is, it hasn't been promoted is probably the wrong word but it hasn't been raised as much as a disability and how you work with someone with a disability.

2.1 Familiarity with anxiety and depression but very poor understanding of schizophrenia

Employer participants were asked what sort of image came to their minds when they heard the word mental illness. Further exploration was done in relation to specific mental illness such as schizophrenia and manic depression and bi-polar to see if there was a difference in perception between perception of common mental illness and severe and enduring mental illnesses. Employers were able to make an association with an individual with anxiety or depression in the workplace but schizophrenia was poorly related to. The researcher frequently made reference to employment of individuals with a diagnosis of schizophrenia but it is noted from all three transcripts that respondents then made reference to mental illnesses such as anxiety and depression. In essence this is a theme by its absence.

2.2 Employers from a caring background or who had experienced mental illness were more caring and empathetic towards individuals with Mental Illness

Where there was a personal association with mental illness acceptance of individuals with MI seemed to be more evident in employer representatives who either had experienced mental health difficulties themselves or who were from a caring background. Participant Geraldine who is employed in a large pharmacy as a manager stated that in her opinion of people with MI:

"...*Some are really good and educated people who can work better than any bank managers as far as I'm concerned, they just need that little bit of help that little bit of whatever, care and concern within the society, that would bring them back with us, you know, not that they are totally discarded or their totally unable to ever, I get a flu I get better what is it that mental illness can't get better, with due care and medication, you know I think everybody can".*

This participant was normalising mental illness and suggesting that mental illness is just like any other ill health. In focus group two there seemed to be a strong emphasis on justifying mental illness or sympathising with it. Where employer representatives were sympathetic towards MI they were also more willing to employ. There was an underlying theme that these individuals have to start from somewhere. Thinking about stacking shelves Geraldine an employer participant commented:

"But as for stacking on a shelf, why not?"

On the other hand Joseph an employer representative from the construction industry found it difficult to consider employing an individual with MI stating that:

"Obviously, we would have, we would have lot less knowledge, than a lot of people in mental health, about knowing how to deal with them about how to safeguard and how to marshal supervise them, so am it would be probably reluctantly that they would am employ somebody like that..."

Where the individual themselves had experienced some diagnosis of MI they were definitely more sympathetic towards the idea of employing an individual in mental health recovery. This participant wanted it to be known quite early on in focus group three. Mark said:

"I had depression, and I know how horrible that is and it is not a nice thing to be, so I I have a lot of time for people that are mentally ill…."

A different employer representative who had also experienced mental illness also had a more sympathetic view of mental illness. Valerie realised that this can happen to anybody. She shared:

"It's true you are never going to get well unless you deal with the issues and from so from that prospective it also has really changed my views because in that room there was merchant bankers, there was people who have their own businesses, there was undertakers, there was a whole lot of also very professional people and it sort of made me think you know what I'm not really alone".

But whilst this participants view or understanding has changed Valerie is still very aware of the general public's perception of mental illness and therefore states that:

"Even now I still have troubles saying it was a mental illness I say it was when I wasn't very well".

An employer representative Mark felt that by being supportive to a staff member who had developed a mental illness resulted in it having a positive impact on the rest of the team. So he used the situation to send a message of caring about his employees to the rest of the team. He said:

"If the rest of the team sees you are going to look after that person they will think he's going to look after me as well and I find I get huge benefits from the rest of the staff".

He went on to say that this attitude was directly linked to his own experience of severe depression in the past.

3. There is still great stigma associated with labels of Mental Illness

Participants were asked to consider if in their view the wider public's perception of individuals with mental illness would include any notion of an individual with a paid job. This technique allowed participants to get in touch with what is essentially their own perception and discuss it in a safe trusting environment. Participants were also asked how many people they knew who were currently employed in their sector with a diagnosis of mental illness.

What emerged is that despite there now being a greater emphasis on recovery from mental illness in government strategies and thinking employers at local level are still very much influenced by the negative images and perceptions associated with the different labels of mental illness. Karen shared that even if you did disclose a diagnosis of mental illness that this would not be shared with the rest of the team.

"To *be honest it is probably something that we don't talk about because am if it was something that was happening and your line manager knew it's not something you'll be sharing"*.

Paul an employer participant who was working as a manager in the health sector had been made aware that a colleague he had been working with for some years had a diagnosis of schizophrenia. Paul was somewhat taken aback as he thought that he would have noticed it or that he should have been told. Relating to stigma within their sector Paul said:

"With professionals with mental health difficulties, it seems to be its all kept pretty pretty quite really people don't generally know about it"

This then leads to the question of whether to disclose or not.

3.1 Employers have a negative association with the label Mental Illness

Asked what image came to their minds when they heard the term mental illness, the conversation drifted into a raft of negative association with labels such as schizophrenia, bi-polar and manic depression. Expanding on what participants

envisaged as the public's perception of the employability of individuals with mental illness it was also evident that employer participants seem to evaluate individuals with mental illness in terms of what they cannot do. So presence of mental illness implies absence of ability or capability. Jobs suggested as being suitable for individuals tended to be menial, low skilled jobs. Some suitable jobs suggested were as a cleaner, gardening, receptionist, a planner and designer, voluntary posts, jobs that provide flexibility and 'no stress jobs'. There was a strong negative association with the label of mental illness rather than with an individual's capabilities or skill.

Employers felt that their negative perception of individuals is down to bad press from the media. Employer participant Geraldine said the following:

"I think what you said is important, you know the lack of information, but it's also that misinformation and what we mostly hear. You said it yourself about the media, what you mostly hear and what you see in the paper".

"The bad things black schizophrenic stabbed somebody at wood green tube, because it's sensationalizing, its headline grabbing the news, and you know big intimidating picture, you know you don't hear that white guy stabs someone in a football match which happens far more frequently on a regular basis"

"Doesn't it doesn't hit the newspaper or you know bla bla bla but what, so the media I think has got a hell of a lot to do with the perpetually bombarding. It's scary these people are scary they're gonna do unpredictable things, they're gonna have knives sticking near that person, and I think that's what people hear .."

The negative association with the label of mental illness was so strong that employer representatives went so far as to say they no longer describe it in terms of mental illness that in their work environment it is now called 'stress'. Mary said:

"I think there is a change actually in the attitudes around mental health so people prefer to call it stress than mental health, when they are like the bigger corporations and organisations".

In the third employer participant focus group one retail employer representative made the point that because people associate fear with such labels that mental illness should be rebranded. Mark said:

"It's like am, in ah words like bipolar, sounds like to the old man in the street, its sounds like polar bear……..as you hear that word you put up a huge wow to defend yourself against this…"

Karen a participant in focus group three felt quite ashamed about her perception of mental illness and this had only changed after that participant experienced mental illness herself. Having been told that she should attend a support group her thoughts were:

"I'm not going to go and sit with a bunch of people sitting rocking to and fro in their seats and dribbling down the coach windows………."

Karen went on to describe a diagnosis of mental illness as feeling like:

"Somebody's trying to put a big flash on my head saying you are really really not well, I just couldn't handle that".

There was recognition that even though employers have a negative perception of mental illness and those individuals in mental health recovery are often given menial, low paid or voluntary post, Sharon a participant who is in the pathway of actually securing employment for people in mental health recovery stated:

"For a lot of clients they come to us and say I want to do the trolleys in Tesco's and often what you find is that is because that's the only thing that they can do".

Paul an employer participant from the public health sector said that his perception of individuals with schizophrenia was:

"Someone who is in the outside am someone you wouldn't to employ, someone who perhaps wouldn't have a partner…"

Later this is powerfully described by Paul as an individual who is seen as having:

"Gone somewhere else, there are no connection between what they were, experiencing any kind of traits of that you know".

The label itself of mental illness is felt to immediately introduce a negative reaction. Mark felt that mental illness should be relabelled. He said:

"So can't you start thinking about it, getting rid of the word mental illness, getting rid of this word mental illness and replacing it with another word, which is more of

a word of the general public would listen to, mental illness as soon as you hear that word you put up a huge woo to defend yourself against this".

3.2 People with Mental Illness and in Recovery are Dangerous

Participants were asked to describe what image came to their minds when they heard words like schizophrenia, depression, anxiety and bi-polar in relation to employment of individuals. Getting individuals to describe the picture that came to their mind allowed them to share their uncomfortable notions about individuals with mental illness in a safe way.

When thinking of schizophrenia Gemma replied: "*Paranoia, I am scared of that word, honestly I instantly think it's someone that might kill me*".

There is concern from employers about the safety of their customers if they employ individuals with mental illness because people with mental illness are seen as dangerous to others. Joseph from a construction company an employer participant says that:

"The worry for people is not about the ability of people if they could perform the job, I think it's about the safety I think that is really the reason why, I mean I notice people. I think it's not because they are mentally ill that they're less able than I am, I think the safety for the other people first because when I'm thinking about is would he harm me would he harm him, would he harm anyone around me, I think that's probably the issue".

Paul a participant in focus group three feels that people with mental illness:

"Can can be dangerous in times when they're really unwell".

Sharon an employer who works towards securing jobs for people with mental illness stated that:

"The minute you see the word schizophrenic it means you are going around killing everybody else, that's what the media says, the minute the word schizophrenia if they put bipolar its fine".

3.3 Mental Illness is associated with illness not recovery

The majority of employers that participated in these focus groups seem to associate mental illness with a permanent form of illness. Those employer representatives from a non-caring professional orientated setting found the idea of recovery difficult to associate with.
Ash felt that employment would be out of the question and commented:

"I think it would have an adverse effect on that individual would mess them up forever".

There was a suggestion that employment would be promoted if the individual could have a stress free job. It would seem to me that this is not very realistic.

4. Employers considered that employment of individuals in Mental Health recovery might be possible

Asked if the diagnosis were depression instead of schizophrenia would it change the employer's likelihood to employ a respondent from the construction industry Joseph replied that it wouldn't. Joseph said:

"Well personally I wouldn't know because depression is a different kind of mental illness altogether but I could imagine again for a lot of small employers am with the health and safety concerns am the sort of the popular image in people might manifest in their mind that somebody who suffers from depression was that you don't want to put them in a vulnerable position where health and safety is concerned".

The idea that employment might help an individual overcome depression is not at all considered. There is a great emphasis on what the individual cannot do rather on their ability.

Employers felt that they might be able to employ individuals in recovery from a serious mental illness. However this was suggested with a cautionary condition attached. Gemma said that:

"I would be willing to give it a go in a very closed, that I would control, in a small basis me personally. But it needs to be the right role for the right person and in retail banking right now is not the place for them".

Asked to consider what type of support or information they would need to encourage them as employers to give people with mental illness a chance of working and proving themselves in their organisation Gemma said:

"But I still don't think it will be the right place because I don't think retail and having that level of pressure one to one with customers all day is correct for anybody".

4.1 There are factors that facilitate employment

Asked about existing support systems which is offered to employees who develop mental health problems, occupational health, and counselling support was cited as an existing support system for managing mental health issues of employees. With that in mind employer participants were asked to identify what support they would need to give an individual with a known mental illness a chance to work in their organisation and prove themselves.

When considering individuals who have recovered from schizophrenia employer representative had a list of things that they felt would facilitate employment of individuals in mental health recovery.

Mary suggested in focus group two "*… that re-education or assurance from other sources or watching a programme, or meeting people with mental illness who had recovered might facilitate employment".*

Sharon, a participant who is in the pathway of actually getting jobs for individuals in mental health recovery, identified systems that they had in place that actually facilitated employment. She said:

 "We could go out and give advice and make reasonable adjustments. We've got a couple of occupational therapist that work on the team from a more complex cases. We got a couple of work assessors so if you are not sure what can they do what their abilities are. They will go on a 12 week work assessment and then we get a report saying, what somebody can do or what they struggle with and we use

a very person centred approach into how can we then go back into marketing that person into employment…"

In focus group three attitudes seemed to influence the decision to employ people with mental illness. Valerie said that:

"… *There's a little part of me that says no it can be reasonable adjustments and you can make changes and you can see the good in people…"*

Geraldine said that they would work with the individual to see what would meet their needs on returning to work after a bout of schizophrenia. Employers felt that flexibility would facilitate employment of an individual with MI. Geraldine said:

"I mean, for me it would be about working with you about what sort of times are suitable for you to work *mumble* what's a good time for you, if you're only going to manage two days a week, that's fine or you can only manage half a day we could work that out" .

Whilst Geraldine advocated flexibility she was also aware that it was because she had the power to make that decision .It was her call.

Paul an employer representative in focus group three shared that on his team in the healthcare sector a colleague who had developed MI was allowed to attend support groups and this enabled him to stay in continued employment. Support from your employer was also given as a factor that facilitated employment by Valerie who had herself experienced mental illness in the past. As a result of receiving no support when she most needed it Valerie said:

"I vowed never to work and stay somewhere that's going to make me unwell again".

Valerie continued referring to her then line management. Referring to an unsupportive work environment she said:

"And after having the complete manager from hell I just thought you know what, I got to get out of this, I've got to do something else and I was only on that job for a year and the people higher up who recruited me and knew what I could do sort of said to me why are you leaving and I said because it's going to make me ill and I'm not prepared to put up with it".

Asked by the researcher what as employer representatives they would see as making employment of individuals in mental health recovery possible? The following suggestions were made. Working from home, and using technology was suggested. It was also felt that putting people into the work place would increase understanding of mental illness, and job sharing was also identified as possible facilitators of employment.

Summary of Employer Focus Group Analysis

Table two summarises the four main themes that emerged from the focus group analysis of the service user participant focus groups. There are also nine sub themes identified, three to main theme one, two to main theme two, three to main theme three and one to main theme four. These themes identify reluctance on behalf of employer participants to employ individuals in a phase of recovery. They also highlight that employers have a poor understanding of the more severe and enduring forms of mental illnesses especially schizophrenia. There is evidence of stigma associated with beliefs linked to labels of mental illness, but despite that employers have not ruled out the possibility of being able to employ an individual with a diagnosed mental illness in mental health recovery.

The themes seem contradictory in effect, on the one hand indicating poor understanding and unwillingness to employ this type of individual whilst on the other hand implying that employability could be made more of a reality if certain measures were put in place. The implications of these themes and how they might be used to underpin strategies or new developments will be discussed more in depth in Chapter 6 and 7 of this thesis.

Table 2

Themes	Sub- Themes
1.Employers are reluctant to employ individuals with MI	1.1 Employers view employing individuals with MI as a burden and added cost
	1.2 People with MI are seen as less able /competent
	1.3 Employers see employment as having a negative impact on mental health and vice se versa

2.Understanding & Knowledge of mental illness	2.1 Familiarity with anxiety and depression but very poor understanding of schizophrenia 2.2 Employers from a caring background or who had experienced mental illness were more caring and empathetic towards individuals with Mental illness
3.There is still great stigma associated with labels of mental illness	3.1 Employers have a negative association with the label Mental Illness 3.2 People with MI are Dangerous 3.3 Mental illness is completed associated with illness not recovery
4. Employers considered that employment of individuals in MH recovery might be possible	4.1 Factors that would facilitate employment

Summary of Themes and Sub Themes from Employer Representatives Focus Groups.

The demographic information for employer focus group participants is detailed in Appendix 7.

Themes that were identified from Service User Participant Focus Groups

Following the completion of the three employers' representative focus groups, three service user focus groups were organised. These took place on the 28th/06/2011, the 6/07/2011 and the final one on the 19/07/2011.

Focus group one was set up by service users at an established day care centre, and the other two groups took place within a mental health care setting in a rural part of North London.

Service user focus groups were diverse and were made up of: 10 Females, 18 Males with participants indicating their ages ranging from in their 20s to mid-60s. The groups were multi ethnic consisting of 16 British participants , 5 African

Caribbean, 3 Black British, 1 English Italian, 1 Asian British, 1 Burindiz, and 1 of Mixed Race.

Through the theoretical freedom and flexibility that thematic analysis provides five major themes, and a number of sub themes were identified from the service user focus group data (Braun and Clarke, 2006:p7). A summary of these are set out in table three (p151) at the end of this analysis.

1. People with MI face significant obstacles to accessing suitable employment.

The same schedule of questions were posed to each service user focus group, with each allowed to spiral in directions informed by the interaction and engagement of respondents. It is evident from the three focus group discussions that individuals with a known diagnosis of mental illness face significant barriers when trying to enter the employment market. Some of these barriers are personal and individual, whilst others are structural. The barriers are varied but there is considerable evidence that they are still very real within this London borough.

1.1 People with Mental Illness felt that there were factors that would enhance the prospects of employment.

Participants were asked what type of support they had been offered to go back into employment full-time or part-time. They were also asked what type of arrangements they thought should be put in place to enable individuals to go back to work. The researcher also sought to identify what type of support individuals were in receipt of where they were currently employed. These questions were looking at identifying what it is that would make employment possible from a service user's perspective.

Ed indicated that if employment of individuals in mental health recovery was to be facilitated that employers would benefit from:

"*training in the area*"

Kevin another participant felt that service users would benefit from:

"*training into a trade or something*",

Training and up-skilling individuals who have mental illness were identified as facilitating employment by a participant in focus group five. Talking about the support she has had from the day centre Julie said:

"*They used to do something like that, courses in English, art stuff like that, computer course as well, yeah it did help me yeah*".

Supporting the idea that employers need to be more aware of mental illness and how to support an employee Kevin said:

"*I think it has to start with education, I think employers have to made more aware of mental illness, I think that's the starting point. Obviously then when people have mental health issues then I think it should be easier for them. Cause I was talking about different situation erm how initially they were very, very supportive and helpful so people should have you know the opportunities to actually access services, I think that are important*".

This service user felt that training for employers in mental illness should be compulsory and that this would improve the prospects of individuals reengage meaningful employment.

Tony said:

"*What would help first of all is if employees, employers were forced to be trained to understand the sign of mental illness*".

Participants felt that employment could be made more possible if the individual with mental illness was given one to one support. Ian thought that this would facilitate employment.

"*Ahh for the person who's got the mental illness to have a shadow*".

Views expressed indicated that just a little extra help could make all the difference. Tony captures his image of that:

"*You might have like thirty people in a shop floor all working around each other and you've got one person in the middle that may need a little bit of extra help*".

Stanley a participant from focus group five busied himself with art using the web but avoided engaging with people. In terms of re-entering the employment market he thought that:

"It would be quite helpful if there was more support you know if you are going into sort of making the first step contact".

Stanley went onto expand on why he felt that was important:

"Hmm for me I supposed I would like help from the authority to help some of my art work, just initially, initial help that making contact in other companies, a stepping stone, hmm yeah that would be quite useful because you get out of contact".

So there is a feeling of being out of touch not knowing the pathway back when you have a diagnosis of mental illness. Participants mainly suggested that they would like support to re-enter the labour market. Jack said that

"….I wouldn't mind some help or even office work or something simple stuff".

However there was also a cautionary note about levels of support that were considered appropriate. Individuals with mental illness would like to have appropriate levels of support when in the employment arena but this should not be over supplied. Otherwise the person can feel just as devalued and stripped of self-confidence. This participant Chris said that:

"It's weird because at the end of the day you don't really want to be supported all the time because you know what it's like, it is treating you like a child you want rather to be treated as an adult".

Gerard another participant also said of too much supports that:

"At the time then that means that when you get back out (referring to out of hospital) then you don't know what you going to do, because you going to think ok there's no support worker there. There's no, there's no social worker that's like, so how am I going to live, how am I going to cope, how am I going to pay the rent ? How am I going to look after the kids, so how am I going to look after a wife? You know what I mean you don't, you, you don't get it that what you need to do is that umm you have to be self-assured in yourself to know what the thing is that you need to cover".

So support is identified as being helpful to facilitating employment but it needs to be tailored and not encourage over dependency. It should be enabling and empowering in style.

Gary thought that you had a better chance of securing employment with an employer if:

"Probably if he suffered himself from mental health at some point".

Sonya, a female participant found that where her employer was a considerate person that this facilitated employment. Sonya said:

"If you've got some good ones who listen to your problems".

Support was repeatedly cited as being helpful in accessing employment or in re-entering the employment market. In focus group six we had one participant working in a childcare setting. When asked what made that possible for her she stated that in the first instance she was encouraged by those around her .Lucy said:

"I do get prompted by some people, my parents and family carers and stuff just to basically go out and do something just get yourself active".

She also identified training in health and safety as facilitating her employment.

"Because we are doing the health and safety when I worked there I've had to look after the kids and keep them safe keep them away from sharp objects and other things".

1.2 Flexibility in employment to accommodate people with MI.

Considering the support needs that would enable employment, participants felt that employers should adopt a greater degree of flexibility when employing individuals in mental health recovery. Peter felt quite strongly:

"If someone wants to go back to work they should be eased back into it and not kicked into it".

Peter went onto say:

"…And there's got to be two criteria someone maybe well enough to do full time work someone maybe only ever get part time work that must be understood".

Much later in focus group four this idea that flexibility should be offered to an individual who's in employment with a known mental illness was reinforced. This participant felt it was imperative that employers consider this. Gerard said:

"Yeah cause the person could have very very bad days or very very good days or they they can go some period of time when they might need to take a few days off, then might need some breathing space if employers can't understand that then they cannot even begin to make a few step to the person to go back to work".

It was felt that a 'give and take' stance would facilitate employment. Jim said that the individual in employment in mental health recovery should adopt an attitude of:

"I *can give you this much, but what are you prepared to do for me because there's got to be some sort of equilibrium if there's no equilibrium it is no good".*

Service user participants contributed ideas which indicated they felt they had something worthwhile to offer to the employment market. This needed to be taken on board by prospective employers. Therefore employer understanding of the fluctuating nature of mental illness and adopting flexibility was thought to be very important in facilitating employment.

 Gerard states *"With the right help and as long as the employer understands one day they will be up and one day they're going to be down".*

There would have to be some element of flexibility built in where individuals needed to attend clinics or pick up medications or have injections. Employers need to be aware of individuals needs around taking prescribed medication. They will need time off to attend their depot clinics and other psychiatric appointments. Mark said:

 "I also think that if you have a depot and got a job as well because I have to take my depot once every four weeks so would they give you time out to get your depot, if you've got the illness".

Flexibility in employment was highlighted as being important for individuals who smoke. People with mental illness felt that they would need to be allowed time out to smoke during employment hours. In focus group six we had an employment

assistant who works in securing employment for people with mental illness. She was supporting a service user in that focus group. Speaking to that service user in the focus group Amelia said:

"If Charlotte is meant to work somewhere they said to you (referring to Charlotte) *start work at nine and you finish at five but you have to stay within the building you can't go out for a cigarette you'll find that hard to cope with".*

1.3 Employment opportunities tend to be voluntary and unpaid.

It is evident from these focus groups that most service users were in previous paid employment, but since having a diagnosis of mental illness they are now more likely to be in voluntary unpaid posts. Participants were asked a number of questions which resulted in this theme being captured from the data. They were asked if they currently are employed and if so in what capacity. They were also asked what type of work they thought an individual with mental illness should do.

ED now works as a volunteer in a day centre and says of employers that:

"Ummm I think ummm the support I've had from employers has been patchy to be quite honest".

Despite diagnosis service user participants convey a determination to work all be it in an unpaid capacity. Tony also working as a volunteer said:

"Sometimes there's been little sympathy or little understanding of your condition but fortunately I've managed to get myself free of these periods, I come in, I have rest periods and fortunately I'm still working which is good".

Jim said that there is a perception held by the public at large in relation to an individual who carries a label of mental illness. He said

"*I think too many people expect to see you working in a charity shop instead of doing something more, more fulfilling".*

Stanley once had his own business and is also now working in a local theatre in a voluntary capacity. Having been diagnosed with Schizoid – affective disorder in his 20's and now in his late forty's he proudly reports that he has worked in a voluntary capacity for the last 10 years. He said:

"I have worked voluntary for Oxfam for about 10 years now".

In focus group five we had yet another participant who despite being employed for four years following onset of mental illness has only worked voluntary since her last paid job, which ended in 2007. Julie explained that she held her last job stacking shelves in Tesco's at night time:

"From 2004 until I fell Ill in 2007. Well I have done voluntary work since I've been ill but I haven't worked paid work, I am hoping to get back into paid work again".

