

**Emerging as a worker: Mental health service users'  
transformation through volunteering.**

FEGAN, Colette M.

Available from Sheffield Hallam University Research Archive (SHURA) at:

<http://shura.shu.ac.uk/20200/>

---

This document is the author deposited version. You are advised to consult the publisher's version if you wish to cite from it.

**Published version**

FEGAN, Colette M. (2014). Emerging as a worker: Mental health service users' transformation through volunteering. Doctoral, Sheffield Hallam University (United Kingdom)..

---

**Copyright and re-use policy**

See <http://shura.shu.ac.uk/information.html>

## REFERENCE

ProQuest Number: 10700845

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.

uest

ProQuest 10700845

Published by ProQuest LLC(2017). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code  
Microform Edition © ProQuest LLC.

ProQuest LLC.  
789 East Eisenhower Parkway  
P.O. Box 1346  
Ann Arbor, MI 48106- 1346

Emerging as a worker: mental health service users' transformation  
through volunteering

Colette Fegan

A thesis submitted in partial fulfilment of the requirements of Sheffield  
Hallam University for the degree of Doctor of Philosophy

June 2014

**CANDIDATES DECLARATION**

I certify that this thesis is my own work and confirm that the work undertaken towards the above named Thesis has been conducted in accordance with the SHU Principles of Integrity in Research and the SHU Research Ethics Policy.

.....Colette Fegan

## **ACKNOWLEDGEMENTS**

I would like to thank my supervisory team for their support and advice:

Dr Sarah Cook, Dr Nick Pollard and advisors Dr Frances Gordon and Sally Bramley

I am grateful to the Faculty of Health and Wellbeing in particular the Department of Allied Health Professions for the opportunity to undertake this study and to the occupational therapy team and work colleagues for their support and encouragement throughout my study. Thank you to John Cleak for his time proof reading this thesis.

I extend warm thanks to all the volunteers who kindly agreed to take part in my study.

Special thanks go to my family and friends for all their love and support.

Finally, I would like to dedicate this thesis to my Mum, Dad and Mary who have always supported and encouraged me to just do my best.

## ABSTRACT

The purpose of this research was to provide a theoretical analysis of the dynamic relationship between volunteering and personal mental health recovery.

There is a gap in the literature investigating the current situation in which a substantial number of service users with enduring mental health problems remain excluded from any mainstream paid work and are unable to fulfil a role linked to work activities.

This situation is informed by debates about the concept of recovery, such as what constitutes the quality of that recovery. How volunteering contributes to this process of recovery was the focus of this study.

A constructivist approach to grounded theory was used to explore the impact that volunteering had on personal recovery. The research took place in England and comprised two distinct phases utilising in-depth interviews with a total of 19 volunteers. Methods consistent with grounded theory were employed. The first phase generated categories that were further explored and developed in phase 2 with the aim of theoretical saturation.

Three main categories: finding meaning and challenge through volunteering; crossing boundaries from patient to volunteer and finding the right sort of work supported a substantive theory *Emerging as a worker through volunteering*. This proposes that volunteering when supported can enhance recovery because it fosters positive risk taking and validates a valued identity that integrates an experience of mental ill health. Volunteering provides authentic work experience, a socially valued role and it confirms capability and readiness as a worker. The findings of the study suggest that mental health professionals are in a unique position to build partnerships with service users to support their recovery and vocational aspirations by providing opportunities for volunteering. A framework for supporting volunteering is essential although different models warrant further investigation.

The study has generated a new theoretical understanding of the experience of volunteering for mental health service users in relation to their recovery.

## TABLE OF CONTENTS

### Contents

<b>CANDIDATES DECLARATION</b>	<b>II</b>
<b>ACKNOWLEDGEMENTS</b>	<b>III</b>
<b>ABSTRACT</b>	<b>IV</b>
<b>TABLE OF CONTENTS</b>	<b>V</b>
<b>TABLES</b>	<b>IX</b>
<b>FIGURES</b>	<b>X</b>
<b>APPENDICES</b>	<b>XI</b>
<b>PART ONE</b>	<b>1</b>
<b>CHAPTER ONE. INTRODUCTION TO THE STUDY</b>	<b>2</b>
1.1 INTRODUCTION TO THE CHAPTER	2
1.2 A CONCEPTUAL FRAMEWORK	2
1.2.1 STUDY METHODOLOGY	2
1.2.2 PREPARATORY WORK	3
1.2.3 SITUATING MYSELF IN THE RESEARCH - TAKING A REFLEXIVE APPROACH	3
1.3 STUDY SCOPE	4
1.4 AIMS OF THE RESEARCH AND RESEARCH QUESTION	6
1.5 CONTRIBUTION TO EXISTING KNOWLEDGE	7
1.6 THESIS STRUCTURE	7
<b>CHAPTER TWO: AN INITIAL LITERATURE REVIEW TO PROVIDE CONTEXT</b>	<b>9</b>
2.1 INTRODUCTION TO THE CHAPTER	9
2.2. RECOVERY	10
2.2.1 RECOVERY RELATIONSHIPS	14
2.3 WORK AND MENTAL HEALTH	15
2.4 WORK IS GOOD FOR YOU	18
2.5 WELFARE REFORMS	20
2.6 VOCATIONAL REHABILITATION	23
2.7 CONCEPTS OF WORK	26