While many service user participants consider their unpaid employment status as fulfilling to them others do not hold that perception. Andy sees such voluntary and unpaid posts as:

"Like skivvy work really, that people don't want to do".

This participant in focus group six was 21 years old when first diagnosed with mental illness and two years on is involved in a number of voluntary type posts .Lucy has undertaken a number of voluntary posts. She shared with pride that:

"Ahhh I do voluntary work to Oxfam and other charity shops. I've done work experience in hairdressers and a salon ummm. I also worked with children and in the town library".

Shifting from that perspective this participant, Olly refers to his voluntary job as a new career. He says:

"I look well, I've seen, I umm well I mean I've started doing different career gardening…. Cos I umm been doing some voluntary work… every Tuesday and Wednesday".

There is evidence that voluntary and unpaid jobs are commonly offered and available to individuals with a mental illness in a phase of recovery. There is also evidence that whilst some participants consider this meaningful occupation others view it as exploitation.

2. Employers have no interest in employing individuals with a mental illness even if they have previous work experience.

This theme was captured from the data having asked participants in all three focus groups what their experience of employment was before their onset and diagnosis of mental illness.

Many reported having had significant work experience before they developed a mental illness. The following is the range of jobs that service user participants in focus group four reported as having held. One as a beauty consultant for eight years, another as a hospital porter, a mini bus driver, a team manager in healthcare and education, a multi activity instructor, a double glazer for a glazing company, a labourer, a handy man for over 20 years, one worked in a forge for over 32 years, one participant had a total of 43 years work experience. Another reported having many jobs including working at McDonalds and also driving a 7.5ton lorry. There was also a participant who worked in trade of computers and televisions for over 20 years.

In focus group five (the second service users focus group) there were many examples of individuals with mental illness having also had real paid employment prior to onset of mental illness.

One lady known as Julie held a number of paid jobs including managing her own business running a bookshop. This participant also worked in medical research for five years, another worked as a labourer in an incinerating plant for four years. He was 26 years of age at the time. Another worked for British Telecom as a 100 operator, also held a job as a receptionist and worked in Supermarkets. She had worked from the age of 16 up until she was 31 before she became mentally ill. Another referred to as Olly worked in Top Man and Top Shop in Oxford Street and he describes himself as 'being right good'. He then went onto work as a security guard with the firm Securicor. He worked from the age of 18 until 25 when he had his first episode of mental illness .He's now 33 years old.

Lee a service user participant reported starting work at the age of sixteen. This was in a Supermarket, then went into working in a mobile phone shop and then became a Cab Driver. He says he was actively employed for 14 to 15 years.

Stanley reported being a tutor of Maths and Physics for five years from the age of 21, before the onset of mental illness in his early thirties. Chris started worked as a computer operator at the age of 19. This was paid employment for two years. Despite many participants having relevant work experience they haven't worked since being diagnosed with mental illness. Ed said:

"I used to work for a media company so I was doing supply to different events jobs for men, reading, admin, post room work, facilities assembly, and a variety of things. I was with that company probably for about almost 20 years".

Peter explained that he was a labourer for 14 years whilst Kevin held a job in a forge for 32 years. Neither has worked since their diagnosis.

As with the two previous focus groups, focus group six also gave strong evidence of individuals with relevant work experience both prior to the onset of mental illness and since having been diagnosed.

Andy stated that he was a gardener prior to the onset of mental illness. Christine said that she had worked for a year in a hairdressers washing hair. Lucy gave examples of various types of employment that she has done and is currently doing. She said:

"I do voluntary work to Oxfam and other charity shops I've done work experience in hair dressers and a salon ummm I also worked with children and in the town library ……. and now I now work in a children's centre ……and I also do drama".

There was also a service user participant who was a qualified chef. He had completed a number of trainings as a chef .Olly tells us:

"I've done I've been to college did my level 1 professional cookery, then level 2 got my BTEC qualifications like that like that … so I'm a qualified chef".

Despite being a qualified chef he said that he still works with his dad on the buildings in paid employment although this seemed intermittent. This of course is only made possible as his employer is his dad. There are no job offers being made for his area of expertise. This suggests that although most mental health symptoms are considered as not being a barrier to work (Warner, 2002) that having a diagnosed mental illness automatically removes individuals from even being considered.

2.1 Fear that Stress from employment and job pressure may exacerbate symptoms of MI.

Service users were asked to identify by means of a show of hands how many of them would actually like to work. Participants were then asked to comment on whether they could see themselves working full time or part time now or in the future. They were encouraged to expand on the rationale behind their answers. They were also asked about their own beliefs around their suitability to employment since they have had a diagnosis of mental illness. I wanted to capture what the lived experience of a diagnosis of mental illness had meant to participants in relation to their view of employability.

In the first of the service user's focus groups known as focus group four it was evident that individuals with mental illness recognised in themselves that pressure from work responsibility can make their symptoms worse. Kevin who used to work in double-glazing said that:

"Not only have I got some general anxiety this, sort of like at the moment, it's very very high, the problem is any pressure on me and my blood pressure goes through the roof and my heart rate can be quite dangerous".

Kevin felt that stress actually caused the mental illness. He was also of the opinion the onset of mental illness for most people was about 40. Kevin comments:

"A lot of people seems to be, more people seems to get mental illness at roundabout around about 40 mark……… and I don't know why that is but what I'm, a lot of people when they have mental Illness , it starts at 40….. stress………… oh yeah it's a lot to do with stress"

He goes onto talk about re-entering employment after long-term mental illness and said that he would like to go back to work but to a job:

"Yeah, a job that's got no pressure".

Whilst this sentiment would seem somewhat unrealistic it also indicates that Kevin is aware of what makes him vulnerable to relapse. Low pressure jobs were also flagged up when this participant identified suitable employment for people in mental health recovery. John said:

"I think it would be helpful if people were given community work to do to start up with so, that they are not put in the deep end of a profit related industry, because they are only thinking about profits (referring to employers) and how much work that they can get from people which can cause stress".

Julie a service user participant who has held a number of jobs following onset of Bi-Polar disorder shared that stress in employment had contributed to her relapsing. She was talking about a research assistant post she had held and was asked to write up a report on her findings. Following presentation of the report to the employer the participant reports:

"And when it came to presenting it to her she thought it was rubbish, and she said that my colleague is going to have to write it for me, and some of the day before, someone who is quite important have seen it, thought it was very good and the shock of that, and I was getting it again anyway because I was overworking I was not going out in the weekend, I was working till 9 at night trying to get this bit finished. And so hmm, I ended up getting sectioned again and I never went back, because my boss was horrible, she was really aggressive and not supportive".

Stanley who had a keen interest in art felt that in order for him to re-enter the employment market in his area of interest 'the arts', that his job would need to ensure   '*that that there isn't really a lot or much pressure'.*

One participant in focus group six was employed with support from an assistant. Amelia an assistant speaking about the impact of pressure on the service user participant in employment highlighted that:

"We have seen that when things get too much for you (referring to Charlotte) when too much pressure is put on you may have a relapse. You head towards breakdown and that's when things get overly stressed or pressurised for you I mean".

In these accounts it is evidenced that stress is very much identified as being linked to possible relapse. Service users were able to identify this both as a concern and a lived experience. This as a barrier to accessing or maintaining employment is also supported in previous studies. It is reported that employment which involves high demands, low control, and poor support for the individual leads to an exacerbation of symptoms (Stansfield et al. 1999).Conversely employment for an

individual with mental illness is associated with reduced clinical symptoms and positive social functioning (Warr, 1987; Bell et al. 1996; Schneider, 1996).

2.2 Attitudinal factors: Service users felt that employers had negative preconceived ideas about individuals with MI.

Service user participants were asked what they thought prevented employers from employing an individual with a known mental illness. They were also asked why they thought an employer found it difficult to keep someone employed with a known mental illness. This theme was captured from the data gathered across the conversations covering these questions.

Gary felt that employers have a greater focus on work productivity rather than on the individual.

"Ehh it's not the case that they need to understand you, it's the case of they are too far up the chain to have to worry about such a person. It's a case of turn up for the job if they are capable of doing the job they are employed, then they go back up there on their high horse".

Participants with mental illness felt that employers are reluctant to employ them because of the cost implications. John said:

"You have to give them extra time, and it's *going to cost them".*

This was again highlighted by Peter in focus group four. He said:

"They get scared because umm that they going to lose their money".

Participants felt they were perceived as being unreliable and not trustworthy. Becky felt that they would see her as:

"Going to say she is, going to have too much time out, is she going to be regular?"

John thought that they worry about the individual:

"What if he relapses"?

ED felt employers and society are afraid of them. He said that:

"People are much more frightened of people who have had or have mental illness".

Service users in focus groups four, five and six also felt that employers are afraid of individuals with a label of mental illness. Speaking of employers and how they might view people with mental illness Peter said that:

"Right umm I think they won't be safe around people like me, yeah *that they feel vulnerable",*

Olly said they believe that: *"And they're going to harm them".*

Julie thought that: *"They are frightened of what may happen if they are in the same room as them".*

Participants felt that an employer's attitude needed to shift to be one of a reciprocal nature. Gary thought that those employers should move to the position of seeing beyond the label of mental illness and looking at what the individual has to offer. Gary felt that employers need to more aware of their employees mental health and well-being. He thought that they should think along the lines of:

"The best thing to look at it is what this person can bring to me. And how can I help them, because the thing is a person with mental health was before part of a team"

Julie a participant from focus group five has worked since onset of mental illness and shared how in one post her employer was aware of her mental illness but she chose not to disclose in her second post because of perceived stigma associated with mental illness. Concerned about the impact of disclosure Julie said:

"I was working In B&Q as a cashier but I think they knew, I think they knew I had an Illness anyway. The second job I had after that was in Tesco's. I didn't tell the employer I had an Illness. I was working as a night assistant stacking shelves".

She went onto explain her reason for non-disclosure was:

 "Because I thought about stigma, you know like stigma, and then I wouldn't get the job".

Asked if in her opinion an employer treats them differently if they disclose their mental illness this respondents experience was:

"Oh they do, yeah. They treat you differently if you tell them".

Service users said that once employers know there is a diagnosis of mental illness the person is defined by the label not as a human being with strengths and abilities. They are defined by their diagnosis. Andy said:

"Once you have mental health that's it, it doesn't matter what you have, bipolar or if you have schizrhenia or you have all different types of mental health but still you're still a label. And as a result of that label you are judged as being a liability rather than an asset".

Service user participants thought that some of the preconceived ideas that employers held about them related to increased risk and putting their business in jeopardy. Participants felt that these ideas led to an attitude by employers of not considering them as employable. In relation to employers perceived increased risk posed by individuals with mental illness Gary said that in his opinion:

"No mistakes can be made. People with mental health issues may be a liability for the company to be sued".

Chris also felt that individuals with mental illness are viewed by employers as being a liability .He said:

"I think that there are a lot people with mental health are liabilities, I think that they see that we are liabilities where we would bring nothing to the job".

Stanley believed that employers would see an employee with a diagnosed mental illness as a burden. He said:

"Rather than instead of uplift the job they think we would bring it down, because you know they'll be looking at you like oh he is in the corner talking to himself".

Attitudes to individuals with mental illness were seen to be linked to people presentation and image. For an individual with mental illness this was seen to reduce the prospects of securing employment. Christine said that:

"Like hairdressers and beauty places seem to have like a certain image of what they want as a whole and depending on who walked through the door it could be two people with mental health problems but if they have to choose between the two it would be based on image".

Lucy simply said: *"They see the worst of you innit".*

And Peter later said that this was because

"Because they don't give a shit. They don't care".

As a means of addressing these attitudinal factors service users were asked what they would like to say to employers. The responses were as follows.

"They should not judge a book by its cover" (Olly a service user participant).

 "*Teach them to feel more calmer more relaxed"* (Lucy a service user participant*)*

"Not to be frightened of them you know have some respect for them" (Peter a service user participant*).*

 "*Give the opportunity to gain a bit respect you know what I mean"* (Christine a service user participant*).*

*"Give them a trial give them the same chance. Have *respect*"* (Olly a service user participant*).*

These personal accounts and perceptions indicate that service user participants find it very difficult to get beyond the negative preconceived ideas that employers have about mental illness. There are lived experiences from these three cohorts that suggest that employers think individuals with a diagnosed mental illness are to be feared. They are seen in terms of how they can damage a business rather than what contribution they could bring. It is all evident from these 28 participants that as a result of these negative attitudes held about them that they fear disclosure either when applying for a job or whilst in employment something that is evidenced across a number of other studies (Warner, 2002; Dalgin and Gilbride, 2003;Bevan et al. 2013).

3. There are individual barriers to employment for people with mental illness.

Service user participants were asked to reflect on what a diagnosis of mental illness has meant for them in relation to their employment prospects. Some individuals seem to tune into very personal experiences of rejection by other

sections of society. These experiences seem clear and poignant. This stops them from having confidence to even consider themselves as suitable for employment.

Mark captures this uniquely and quite powerfully what a diagnosis of mental illness has meant for him and his life. It helps make sense of why people with mental illness have such low expectations. They have to be grateful for being allowed out for fresh air when under section in hospital, so the idea of employment is so far off the scale. Mark says:

"But you apologise, way through hospital like once you are sectioned. You apologise way through the hospital, they give you a little freedom, you can go out, get some fresh air come back in, get some fresh air, and the more they trust you the more they let you go back home, see your family and stuff like that. Then after that they put you out in supportive housing and then from there you get your own place but ahm as well as that, it's always that why do we always have to explain or apologise for having a mental illness that's the problem that's the part that I don't like. That's why I don't really talk to a lot of people about my mental health illness unless they already know me like my family or unless I trust them, because sometimes when you tell someone, oh you know what you are like in the past, they look at you differently…."

Reflecting on what a diagnosis of mental illness meant to him Stanley says that he

'*Feels treated like a guinea pig'.*

"I tell you what it is, when you become mentally ill you feel downgraded, you feel less of a man or less of a woman and the worry is that you have to work back up the ladder but hmm in a way you're being treated as a guinea pig as well, with the medication …"

Some participants said they simply were not able to take on employment. Jack said:

"*I couldn't work full time; I can't get up in the mornings".*

3.1 People with MI have low self-esteem, low expectations of themselves and a lack of motivation.

Asked what they thought the wider publics images of people with mental illness is and if it would include any notion of people with mental illness doing a paid job it became evident the individual participants with a diagnosis of mental illness have low expectations of themselves. This has been confounded by being excluded from many possibilities in life with employment being only one domain.

Jim explained that he has been mentally ill all his life and that it is only in the last three years that he has regained some levels of recovery and wellness. As a result of being diagnosed with a mental illness Jim says:

"I lost my confidence, without your confidence you can't do anything".

He goes onto say that he still has issues that he is dealing with:

"And that's sort of stopping me from going back to work but if anything I'll do voluntary work because I'm lazy…because I haven't worked for so long… because I haven't been to work for so long…. I've got I've got lazy, my motivation and I need a boot up the back side you know what I mean butt".

So being unemployed for too long, due to mental health diagnosis can create a culture of unemployment; this culture can be reinforced by employer's attitudes and their lack of understanding in mental health.

When participants were asked what type of job might be suitable for an individual who had recovered from schizophrenia they themselves seemed to identify low skilled jobs as options.

Cleaning was identified as suitable employment in focus group four. One participant who had worked on a production line for over 25 years returned to work following a mental health breakdown and was offered the new post of brushing the floor around the bin areas. Whilst this was a low skilled job this individual was quite happy to accept it.

There was a general consensus that people with mental illness in employment tend to hold low status jobs. Garry a service user participant said that this is not always the case and that such outcomes are dependent on the individual. This is his example of a person with mental illness driving himself or herself into a

position of status in society. Describing a former editor of The Sun newspaper Gary says:

"He was hmmm at one point he was editor of the Sun, then he sort of hmm descended into mental illness and alcoholism……Drug taking as well, hmm he got sort of, you know pushed out, and now he sort of recreated himself as an author".

This was not the prevalent view of all participants. This participant felt that you are destined for lower status jobs once you have been given the label of mental illness. Stanley said:

"What it is, is the government it's like a propaganda, it's all against you and even though like you've got the mental health, you've got this and you may have like some computer skills or higher diplomas, you might have all the education and the experience behind you, even though you go for a job you still going for the, even for the lowest stage job……., why do you have to scrape from the bottom to work your way up, it's hard to get".

Whilst service user participants see themselves in low skilled jobs, indicating low expectations of themselves this is compounded by actually being put in jobs with the reduced opportunities. These participants said that confidence could be improved if they received praise and recognition in employment. Lucy describes herself as losing confidence but would find it helpful if the employer said:

"Say well done Lucy that's fine keep doing it as it is".

Capturing why an individual might have low self-esteem or low expectations Andy explains how he feels 'robbed' of opportunity since a diagnosis of mental illness. He says that:

I'm a person that used to have my own house not my own house but my own place, I was driving two cars and everything, so have a job and everything so I have prospects…..16 years later I have to start all over again, in a way I've got more respect for it but still you know it's like a step in backwards rather than to go forward you know I would probably have a lot more things by now ….

These experiences and perceptions held suggests that employers focus on what an individual lacks in ability rather than focusing on what they have to offer. This is

not unique to this group of service user participants and it is well documented that even though work place mental health problems are prevalent (Grove, 2006) individuals experience unsupportive attitudes (McArthur and Dunion, 2007), stigma and bullying which causes great distress and resulting low self-esteem (Warner, 2002: Corrigan et al. 2004). The sense of loss and low self-esteem is experienced not just in terms of employment prospects but across many domains of the service users life, many of which the non-mentally ill person takes for granted.

3.2 People with mental illness suffer side effects from their medication, which make employment difficult.

Service user participants were asked about life in terms of employment following a diagnosis of mental illness. What were the individual experiences in relation to being able to work or accessing work? For some participants medication made it difficult for them to keep or to access employment. Julie found that taking antipsychotic medication made it very difficult to work. She said:

"Yeah, I did, I did work whilst put on medication, where I was put in lithium and it really dulled my senses and emotions and stuff, it really affected me, I didn't like it at all so I chose to come off it".

Chris also felt that medication impacts on whether an employer might be willing to employ an individual with mental illness or not. For him he said that:

"Some *have side effects like make you sleep too long or a lot of people dribble, stuff like that and do they really want to employ people that dribble, you know".*

The notion of people with mental illness dribbling was also a perception that came up in employer representative focus group three. This is a known side effect of some anti –psychotic medication it but it really impacts on individuals confidence and self-esteem.

Tony said that medication affects some people's ability to express themselves. There was a consciousness of looking or sounding stupid. There was an assumption that the public or customer might be put off by this.

Speaking of individuals with mental illness on anti- psychotic medication Tony said:

"Medication might make them slur or may, may, ah may affect their judgement things like that, from what they ah people on the shop floor, and costumers expect certain service".

Despite the usefulness of anti- psychotic medication helping individual's get into a recovery phase from their mental illness, some suffer considerable side effects from this family of drugs. The side effects of such medication are well documented. However this sub theme has relevance when considering employment of individuals in recovery, especially where such side effects affect alertness.

4. There are structural barriers for people taking with MI taking up employment.

Participants were asked what they thought employers should do to help people with mental illness get back into work. It was felt that even if individuals in mental health recovery wanted to work that employers set the bar too high. Employers were seen as making it difficult for non-mentally ill people to access employment, never mind those with mental illness. Whilst Jim is serious about his observations of job vacancy advertisements he also injects some humour to capture what he perceives as unrealistic expectations of employers. Jim said:

"When I look up the, the job centre descriptions of what employers are asking of their employees, it tends to be most have an NVQ in it. Most have a Diploma on them, that most have the ability to fly and be able to work 17 days without sleep".

Gary agrees and adds *"I mean the criteria of what employers are asking for , even for some able body people out there are going to find it tough to meet the demands of employers and what their asking from people in today's society".*

This creates a sense of disappointment, a feeling of discouragement to work, not to be given a chance like other people are, seen as less able to work, others get the job, employers don't want to employ people with mental illness. This results in

people with mental illness not even wanting to bother, as there are too many obstacles. Becky captures that sentiment even further:

"Well obviously the criteria are that certain people who have mental disabilities are not going to be able to meet the criteria due to their disabilities so they're not going to get a look in, it's a case of; don't even bother turning up for the interview".

This type of belief indicates that individuals with mental illness have already written themselves off .They already believe that there is no point of even attending an interview. They believe that the qualifications required already put them at a disadvantage. Gary felt that employers would simply have to: "*Bring the bar down".*

Jack said well you do actually need someone to vouch for you. He identified that gaining a reference is difficult when you have a history of mental illness. Adopting some humour he said:

"For someone who is like I am, I still need a reference for someone to say that well he's not going to take the diamonds saw to cut everyone up or to cut himself up".

There is evidence in this theme that each individual with a diagnosis of mental illness will have barriers and obstacles that are unique to them. There is also an indication that people with mental illness might be at a disadvantage because of their educational attainments. This suggests prospective employers might need to adopt more flexible approaches to filling job vacancies. There seems to be a heavy reliance on qualifications and educational qualification. Many individuals in mental health recovery have previous work experience which could be tapped into.

4.1 Keeping people on long-term benefits contribute to unemployment of individuals in mental health recovery.

The responses to the question; what kind of thoughts come to their mind when you consider employment and how this might impact on you benefit entitlements, could be grouped into two themes. Some individuals felt that they would go back to work if their benefits were stopped. Conversely others thought that being in

receipt of adequate benefits reduced likelihood of people wanting to or trying to access employment. In focus group four, Stanley was quite clear for himself when it came to a question of stopping benefits. He said:

"If *they stop my money because they calling everyone up and who is on DLA so if I don't get my money, I need my money so I have to go back to work, I feel I'm ready to go back to work …."*

There was concern about going back to work and how this would impact negatively on their current entitlements. Rather than risk losing their entitlement they stay in that safe place where they are sure of their income. This contributes to their long-term unemployment and feeds into their anxiety about re-accessing meaningful employment. Gary's understanding was simple. "*If I go back to work then my benefits they're going to get stopped".*

Brigid took a different stance and thought that it would propel her back to work. Referring to the current benefits she gets Brigid felt that their provision encourages her to stay unemployed. It is easier for her not to go back into the employment market. Reflecting on the benefits she is currently is in receipt of she said:

"*It will probably make it easier not to go back".*

This sentiment was echoed by Gerard. He was in no doubt about his current status. He said:

"*Well benefit is definitely better for you than to earn".*

There was a feeling that being on benefits painted a more comfortable position than trying to get back into paid or voluntary employment. Kevin suggests:

"*If I if I work full time 40 hours and I get twelve hundred pounds after tax and on benefit, I get child support, this support, that support and one hundred and eighty pounds, a free house of course I'll sit back home definitely".*

Benefits were again stated as a good reason not to access employment. In relation to going back into the employment market Mark said:

"*Not if, not if it's going to affect your benefits though".*

Julie who has some paid employment in the past since onset of mental illness points out that working actually affects your benefits. She tells the other participants:

"Well *at the moment you are only allowed to earn £20 a week"*.

This therefore limits the number of hours individuals could work in paid employment if they wished to without it affecting their benefits. Therefore Chris pointed out:

"*For voluntary work it's going to be all right what you want to do because I enjoyed mine working in Oxfam"*.

Individuals with mental illness felt that whilst on benefit that they knew how much they were getting and could plan for certain things. Coming off benefits going back into employment presented great concerns as highlighted by Mark:

"*That was one thing; if you come to a paid work and there you have a problem you can be in real trouble in trying to get benefits again"*.

In focus group six participants went on to guesstimate what the costs would be if they were to be in paid employment .Peter led the conversation as follows:

"*So say if you pay around 120 pound a week for your room then you have to do your shopping and you won't have a freedom pass so you will have to have your travelling expenses as well"*.

"*housing um council tax, your gas your electricity your mobile , phone bill, your TV license, your car , travel pass travel cost, you're shopping as well, all the time you've added that up you need to be earning about 400 pound a week"*

The point being made was that it is difficult to get that type of salary and then if this person relapsed how would they survive. There is also the point that on benefits an individual is sure of what is coming in and they get great subsidies such as housing benefit, disability allowance, employment and support allowance. These are real structural barriers to individuals with mental illness re-engaging in paid employment. Therefore staying within the benefit system was a better option at least for the majority of these 28 participants.

5. People with mental illness feel employment is very important to them.

This theme has emerged across data from a number of questions posed. Individuals were asked to consider what types of work a person with mental illness might be suitable to. Where they were already in employment they were asked what made this possible and what role employment played in their lives. It is known that holding on to and building an identity through valued employment, or defined meaningful activity, is important in peoples' recovery (RCP, 2003; Brown and Kandirikirira, 2007). This is captured in the statement by Tony below. Tony then a young man was advised not to go back to work because of his mental illness. Tony told the social worker "I'll be the judge of that". Commenting on that decision he said:

"It's *the best thing I've done".*

He went onto complete 43 years in paid employment.

For some participants being able to return to employment gives reassurance to that individual that they are in a state of recovery. Returning to employment following a diagnosis of mental illness ED shared:

"When you go back, I know when I went back after 9 months; I thought I'm going to be alright now".

Other participants wished to work and viewed it as being a helpful prospective. Olly said he would feel better off if working. Asked in what way he would be better off he said:

"Yeah I mean you're doing something".

Christine felt similarly. She thought that being employed would give her life purpose, and give her greater independence.

"I'd like to work it would get me out of the house every day, I'm stuck in the house every day. She went onto explain that: *I'd like to work to get money, I want to live on my own, to pay rent".*

The notion that having one's own income gives a greater sense of autonomy and responsibility was also stated by Peter as something positive. He felt that employment would give him more money.

"Well if I'm working and being paid it will pay off the bills and the electric and stuff".

Gary also looked on employment as promoting social integration and cohesion. He said he: "… *wants to feel part of the community".*

Speaking of individuals with mental illness Gary went on to say:

"They don't want to feel isolated *mumble*, they don't want to axe put over them…. if you don't do 100% as the same as everybody else, then we can come down on you".

Service users feel that employment is important to them because of their ability and what they have to offer. Lucy enjoys her work because she feels:

"Because umm I'm good with kids".

And she is

"Passionate about working with children … umm I'm passionate about my skills".

Peter stated*:*

"*I'm good at gardening, and I'm good at cooking".*

Employment was stated as being important as it gave the individual confidence. Lucy said that it:

"Builds up my confidence and it *helps me learn about how working life could be like".*

Olly said employment is important to him because:

"*It makes me feel proud like that I can do it, and* umm I feel over the moon".

It is evident from service users' perspectives that they consider employment as an option very important to them. It makes them feel proud and gives them a sense of purpose. It creates a sense of community, self-worth and independence in individuals. Just getting participants to consider what employment would mean to them seemed to get individuals to focus on positive aspects of life such as being proud of their ability, having greater community connectedness and integration. Overall simply being accepted as someone who can work was a rewarding thought.

5.1 Individuals with Mental illness would like to be given the opportunity to work again.

It is reported that between 86% and 90% of individuals with a known mental illness would like to work (ONS, 2013(b). 26 Service user participants were asked if they would like the opportunity to work again. John had been a handy man for over 20 years and has not worked since being diagnosed with mental illness. Asked if he would like to be employed again he said:

"Yeah I would like to do something in mental health, working in a place like this (referring to the day centre) or something like that".

So he doesn't necessarily want to be in paid employment but would like to work again.

Gary said that he would like to be given the opportunity to work. Garry said that employers should:

"Give you the job. Give you the chance to take the job you know".

Individuals want to be considered for employment rather than the scrap heap. Service user participants felt that they have strengths as well as weaknesses. Margaret felt that:

"It's finding out how you can actually, how someone who has mental health issue can actually be a valuable team member ….."

Participants want to be respected and not treated with offers of menial jobs. Becky said that:

"It's not a case of just stick them in the end of an aisle on the till and just have them fill bags".

These individuals want a job that carries no labels, a job that a non-mentally ill person has access to. Participants with mental illness want something to look forward, a brighter future, some respect, to have hope and encouragement. Ian said that for him he would like a job that has:

"Has some prospects of improving this life and ……, and there are work prospects".

Becky seemed concerned with how employers view an individual with mental illness. She felt that the conversation focused heavily on what individuals with mental illness can offer the employment market. Referring to a prospective employer Becky thought it would be more productive to get them to shift their way of thinking about employing a person with mental illness to:

"How about stop employers thinking about what we could do for them while the employers should think what are they going to do for us".

We see this theme that individuals want to be afforded the opportunity of employment emerging in focus group five the second of the service user focus groups held. Chris said that:

"I would want to be like anyone else, be normal and trying to get back myself into it and I'm like an old person".

Olly who is a qualified chef plans to go back to work part time whilst attending college. He had already distributed a number of CV's the previous week. He says:

"But I think because I'm in college this September I'm probably doing a part time job in a kitchen".

Another participant Lucy in that group also had a vision for the future in paid employment. Not alone would she like to work but she was able to see how that might help individuals express themselves. Given the opportunity Lucy said she would like to do:

"Acting acting it's like starting my own acting class um doing my own um my own choreography singing and dancing being a dance teacher and teaching young kids and older how to express their feelings through singing and dancing".

These service user participants seem to indicate that they would like to see employment as an option for people with mental illness as the norm as opposed to the exception.

Where individuals are engaged in meaningful activity all be it voluntary they are clearly very happy and proud to share their achievement. Where others have not been able to secure employment but would like to work there is a sense of being excluded from the possibility. There were also some participants who were happy

on benefits and not that interested in the prospect of employment now or in the future.

Summary of Service User Focus Group Analysis

Three service user focus groups with 28 service user participants were held which explored the research question; do mental health service users experience any barriers to employment in a recovery phase in an outer London borough? The themes that have emerged in relation to this question seem to be across four main themes. According to this cohort of participants' people with a diagnosed mental illness still face significant obstacles when trying to access suitable employment. Service user participants felt that their employment prospects could be enhanced if employers had a greater understanding of mental illness, if they could offer some greater flexibility around posts advertised. Some individuals are fulfilled in voluntary posts whilst others would like the opportunity to be in paid employment.

Many of the participants in these three focus groups had previous work experience but most had not managed to secure employment since the onset of their mental illness. Service users felt that they are seen as less able and less competent as a result of the label of mental illness. Whilst employers might be reluctant to employ individuals with a mental illness, service users themselves worried about how stress might cause them to relapse. They also believed that prospective employers had preconceived ideas about people with mental illness. These were mostly associated with an employer not being able to see what an individual with mental illness has to offer, seeing their potential.

Some participants struggled with low self-esteem, poor motivation and lethargy as a side effect from medication. These self-defeating personal barriers can be difficult for individuals to break out of. Alongside these personal barriers there are real concerns about financial security. Some service user participants felt safe and secure while on benefits whilst others welcome the possibility of breaking out of the benefits system and getting into the employment market.

Service user participants would like to be considered for employment .They do not want that choice removed from them because of a diagnosis of mental illness. Employment is important to people with a diagnosed mental illness in a phase of

recovery. Employment gives these individuals the possibility of greater autonomy, independence, social integration and identity. One participant made a plea along the lines of "*we just want to be given a chance*". A summary of these themes is outlined in table three below.

Table 3

Theme	Sub Theme
1. People with MI face significant obstacles to accessing suitable employment.	1.1 People with Mental Illness felt that there were factors that would enhance the prospects employment 1.2 Flexibility in employment to accommodate people with Mental illness 1.3 Employment opportunities tend to be voluntary and unpaid
2. Employers have no interest in employing individuals with a mental illness even if they have previous work experience.	2.1Stress from employment and job pressure can exacerbate symptoms of Mental illness 2.2 Attitudinal factors: Service users felt that employers had preconceived ideas about individuals with Mental illness
3. There are individual Barriers to employment for people with mental illness.	3.1 People with MI have low self-esteem, low expectations of themselves and a lack of motivation 3.2 People with mental illness suffer side effects from their medication which make employment difficult
4. There are structural barriers for people taking with MI taking up employment.	4.1 Keeping people on long-term benefits contribute to individuals in mental health recovery not seeking employment.
5.People with mental illness employment is very important to them.	5.1 Individuals with Mental illness would like to be given the opportunity to work again

Summary of Themes and Sub-Themes from Service Users Participant Focus Groups.

Service user biographical data is detailed in Appendices 7 and 8.

Chapter 6: Discussion

This research commenced at a time when the United Kingdom was considered to be in deep recession (O.N.S., 2011). The aim of this study was to gain an in depth understanding of the reluctance by employers to employ individuals with a known mental illness who are in a phase of recovery. It also sought to hear about the lived experiences and perspectives of the barriers experienced to accessing or being in employment from a service user's perspective.

This chapter will present the research findings and consider their implications in context of the current contextual political and social care climate. A number of resources were used to address the research questions posed.

- These included examining the political and social policy climate leading up to and existent throughout the life cycle of the research process.

- A literature review was undertaken which considered various studies in different countries around the research topic.

- Quantitative and statistical data were accessed to gain knowledge about the population of people the study related to nationally and in context of the North London borough in which the research took place.

- Included are the findings from six focus group sessions, three of which were with service users and three with employers within a North London Borough.

The discussion will present the key themes that were identified through the process of thematic analysis, firstly from the employer focus groups followed by the themes that were identified from the service focus groups. The discussion will look at the relevance of the research findings in terms of current political and social policy with reference to other research done in the subject area and the research questions that were posed.

The role and possible implications of being the inside researcher (Robson, 2002: p382) will be discussed. Being alert to these biases is especially important when working with vulnerable populations (Silverman, 2005). A strong engagement with

the six focus group transcriptions has developed. Mindful of this the themes that emerged will be presented with the view to remaining as neutral as possible from what the analysis points towards. The data analysis identified nine main themes, four from the employer focus groups and five from the service user focus groups. A number of sub themes were identified relevant to each broad theme. These will be considered in context of the discussion.

Employer Focus Groups: Table 2 (See Page 129, for further detail).

Theme One: Employers are reluctant to employ individuals with Mental Illness (MI).

This might seem like a very obvious theme to emerge in view of the research questions posed and in view of the well documented negative media coverage of mental illness. However I was struck by the frankness with which employer representatives discussed this freely. This was likely to be aided by my deliberate awareness of striking the balance between taking an active or passive role as facilitator. Efforts were made by the researcher not to influence the discussion or reinforce existing preconceived ideas around employment of individuals with mental illness but instead to focus on encouraging interest and engagement with what was and continues to be a sensitive topic (Sim, 1998: p.347).

Discussing mental illness in context of employment triggered lots of dialogue around added costs and burden to the employer. There was poor association if any with the notion of human beings with mental illness but more of an association with the label and illness and what that constitutes. There was no reference to employment of an individual with mental illness as a benefit. This is likely to be related to participants' exposure to more traditional thinking associated with the Medical Model (Engel, 1977) and The Bio-psychosocial Model (Carpenter, 1987) within which the basic assumption about mental illness is associated with disease. There is clearly a gap here that needs to be addressed and will be considered in the next chapter.

1.1: Across three focus groups the theme of predicted cost and burden to the employer came up repeatedly. One participant said that it was like 'having a dog and barking yourself', which clearly captures the point being put forward.

Is this the case and why is it such a powerful concern and belief held by these participants? The cost of mental illness to the public purse is frequently highlighted with most recent figures suggesting that the health service spent £2.0 billion on services for people with psychosis in 2012/13, with over half (54%) of this total devoted to inpatient care (Schizophrenia Commission, 2012). Therefore it is possible to understand why this seemed to be such a powerful point of concern. There is also frequent coverage of the cost of mental illness to the public purse in terms of benefits paid out by The Department of Works and Pensions (DWP). Mental health conditions have been stated as the most prevalent reason for people being dependent on health related benefits (Black and Frost, 2011). Mental ill Health is also reported to be the cause of 40 per cent of the 370,000 new claims for Disability benefit each year (Mental Health Network, NHS Confederation, 2014).

These figures and are typical of the type of headlines that get reported regularly. They are especially poignant at a time when the economy is dipping in and out of recession. This type of reporting could be influential on employers and their perception of employability of individuals in a recovery phase from mental illness, therefore also likely to be a reason why they will remain reluctant to employ. The employer participants in this research did not link employability of individuals in mental health recovery directly to cost to the public purse, but they did associate employment of an individual as a direct additional cost to their purse and businesses. Currently there are one million claimants on Employment and Support Allowance (ESA), and as many on Jobseeker's Allowance (JSA) and other working-age benefits, whom have a mental disorder such as anxiety and depression that impact on their prospects of finding work (OECD, 2014(b).

Reference is made to employer's participant perception as there was no identification of actual employment of an individual with mental illness from the 16 employer representatives that attended (See Appendix 7 for a list of employer participants). That may be related to this population of individuals continually attaining low levels of employment, or not presenting themselves for employment or not being identified as such. In the early phase of this research it was noted that between 10 per cent and 16 per cent of people with a mental health condition, excluding depression, were in employment (DWP, 2009: p14). An earlier study suggested that employers have a tendency to be less sympathetic to employing

people with schizophrenia, compared to people with depression (RCP, 2003). It is worth noting that as one examines what needs to be developed to address some of these issues that the population of mentally ill is predicted to rise over the coming years. Prior to the commencement of this research the 2007 adult psychiatric morbidity survey found that the proportion of the English population aged between 16 and 64 meeting the criteria for one common mental disorder increased from 15.5 per cent in 1993 to 17.6 per cent in 2007 (Health and Social Care Information Centre, 2009).With the population of mentally ill people in the UK estimated to rise by 2 million more by 2030 (Mental Health Network, 2014) it would seem that this theme on the cost associated with mental illness has a real evidence base for concern (The economic impact of mental illness is discussed in chapter two of this thesis).

Although there was no evidence in this research with employers that to their knowledge individuals with mental illness frequently apply for work it is reported in the literature that between 87 and 90% of this population wants to work (ONS, 2013). Therefore the idea that individuals with mental illness cost more or are an added burden is one of the barriers that these individuals continue to experience when trying to access employment. Distinguishing individuals according to their mental health diagnosis is not specific to this cohort of employer representatives. There is a need to redress mental health inequality and to promote equality of opportunity at an employer level within this North London borough. With the implementation of the EqA (2010) there is a legal onus on employers to comply with disability provisions. The legal obligations arising out of the EqA (2010) are considered further later in this chapter.

1.2: Related to the theme of 'reluctance to employ individuals with a known mental illness in a phase of recovery' was the idea that people with mental illness are seen as less competent. There is evidence that once people have been diagnosed with a mental illness they are considered no longer employable. This is borne out in the findings published by Avon and Wiltshire Partnership Mental Health Trust (Butterworth, 2001: pp17-20). They found that 80 per cent of service users who were employed on admission to hospital lost their job as a result of their admission.

There have been many efforts to change the way mental illness is viewed by society (Time to Change, 2013).The OECD (2003) have suggested that the term

'disabled' should no longer be equated with unable to work (2003:4). It would seem that from an employer's perspective that mental illness continues to be viewed in a different way to other disabilities with a strong association with individual's inability rather than their ability. Mark an employer participant referred to having 'no spare capacity' suggesting that in order to employ an individual in mental health recovery an employer would need something extra, something spare to allocate to that individual. It could not be accommodated within the norm. Employers felt that it was enough of a challenge to manage the able bodied people. There is an inference that people with mental illness are disabled, but it is known that people with mental health problems may not see themselves, or may choose not to see themselves as 'disabled' (Beresford et al. 2002; McFarlane 2000; SEU, 2004). This reveals that there is mental health inequality when considering this client group for employment. However there is evidence that attitudes are changing with the percentage of the 1,727 people surveyed agreeing that 'People with mental illness should not be given any responsibility' decreasing from 17% in 1994 to 10% in 2012. Additionally the percentage agreeing that 'Anyone with a history of mental problems should be excluded from public office' decreased from 29% to 18%, over the same period (Time to change, 2013: p3). It is thought that this reduction in negative attitude towards individuals with mental illness may be influenced by the Mental Health (Discrimination) Act 2013, (HMSO, 2013). The EqA (2010) and the amendments to the Mental Health (Discrimination) Act 2013 firmly places a legal responsibility on employers to have a disability provision for the employment of individuals in a phase of mental health recovery. That has significant implications for the themes emerging from this current study.

1.3: Employers also worried that employment would impact on an individual with mental illness negatively, which may indicate that employers would not know how to manage that. Employer participants were convinced that employment would exacerbate the symptoms of mental illness. They also felt that having a mental illness would impact negatively on the individual being able to do the job. This suggests that mental illness is still widely misunderstood and awareness of mental health well-being in the work place is not commonplace. However there is a lack of evidence supporting the association between mental health problems and impaired performance (The Sainsbury Centre for Mental Illness, 2007). It is indicated that 'presenteeism' ((Simpson, 1998: 31-50) as it has now come to be

known, has a significantly larger impact on worker productivity than absenteeism. Conversely unemployment is considered to have a negative impact on individuals mental health with it been proposed that if one thinks work is stressful, then one should try unemployment, (Marrone and Golowka, 1999). There are established links between job stress and occupational health (McDaid et al. 2005: p 65-373; Marmot Review Team, 2010), between unemployment, poor mental health, raised levels of suicide rates (Stack, 2000), and premature death (Wadell et al. 2006: Roelfs et al. 2011).

For example it is noted that men who lose their jobs are at 63% greater risk of premature death, with the mortality risk being greater in men than women, 78% versus 37% respectively (Roelfs et al. 2011; 840-854). The risk of death is reported as being even greater for individuals under the age of 50 (Roelfs et al. 2011; p840-854). Employment status is an important determinant of health inequalities for all and contrary to employer participant perception it remains the case that unemployment leads to a higher prevalence of illness and disability and increased mortality rates (Schuring et al. 2009).

Considering this worry about the negative impact of employment on individuals with a known mental illness in a phase of recovery, employers may benefit from looking at the Danish Model of Job Rotation discussed in chapter two of this thesis. The thinking behind this concept could be adapted to accommodate employment of individuals in a phase of mental health recovery. The model might help manage employer's anxieties around employing individuals with mental illness if posts could be offered on a short term rotating basis. It is reported that employers who promote mental health by eliminating or cutting down on sources of stress through such methods as improving physical working conditions, creating more flexible working arrangements, such as job sharing, job rotation, and flexible hours, and allowing employees more input into corporate planning and decision-making, can expect to reap benefits in reduced absences and increased productivity (Mental Health Foundation, 1999, 2000). Employers may consider exploring the Job rotation model piloted by nurses in Central and North West London (CNWL) Mental Health Trust and West London Mental Health Trust (WLMHT), (Coyne, 2011). This job rotation model and interpretation of job rotation could be transferable to individuals in mental health recovery aiming to access and retain employment. The concept of 'job rotation' for individuals in mental health

recovery is one that could be developed as part of a Patient Employment Pathway.

Theme Two: Understanding and Knowledge of Mental illness

It became evident throughout these employer focus groups that even the most common forms of mental illness were poorly understood in relation to employment and the work place. Participants could not associate employment with the notion of an employee who might be classified as having a serious enduring mental illness. There was a suggestion that the word schizophrenia or bipolar-affective disorder might benefit from re-labelling as they conjure up all sorts of negative associations in the minds of non-mentally ill people. To place the commonality of mental disorders in context there is a survey conducted every seven years in England to measure the number of people who have different types of mental health problems. Last published in 2009, prevalence is reported in Figure 7 below.

Depression	2.6 in 100 people
Anxiety	4.7 in 100 people
Mixed anxiety and depression	9.7 in 100 people
Phobias	2.6 in 100 people
OCD	1.3 in 100 people
Panic disorder	1.2 in 100 people
Post-traumatic stress disorder	3.0 in 100 people
Eating disorders	1.6 in 100 people

Figure 7: Adult psychiatric morbidity in England, Results of a household survey (2009) Source: The Health and Social Care Information Centre, 2009, Adult psychiatric morbidity in England, Results of a household survey.

Other figures published are captured in terms over one's life time as opposed to per hundred of the population per year. These are on mental illness such as bipolar disorder, schizophrenia and personality disorders. The most commonly reported figures are: Personality disorders: 3 to 5 people in every 100, (Coid et al. 2006) Bipolar disorder: 1 to 3 people in every 100 (Perala et al. 2007) and Schizophrenia: 1 to 3 people in every 100 (Perala et al. 2007) with about 1% of the UK population predicted to develop psychosis and schizophrenia over a lifetime (National Institute for health and Care Excellence (NICE),

2014:p178).Despite such prevalence of mental illness in society, poor understanding of mental illness is not exclusive to the group of employer representatives in this study. Talking about how mental illness is understood in the police force, Commander Christine Jones of the Association of Chief Police Officers stated that she agreed 'senior officers recognised that the experiences of people with mental illnesses were not widely understood' (Casciani, 2013). Many of the 361 mentally ill people questioned in a recent survey said they were often disbelieved when they sought help after a crime (Pettitt et al. 2013: p4). After allowing for socio demographic differences it is suggested that people with severe and enduring mental illness (SEMI) are five times more likely to be a victim of assault, and three times more likely to be a victim of household crime, than people in the general population. Furthermore women were 10 times more likely to be assaulted (Pettitt et al. 2013: p4).

The perception that individuals with mental illness are dangerous or violent seems to be somewhat of a myth. Other statistics indicate that people with mental illness are responsible for perpetrating only 5% of violence in our society as a whole (Fazel and Grann, 2006; Fazel et al. 2009). However these misconceptions might be explained when it is considered how current legislation discriminates against individuals with mental illness (Smuckler, 2010). The legislation carries underlying assumptions that people with such illnesses are not fully autonomous and that they are dangerous to others reinforcing the stereotyping of individuals with mental illness (Smuckler, 2010). Not only is mental illness poorly understood in the realms of employment in this North London Borough, but it is also poorly understood in UK society at large.

2.1: During the employer focus group sessions there was a tendency to refer to mental illnesses such as anxiety and depression even when trying to draw particular attention to individuals with schizophrenia or other forms of severe and enduring mental illness. This perhaps indicates lack of contact with individuals in the labour market with such a diagnosis as reported on earlier. It is also the case that depression is very common and it is predicted to be the second leading cause of global disability burden by 2020 while schizophrenia is ranked as the ninth leading cause of disability among all illnesses worldwide (World Health Organisation (WHO), 2013). It is also obvious from Figure 7, published above that depression and anxiety are most prevalent in society with 9.7 in every hundred

presenting with a mix of depression and anxiety (The Health and Social Care Information Centre, 2009).

2.2: The thematic analysis identified that Employers from a caring background or who had experienced mental illness were more caring and empathetic towards individuals with mental illness. I wondered if this had anything to do with the age of the employer participants. The Attitudes to Mental Illness Research Report (DoH, 2013) suggests that as people age, they show increasing understanding and tolerance of mental illness, while younger people show the lowest levels of tolerance. All three participants who stated they had experienced mental illness in their career were all in their early to mid-50s. The employer focus groups were also predominantly women (4 males and 11 females), which may have influenced this theme, as two of the three who disclosed were women. Furthermore according to the Attitudes to Mental Illness Research Report (DoH, 2013) there has been a consistent finding over time that women generally express more positive and tolerant attitudes towards mental illness than men. In terms of employment and reemployment of individuals in a phase of mental health recovery this might mean that all three influences that led to this theme might need to be considered, an employer in the older end of the spectrum, preferably women led and one who has experienced mental illness themselves. Some research suggests that women make more empathetic managers and leaders because they communicate using more effective relational strategies (Eagly, 2003; Covel 2008). If all three influences could be built into the equation then there is a good chance that they might take on an individual in mental health recovery.

Theme Three: There is still great stigma associated with labels of mental illness.

Stigma associated with a label of mental illness is not new with rather surprisingly health care providers reported as being amongst the most stigmatising when dealing with mental illness (Lauber et al. 2006; Abbey et al. 2012; Stuart et al. 2012). The employer cohorts for this research had employer representatives both from the private health care and the public health care sectors. Individuals with a diagnosis of schizophrenia say that they suffer more from the diagnosis of schizophrenia than they do from the illness itself as a result of associated stigma

(Bevan et al. 2013: p111). Despite many attempts by the government to promote a more balanced view of mental health it is evident that the process of delivery to the employer base or those involved in supporting individuals with a known mental illness back into work has been slow if evident at all in some cases (Andrews et al. 2012).It is well established that attitudes and beliefs about mental illness are formed through personal knowledge about mental illness, through getting to know and mixing with or living with someone with mental illness. Attitudes are developed by association with cultural stereotypes about mental illness, media stories, and familiarity with institutional practices and past restrictions (e.g., health insurance restrictions, employment restrictions; adoption restrictions) (Wahl 2003 p1594 – 1600; Corrigan, Markowitz and Watson, 2004: p481-491). Direct contact is consistently identified as the most effective means of producing sustained improvement in public attitudes (Thornicroft, Rose, and Mehta, 2010).

The data indicated that the employer participants had little contact and poor personal knowledge or engagement with individuals with a known mental illness. It also suggests that if that obstacle is to be overcome there has to be some groundwork done in getting them to engage with individuals in mental health recovery so that they can begin to see what these individuals have to offer. There are also issues around that of the service user's perception of stigma and actual stigma experienced. The following bar chart captures individual's actual experience of stigma versus what they had anticipated (Stringer, 2010: p24 -34).
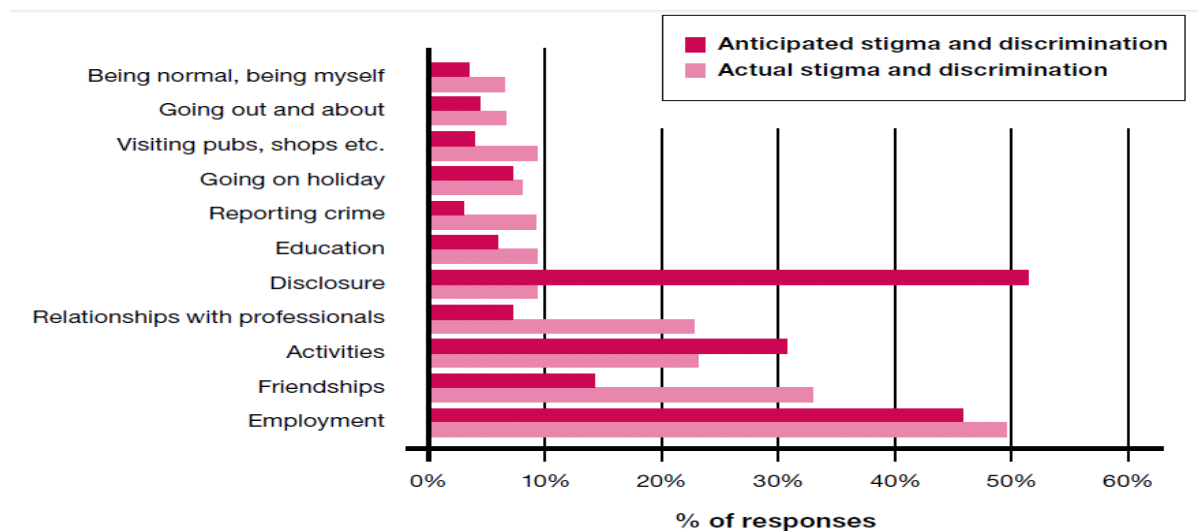
 Figure 8: **Anticipated Versus Actual Stigma and Discrimination. What service users stop or fear doing because of stigma or discrimination. Sourced: Time to Change (2008) Stigma Shout Survey (Corry, 2008: p7).**

In Figure 8 it is notable that actual stigma and discrimination experienced by individuals with mental illness in relation to employment was greater than what was anticipated. Over 50% respondents worried about disclosing their mental illness for fear of discrimination, but for those who disclosed fewer than 10% actually experienced stigma or discrimination. 87% of respondents (Corry, 2008:p6) said that stigma and discrimination had a negative impact on their lives. Two thirds of participants stopped doing things because of stigma and two thirds have stopped doing things because of discrimination (Corry, 2008: p6). Interestingly with equal numbers of men (47%) and women (53%) participants, women seemed to be more affected by stigma than males. So the issue of stigma is two-fold in that stigma actually exists in society but it is also clearly anticipated by the individual experiencing mental illness.

Of the three employer participants who had suffered mental illness in the past one was working in the care industry, one as a pharmacist and one owned his own very successful retail business. However when they became mentally ill they felt that there were insufficient support systems for them in their work environments, leaving them isolated and increasing the symptoms of their mental illness. The evidence of ongoing stigma in society is detrimental to the individuals experiencing mental illness, those around them and the economy as a whole. The stigma associated with mental illness contributes to it receiving low funding priority and neglect (Jamison, 2006). Clinicians do not even consider employment as an outcome for individuals with mental illness with up to 70% of people with schizophrenia continuing to experience stigma and discrimination (Bevan et al. 2013: p8).

Stigma also impacts on the willingness of public policy makers to invest in mental health (Sharac et al. 2010). In doing so they miss out on the economic factor of mental ill health with this costing the United Kingdom £70 billion pounds each year or roughly 4.5% of the gross domestic product (OECD, 2014(c). Rather interestingly the majority of these costs are incurred outside the health care system with the costs of lost productivity from employment across Europe accounting for as much as 80% of all cost of poor mental health (Knapp, 2003: p. 477-8).

That points to the need to avail of every opportunity to help employers or individuals or agencies involved in getting individuals back into employment to

understand mental illness and mental well-being in the work place. It also indicates that policy makers have to be more aware of the link between investing in mental health even in time of austerity as long-term there are significant benefits for the economy as a whole. They need to recognise employability of individuals in mental health recovery as a real possible outcome. Culturally competent stigma reducing initiatives need to be developed and embedded locally, regionally and nationally. There is also a case for educating the media on a more balanced approached to reporting on incidents, which involve people with mental illness. It is possible that they can be encouraged to place greater emphasis on reporting on 'good news' stories and achievements of individuals who are in mental health recovery in the employment market.

3.1: Employers conveyed a negative association with the label Mental Illness. This theme is strongly associated with the sub-theme above; employer participants reported very little exposure to or experience of being around individuals with mental illness. Their main source of knowledge was from what they had learned from media sources and this is likely to have led to their negative association with the label. If clinicians do not consider employment for individuals with mental illness as an outcome (Bevan et al. 2013), it is easy to understand why this group of employers also had poor access to a positive association with mental illness and employment.

This negative association is also not helped by the bio medically dominated conception of mental illness because it creates in the public's mind a perception that mental illness is less under a person's control, that people with mental illness are more unpredictable, more potentially dangerous, more fundamentally different, and less likely to recover (Corrigan and Watson, 2004: p 477- 479; Schomerus et al. 2012; Stuart et al. 2012). Following the Sayce Review (DWP(b), 2011), the government has redirected its funding from Remploy's 54 factories since March 2012 into supporting disabled people to access mainstream employment. While this initiative was aimed purely at maximising economic value of governments' funds it may unintentionally contribute to challenging the negative attitudes that employers hold towards individuals with mental illness. Liz Sayce (DWP(b), 2011) argued that by redirecting monies from Remploy factories to supporting disabled individuals to access mainstream employment they could move to supporting 8'000 people, instead of the 2'150 employed by Remploy during 2011/2012

(DWP(b), 2011). The report proposed that funding released by reforming Remploy should be used to increase funding for Access to Work scheme (DWP (b), 2011: p16). Sayce's proposal was that funding should follow the individual rather than a project.

Notably out of the 2,000 disabled former Remploy workers that were made redundant as a result of factory closures, 1,530 have engaged with personal caseworkers to find jobs. By the 7th of February 2014, 691 former workers who had taken up the government's support package were in work, while 839 were receiving Jobseeker's Allowance (JSA) or Employment and Support Allowance (ESA). Information on the activity of those who have not engaged with DWP is not available (McGuiness, 2014). So the closures of the factories have not been entirely successful in engaging all individuals made redundant in to mainstream employment. But it does mark a shift in government thinking and recognition that individuals with mental illness can work and should be supported to work.

There is also recognition that supported employment contributes to lower cost and better employment outcomes: something that is consistent with evidence around the Individual Placement Support (IPS) model (Knapp et al. 2013). As the evidence base grows these subtle shifts are likely to begin to challenge such negative attitudes held by employers.

3.2: 'People with MI are Dangerous'; the most poignant recollection I have on this particular theme is when an employer participant from the banking industry quite firmly believing that people with schizophrenia kill you. There is a long-standing myth that people with mental illness are dangerous and violent. In fact over a third of the public think people with a mental health problem are likely to be violent.

The reality is that people with severe mental illnesses are more likely to be victims, rather than perpetrators, of violent crime (Time to change, 2013). According to the British Crime Survey (Home Office, 2009), almost half (47 per cent) of the victims of violent crimes believed that their offender was under the influence of alcohol and about 17 per cent believed that the offender was under the influence of drugs (Home Office, 2009). Another survey suggested that about 30 per cent of victims believed that the offender attacked them because they were under the influence of drugs or alcohol (ONS, 2013).

In contrast, only 1 per cent of victims believed that the violent incident happened

because the offender had a mental illness (Coleman, Hird, and Povey, 2006). Much earlier studies indicate that people with mental health problems are more dangerous to themselves than they are to others with 90 per cent of people who die through suicide in the UK reported as experiencing mental distress (Hall et al. 1998). Corroborating this evidence is the report by Kings College London (Pettitt, 2013) which found that the majority of violent crimes and homicides are committed by people who do not have mental health problems. In fact, 95 per cent of homicides are committed by people who have not been diagnosed with a mental health problem (Pettitt, 2013). Most recently it was reported by the home affairs correspondent for BBC News, that people with mental illnesses are three times more likely to be victims of crime than the general population (Casciani, 2013). This suggests that there are significant barriers around perceptions of individuals with mental illness to be overcome. These negative perceptions of individuals with mental illness are not helped by the media drawing attention to the mental illness diagnosis when an individual has murdered someone.

In October 2013 the Daily Mail carried the headline: 'Why was schizophrenic who stabbed this girl to death on a bus not having treatment?' (Dolan, 2013). Earlier in 2013, there is another sensational headline in The Daily Mail,

'*The last time I felt like this I killed my mum': Schizophrenic's FIVE desperate 999 calls for help before decapitating grandmother*' (Allen et al. 2013).

It is recognised that these cases are of course a tragedy but such headlines only adds to the public's belief that people with mental illness are dangerous. There is some evidence though that those public attitudes are shifting slightly to being less afraid of individuals with mental illness integrated into the community at large. Out of 1,727 respondents surveyed for the Attitudes to Mental Illness research report (DoH, 2013) the proportion of people agreeing with the statement that 'It is frightening to think of people with mental problems living in residential neighbourhoods' rose from 15% to 26% between 1994 and 1997, but agreement with this had decreased substantially to 13% by 2012 (DoH, 2013:p9).

3.3: Mental illness is associated with illness not recovery; Once again I was surprised by this theme, coloured again by my own eighteen years working in promoting recovery of individuals with severe and enduring mental illness. This theme might be more aligned with the employment arena, those who can offer

employment or in positions of facilitating employment where association with risk prevails. Looking to the Attitudes to Mental Illness research report (DoH, 2013) which used The Mental Health Knowledge Scale (MAKS), (Evans-Lacko et al. 2013) to look at people's perception of recovery, it is indicated that there was a high level of agreement that mental health problems can be treated, with around eight out of ten respondents agreeing that psychotherapy (81%) and medication (80%) can be effective treatments for people with mental health problems (DoH, 2013: p23).

Figure 9: MAKS-Stigma- related mental health knowledge (2009- 2012).

Source: Attitudes to Mental Illness Research Report 2012 - Prepared for Time to Change, DoH 2013.

The responses to MAKS (Evans-Lacko et al. 2013) are captured in Figure 9 above. Note that 61% of the 1'727 adults (aged 16 +) surveyed thought that people with severe mental health problems could fully recover. This is the highest percentage since that question was first asked in 1994 as part of this annual survey. But it does indicate that this concept of recovery from mental illness, never mind employment, has not been taken on by most employers in ways reflected in their attitudes to employment practice at least those who took part in this research.

Theme Four: Employers considered that employment of individuals in MH recovery might be possible.

This theme was found to be prevalent in all three focus groups. It is possible that it

was aided by three employer participants disclosing that they had experienced significant bouts of mental illness at some point in their career. Experiencing mental illness during one's career and whilst employed often signals the end of one's career or profession. However there are some long-term studies and established vocational programmes that support the feasibility of the employment of this population of people (Harding et al. 1987: p718-728). Notwithstanding the legislative onus placed on employers under the Equality Act (2010) and the Disability Discrimination Act (1995, 2005), (defined in the glossary and chapter 2 of this paper) there was a sense that employment of this client group could be possible. This idea seems to be gathering strength and it has been recently recommended that individuals with psychosis or schizophrenia should be offered the opportunity to join supported employment programmes if they have indicated that they wish to find or return to work (NICE, 2014).

4.1: There were proposed factors that would facilitate employment. Various suggestions were put forward by employer participants that might enable the employment of individuals in mental health recovery. These included educating employers about mental illness, flexible working hours, and flexibility by working from home, using technology, providing additional support to the employer, identifying specific types of jobs, having support from your employer. The IPS model is recognised as having superiority over other available models in supporting individuals with mental illness back into work (Bond et al. 2008: pp 280-290). While this group of employer participants strongly associated mental illness with illness that you do not recover from, there is a strong evidence base that the IPS model can be effective in promoting recovery in employment (Rinaldi et al. 2010(b).

That then indicates the need to alert service users and those in the pathway of employment about such possibilities. It is not enough to keep recognising that there are models that help employers move beyond these barriers. The findings from this current study indicates that if change is to be truly embraced there has to be cross agency working, shared understanding and a real breaking down of prejudices for this client group.

Service User Focus Groups: Table 3 (See Pages 159 for further details)
Theme One: People with MI face significant obstacles to accessing suitable employment.

Research in recent years report that people with mental illness suffer greater levels of unemployment than that of the wider population in the UK (Kilian and Becker 2007; Rinaldi et al. 2010(a); Bevan et al. 2012). It also suggests that the employment rate for working-age people with a long-term health condition is only 58 per cent, compared with 77 per cent for working-age people without a health condition. For disabled people it is lower, at 45 per cent, and for individuals with a mental health condition it is only 37 % (Labour force survey, 2013).

Therefore it is no surprise that this theme has emerged from the data gathered from the participants in this research. The 28 participants conveyed numerous obstacles to accessing suitable employment. This was despite many of them having had previous work experience prior to the onset of mental illness. Note that overall employment rates are low in the UK when compared with other high income OECD countries, but add into the equation a moderate to severe mental illness and they are significantly lower compared with those with no disorder (OECD, 2014(b).

This is captured in Figure 10 below.
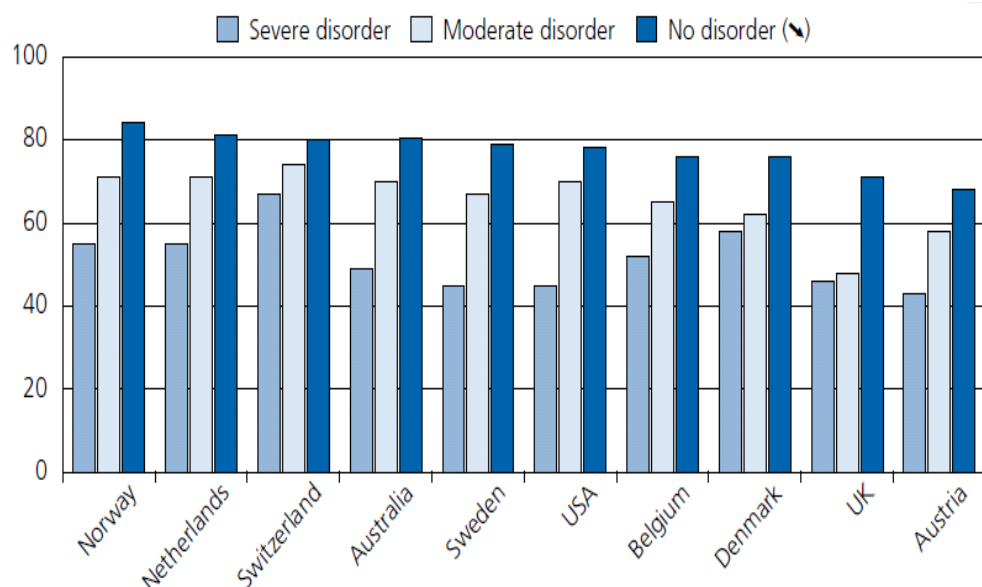
Figure 10: Employment rates by mental health status across 10 high-income countries

Source OECD (2014(b), Sick on the Job? Myths and Realities about Mental Health and Work

1.1: People with Mental Illness felt that there were factors that would enhance their prospects of employment; despite having experienced different obstacles to overcome. They felt that their employment possibilities could be greatly improved if employers understood mental health issues. There were repeated suggestions that employers would benefit from training in mental health awareness. Employer participants had also identified that mental illness is poorly understood in terms of employability of this category of individuals. It was also suggested that individuals with mental illness would also benefit from training in a trade or up-skilling themselves in order to become more employable. Flexibility in employment was also strongly posited as a way forward.

1.2: Flexibility in employment to accommodate people with Mental Illness: This sub-theme also emerged from the employer focus group analysis and raises the concern; do people in mental health recovery with a known mental illness need special conditions or support in order to facilitate employment? This theme is supported by a number of systematic reviews which show that offering employees greater control and flexibility in terms of employment improves mental health, reduces stress and is a relative simple thing and advantageous to do (Michie, 2003: Nieuwenhuijsen et al. 2004).

1.3: Employment opportunities tend to be voluntary and unpaid; the 28 service user participants in this research who worked held posts that were either voluntary or unpaid. We know that there is currently a greater emphasis in public policy on getting people back into paid or competitive employment (DWP, 2011(a) so it is possible that we will see a shift in the types of jobs individuals could be considered suitable for. Earlier research done indicates that with appropriate support a mean average of 58% of people with serious mental health problems could achieve competitive employment (Bond et al. 1997; Crowther et al. 2001). While this research dates from 17 years ago, this way of thinking has not been embedded in employment culture or the employment market.

Some service user participants found volunteering work quite satisfying and fulfilling with one participant being proud of having done his voluntary work with a charity for over 10 years. Other participants felt that volunteering work was only given as nobody else would do the job. Jack (Pseudonym) a service user participant suggested that this type of work is 'like skivvy work', low level and unimportant. Although what might first seem like a throw-away comment there is

research that indicates that being in work is mainly protective of health when it is good quality work. Such work is thought to give employees some control over their work, rewards achievements, is safe and provides a decent standard of living (Marmot Review Team, 2010). Jobs that are insecure, low-paid and that fail to protect employees from stress and danger are thought to make people ill (Marmot Review Team, 2010). So there is reason to re-evaluate the role of the volunteer or the apprentice in terms of its benefits or disadvantages to individual well-being.

Theme Two: Employers have no interest in employing individuals with a mental illness even if they have previous work experience.

This theme emerged in some ways by absence of evidence. The majority of service user participants had been employed previously and between them had many years' experience of work. Out of the 28 service user participants none were in paid employment at the time the focus group was held. Please see the biographical data set out in Appendix 8. We know from the literature that the single biggest indicator of the likelihood of an individual with mental illness regaining employment and being successful is if they have previous work experience (Grove and Membrey, 2005). There is also an association between non-work contact with people with mental illness and an employer's willingness to hire (Hand and Tryssenaar, 2006).

2.1: Stress from employment and job pressure can exacerbate symptoms of Mental illness: Service user participants were worried that pressure could lead to stress, which might trigger or affect their mental health symptoms and their reintegration in to the work force. Service user participants were keen to get back into employment but in jobs that carried no pressure. It is difficult to imagine how realistic this is. There is a well-established link between stress at work and impact on mental well-being. Looking beyond this research to the situation in the European Union, overall work-related stress was reported to affect one third of the workforce (Ivanov, 2005). In Spain it was estimated by The General Workers Union that between 50% and 60% of sick leave and disability claims were due to stress at work (McDaid et al. 2005: p 65-373).

To put this in context it was suggested by The Mental Health Economics European Network (MHEEN, 2008) that one in four (132 million) Europeans are affected by

mental health problems each year. More recently it is noted that poor mental health is the leading or second most reason for early retirement or withdrawal from the workforce on health grounds (McDaid, 2011). In terms of managing stress that leads to mental health problems in the workplace there have been few controlled trials of organisational workplace health promotion interventions and to interventions where mental health components can be identified (Corbiere et al. 2009).

This worry by service users that stress from employment and job pressure may exacerbate symptoms of mental illness was also a theme that was raised by the employer participants in their focus groups. They worried that work could make an individual's mental health issues worse and also that it would impact on their ability to do their job. So service user participant concerns need to be considered in terms of how stress is managed in the work environment for those with a diagnosed mental illness.

2.2: Attitudinal factors; Service users felt that employers had preconceived ideas about individuals with a diagnosed mental illness. Given that 43% of employers underestimate the prevalence of mental illness in the workplace, and almost half do not have a diversity strategy and 72% do not have a stress management or mental health policy it is not surprising that individuals with a mental illness experience attitudinal issues when trying to access employment (Chartered Institute of Personnel and Development (CIPD, 2011; Seaford, 2010). There is already a plethora of research, which suggests that employers have negative preconceived ideas about individuals with mental illness. In the most recent document published called Attitudes to Mental Illness (DoH, 2013) it is reported that attitudes to the statement that

'*People with mental health problems should have the same rights to a job as anyone else has increased from 66% in 2003 (when this question was first asked) to 77% in 2012'* (DoH, 2013 : p3).

This identifies an 11% shift in a positive direction supporting the rights of individuals with mental illness to employment. The percentage of individuals willing to work with someone with a mental health problem had also increased from 69% to 75 % (Time to Change, 2013:p4). This is a fairly significant shift of 11% in the first instance and 6% in the second. While there is still a considerable way to go

and the shift that is needed is seismic, there is evidence that it has started.

Theme Three: There are individual barriers to employment for people with mental illness.

For some the label of mental illness results in the individual feeling less of a person in society. People struggle with their own demons when given a diagnosis of mental illness. For many this marks the end of many possibilities. Prospects of an 'ordinary life', of marriage, procreation, a career, and life as they know it get 'written off'. For these individuals the idea of ever having a meaningful worthwhile role to play again in society is considered not possible.

3.1: People with mental illness are found to have low self-esteem, low expectations of themselves and a lack of motivation, as also noted in this study. Poorer mental health is associated with lower confidence in job-seeking abilities (McManus et al. 2012). This theme relates to individual unique experiences as a result of having a diagnosed mental illness. There was a great sense of loss, being somewhat less of a person, feeling downgraded in society as a result of having mental illness. This deep sense of social loss and loss of self is made sense of by Frankenberg in his review of Peter Marris' theory of bereavement work (Marris, 1974) as 'the present appears to be made structural, functional and meaningful by contemplation of the past, but . . . when the imagined future suddenly disappears, the present is torn apart and fragmented by the realisation . . . of continuity and the acceptance of inevitable change' (Frankenberg, 1996: 213-217).

The notion of not been equal in society as a result of carrying the label of mental illness has also been reported as commonplace in the research literature (see for example, Rapp and Goscha 2006; McCartney et al. 2013). Many people with mental illness commonly report feelings of loneliness; treatment as unequal members of society, limited employment opportunities, and reduced life satisfaction (Rapp and Goscha, 2006). This sense of isolation contributes to the individual remaining unemployed. It is interesting to note that where individuals with a mental illness are able to work that they report an increase in their self-esteem and quality of life (Latimer et al. 2004).

There seems to be the existence of a vicious negative cycle (Rinaldi and Perkins,

2005) and low expectations. In addition to the vicious negative cycle (Rinaldi and Perkins, 2005) that has been identified it is suggested that individuals have already written themselves off as a result of a diagnosis of mental illness. The bar chart below (Figure 11) shows the results from three studies (Perkins, 2011: Slide16) of the proportion of people who had 'written themselves off' as unable to work because of their mental health condition. It is suggested that by providing people with support that works expectations can be increased (Perkins, 2011).
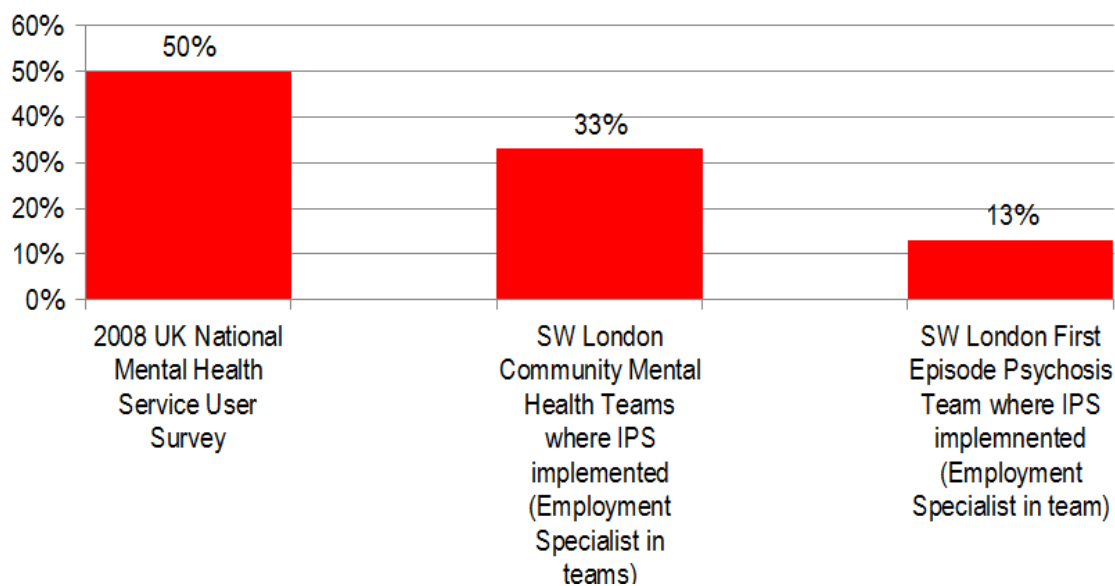
Figure 11: Proportion of people who had 'written themselves off' as unable to work because of their mental health condition. Sourced: Power point presentation: New Thinking about Mental Health and Employment; what a whole system approach might look like (Perkins, 2011: Power Point Presentation: Slide 16).

The idea that people have given up hope of employment as a result of a diagnosis of mental illness suggests that mental illness can somehow completely shatter individual resilience. That is a powerful notion and one that needs to be understood in more depth. For example children and adolescents who have been exposed to tremendous levels of stress and distress prior to migration and following resettlement do not experience mental health problems and this emphasises the complex role of resilience (Hodes, 2000; Summerfield, 2000). It is of great interest that when resilience was explored across one hundred and seventy multi ethnic refugee adolescents aged 13–17 from South Australia those adolescents suffering from depressive symptoms or other emotional or behavioural problems had lower resilience (Zianian, 2012). The role of resilience

in the onset or development of mental illness would benefit from further exploration. Does poor resilience indicate an increased vulnerability (Zubin and Spring, 1977) to mental illness or is resilience broken down as a result of mental illness? Is it that an individual feels that they have no control over mental illness occurring when it occurs whereas they automatically tap into their resilience when faced with danger? The correlation between the two is clearly evident but not well understood (Friedli, 2009; Marmot 2010).

3.2 People with mental illness suffer side effects from their medication, which make employment difficult. Service user participants were conscious of the impact taking medication can have on their daily lives and how this might reflect on the chances of securing a job. A question posed by Chris a service user participant was; 'is an employer willing to employ an individual who dribbles a lot?' Another statement by participant Julie in focus group 5 was that the medication completely 'dulled my senses'. Interestingly in the employer focus group Mark an employer representative who had experienced serious clinical depression said that he was lost for 3 or 4 years because the tablets had 'de-synthesised' his brain.

This highlights that there are definite issues around side effects of medication prescribed for individuals in mental health recovery and accessing and securing employment. Is this issue of feeling dulled or lost a cause of the mental illness or the medication? There is a debate around whether it's the actual mental illness that causes the negative symptoms associated with mental illness such as schizophrenia or whether this is a side effect of the actual anti–psychotic medication prescribed (van Os and Howes, 2012: p2030-2031). The research suggests that persistent dysphoria and motivational impairment are rarely investigated as side effects of antipsychotic medication. Side effects which impact on both the individual's ability to do the job but also on their levels of enthusiasm include sedation, cognitive impairment, emotional flattening and loss of interest, stiffness and shakiness (similar to Parkinson's disease), abnormal and persistent movement especially in the jaw, lips and tongue (tardive dyskinesia), sexual problems, and severe weight gain (Moncrieff et al. 2009).

The concerns raised within these focus groups are real and will need to be thought about in terms of how this information informs this research. It could be that some individuals will always be considered as not suitable for employment if they have these side effects. It could also be that we might need to see a greater

degree of research into the side effects of antipsychotic medication as highlighted by van Os and Howes (2012).

Theme Four: There are structural barriers for people with MI taking up employment.

Service user participants felt that qualifications needed to access competitive employment excluded them from even attempting to apply for jobs. This created a structural barrier for individuals who might otherwise be willing. It has been shown that where this has been addressed through supported education programmes that individuals reported improvements in self-confidence, cognitive functioning, and completion of college courses for people receiving supported education (Collins et al. 1998: p595-613). Other researchers have looked at this and found that that by combining a social skills training module with appropriate professional support afterwards social competence and vocational outcomes for people with a mental illness was enhanced (Tsang, 2001).

4.1: Keeping people on long-term benefits contribute to individuals in mental health recovery from seeking employment. Service user participants said that being on benefits actually made them stay on benefits and that only if the benefits were stopped then they would have to go back to work. One participant could not see the point in working if he could be better off staying at home by maximising his income from different benefit streams. Individuals with severe and enduring mental health problems are at higher risk of being unemployed than even those with severe physical disabilities, which mean they are more dependent on state financial support (Marwarha and Johnson, 2004: p337-49).

Following the introduction of The Welfare Reform Act (2012) it is possible that this would be not be a continued theme or shared sentiment by service user participants. However there seems to be some evidence to support this to be the case. People are reluctant to apply for jobs for fear of losing their benefits so they remain on long-term unemployment benefits. Other studies report that over half of the participants stated they could not risk losing their benefits by getting a job (McQuilken et al. 2003). It could be argued that this presents the case for possible interest in employment if the service user was educated about how to maximize their income through employment and to minimise the benefit incentives. It may

also be helpful if they were given reassurances that should the venture into employment not be successful that they would be able to return to the same level of benefit without penalty.

Other research studies conducted supports this theme in that it has found that being on benefits acts perversely as a barrier to returning to employment (see for example MHEEN, 2008). One might say this is old news because an earlier governmental report noted that psychiatrists were often reluctant to encourage individuals to take paid employment specifically because of the delay in reclaiming benefits, which might cause undue hardship (ODPM, 2004). My research indicates that there is a culture of fear fostered around what is largely the unknown mentally ill person in the employment market. It is not just the case in England, it has also been noted in Ireland, that this fear of loss of welfare benefits has been a powerful barrier to employment for people with mental health problems (National Economic and Social Forum (NESF), (2007). In light of the government's Welfare Reform Act (2012) there is a very strong need to address this issue with the Department for Work and Pensions (DWP), and Job Centre Plus (JCP) staff if there is to be effective employment outcomes for individuals in a phase of mental health recovery re-entering the employment market. There needs to be a pathways approach adopted by these agencies which extends beyond policing of benefit entitlement. In considering the concept of care pathways (Centre for Mental Health, 2011(a), it would be helpful if every person had a personal DWP advisor who would form part of the patient support team (along with clinician and social services named staff). The concept of a care pathway, which is already in existence for NHS patients, could be extended to include social and benefit named staff. This would help bridge the gap between individuals with mental illness who are unemployed and mainstream employers.

Theme Five: People with mental illness felt that employment is very important to them.

This theme is supported by the statistics released by The ONS (2013), where it is stated that between 87% and 90% of individuals with mental illness want to work (O.N.S., 2013). It is reported that there were 1.590m people in contact with specialist mental health services in 2012/13 (NHS Confederation, 2014). Of that

population less than one person in ten using mental health services is in work (Strathdee, 2014). People with mental illness want to be involved in society and engage in productive activity, and this is a central pillar to recovery (Centre for Mental Health (a), 2013). Service user participants in this research spoke passionately about why employment is important to them. Most participants had been employed prior to the onset of mental illness. Please see biographical data set out in Appendix 8.

Individual participants said that employment gave them identity, structure to their life, provided opportunity for meeting others, and gave them a sense of belonging. Roger (Pseudonym) a service user participant said, 'we just want to be given a chance' almost like a plea. These individuals felt robbed of opportunity yet it is known that   when individuals with mental illness are in meaningful employment that they have shown a greater rate of improvement in several non-vocational outcomes, for example, a reduction in psychiatric symptoms, satisfaction with vocational services, leisure and finances, and improvement in self-esteem (Bond et al. 2001(b).

It is also known that loss of work results in the loss of a core role, linked to one's sense of identity (Siegrist et al. 2009). Linking this theme with the employer theme that employers think it is possible to employ individuals in mental health recovery in meaningful employment it would seem absurd not to address this in view of the positive social benefits it could have across other domains of the individual's life. When unemployment rises benefit payments increase and tax payments to the government decrease therefore addressing this issue could have positive economic benefits on government expenditure, taxation and levels of government borrowing each year.

5.1: Individuals would like to be given the opportunity to work again. There was a strong sentiment that service user's participants would like the opportunity to work again. I was surprised by this and conscious of my own experience of working with individuals with mental illness long-term (mostly the same individuals over 18 years) who have never been considered as suitable for re-entering the labour market. In this current climate in 2014 in the UK there is a perceptible shift in how we understand people with mental illness. The proportion of people saying they know someone close to them who has had some kind of mental illness increased from 58 per cent in 2009 to 63 per cent in 2012, perhaps indicating a growing

openness about discussing mental health amongst friends and family (Time to Change, 2013).

There is now more discussion and drive towards getting individuals on long-term unemployment back into mainstream employment. Given that employer participants identified that employment of individuals with mental illness is possible and the appetite for service user's participants wanting to work it would seem timely and appropriate to identify what needs to happen including what training materials might make this possible. Such developments will be discussed further in Chapter 7.

Implications for the Research

Implications for Mental Health and Employment

The findings from this current study have unveiled a range of challenges and these are necessary to consider with regard further developments. What has been uncovered is that mental illness in relation to employment prospects has been considered in illness terms for too long. Mental illness, employment and mental well-being need to be considered alongside each other, as there is an interrelationship between all these areas. They would benefit from being parcelled together as essential components of mental wellbeing. However the solution or solutions are not straightforward even if the research findings have found some answers to the questions posed.

Considering the wider picture and noting that although there have been clear benefits established by having people with mental illness in employment the unemployment rates for individuals with severe mental illness remain high worldwide. More than 450 million people across the globe suffer from mental illnesses (WHO, 2014). However across OECD countries almost 50% of those with a severe mental disorder and over 70% of those with a moderate mental disorder do not receive any treatment for their illness (OECD, 2011). Individuals receiving treatment for their mental illness across the OECD countries by specialist or non-specialist practitioners is captured in figure 12 below.
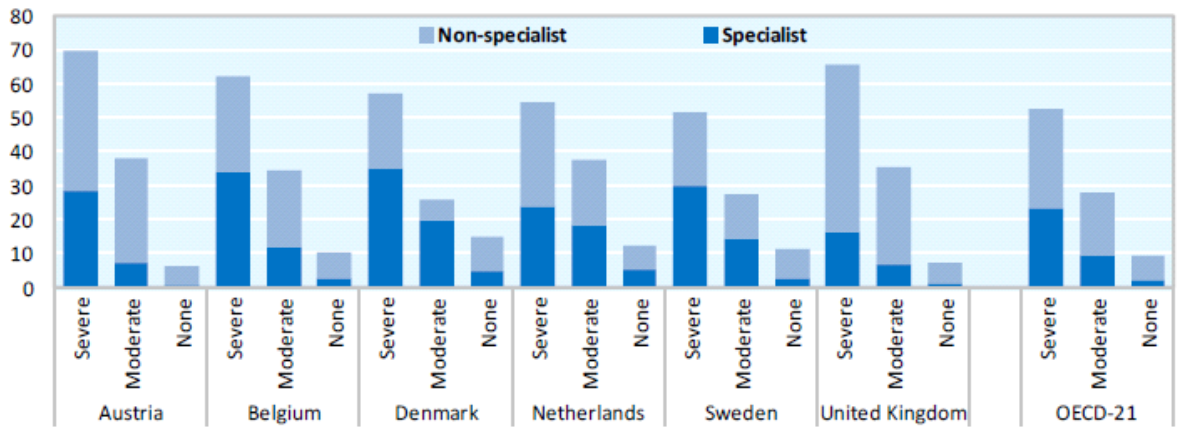
Figure 12: Proportion of people being treated by a specialist or non-specialist, by severity of their mental disorder. Sourced: Sick on the job, Myths and Realities about Mental Health and Work, (OECD, 2014(b).

It is suggested that half of those identified with a severe mental disorder and about two thirds of those with a moderate mental disorder receive treatment from a non-specialist practitioner (OECD, 2011). In most cases this is provided by the general practitioner who does not have expertise in treating mental illness. The bar chart above suggests that treatment rates across the OECD countries are very low and of those who do receive treatment for their mental illness, they may not be receiving adequate treatment in accordance with clinical guidance. Without adequate treatment the chances to stay in or to return to employment are greatly reduced. Therefore specialist treatment for service user participants in this study and for individuals experiencing mental illness has to be a prerequisite to achieving better employment outcomes for this client group.

Levels of mental and psychosocial disabilities are associated with rates of unemployment as high as 90% (WHO, 2014), with that being estimated at around 20% of the working-age population in the average OECD country (OECD, 2011). These global indicators considered alongside the themes generated from this research are another significant reason why there has to be a joined up integrative approach across systems, employers, agencies, policy makers and countries. The rates of individuals absent from work every year because of mental illness and the levels of those continuing to be unemployed as a result of mental illness indicate that there has to be a seismic shift in policy and practice if the challenges for better labour market inclusion of people with mental illness are to be addressed.

Placing the relevance of these research findings in context of the O.E.C.D. countries reported levels of absenteeism and presenteeism there is a powerful case for driving change. Workers with a mental disorder are absent from work for health reasons more often than other workers (32% versus 19%); their absences are usually longer (6 versus 4.8 days of absence). The bar chart below (Figure 13) clearly illustrates that a proactive approach to mental health awareness and prevention is important in the workplace long before an individual goes off sick. It also indicates that workers with mental disorders may tend not to take sick leave but are inclined to underperform in their jobs. 74% of all workers with mental disorder reported reduced productivity at work in the previous four weeks, compared to only 26% of workers without a mental disorder (OECD, 2011).
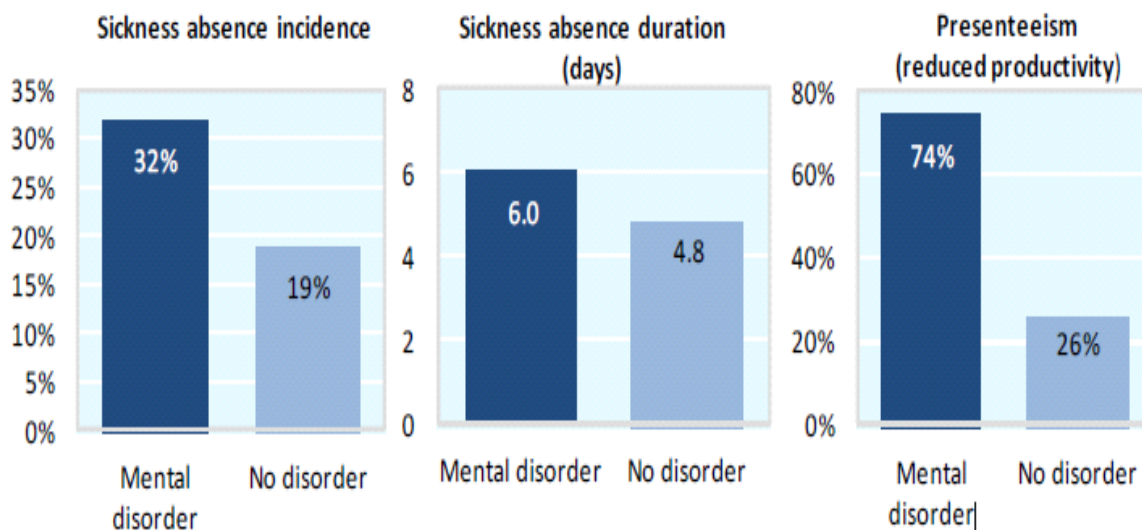
Figure 13: Absenteeism and presenteeism for people with and without a mental disorder Sourced: Sick on the job, Myths and Realities about Mental Health and Work, (OECD, 2014).

The Centre for Mental Health (2013(b) has estimated that 'presenteeism' (issues of underproduction in the workplace due to health issues) may be costing the UK economy double the amount (at £15.1 billion per year) that absenteeism is thought to currently cost (£8.4 billion per year) (Centre for Mental Health, 2013(b). Given these statistics and the research findings from this study that employers have poor understanding of mental illness, and service users feel that employers have negative preconceived ideas about individuals with mental illness these findings are not at all surprising.

Having examined this topic and looked at what is happening locally, nationally and in other countries there is a wide evidence base in existence of what supports an individual in a phase of mental health recovery to go back into work and retain work. Employment support models have been reviewed by the National Institute for Health Research School for Social Care Research (Wilkins, et al. 2011) and previously in Valuing Employment Now (DoH, 2009(c) and No Health without Mental Health (DoH, 2011). Policy recommends that there must be a whole system approach adopted, which targets three areas: Supporting individuals back into work that have long term mental illness, supporting employers and individuals who are in work and experiencing mental illness, and working out support for employers, and employees that keep individuals in long-term employment. The support devised will need to address all the themes identified in this research if such packages are to be effective. That means that the information emerging from this research supports existing policy and guidance. The following is suggested.

1. All employers, individuals involved in the employment pathway, need to fully understand mental illness and how to support individuals in a phase of mental health recovery back into work. (For the Unemployed)

2. All employers and employees, across all industries, large and small, private sector, public sector, need to be fully conversant with mental illness and have staff trained in recognising its earliest warning signs in work place environments. First aid training could be extended to include training on mental illness as a legal requirement. (Employed)

3. All employers, individuals in the employment pathway, and employees, need to be educated on how they can support an individual with mental health issues regardless of diagnosis when they are in employment following a diagnosis of mental illness. (Sustainable Employment)

There is a case for arguing that what would benefit from greater scrutiny is prevention of the development of mental illness in the first place. Creating greater mental health awareness in workplace environments that allow mental illness to be discussed openly is essential. Employers and employees need to be educated and supported in managing mental health at work.

Implications for employers on the disability provisions under the Equality Act 2010

The definition of what constitutes a disability under the Equality Act (EA) 2010 is described in chapter two of this thesis. With that in mind and the findings that have emerged from this current study, consideration needs to be given to the legal framework for the employment of individuals in a phase of mental health recovery especially in relation to the disability provisions. Evident from this current study is that there is still great stigma associated with labels of mental illness. This raises concerns about how employers will meet the legal requirements under the EQA (2010). This is further complicated by the other major another theme emergent from this study that employers have a poor understanding of mental illness. If employers lack understanding of the various types of mental illness how can they then begin to support individuals in mental health recovery back into work or whilst in work.

Some of the verbatim content cited in this study suggests that employers are 'technically' in contravention of legal requirements.

Mark an employer participant said ' *I think from my point view as an employer of mentally ill people is, we do not have the spare capacity to, have somebody mentoring that person*' therefore he or his company won't consider employing an individual in mental health recovery.

This indicates that there is continued ignorance by employers of the legal requirements. Employers continue to get rid of disabled employees through their sickness absence, capability or other procedure without taking account of their disability (Trade Union Congress, 2013). So how then will employers make provision for individuals in mental health recovery? How will they support them whilst at work and how will they make provision for disability leave?

To facilitate this act issues around disclosure of mental illness or a disability will also need to be addressed. Currently an employee does not have to disclose if they have a disability. If this remains the case it is difficult to see how an employer can accommodate an individual who is in a phase of mental health recovery in the employlment place. This study does not attempt to provide the answers to these legal questions but it does highlight the need for training and guidance on the

principles of disability discrimination so that employers can meet the legislative requirements and that there are improved outcomes for those individuals in mental health recovery who want to work.

Implications for different employment sectors

The phrase 'employment pathway' is used throughout this study to refer to agencies or individuals involved somewhere along the journey to getting individuals in a phase of mental health recovery back into employment. The current study findings indicate that while a common protocol for managing mental health well-being at work might be useful it will not be sufficient in itself. The fragmented employment pathway for individuals who are trying to get back into employment needs to be given greater scrutiny. That could be an agency, an individual or an employer. It is recognised that the challenges will be different depending on employer size, employment type, whether a public or private sector employer. These challenges could be addressed from the development of a pathways approach which combines NHS patient care and employment pathways.

There is evidence that levels of mental health problems at work have increased (CIPD, 2013). Two-fifths (42%) of organisations claim an increase in reported mental health problems such as anxiety and depression (CIPD, 2013). Stress has been stated as the most common cause of long-term sickness absence for both manual and non-manual workers (CIPD, 2011).

Moreover there was a reported increase in mental health issues in work place environments in 2013 but this varied hugely dependent on the employment sector (CIPD, 2013). For example public sector organisations and (to a lesser extent) non-profit organisations were more likely than the private sector to report that stress is among their most common causes of long-term (as well as short-term) absence (CIPD, 2013). It also reported that the private sector was less likely than the public to report that mental ill health is among its most common causes of long- and short-term absence (CIPD, 2013). The Public sector reported the increase in reported mental health problems as being 60% with only a 38% increase reported in the Private Sector and 37% in Non-Profits organisations (CIPD, 2013). As stress has been reported as the most common cause of absence from work (CIPD, 2013) and the public sector employers report the greater

percentage of absences (CIPD, 2013), this might help explain why more public sector employers (52%) are currently having difficulties filling vacancies than private sector (37%) or voluntary sector employers (CIPD, 2014).

Regardless of employment sector, larger organisations were also more likely to report increases in mental health problems. 82% of organisations with 5,000 plus employees reported an increase, 50% of organisations with between 250 and 999 employees reporting an increase and only 21% of those with fewer than 50 employees (CIPD, 2013). This would indicate that an employee is more likely to experience mental health problems in a large public sector organisation than if they work in a small private sector or a not for profit organisation. This analysis was based on replies from 618 organisations employing a total of 2.3 million employees (CIPD, 2013). This highlights that there is a strong association between mental well-being and employment as a determinant of mental health and the need to be alert to mental health and well-being outside of our mental health care systems. Promoting and protecting individuals' mental health and wellbeing outside of mental health care systems has the advantage of contributing to increasing the resilience of society as a whole (WHO, 2013(b).

The above findings also highlight a real dilemma. How do we get people back into work that have been on long-term benefits as a result of mental illness if statistics suggest that those already employed in the public and other sectors are reporting an increase in levels of mental health issues. The statistic that between 87 and 90 % (ONS, 2013(b) of people with mental illness wants to work is going to remain unchanged or even rise if mental health and well-being is not addressed in current work environments. The statistics from the recent CIPD (2013) report add weight to the findings of this research that employers have poor understanding of mental illness. The statistics also underpin a strong case for mental health at work training to be devised with it being tailored to each setting depending on the challenges posed by each setting.

Implications for Welfare Reform

The UK welfare state is experiencing radical reform and has been described as becoming leaner and meaner, and poverty and inequality are predicted to rise

even further (OECD, 2013). Deep inequalities are expected to remain in our society with the gap between the rich and poorest increasing (Howell, 2013; Black and O'Sullivan, 2012). The Welfare Reform Act (2012) outlines £18 billion of welfare savings as part of its austerity programme and it has been suggested that there may be £10 billion more to come by 2016 (Her Majesty's Treasury, 2012). There are as many as one million claimants on Employment and Support Allowance (ESA), and as many on Jobseeker's Allowance (JSA) and other working-age benefits, with a mental disorder such as anxiety and depression (OECD, 2014(c).

This is a significant population with the welfare reform aimed at getting more people off long-term benefits and back into employment. The reform provides for the introduction of a 'Universal Credit' to replace a range of existing means-tested benefits and tax credits for people of working age, starting from 2013. The Act also makes other significant changes to the benefits system. There will be an introduction of Personal Independence Payments (PIP) to replace the current Disability Living Allowance (DLA). A significant proportion of individuals with a diagnosed mental illness receive DLA; the new benefit removes any association with disability, which is likely to be greeted with a positive reaction for those with mental illness. There will be limits placed on the payment of contributory Employment and Support Allowance (ESA) to a 12-month period. Service user participants in this research felt that being on long-term benefits contributed to them not seeking employment. The difficulty with this policy reform is that where service users with a known mental illness are put on ESA and they are not job ready in 12 months' time they risk losing their benefits and finding themselves in this vicious circle of reoccurring symptoms of mental illness because of pressure and possible poverty. This particular avenue of getting people back into work is being aggressively pursued by DWP at the moment as part of implementing this welfare reform (DWP, 2013(a).

It is reported that in countries with good formal social protection, health inequalities did not necessarily widen during the recession (Stuckler et al. 2009). In countries such as Sweden and Finland, health inequalities remained broadly unchanged during the recession and the rates of suicide actually diminished (Hintikka, Saarinen and Viinamäki 1999; Ostamo and Lönnqvist 2001; Lahelma et al. 2002).In the United States during the economic downturn in 2010, there were

increased numbers of suicides linked to reduction in state welfare benefits (Uutela, 2010). Increases in levels of suicide rates were also reported during the economic downturn in Greece (Economou et al. 2011), Ireland (Central statistics office, Ireland, 2009) and England (Barr et al. 2012). A total of 4,513 suicides were recorded in England in 2012 (Davies, 2014: p16). The number of suicides has increased even though there is a plethora of research conducted during previous periods of economic downturn that identify risk of increased levels of suicide (Stuckler et al. 2009, Hogarth et al. 2009). People with lower skills and those with mental illness are more vulnerable to unemployment during an economic down turn (Brenner, 1979). Overall, recessions have coincided with higher levels of work-related disability, especially related to mental health problems (Hogarth et al. 2009).

This suggests that policy and welfare reform and state of the economy are directly linked to, and impact on, the mental health populations. It also suggests that welfare reform decisions are being made and vast amounts of money are being spent or withdrawn without reference to the evidence base of the negative impact on the determinants of health that already exist. Actions to address these health inequalities and the economic impact are considered in a range of national and international policy related documents (Friedli 2009; The Marmot Review 2010; WHO 2013).

The developments from this current study will seek to influence local government with the view to pointing them towards the data generated from this study and encouraging them to examine the broader evidence base thus reducing the likelihood of adverse effects on mental health and health inequalities as a result of welfare reform.

Impact on models of employment

This data from this current study indicates that while the IPS model has made great headway in breaking down barriers to employment of individuals with mental illness, there are still a range of changes that need to take place to achieve greater integration of this client group in the employment sector, making it the norm rather than the exception.

This study indicates that it is not enough to educate the public or lay person, it is not enough to support the individual with mental illness in their employment environment, or is it enough to provide support to the employer to support that individual whilst they are in employment. There has been a suggestion that employers might benefit from introducing IPS trainers in the work placements with the view to them improving implementation and awareness of mental illness and wellbeing (Knapp, 2013) but based on the data from this current study this may not be enough. There needs to be a shift from the notion of isolated groups being trained in mental health awareness, or from the 'individual' in the IPS model, to mental health support for all employers and employees. In order to achieve this there needs to be a whole employment culture change which addresses all employees' mental health in the work place environment alongside educating all employers or individuals in the employment pathway on mental illness and effective support systems.

Specifically in the employment environment there has to be what I term a 'dual carriageway' approach (employer and employee) to the implementation of mental health education and support systems. The package, which is being developed out of these research findings, aims to address this gap in education and supported employment models by combining training that addresses both the employer and the employee in its target audience. The need to develop a mental health employment pathway for individuals in a phase of mental health recovery will be expanded on in

Chapter 7: Summary and Conclusions

The aim of the study was to gain an in depth understanding of the reluctance by employers to employ individuals with a known mental illness who are in a phase of recovery. It also sought to hear about the lived experiences and perspectives on the barriers experienced to accessing or being in employment from a service user's perspective.

A number of themes have emerged from the data gathered. These suggest that there are a number of significant factors as to why employers are reluctant to employ individuals in mental health recovery. Barriers to accessing employment were also identified by individuals with mental illness who considered themselves in a phase of recovery. These themes have unearthed a range of challenges in getting individuals locally with mental illness back into work and then helping them retain employment. The challenges and likely obstacles are vast and some of these are outside the scope of this piece of work to address. The implications of these research findings and the answers to the research questions will be considered later in this chapter.

Recommendations

This study has highlighted that different agencies, different employer types have different needs in supporting individuals with mental illness back into employment. It also emphasised that there are shared gaps around poor understanding of mental illness despite the agency or employer, with other specifics dependent on the actual agency or employer type concerned. What joins both sets of emergent themes together is the shared narrative that mental illness is not well understood by people in the pathway of employing individuals in mental health recovery. This is evident from the shared experiences of employers and that of individuals who consider themselves in a phase of recovery. This indicates the need for a 'whole system' approach to mapping the existing territory. The following processes are suggested to support the development of integrated employment systems for individuals in mental health recovery.

1. Whole System Mapping

This system of mapping has been adapted from a framework that has been developed to plan and evaluate public health interventions in a community (NHS Institute for Innovation and Improvement, 2006 - 2013). The findings indicate that employers and agencies involved in the employment pathway whether paid or unpaid employment need educating on understanding mentally ill health and mental well-being in the work place. It is also evident that there are a range of agencies and stakeholders involved in any pathway of employment. This emphasises that training needs to be tailored to the world of employment. Training and education needs to be considered in context of the different type of employer, large and small, public and private the different agencies involved in accessing and securing employment of individuals in mental health recovery ensuring that the barriers identified in this research are addressed.

A map for the development of an integrated conceptual training and support model focused on recovery is proposed in figure 14 below.

Mapping the Employment Pathway for individuals in mental health recovery. Who is involved?
Engaging and Enrolling relevant employers and or agencies involved in the employment pathway**.**
Sustaining employment - Embedding Mental Health Awareness and Mental Wellbeing in the Workplace Culture
Developing and delivering of an Integrated Patient Employment Pathway(PEP) for the Management of Mental Health, Work and Well Being relevant to that employer or agency.
Lobbying for Policy Change Locally and Nationally
Evaluating of Training: Pre and Post outcome questionnaires /development of evidence base to inform policy change, strategies and decisions.

Figure 14: **Process Mapping: A conceptual model for the development of an Integrated Employer and Employee Support Package for the Management of Mental Health, Work and Well Being.**

It is suggested that a support package is developed covering each area of concern that has been highlighted between both focus group types (Tables 2 and 3: p129 and p159). The support package will have different content depending on

the audience that it is being delivered to and depending on where the employer or agency is placed in the process of employment. The package will need to cover both the employee and the employer support needs. This is where the package will differ from any other developed before.

The package will cover three main learning outcomes the first around; knowledge of mental illness, what does an employer or those involved in supporting individuals back into work need to know about mental illness and mentally healthy work environments; and secondly how do you then support that knowledge and awareness in the event its needed, so how do they deal with individuals when there are concerns about an individual's mental health at work; and thirdly what other support is available for the employer and employee when signs of mental illness become evident. This support package will look to support the challenges along the route of employment for both individuals in mental health recovery and for enablers of employment. It will be tailored to address the support needs of differing employer organisations involved in the 'Patient Employment Pathway' (PEP). This means taking on the challenge of developing an integrated employment pathway.

2. An Integrated Whole System Approach

This study has identified the need for a cross agency integrated whole system approach to employment of individuals in a phase of mental health recovery. To facilitate this process contact has been made with a number of agencies and individuals involved in the employment pathway. The concept of integrated cross agency working is underpinned by the Sociotechnical System Theory (STS), (Trist, 1951). STS postulates that there is interdependence between people, technology and work environment (Emery and Trist, 1965). The STS model focuses on group rather than individual job design (Parker et al. 1988; Wall and Cordery, 2001), making it a very appropriate design to underpin the development of a conceptual framework that addresses the barriers to employment for individuals in a phase of recovery. Supporting the theoretical and epistemological stance adopted in this research enquiry any new development will assume an inductive approach allowing for tailoring and adjustment depending on the employer type, size, whether public or private sector positioned.

Challenges of Creating Multi Agency Cohesion

The research analysis outlined in Chapter 5, has identified nine key themes alongside a number of sub-themes. These have highlighted that there are a number of stakeholders that need to be considered when looking at individuals with mental illness accessing and retaining meaningful employment or individuals experiencing mental illness in the course of employment. This in itself poses unique challenges around interagency collaboration and working. Working across agencies or disciplines and allocating appropriate mental health treatments has been hampered over the years as a result of impediments including the marginalisation and stigmatisation of mental illness, as well as interdisciplinary fragmentation of research (Klin and Lemish, 2008: p434-449; Prince et al. 2007: p859-877; Wittchen et al. 2011 655-679).

The challenge therefore is how to bring these employer groups together. Can employers and employees come under the same roof and work together towards overcoming these barriers to employing individuals in mental health recovery? How will that power imbalance be achieved? There is some considerable work done on how to bring teams together to work effectively for the common outcome. Adair (2003) has put forward a 'Three Circles Model' Adding Value through Team Working. This is set out in Diagram 3 below.

Diagram 3:

Three Circles: Adding-value through Team-Working. **Sourced: Public Health Action Support Team (PHAST) (2011) Motivation, creativity and innovation in individuals, and its relationship to group and team dynamics; Understanding individuals.**

This model was developed at the UK's Royal Military Academy at Sandhurst

during the 1970's (Adair, 2003). Adair observed what effective leaders did to gain the support and commitment of their followers. The thinking behind this model will be used to underpin the bringing together of different target groups involved in the employment pathway for individuals in a phase of mental health recovery. The model proposes that effective leaders pay attention to three key areas of need for members of the team: those relating to the task, those to the team itself, and those to individual members of the team. At any time, the emphasis on each circle may vary, but all are interdependent and hence the leader must keep an eye on all three.

With that need to develop integrated ways of working the following employer and employee work and support package is proposed to promote mental health awareness and management of in the workplace. The thinking is that a well-designed job may foster employee wellbeing and engagement (Demerouti et al. 2001).

3. Development of an Integrated Employer and Employee Support Package for the Management of Mental Health, Work and Well Being.

In view of the research themes outlined in Table 2 (on page 129) and Table 3 (page 159), there seems to be a need for the development of an integrated employment, mental health at work and wellbeing support package. The integrated package will adopt a three-pillar approach to promote the management of mental health in workplace environments with the view to addressing all nine themes that emerged in the research analysis.

Mental Health in Work Place Environments: Education on the most common forms of mental illness and severe and enduring mental illness (To address Employer Participant themes 1, 2, 3, & 4, and Service User Participant Themes 1, 2, & 5).

Normalising Approach to Mental Illness in the Workplace: Development of a standard protocol considering language styles that might be helpful that's non-judgemental including consideration of flexibility in the work schedules or job sharing opportunities for employees in mental health recovery. Consideration of 'reasonable adjustments' in line with the Equality Act (2010). The packaging of employment essential to good mental health and wellbeing to create sustainable employment. (To address Employer Participant themes 1, 2, 3, & 4 and Service

User Participant Themes 1, 2, 3, 4, & 5).

Mental Well Being Support Networks for Employer and Employee: Outlining what is available for the employer as additional support if employing an individual in mental health recovery. Outlining what is available to the employer and the employee if they are finding management of their mental health difficult including welfare advice. (To address Employer Participant themes 1, 2, 3, & 4 and Service User Participant Themes 1, 2, 3, 4, & 5).

Additional consideration will need to be given as to how multi agencies can work together and how such a model is likely to contribute to meeting some of the responsibilities placed on local authorities 'Health and Well-Being boards' (DoH, 2012(a). This recommendation to practice is supported by the Annual Report of the Chief Medical Officer 2013 (Davies, 2014). This report puts forward an integrated approach that has been developed by Harvey et al (2014).

Contributions to Practice

The research findings indicate that the answers to the research questions pose significant challenges for those involved. Is there a united way forward for a panacea? The current research findings indicate that there is a need for greater communication between all stakeholders involved in getting individuals recovering from mental illness back into work. Reflecting on the historical perspective (outlined in Chapters 1 and 2) around the topic of employment and mental illness, there is a need to pool and consolidate what has been developed already in a more co-ordinated way.

The research journey has been one that continues to involve some continuous personal learning through examining practices both reflexively and reflectively (Bolton, 2010). During the process it became evident that there was no clear 'Patient Employment Pathway' for individuals in a phase of recovery who want to go back to work. It was also evident that there were poor joined up ways of communicating or working cross agency. This meant that the research journey took on new directions and that the impact of work and employment could not be assessed in isolation from the individual's wider social environment (Kuh and Ben Shlomo, 2004).

In an effort to engage the wider social audience the findings from the data generated from this study were presented at two different public consultations. These were on the 7th January 2014 at a public venue in a North London Borough and on the 21st January 2014 at a public facility in the North London Borough. This provided the opportunity to test the themes generated with an audience made up of social care commissioners, service providers, carers and users of mental health services. Details of these consultations are available on line under the following title 'NLB *Joint Mental Strategy 2014-2019'*. A copy of the structure and content of the events is also included in Appendix 10 of this thesis.

Attendees at these events were invited to participate in discussions around how to address the barriers to employment for individuals in a phase of mental health recovery in the borough. The following questions were posed in each break out session: What is good about what is currently provided in the borough to support individuals in mental health recovery back into work which attendees did not want to lose? What did attendees think should be improved? What did attendees perceive as barriers to achieving better employment outcomes for individuals in mental health recovery? How did attendees think these barriers could be overcome? And finally was there anything else that attendees thought should be considered to address the barriers identified in this current study?

The feedback gathered from the consultations was used to influence the development of an Adult Mental Health Strategy in the North London Borough within which the research took place. In addition the feedback from attendees has helped to position these research findings that NLB. The feedback given by these non-participants of the focus groups have also indicated that there is a lack of knowledge about mental illness across all sectors of society employed and unemployed, mentally ill and non-mentally ill in this North London Borough. This has enabled the researcher to take these research themes forward to affect change something that is cognisant with action research. The findings from the research have been made available to the public health team in that NLB. The impact of doing that has resulted in the development of a specific integrated training and support package addressing each theme identified in the current study, and tailored to each agencies need. The findings from the study have also impacted on the boroughs employment and mental health strategy and they continue to generate discussion and debate cross agency.

I had six meetings with the public health team based in the Civic Centre in The North London Borough within which the research took place. Having identified nine key themes from the research and examined the local and UK wide population of service users with mental illness in context of employment, it became very clear that the population that would benefit from education, awareness and training on mentally ill health in the work place, would be quite large and diverse. Access to a diverse group of representatives was facilitated by joining a local working task force made up of representatives from, The DWP, The local public health team , A Local Volunteering Agency (LVA), The Clinical Commissioning Group and other agencies in The North London Borough (NLB)(A full anonymised list of members are in Appendix 9).

Employing an estimated 1.7 million people across England, Wales, Scotland and Northern Ireland the NHS is the biggest employer in the UK, in Europe and the fifth biggest employer in the world (The Telegraph, 2014). With that in mind the research findings were also presented to 60 Heads of Departments from The NHS Trust in a Mental Health Hospital Board Room on the 16th May 2014. The purpose was first to disseminate the findings to a wider audience, and secondly to get feedback from these employees on what their thoughts were in context of addressing these barriers within the NHS service. This study identified the need for a more integrated approach between physical health, mental health; social care and employers. These are usually provided by different sectors and agencies. Presenting the research findings at this event provided an opportunity to promote an awareness of mental health and well-being in the health service, and to encourage reflection on how attendees own mental health is supported as an employee of the largest employer in the UK (The Telegraph, 2014).

The findings from this current study are supported by a recent government initiative driven by the European Policy Framework called '*Health 2020'*, on health work and well-being (WHO, 2013(a). That frame work aims to engage governments so that they can achieve real improvements in health by working across government to fulfil the strategic objectives of improving health for all and reducing health inequalities and improving leadership and participatory governance for health. As the research cycle moved forward it became clear that in order to address the findings from this research in a meaningful manner that cross-agency consultation and communication was actually an essential element

of the process therefore the following is proposed.

There are some effective initiatives such as the IPS model, which deal with this issue of employment of individuals in a phase of mental health recovery well on an individual basis (Rinaldi, 2010). But there are some very large gaps that still need to be addressed. This model could be developed further by becoming an employer and employee placement support package (EEPSP) as opposed to an individual support package.

The Strengths Model (Rapp and Goscha, 2006), the 'Assets based Approach' (McLean 2011: p.2), The Stress Vulnerability Model (Zubin, Spring, 1977) all could be adapted and built on with the inclusion of the Connor–Davidson Resilience Scale (CD-RISC), (Connor and Davidson, 2003: 76-82) to establish the role of resilience if any on employment of individuals in mental health recovery. The CD-RISC Resilience scale comprises of 25 items each rated on a 5-point scale (0-4), with higher scores reflecting greater resilience. The CD-RISC has sound psychometric properties and distinguishes between those with greater and lesser resilience.

Building on what already exists to help employers and individuals in a phase of mental health recovery to access employment, guidance on reasonable adjustments that can be made under the Equality Act (2010) have been developed by Mindful Employer (Grove, 2014). This guidance could be bolted onto the role of human resources (HR) and integrated into all health and safety contracts. It would seem a sensible way forward to make mental health awareness a compulsory part of the induction process of all employees. Mental Illness needs to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing (WHO, 2009: p5).

With the estimated population of mentally people set to rise in the UK (Mental Health Network, NHS Confederation, 2014) and funding for adult mental health services set to drop (DoH, 2012(b) the challenges to implement any strategy or guidelines are even greater. Any such developments will take time to consider develop and implement. Interventions aimed at improving overall levels of mental health can have a substantial effect on reducing the prevalence of common mental health problems, as well as the benefits associated with moving people

from 'languishing' to 'flourishing' (Huppert, 2005: p 307-340).

Continued work with the North London steering group will give the research findings a voice and platform which will also promote access to employers and agencies in the employment pathway. It will aim to ensure that mental health and well-being will be embedded in employment culture locally. Employers and those involved in the employment pathway will then be invited to undertake training in the 'Integrated Employer and Employee Support Package for the Management of Mental Health, Work and Well Being'. This training has already been commissioned by the public health team in the North London Borough. The overall NLB Mental Health and Employment schedule is included at Appendix 9.

This package will complement and support the development of a Patient Employment Pathway (PEP). The support package is currently being trialled and has already been delivered to two cohorts of DWP employees in a designated catchment area in the local NLB in May 2014 and in another location in the NLB in June 2014. 41 employees of the DWP have undertaken the training to date. The training took place within the North London borough in which the data was gathered.

Integrated ways of communicating have already commenced. A number of cross agency meetings have already taken place and an initial pilot scheme agreed. These have been with The Director of Public Health Team, Clinical Commissioning Managers, and Managers from The Department of Works and Pensions in the NLB, Managers from Job Centre Plus, and Managers of a Local Volunteer Centre, staff, and Manager of the NLB's Improving Access to Psychological Therapy (IAPT) service.

The first ward selected to partake in the pilot study was The North London ward, which has the highest reported rate of benefit claimants in the borough estimated to be 30% (NLB's JSNA, 2014). The support model will then be rolled out across the borough. It's worth restating the pertinence and rationale for this. The NLB's caseload as a proportion of the estimated working age population was 15.9%, compared to 13.2% in London and 13.9% in England (NLB's Joint Strategic Needs Assessment (JSNA), 2014-2019). It has the joint 107th highest rate of unemployment amongst 326 local authorities in England and the joint 6th (with Haringey) highest of the 32 London boroughs (NLB's JSNA, 2014). Following

completion of this pilot, many other agencies and employers in the employment pathway have been engaged to undertake the training in the Integrated Employer and Employee Support Package for the Management of Mental Health, Work and Well Being. Some of these are: Training of all DWP staff employed at two other Job Centre Plus sites, A Local Volunteering Agency (LVA), Reed Employment Staff, The NLB's council staff across all departments, selected groups from the Local NHS Trust. This will encompass thousands of employers and employees. A copy of the NLB's project plan and my role within that is included in Appendix 9. This is a long-term plan, which is likely to go on over some years as it takes time to address system and attitude change especially around what can be considered a sensitive area.

Limitations of the study

There are a number of biases in this study which warrant recognition. Some of these are linked to being in the same post of manager of community mental health services for over eighteen years now. Not alone am I an 'inside researcher' (Robson, 2002), but I am also well known in the local community.

Both cohorts of participants were selected on the basis that they were willing to participate. There was no attempt made to estimate the probability of being included and no assurance was made that every employer or service user in the borough had the potential of inclusion. As the sampling method was purposive and targeted, the findings may therefore be considered not to be representative of these two population participant types (Employers and Service Users) as a whole. Probability sampling would have avoided this where by each individual in the sampling frame had a possibility of being sampled. However the sampling method was considered appropriate as justified earlier in chapter three.

It is possible that I may have influenced how the questions were asked or the way in which the responses was received due to my longstanding involvement with individuals who have mental illness in the local community and my keen interest in recovery orientated practices. Despite trying to remain completely neutral the rapport that was established between I the researcher, and both cohorts (Employer and Service User) of participants, will have influenced answers to some degree. There was a risk that respondents gave answers to please me. This could

be as a result of being afraid to say how they really felt, or because of the natural tendency to give the response the researcher wants.

This study neglected to gather the highest educational attainments of participants from either group. This would have been useful as it is known that individuals with moderate to severe mental illness are more likely to quit full time education before the age of 15 (OECD, 2012). This is reported to be significantly higher in the UK, compared with other OECD countries (OECD, 2012). The proportion of those with no mental disorder and those with severe mental disorder is greater in the UK than in any of the other of the high-income OECD (2012) countries considered (Norway, Netherlands, Switzerland, Australia, Sweden, USA, Belgium, Denmark, and Austria). Conversely it is reported that poor mental health contributes to lower educational attainments, work performance and productivity (McCullogh and Goldie, 2010).

At least one participant Mark in the employer focus group had left school with no educational achievements and he is the founder and owner of a multi-million pound business. He was also one of three employer participants that have experienced severe clinical depression. Out of nine of the service user participants contacted after the research, the highest level of educational attainment by participants Julie and Chris were at 'A' level. Chris also went onto study for three months at Higher National Diploma level, at which point he developed mental illness. Stanley has completed a NVQ level 2 since taking part in the focus groups. Given that there is a relationship between employment, mental illness and income inequality in developed countries it would have been interesting if this could be explored further in this study (Picket et al. 2006; SCIE 2011).

From the perspective of trying to secure a homogeneous sample in terms of educational attainment it is argued that too much homogeneity in a group can lead to a lack of disagreement and teasing out of issues (Phillips and Apfelbaum, 2012). Post-doctoral work will continue to locate the other 19 service user participants with the view to getting a more comprehensive picture of educational attainments and how they related to job status in the past or since the onset of mental illness.

Future research should consider the impact of the development of integrated patient employment pathways. These should clearly involve Clinical

Commissioning Groups (CCG's) working with agencies such as The Department of Works and Pensions with each service user having a designated 'key worker' in each agency.

Conclusions

This study is considered to have achieved its aims and objectives which are set out in Chapter Two. The research sought to answer two specific questions: Firstly are employers' reluctant to employ people in the recovery phase of mental illness? If so what are their possible reasons?

It would seem that there is compelling evidence in this research study that employers remain reluctant to employ individuals in a phase of mental health recovery (Table 2, p129). While the question posed seemed very straightforward it is evident that the answer to it is not so. What emerges is a raft of different challenges meaning the answer is somewhat multifaceted. This in turn resulted in the emergence of many more questions and the risk of the focus of the research spiralling off into many new directions (McNiff, 1988), something that can happen when conducting Action Research (AR).

Employer participants conveyed that they did not have an understanding of Serious and Enduring Mental Illness (SEMI) and to a lesser degree those considered as common mental illnesses. This is not surprising when one examines the rates of employment of individuals with mental illness. This is currently estimated as being between 5% and 15%, with the average rate of only 8% for people with schizophrenia (Bevan et al. 2013). It is estimated that unemployment rates for individuals with severe mental illness is four times greater than it is for individuals with no disorder with the rate for more common mental disorders reported as being double (OECD, 2014(c).

Employers highlighted many 'good reasons' why they were reluctant to employ this client group. They were seen as likely to cost more money, less able thus not worth considering. Employers indicated that they had 'no spare capacity'. This may be related to the study taking place during a recession when it is recognised that there is increased economic hardship and that the social exclusion of people with mental health problems may intensify (Evans-Lacko et al. 2013: p1).

With the added complication of the economic downturn it became apparent that the employment pathway for individuals in a phase of mental health recovery is complex and peppered with various obstacles. As a result of the employer participants being from diverse employer representative back grounds this highlighted different challenges and misconceptions held by them dependent on what their type of employment was. For example participant Joseph from the construction industry tended to lean heavily on health and safety issues as a reason to justify why he would not be willing to employ an individual in a phase of mental health recovery. This could be linked to the construction industry being male dominated or to the economic down turn where it is known that downturns tends to affect males to a greater degree as well as those with lower education (Evans-Lacko et al. 2013: p1). So that might have been an influencing factor.

Linked to employers' lack of understanding about mental illness were misconceptions associated with stigma that are often attached to the labels of mental illness. This is supported in recent literature which suggests that 70% of people with mental illness have experienced discrimination, and there are indications that employment is often not even considered as an outcome by their clinicians (Bevan et al. 2013).

Whilst most employer participants knew someone or could associate with someone who had experienced depression or anxiety during employment there was poor association if any with an individual with schizophrenia, bi-polar disorder or psychosis being employable. Those participants who themselves had experienced mental illness during their working life were more sympathetic towards individuals with mental illness and the prospect of employment.

Employer representatives thought that it was possible to employ an individual in a phase of mental health recovery, indicating possibility. Service users indicated that they would like to work again also indicating aspiration. These shared notions improve the prospect of creating a Patient Employment Pathway (PEP) that will contribute to addressing these barriers and misconceptions.

Overall the themes that emerged from the employer focus groups point to the need to package employment as a means to promoting and maintaining good mental health.

The second question that the research sought to answer was; do mental health

service users experience any barriers to employment in a recovery phase in a North London borough? The themes that emerged from the service focus groups (Table 3, p159) have indicated that people with mental illness are faced with many obstacles when trying to access employment opportunities.

There was a sense of doom in relation to employment prospects as a result of having a diagnosis of mental illness. It was experienced like bereavement (Marris, 1974), as service user participants felt that despite their previous work experience or qualifications they are removed from the prospect of employment because of a diagnosis of mental illness. The employer participants corroborated this in that they did not understand mental illness and tended to view it as a permanent state that cannot be recovered from.

Individuals reported difficulties they experience as a result of having low confidence and side effects from being on anti-psychotic medications. There were concerns around benefit loss in the event of re-entering the employment market.

Service user participants felt worried about engaging in employment in case they relapsed and were then left with no money. They indicated that they want to work, but thought that employers or individuals involved in the employment pathway had negative preconceived ideas about individuals with mental illness. They thought that employers need to be educated about mental health, mental illness and the role of employment in an individual's life. Poor understanding of mental illness by employers is a theme that was flagged up by both participant types. Most recently education, direct contact, interaction with people who have mental illness and protest to change behaviour and challenge attitudes are three strategies identified to address stigma and discrimination experienced as a result of having mental illness (Davies, 2013, p182). It is worth noting that direct social contact was found to be more effective than education in reducing stigma for adults with mental illness (Corrigan et al. 2012).

Service users suggested that employment meant that they had an identity, a role in life a chance to be involved in society, which in itself contributes to better mental health. There is evidence that individuals in mental health recovery who are in paid employment are over five times more likely to achieve functional remission than those who are unemployed or in unpaid employment (Bevan et al. 2013).

As there is less money available and increased demand for mental health services

(DoH, 2012(b); Schizophrenia Commission, 2012) there is a strong case for building on what already exists, no need to reinvent the wheel. As discussed and considered in this closing chapter there are a number of existing models and strategies that could benefit from further development.

There is a possibility that huge personal and socio- economic benefits can be had for the individuals in mental health recovery and those involved in the patient employment pathway. This recommendation to adopt a cross agency improved employment pathway for individuals in mental health recovery is supported by the CIPD (2014) where employers have been encouraged to address labour shortages by improving the pay and employment conditions package and investing more in human capital (CIPD, 2014). The development of a Patient Employment Pathway (PEP) for individuals in mental health recovery could aid this integrative process.

Postdoctoral goals for the outcomes of this research are to build the case for employment being an essential component of recovery. Efforts to promote more integrated employment mental health pathways will be made. Employers will be encouraged to invest in developing healthier mental wellbeing work place environments. Given the importance of employment, as a precondition to full citizenship efforts will also be made to drive policy change locally and nationally by engaging policy makers and commissioners locally and nationally.

Dissemination Strategy

- Dissemination of the findings from this study has already begun. The findings were presented to a wide range of stake holders at two separate public events in a North London Borough on the 7th and 21st of January 2014.

- They were also presented to an audience of sixty plus NHS managers from The Mental Health Trust; on the 16th May 2014.This was attended by the Chief Executive of the Mental Health Trust.

- Dissemination could further be enhanced as the study provides a template for the development of a conceptual model that will support employers and employees to manage mental health and wellbeing in workplace environments. This model will be developed and made available initially to employers and

agencies at local level and then nationally.

- Leaflets mapping the 'Patient Employment Pathway' will be developed and distributed to all agencies or partners involved in employment and provision of support to individuals in mental health recovery. This leaflet will be developed through cross agency working and communication.

- Findings will be presented at future conferences, one of which is currently in the planning in the North London Borough within which the research took place.

- A number of journal articles will be prepared and distributed to as many health and labour journals as possible with the view to reaching a maximum audience. These will be co-written by my academic supervisors Dr. Gordon Weller and Dr. Catherine Kerr. The title of the publications in press is as detailed; Shanahan. P., Weller, G., Kerr, C. (2014) Leading Recovery Orientated Mental Healthcare. In Press, Due to submit dissertation October 2015, Middlesex University.

- Finally the research findings will be disseminated by uploading them onto Middlesex University research repository where other researchers can access and use them to inform or develop strategies in their local communities.

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Appendix 1: Employer Participant Focus Group Interview Schedule

Focus Group

Interview Schedule

April 2011

Q1. What sort of image springs into most people's minds when they hear the word mental illness? (Schizophrenia, depression, anxiety, bi-polar,)

I WILL ONLY USE THESE TERMS TO TEASE OUT IF THE RESPONSE IS LIMITED .

Q2.Why do you think such negative notions come to mind?

Q3. If there is a more positive response from some or all ask why is their /your idea so different to the general public.

Q4.Do you think that the wider public images of people with mental illness would include any notion of people with mental illness doing a paid job?

Q5. Some will say no so explore why.

Q7. If some say yes explore what type of job would be envisaged

Let's take one of your roles / jobs …… how would having mental illness interfere with the ability to do the job you currently do or some other responsible or reasonably demanding job.

What arrangements would you (as an employer) make if somebody broke their dominant arm or something, which prevented them from working to their full capacity? This might lead them into thinking about strategies, which might support a loyal staff member who was mentally ill, but in recovery?

Q3. What prevents employers considering the employment of or working with an individual with a known mental illness?

Q4. To your knowledge does the sector you represent currently employ individuals with a known diagnosed mental illness? If so in what capacity and why?

Q5. How many people with mental health difficulties do you know who are employed in either full time or part time employment?

Q6. What type of support if any does your sector/ company offer to individuals with mental health problems? Then ask what is it about your company that allows them to support these individuals

Q7. I would ask what information and support would you need in your sector (as an employer) need to encourage you to give people with mental illness a chance of working and proving themselves in your organisation?

Q.8 How might that be different for a small firm such as a builder, a local cafe, and a hairdresser?

Q9.Are you /or your employer aware of any agencies, which can offer support to your sector in the employment of an individual with a known mental illness

Q10. I/ Patricia present a scenario: E.g., if she turned up for an interview and had ticked the box that asked if I/she had a history mental illness,

Would they still interview me?

Would they interview me anyway but already have made up their minds not to employ me?

Q11: What happened if I did not disclose my mental illness at the outset and later having developed a friendship/relationship with you told you off the record? Do you think you would have a different reaction than if I disclosed at the outset?

Q12.Is there effective engagement/link between policy writers, employers and service users around employment of individuals in mental health recovery? Is equal status employment in the future out of the question?

Q13. Are you/ employers/individuals in the pathway for employing these individuals under supported in understanding the nature of mental health problems among the work force? Do they know how to access advice in helping to manage employees who have or experience mental illness other than sacking or dismissing them?

To KEEP THESE QUESTIONS TO EXPLORE AS AND WHEN THEY ARISE AND IF THEY ARE NOT COVERED BY THE PREVIOUS QUESTIONS

Appendix 2: Service User Focus Group Interview Schedule
Focus Group
Interview Schedule
June 2011

Q1. Have any of you been employed prior to the onset of your mental illness?

Q2.What kind of employment did /do you hold and how has that changed? (Although will probably come out of Q above) If employed what role does it play in your life? What does it mean for that individual?

Q3. Since the onset of your MI have any of you been employed? If so what kinds of jobs have these been? Has the type of job you would consider taking now changed?

Q4. What type of support have you been offered to go back into employment full or part time? Or what type of arrangements should be put in place to enable individuals to go back to work? Or what type of support are you in receipt of ….if currently employed. What is it that makes it possible?

Q5. Hands up, how many of you would actually like to be in some sort of employment? Would this be full time or part time? And the thinking behind this?

Q6. What type of work do you think individuals who experience mental illness should be employed in?

Q7. Has your thinking about this changed since experiencing mental illness?

Q8.Do you think that the wider public's images of people with mental illness would include any notion of people with mental illness doing a paid job?

Q9. Some will say no so explore why.

Q10. What do you think prevents employers considering the employment of or working with an individual with a known mental illness?

Q11. How many friends/people with mental health difficulties do you know who are employed in either full time or part time employment?

Q12. What kind of information do you think employers need to encourage them to give people with mental illness a chance of working and proving themselves?

Q13. Does this change depending on type of employer? How might this be different for a small firm such as a builder, a local cafe, and a hairdresser?

Q14.Are you aware of any agencies, which can offer support to you in securing employment?

Q15. What kinds of thoughts come to mind when we consider employment and how this might impact on your benefit entitlements?

Additional points to tease out:

Reflect upon factors relating to employment that have helped or empowered these individuals?

Discuss what factors have helped them sustain their employment.

Discuss any learning they had experienced from employment or being unemployed.

Describe what role employment does or might play for them.

Reflect on what a diagnosis of mental illness has meant to them as individuals in relation to employability in the past, now and in the future.

Appendix 3: Ethical Approval Letter

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      DProf Doctorate in Professional Studies in Health

Date: 8th April 2010
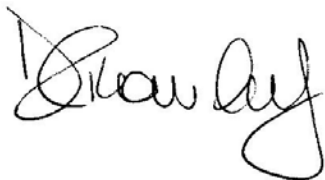
Dear Patricia

Re: Patricia Shanahan – Application 639 – '*Pathways to employment for people in the recovery phase of mental illness'.* Category A3 – Supervisor, Mary Tilki

The ethics subcommittee (Health Studies) considered your application on the 25th March 2010. On behalf of the committee, I am pleased to inform you that your application has been approved. However, please note that the committee must be informed if any changes in the protocol need to be made at any stage.

I wish you all the very best with your project. The committee will be delighted to receive a copy of the final report.

Yours sincerely

Ms Dympna Crowley
Chair of Ethics Sub-committee (Health Studies)

Appendix 4: Employers Participant Information Sheet

MIDDLESEX UNIVERSITY

SCHOOL OF HEALTH AND SOCIAL SCIENCES

HEALTH STUDIES ETHICS SUB-COMMITTEE

PARTICIPANT INFORMATION SHEET (PIS): Employers

1.   Study title:

Pathways to employment for people in a state of recovery from mental illness.

2.   Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

3.   What is the purpose of the study?

The purpose of this study is to identify through the action research process the reasons that employers' are reluctant to employ individuals with a known diagnosis of severe and enduring mental illness but in a current state of recovery and secondly   what the barriers are, as experienced by service users in the recovery phase of mental illness in an outer London borough when seeking or considering employment.

It also aims to raise consciousness and empower participants by encouraging dialogue, the sharing of good practice and coping strategies amongst participants so that appropriate training strategies and materials can be provided to challenge misconceptions and support them.

4.   Why have I been chosen?

You have been chosen to take part in this study because you are one of thirty employer representatives of employer organisations identified in the NLB who could contribute in a meaningful way to the topic under consideration.

A total of 24 employer representatives from and within the NLB will be invited to participate.

They will make up three focus groups with at seven to eight employer representatives participating in each. There will be employer representatives from a cross section of employment sectors invited to participate.

5. **Do I have to take part?**

Participation in the study is entirely voluntary and you can refuse to participate or withdraw at any time and without giving a reason. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. A decision to withdraw at any time, or a decision not to take part, will not affect you as an employee/or employer representative adversely

6. **What will happen to me if I take part?**

 If you agree to participate in the research you will receive a letter inviting you or your organisation representative responsible for recruiting to attend a group where the reasons that employers' are reluctant to employ individuals with a known diagnosis of severe and enduring mental illness but in a current state of recovery will be discussed.

Gathering information in this way for research purposes is commonly known as a focus group.

A **focus group** is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs and attitudes towards a product, service, concept, advertisement, idea, or packaging. In this case the topic is the reluctance by employers to employ an individual with a diagnosis of severe and enduring mental illness but in a current state of recovery.

Questions are asked in an interactive group setting where you and other participants are free to talk with other group members.

It is expected that each group will be made up of at least six to seven other employer representatives and will last for roughly one hour.

I/We will try to organise these sessions at a time and location that is convenient for you and to minimise disruption to your organisation or company.

You will be expected to, arrive on time to the focus group, contribute to the discussion in hand and be willing to listen to each other. It is expected that you will show respect for each other's contributions and or considerations shared in the group.

7. What are the possible disadvantages and risks of taking part?

There are no *known* risks or harm in taking part in the study, and your terms of employment will not be compromised in any way.

It is possible that you might find some of the issues raised upsetting, challenging, and /or anxiety provoking. You may feel uncomfortable at times discussing some of your own prejudices in relation to this sensitive issue.

8.   What are the possible benefits of taking part?

The information generated by participants may in time help us understand what are the real issues/obstacles faced by employers in employing individuals with S.E.M.I. Participation may also help you relay some of your anxieties or understand your hidden prejudices and share your fears with other employers. It will provide a safe environment to share your concerns around what might be considered a sensitive issue.

9.   Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you or your organisation, which is used, will have your name and address or company details removed so that you cannot be recognised from it.

Recordings and transcriptions will be stored under the Data Protection Act (1998). I (The Principal Researcher) will be the only one who will have access to the data and it will be stored in a password-protected file on my PC. Tape recordings will be destroyed on completion of the project.

All data will be stored, analysed and reported in compliance with the Data Protection legislation.

10.   What will happen to the results of the research study?

The results of the information will form part of a project for a postgraduate Doctoral programme at the Middlesex University.

I will provide an executive summary of the results of which you can have a copy on request. Findings from the research may be published in articles, in newsletters, or at conferences. You will not be identified in any report or publication.

It is anticipated that the research findings and writing up of will be completed by September 2012 and a summary will be available in 2012.

11.   Who has reviewed the study?

Programme approval has been granted from the Middlesex University, School of Health and Social Sciences, Health Studies Dprof committee subject to ethical approval.

My employer the company De Bohun Care Ltd are also fully aware of the proposed study and agree to it being conducted.

12. **Contact for further information**

For further information please contact:

Patricia Shanahan

Manager De Bohun Care Ltd, No 1 Bramley, Rd, Southgate, N14 4HL, Tel: 020 84495878

E-mail: debohuncare@aol.com

E-mail 2: shanahanpatricia@aol.com

Dr Mary Tilki -principal lecturer (Social Policy) (Project Supervisor), School of Health and Education, Middlesex University The Burroughs, London, NW4 4BT   Email: M.Tilki@mdx.ac.uk

Thank you so much for your time and considering taking part in the study. You will be given a copy of this information sheet and a copy of the signed consent, should you choose to participate to keep for your records

Appendix 5: Service User Participant Information Sheet

MIDDLESEX UNIVERSITY

SCHOOL OF HEALTH AND SOCIAL SCIENCES

HEALTH STUDIES ETHICS SUB-COMMITTEE

PARTICIPANT INFORMATION SHEET (PIS): Service Users

1.   **Study title: Pathways to employment for people in a state of recovery from mental illness.**

2.   **Invitation paragraph**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

3.   **What is the purpose of the study?**

The purpose of this study is to identify through the action research process what the barriers are, as experienced by service users in the recovery phase of mental illness in an outer London borough when seeking or considering employment and secondly   what are the reasons that employers' are reluctant to employ individuals with a known diagnosis of severe and enduring mental illness despite they being considered in recovery.

The study also aims to raise consciousness and empower participants by encouraging   dialogue, the sharing of good practice and coping strategies amongst participants so that appropriate training strategies and materials can be provided to challenge misconceptions and support them.

4.   Why have I been chosen?

You have been chosen to take part in this study because you are one of thirty service users identified as living in supported accommodation in the NLB and in the recovery phase from severe and enduring mental illness (S.E.M.I.).

A total of 24 individuals will be invited to participate. They will make up three focus groups of eight service users in each.

Service users in this context are individuals with a known diagnosis of severe and enduring mental illness making use of supported accommodation in the community in the NLB.

Examples of severe mental illness include schizophrenia, bipolar affective disorder (manic depression), organic mental disorder (dementia), severe anxiety disorders, severe eating disorders, severe depression, and severe panic disorder.

5. Do I have to take part?

Participation in the study is entirely voluntary and you can refuse to participate or withdraw at any time and without giving a reason. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. A decision to withdraw at any time, or a decision not to take part, will not affect you or the services you receive adversely

6. What will happen to me if I take part?

 If you agree to participate in the research you will receive a letter inviting you to attend a group where barriers to employment in the local borough as experienced by you and other service users will be discussed.

Gathering information in this way for research purposes is commonly known as a focus group.

A **focus group** is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs and attitudes towards a product, service, concept, advertisement, idea, or packaging. In this case it is barriers to employment as experienced by you a service user.

Questions are asked in an interactive group setting where you and other participants are free to talk with other group members.

It is expected that the group will be made up of at least six to seven other service users and will last for roughly one hour.

I/We will try to organise these sessions at a time and location that is convenient for you.

You will be expected to, arrive on time to the focus group, contribute to the discussion in hand and be willing to listen to each other. It is expected that you will show respect for each other's contributions and or considerations shared in the group.

7. What are the possible disadvantages and risks of taking part?

There are no known risks or harm in taking part in the study, and the care and/or support that you normally receive in the community will not be compromised in any way.

It is possible that you might find some of the issues raised upsetting, challenging, and /or anxiety provoking. You may feel uncomfortable at times discussing some of your own prejudices

8.   What are the possible benefits of taking part?

The information generated by participants may in time help us understand what the real issues/obstacles are for people with severe and enduring mental illness when considering engaging in employment.

9.   Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you, which is used, will have your name and address removed so that you cannot be recognised from it. Recordings and transcriptions will be stored under the Data Protection Act (1998). I (The Principal Researcher) will be the only one who will have access to the data and it will be stored in a password-protected file on my PC. Tape recordings will be destroyed on completion of the project.

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11.   Who has reviewed the study?

Programme approval has been granted from the Middlesex University, School of Health and Social Sciences, Health Studies Drove committee subject to ethical approval.

My employer the company De Bohun Care Ltd are also fully aware of the proposed study and agree to it being conducted.

12. **Contact for further information**

For further information please contact:

Patricia Shanahan: Manager De Bohun Care Ltd, No 1 Bramley, Rd, Southgate, N14 4HL, Tel: 020 8449587

E-mail 1: debohuncare@aol.com

E-mail 2: shanahanpatricia@aol.com

Dr Mary Tilki -Principal Lecturer (Social Policy) (Academic Supervisor), School of Health & Education, Middlesex University, The Burroughs, London, NW4 4BT E-mail: M.Tilki@mdx.ac.uk

Thank you so much for your time and considering taking part in the study. You will be given a copy of this information sheet and a copy of the signed consent, should you choose to participate to keep for your records

Appendix 6: Consent Form

Title of Project: Pathways to employment for people in the recovery phase of mental illness.

Name of Researcher: Patricia Shanahan

Please initial box

I confirm that I have read and understand the information sheet dated ....…………………for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdr at any time, without giving any reason.

I understand that my interview may be taped and subsequently transcribe

I agree to take part in the above study.

I agree that this form that bears my name and signature may be seen by designated auditor.

_____   _____   _____

Name of participant   Date   Signature

_____   _____   _____

Name of person taking consent   Date   Signature   (If different from researcher)

_____   _____   _____

Researcher   Date   Signature   1 copy for participant; 1 copy for researcher

Appendix 7: Employer Participants Biographical Data Table

Code	M/F	E/O	Age	Employ Individu With M Before	Busines Sector
Mary		British		N	Mental Health Care-Public Sector
Jaz		Indian		Y	Banking
Gemma		W/British		N	Banking
Ash		Bangladeshi		N	Banking
Pam		Irish		N	Care Private Sector
Geraldine		Indian		N	Pharmacist
Anna		Asian British		Y	Voluntary Sector
Joseph		W/British		N	Construction
Sonya		B/African		N	Retail
Valerie		British		Y	Charity
Emma		-		N	Counselling/Psychology
Karen		W/British		Y	Local Authority
Paul		W/British		N	NHS
Mark		British		N	Retail
Sharon		British		N	Local Authority
Jill		British/Asian		N	Private Sector

Appendix 8: Service User Participants Biographical Data Table

Code	M/F	E/O	Employ Before MI	Type Of Work
Gerard	M	British	Y	On Line
Mark	M	British	Y	Buildings
Tony	M	British	Y	Trade Counter
Kevin	M	British	Y	Window Firm
John	M	British	Y	Hospital Porter
Peter	M	White British	Y	Research Administration
Brigid	F	Afro Caribbean	N	-
Shane	M	Black African	N	-
Garry	M	British African	Y	Sales Assistant
Jim	M	British	N	Office Work
Steve	M	British	Y	Machine -Operator
Olly	M	Black British	Y	Supervisor; Bakery
Sonya	F	M/R	Y	Beauty Consultant
Christine	F	British	Y	Mobile Oven Cleaner
Rose	F	British	Y	cleaner /Hovering Grass Cutting
Liz	F	B/Car	N	-
Becky	F	Burundiz	N	-
Lee	M	British	Y	Cabby
Margaret	F	B/Car	Y	Call Centre & Receptionist
Julie	F	British	Y	Medical Research Training for Met Book seller
Stanley	M	British	Y	Tutoring
Jack	M	B/Car	Y	Retail & Security
Andy	M	British	Y	Laborer
Chris	M	Ais/ British	Y	Computer Operator
Lucy	F	Eng/Itl	N	Beauty, Hairdressing.
Ian	M	British	N	-
Amelia	F	British	Y	Hair Dresser
Graham	M	B/ British	N	Various jobs over 40 ye

Key to Table

Code = Service User Participant;

E/O= Ethnic Origin;

Y/N= Yes/No;

Employed before MI= Employed Before onset of Mental illness

Type of Work= Work line

Vol Work= Voluntary Work

Appendix 8 Continued: Bio Graphical Data- Employment status

Code	Type Of Work	Voluntary Work Y/N	Type Of Voluntary	Work Now	Type Of Work	Age
Gerard	On Line	N	-		-	60s+
Mark	-	N	-		-	60s+
Tony	-	Y	-		-	-
Kevin		Y	Serving Customers		-	40's
John	Handy Man	Y	Administration Sealing Envelopes		Volunteer	50s
Graham	Receptionist	Y	Receptionist Administration Day Centre Support		MH Charity	40s
Brigid	-	Y	Drop In Support		-	50s
Shane	-	Y	Social Support		Community Support Worker Customer Services	30s
Gary	-	Y	Mind		-	30s
Jim	-	Y	Office Work Computing		-	30s
Steve	-	N	-		-	-
Olly	'Presser in Clothes – Factory	N	-		-	50s
Lucy	-	N	-		-	40s
Christine	-	Y	Cleaning		Training to Drive a Mini Bus	30s
Rose	Cooking	Y	Cooking For MIND		Voluntary	60s+
Liz	-	Y	Social Support		-	50s
Becky	-	N	-		-	30s
Lee	-	N	-		-	40s
Margaret	B&Q Nights Receptionist	Y	Supporting people with LD's to Sew & Knit		-	40s
Julie	Working Mental Health	Y	B/Red Cross Admin CS-Theatre		Voluntary	50s
Stanley	Sells own Art work	Y	General Administration Charity & Community Care		-	40s
Jack	-	Y	Age Concern Cutting T/nails		Applied for St. Johns Ambulance, FA	30s
Andy	-	N	-		-	40s
Chris	Computer Sales Rep	Y	Charity Shops Oxfam, MIND First Step		-	40s
Sonya	-	Y	Nail Bar, Children's Library, Oxfam, hair Dresser Charity Shops		Children's Centre	20s
Ian	Comi Chef	Y	Gardening, Working in Charity Shops		-	20s
Amelia	-	Y	Cooking for elderly		-	50s
Graham	-	N	-		-	40s

Key to Table
Code = Service User Participant
Y/N= Yes/No   Employed before MI= Employed Before onset of Mental illness
Employed since MI= Employed since diagnosed with a Mental Illness
Type of Work= Work line
Voluntary Work= Voluntary Work

Appendix 9: NLB Mental Health and Employment Project: North London

EG, National Management Trainee in Public Health Reviewed by SL and NO (Public Health) and FD (Mental Health Commissioner)

Contents

1. Introduction

NLB has higher than average levels of benefit claimants in the working age population, both those receiving Jobseekers Allowance (JSA), and Employment and Support Allowance (ESA). In a local catchment area, these figures are even higher, with between 9 and 12% of the population receiving ESA, and an additional 6-7.5% in receipt of JSA.

We know that there is much evidence linking unemployment to poor mental health, including depression, anxiety, psychosomatic symptoms, reduced subjective well-being and reduced self-esteem.[1] We also know that high numbers of benefit claimants in the borough and especially those in the most deprived catchment area encounter many of these problems. Finally, we know from the wealth of evidence that employment, and specifically 'good' work (which is stable, safe and decently paid), has many mental and physical health benefits of employment.[2]

In NLB, there is already a coalition of partners who recognise the links between employment and mental health and are driven to tackle this problem further. These include council departments (Public Health, Employment and Skills, Welfare Advice and Support Hub [WASH]), DWP, The Local Mental Health Trust, the Clinical Commissioning Group (CCG) and others. Employment is also a key priority in the joint mental health strategy for the borough (2014-19).

This document sets out the rationale and plans for a project focusing on mental health and employment in a local catchment area in this NLB. This project will put into practice the interventions that have been established in response to evidence base on mental health and employment.

2. Project Aim and Objectives

The ultimate aim of this project is to improve the health and well-being of people with both mental health issues and employment issues in this catchment area.

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[1] 'Unemployment impairs mental health: Meta-analyses', Paul and Moser, *Journal of Vocational Behaviour*, (2009)

[2] *Fair Society, Healthy Lives: The Marmot Review* (2010), 26-27

This is in order to reduce health inequalities and create healthier, stronger communities.

There are a number of component objectives:

Overall outcomes:

Improved employment outcomes for people with mental health problems or at risk of developing them

Improved mental health and well-being of people with identified mental health problems who are also unemployed (or underemployed/ in precarious employment).

Improved mental health and well-being of all people who are unemployed.

Early intervention/prevention of mental ill health in workplace.

Process outcomes:

Improved pathways between services so that the experience of being both out of work (or underemployed/precariously employed) and having mental health needs is clearer and empowers the user.

Mainstream employment services equipped to understand and deal with mental health issues.

Increased awareness among employers about mental health problems and their impact, and contribute to practical approaches to recruitment and support.

Identification of **evidence-based interventions/approaches**.

3. Approach

Partnership approach Central to this project is a **partnership approach** – in order to secure the best outcomes for the population there must be engagement from a wide range of services/agencies.

The partnership approach centres on knowledge sharing between those with expertise in mental health and those with expertise in employment. This will take place in the form of training, sharing employer contacts and knowledge, and bringing together knowledge of services into a pathway.

The approach will entail co-production with service users, carers and local communities as well as other stakeholders.

This project consists of a steering group and a wider group of stakeholders, the membership of which are listed in Appendix 1.

Focused approach

The approach will be to focus on a designated catchment area for a number of reasons:

To address health inequalities by focusing on the area with the poorest health outcomes in this NLB.

To contain efforts, deliver real outcomes and gain learning which will inform future work.

We will implement these recommendations in this designated catchment area first before replicating elsewhere in the borough.

Evidence based approach

There is an increasing amount of evidence on what works in supporting people with mental health problems into employment, nationally and internationally.

Making use of existing evidence based approached gives greater chance of successful intervention and saves time and resources spent creating unsuitable programmes.

However, this evidence-based approach will be combined with local information and user input to create a solution that is most appropriate for the area and population of this designated catchment area.

Deliverables and project plan overview

Deliverable	Target	Milestones
Mental health training programme	Specific training on mental health awareness, available pathways and referral routes, tailored to individual organisations including: Jobcentre Plus (50 staff in a designated catchment area) Local Volunteer Centre (16 Volunteer involving organisation Work Programme providers (15 Reed staff, Maximus, 5E) Employers	Secure training provider Prepare training (including shadowing relevant team) Deliver training Evaluate training Repeat for each organisation
Two clearly defined pathways: Common mental health problems Serious and enduring me health problems	Production of pathways, which outline available referral routes and support agencies for people at different stages of mental health/employment. Including clear signposting to information, support and advice.	Gather information from all relevant partners including users Create pathways Publicise widely Test out pathway with cohort from designated catchment area
Enhanced provision of IAPT employability	Employability group for IAPT patients and others in designated catchment area – seeing a total of 80 clients.	Recruit attendees – from existing IAPT client base designated catchment area n, then expand to

support	Involvement and training of statutory services and	include Jobcentre and Jobs net referrals
	community groups – so that sustainability of these groups is ensured after year-end.	Organise staff and venue
		Run on a rolling basis – 5-week course repeated throughout the year.
		Track outcomes using IAPT data collection
		Training up of Jobcentre staff and community
		groups to run the sessions independently
Enhanced jobs brokerage provision in a designated catchment area, using the evidence based IPS (Individual Placement Support) model	1 Jobs net staff member to focus on a designated catchment area residents	Appropriate training for Jobs net staff Member Publicise service through existing routes in a designated catchment area Deliver IPS service

Engagement with local employers, starting with The Local Council	What does this look like? Raising the issue at as many employer meetings/forums as possible Working with Jobcentre Plus and Jobs net to approach employers on this issue Mental health embedded in Employment Enterprise board agenda Employment and mental health conference	Promote employment of people with MH problems the Council and support their recruitment Approach 'friendly' employers identified by providers e.g. Reed Organise employment and mental health conference for employers
Evaluation	Undertake evaluation of activities Evaluation of IAPT group through existing mechanisms Evaluation of training programme through questionnaires Evaluation of pathway through capturing experience of coho Evaluation of IPS service through tracking outcomes Formal evaluation report?	

Mental health and employment: project plan for Edmonton

Service users and communities

Mainstream employment support	More specialist/targeted employment support	In-work support

Jobcentre Plus

Work Programme providers

Volunteer Centre

Jobsnet

IAPT employability group

Employers

1. Enhance with training

2. Support with funding

3. Raise awareness and support with training

4. Produce a pathway for mental health and employment

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Project Management, Reporting and Communications

Project management and reporting

The project will be accountable to the Public Health Life Expectancy programme in a designated catchment area. This may be subsumed under the designated partnership in the future.
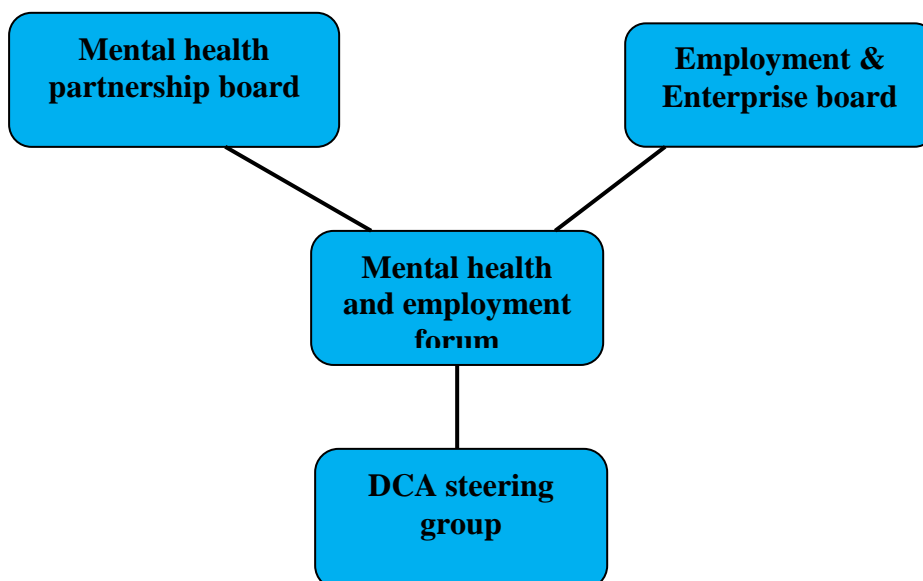
The project will be managed by a steering group, led by Public Health. The membership of the steering group can be found in the Appendix.

It will report back to a **mental health and employment forum**, which includes members of a range of Council departments, DWP, the CCG, mental health and employment services, both statutory and third sector. Organisational membership listed in the Appendix. This forum will meet on a bimonthly basis.

It will also report back to the **Mental Health Partnership board**. This will be via the mental health employment subgroup, currently chaired by James Armstrong. In the future it may be more appropriate to combine this work with the existing work being undertaken by the sub-group.

Finally, the mental health and employment forum will report back to the **Employment & Enterprise board.**

The reporting framework will be in line with the deliverables and measurable outcomes set out in this document.

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┌─────────────────┐              ┌─────────────────┐
│  Mental health  │              │  Employment &   │
│ partnership board│              │ Enterprise board │
└────────┬────────┘              └────────┬────────┘
          \                              /
           \                            /
            \    ┌──────────────┐      /
             \   │ Mental health │     /
              \──│ and employment│────/
                 │     forum      │
                 └───────┬───────┘
                         │
                 ┌───────┴───────┐
                 │  DCA steering │
                 │     group     │
                 └───────────────┘
```

5.2 **Project Communications**

Activity	Communication required	Date
IAPT employability group	Publicising to relevant client groups in designated catchment area	Ongoing
Jobs net service	Targeted publicity in a designated catchment area	Ongoing
Mental health employment pathway	Publicity targeted at organisations and services	Summer 2014 onwards
Employer engagement	Presentations at meetings/forums involving employers Targeted training opportunities	Summer 2014 onwards
Reporting	Mental health partnership board/sub group	Bimonthly

6. Interfaces

Health and mental health	Public Health Life Expectancy Programme a designated catchment area Public Health – Healthy Workplace agenda Clinical Commissioning Group Joint Adult Mental Health Strategy (2014-19) activity NHS mental health services (The Local Mental Health Trust) Council enablement services Third sector organisations: Mind, Richmond Fellowship

	User groups: NLB Mental Health User Group (EMU), NLB Disab[...] Action
Employment	Employment & Enterprise Board (NLB) Council Employment Group Jobcentre Plus/DWP Work Programme providers Third sector organisations: NLB Volunteer Centre
Community groups	Community groups in a designated local catchment area

7. Project Resources

Public Health funding 2014/15

Activity	Costs
Training for Jobcentre and Work Programme staff: Average cost for whole day's training: £250	£4,000
Raising awareness and supporting employers	£7,000
Training for volunteer-involving organisations and employers	£3,000
Production of mental health and employment pathways (staff costs)	£4,000
Enhanced IAPT employability support in a designated catchment area. Staff costs for 0.6 FTE band 6/7 (to include employment work and therapist)	£25,000
Extra funding to support Jobs net in a designated catchment area	£55,000

Evaluation and development fund This may include training and support for groups taking on the IAPT group work role	£10,000
Total	**£108,000**

Other resources:

Crucial to the project is the sharing of knowledge and expertise of professionals in both the mental health and employment fields.

8. Project Risks

Risk	Mitigation
Capacity: staff capacity to carry out the range of interventions in the project plan	Realistic expectations Robust planning of staff time
Complexity: the project contains a whole range interventions which may make it difficult to work on and communicate	Use clear language when presenting and communicating Make clear the distinct section within the project and how they apply to differe groups/organisations. Project members to be skilled in political awareness
Responsibility/resourcing: Joint working may mean unclear lines of responsibility, includin staff time and resourcing Ownership of deliverables: different agendas coming into conflict	Public Health resources set out in this document Good communication in setting realistic expectations Outcomes agreed at meetings and recor

Duplication: Potential for duplication of work by other services	Maintain strong communication links with services and organisations in the area
Sustainability: risk that the activities won't continue after the year end	Plan is for joint working practice to establish a change in culture so that mental health becomes a concern in mainstream employment services Training will contribute to sustainability by embedding practices in organisations Work will include capacity building for statutory services and community groups so they can run future activities themselves.

9. Action Plans

Mental health training			
What?	**When?**	**Who?**	**Outcome**
Training for a designated catchment area ***Jobcentre staff*** *(52 total)*		Public Health	
Secure training provider	April 2014	PS	
Tailor training for organisation	April 2014	PS	Detailed training outline
Deliver training for first cohort and evaluate	May 2014	PS	26 staff trained Evaluation
Make changes based on evaluation if needed	May 2014	PS	Training outline
Deliver training for second cohort and evaluate	June 2014	PS	26 staff trained Evaluation
Reassess needs. Deliver specialist training to selected staff who can offer more support	September 201	PS	2-3 staff trained Evaluation
What?	***When?***	***Who?***	***Outcome***

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What?	When?	Who?	Outcome
Training for Work Programme staff *(? total)*			
Tailor training for organisations			
Deliver training to Reed (15 staff)			
Deliver training to Maximus			
Deliver training to 5E			
What?	*When?*	*Who?*	*Outcome*
Training for volunteer-involving organisation (total 20 organisations)		Public Health/ NLB Volunteer Centre (HP)	
Recruit local volunteer-involving organisations		Local Volunteer Centre	
Tailor training for context	August 2014	PS	
Deliver training session 1 (20 organisations)	September 2014	P S	20 organisations trained Evaluation
Follow up	Periodically –	H P	

		using Volunteer Centre mechanisms		

Mental health and employment pathways			
What?	*When?*	*Who?*	*Outcome*
Pathway for mild/moderate mental health problems		*IAPT* *DWP* *Public Health:* *signposting role*	*Pathway* *(document/flowchart)*
Engage with and map existing services	May-June 2014		
Produce pathway	June 2014		
Sign off	July 2014		
Distribute pathway to services.	Summer 2014		
Test user journey with a group of ident residents in designated catchment are	September 2014 - April 2015	Jobcentre Plus	Track outcomes using health and well-being questionnaire

Capture their experience			
What?	**When?**	**Who?**	**Outcome**
Pathway for severe/enduring mental health problems		**JA/Enablement services** **Secondary care** **Public Health: signposting**	**Pathway** **(document/flowchart)**
Engage with and map existing services			
Produce pathway			
Consult with services, make amendments			
Distribute pathway to services.			

Enhanced IAPT provision			
What?	**When?**	**Who?**	**Outcome**

IAPT employability group for a designated catchment area.	*June 2014-July 2015*	*IAPT* *Public Health support*	Rolling 5-week sessions of the IAPT employability group, focusing on practical employment skills and dealing mood/motivation in applying for work and at work.
Organise staffing	June 2014		IAPT to second staff to run this, and backfill using PH funding
Arrange location	June 2014		Location for weekly group in a designated catchment area
Publicise to existing IAPT clients/ waiting list	June 2014		
Publicise to other partners (JCP, Jobs net)	June 2014		
Run first group	July 2014		Numbers attending
Evaluate before, during and after 5 week course	July 2014		Evaluation forms, retention rate
Onward referral at end of course			Measure destinations
Repeat course on rolling 5 week basis	July 2014- April 2015		7 sessions Total of around 70-90 attendees
What?	*When?*	*Who?*	*Outcome*
Capacity building for local organisations to run the groups in	*September 2014*	*IAPT* *Support from other*	*3 community groups* *equipped to run IAPT-style*

the future	*onwards*	*partners*	*sessions by April 2015*
Make contact with community groups			
Community group representatives to attend and observe IAPT group			
Training for community groups			
Periodic updates on progress/attendan			Numbers attending Destinations on course comple

Engagement with employers			
What?	*When?*	*Who?*	*Outcome*

Enhanced jobs brokerage provision in a designated catchment area			
What?	*When?*	*Who?*	*Outcome*
Dedicated Jobs net member of staff a designated catchment area*, with*		*Jobs net*	*X number seen by jobs broker*

focus on mental health			*X number in training* *X number volunteering* *X number employed*

10. Measurable outcomes

Activity	Outcome	Data located	Timescale
Short Term			By April 2015
Mental health awareness training program	All designated catchment area Jobcentre staff trained	DWP/NLB	
	20 local volunteer-involving organisations trained	Volunteer Centre/ NLB	
	45 Work Programme staff trained	WP/LBE	
	90% positive evaluation/learning outcomes achieved	NLB/trainer: evaluation questionnaire	

IAPT employability group	80 people taking part in UE IAPT employability group (10-15 per 5 week course across the year)	IAPT	By April 2015
	85% satisfaction rating with IAPT group	IAPT/questionnaire	
	70% of participants employed, volunteering or engaged in training after 6 months	IAPT	
	3 community groups trained to run IAPT-style sessions	IAPT/ NLB	
IPS service	Numbers seen	Jobs net	
	Numbers going onto volunteer	Jobs net	
	Numbers going on to further training	Jobs net	
	Numbers going into employment	Jobs net	
	Job retention after 6 months	Jobs net	
	Improved health and well-being of	Jobs net/ NLB questionnaire	

	IPS cohort		
Medium term			
Volunteering	Increased proportion of designated catchment area volunteers reporting a mental health condition	Volunteer Centre	
IPS service	Job retention after 1 year	Jobs net	
Long term			
IAPT	No. Of people accessing IAPT services who move off benefits or sick pay	IAPT/Community and Mental Health Team	
	IAPT recovery rate	IAPT/Community Mental Health Profile	
Health outcomes	% Of adults registered with a GP with a diagnosis of depression (practice level)	Quality Outcomes Framework	
	Well-being risk score (ward level)	GLA tool- Broken down to ward level.	
	Emergency admissions for self-harm (borough wide)	Public Health England – Local Health Profile	

	Directly standardised rate for hospital admissions for mental health (borough wide)	Community Mental Health Profile	
	Employment rate for people in secondary mental health services/gap in employment compared to overall	Public Health Outcomes Framework	
Employment outcomes	No. Of people moving off ESA into work	DWP	

Steering Group: Mental Health Employment Strategy-Designated Catchment Area Group		
Name	**Organisation**	**Contact details**
EG	Public Health, NLB	
NO	NLB	
FD	Mental Health commissioner, LBE/ NLB CCG	
MF	DWP	
AL	Employment and Skills, NLB	
PS	Local MH Service Manager & Lecturer	
JA	Enablement service, NLB	
TK	IAPT NLB	
SS	Welfare Advice and Support Hub, NLB	
MOS	Employment and Skills, NLB	
CD	Mental Health, NLB	
LR	DWP	
HP	NLB Volunteer Centre	
DK	WASH, NLB	
BJ	Mental Health commissioner, CCG	
PP	RF NLB	
MS	North London Mental Health Trust	
AS	WASH, NLB (secondment from DWP)	
MT	Public Health, NLB	
SLB	NLB Mental Health User Group (EMU)	
SK	North London Mental Health Trust	
HVL	IAPT NLB	
AC	NLB Reed (Work Programme)	
EC	Local M (Work Programme)	
RS	Local E (Work Programme)	
JD	RF NLB	
	Mind	
RL	NLB Disability Action	

Appendix 10- North London Consultation Event
NLB Joint Adult Mental Health Strategy
Consultation Event

7 January 2014

12.00	**Arrival and Lunch**	
12.20	**Welcome and Introductions**	GMD, Acting Director of Strategy and Partnerships, NLB Clinical Commissioning Group
12.30	**Overview of the NLB Joint Adult Mental Health Strategy and Questions and Answers**	FD, Interim Joint Commissioning Manager (Mental Health)
1.05	**Bringing the Vision Alive: 3 Examples of How We Plan to Make A Difference** - Accommodation - Employment and Meaningful Occupation Findings from recent research on: Barriers to employment of individuals in a phase of recovery from mental illness in NLB. - A Community Based Mental Health Service	I H, Contracts and Quality Manager, NLB A L, Employment and Skills Commissioning Manager, NLB PS, Service Manager MH Services & Lecturer, CD, Head of Mental Health Services, NLB
2.00	**Your Opportunity to Have a Say: Breakout Session 1** 1.1 Vision, Purpose and Strategic Objectives 1.2 Topic Group: - Accommodation and Flexible Support - Community and Primary Care Based Mental Health Services - Employment and Meaningful Occupation	Group Work
3.00	**Your Opportunity to Have a Say: Breakout Session 2** 2.1 Topic Group: - Accommodation and Flexible Support - Community and Primary Care Based Mental Health Services - Employment and Meaningful Occupation 2.2 Getting Involved	Group Work
3.40 - 4.00	**Summary Feedback from Breakout Sessions 1 and 2 and Next Steps and Close**	All

Important Feat of Data	Interpretat	Code	Theme	Sub Theme
P- I think depression and schizophrenia – depression would be more manageable than someone with schizophrenia. I think the milder of the two. *P- well it depends, people swing the word depression around a lot you can get a girl on her period saying oh I am depressed compared to somebody who cannot get out of bed months on end* *P - It's very hard to classify it depression it could be anything it's very hard to define it.*	Comparing depression with schizophrenia Milder Versus Severe? Depression the word misused Depression versus clinical depression Trying to classify depression Difficult to define	Discussing understanding of level of knowledge on MI	Understanding and knowledge of mental illness	Familiarity with depress-ion and anxiety but poor understanding of schizo-phrenia

Employer Focus Group One: Lines 115- 124

Code definition

Participants make reference to /discuss understanding of mental illnesses.

Appendix 11: Coded data from focus group one & focus group two

Important Features of Data	Interpretations	Code	Theme
P. Personally I <u>don't know a lot about mental health issues</u> *I I am aware that there's a <u>different level</u> of mental health issues, there's <u>different range</u> of mental health issues but that's about it. I'm* <u>not an expert on it,</u> *I haven't, and you know I know it exists. There is I know that it's there but I don't anything about it you know and ah the argument is <u>I'm not a professional so it's not my responsibility</u> to know what level of <u>mental health is acceptable</u> quote unquote for want better word*	Discussing understanding of level of knowledge on MI Mental illness related to different levels of and ranges of. Only experts would know about le and ranges of mental illness Removing knowledg awareness of this from the non-mentally ill. Someone else's responsibility to know about mental illness Certain levels of MI are acceptable?	Discussing understanding of level of knowledge on MI	Understanding and knowledge of mental illness

Employer Focus Group 2: LNs 421-439

Code definition

Participants make reference to /discuss understanding of mental illnesses.