2.7.1 HIDDEN WORK	28
<b>2.8 AN INTRODUCTION TO VOLUNTEERING</b>	<b>29</b>
2.8.2 THE DIFFERENT LENSES OF VOLUNTEERING	34
2.8.3 VOLUNTEERING IN THE HEALTH AND SOCIAL CARE SECTOR	38
<b>2.9 CHAPTER SUMMARY</b>	<b>42</b>
<b>CHAPTER THREE: METHODOLOGY</b>	<b>43</b>
<b>3.1 INTRODUCTION TO THE CHAPTER</b>	<b>43</b>
<b>3.2. EPISTEMOLOGY AND ONTOLOGY</b>	<b>44</b>
3.2.1 SOCIAL CONSTRUCTIONISM	44
<b>3.3 THEORETICAL PERSPECTIVE</b>	<b>46</b>
3.3.1 SYMBOLIC INTERACTIONISM	47
3.3.2 INTERPRETIVISM	48
3.3.3 QUALITATIVE RESEARCH	48
<b>3.4 METHODOLOGY</b>	<b>49</b>
3.4.1 THE EVOLUTION OF GROUNDED THEORY	49
3.4.2 SOCIAL CONSTRUCTIVISM AND GROUNDED THEORY	55
3.4.3 REFLEXIVITY	56
<b>3.5 RESEARCH DESIGN AND METHODS</b>	<b>57</b>
<b>3.6 SUMMARY OF THE CHAPTER</b>	<b>57</b>
<b>CHAPTER FOUR: METHODS - PHASE 1 AND PHASE 2 STUDY DESIGN</b>	<b>59</b>
<b>4.1 INTRODUCTION TO THE CHAPTER</b>	<b>59</b>
<b>4.2 OUTLINE OF THE STUDY</b>	<b>59</b>
4.2.1 AIMS OF PHASE 1 AND PHASE 2 STUDY	59
4.2.2 TIMEFRAME FOR THE STUDY	60
<b>TABLE 2. KEY STAGES IN PHASE 1 AND PHASE 2 STUDY</b>	<b>60</b>
4.3.1 STUDY CONTEXT-P HASE 1	61
4.4.2 PHASE 1 RECRUITMENT AND DATA COLLECTION	64
4.4.3 PHASE 2 RECRUITMENT AND DATA COLLECTION	65
4.4.4 THEORETICAL SAMPLING	68
<b>4.5 THE INTERVIEW</b>	<b>72</b>
<b>4.6 THEORETICAL SENSITIVITY</b>	<b>73</b>
<b>4.7 DATA ANALYSIS PHASE 1 AND PHASE 2</b>	<b>74</b>
4.7.2 FOCUSED CODING	77
<b>4.8 PHASE 2 ANALYSIS</b>	<b>77</b>
4.8.1 CONSTANT COMPARATIVE METHODS	78
4.8.2 THEORETICAL CODING	78

4.8.3 MANAGING PRE-CONCEPTIONS WHEN CODING	79
4.8.4 MEMO WRITING	80
4.8.5 THEORETICAL SENSITIVITY AS AN AID TO THEORY BUILDING	81
<b>4.9 ETHICS</b>	<b>84</b>
4.9.1 CONFIDENTIALITY AND ANONYMITY	85
4.9.2 CONSENT PROCEDURES	86
4.9.3 TRUSTWORTHINESS AND RIGOUR	86
4.9.4 CREDIBILITY	88
4.9.5 REFLEXIVITY	88
4.9.6 CONFIRMABILITY	89
4.9.7 DEPENDABILITY	89
4.9.8 TRANSFERABILITY	89
<b>4.10 SUMMARY OF THE CHAPTER</b>	<b>90</b>
<b>PART TWO - FINDINGS AND DISCUSSION</b>	<b>91</b>
<b>CHAPTER FIVE: FINDINGS - FINDING MEANING AND CHALLENGE</b>	<b>92</b>
5.1 INTRODUCTION TO THE CHAPTER	92
5.2 TREADING CAREFULLY AT FIRST	95
5.3 POSITIVE RISK TAKING	98
5.3.1 RISKING HEALTH	99
5.3.2 RISKING POVERTY	102
5.3.3 POSITIVE RISK TAKING - DISCLOSING MENTAL HEALTH	108
5.4 FINDING MEANING AND CHALLENGE	110
5.5 SUMMARY OF THE CHAPTER	125
<b>CHAPTER SIX: CROSSING BOUNDARIES FROM PATIENT TO VOLUNTEER</b>	<b>126</b>
6.1 INTRODUCTION TO THE CHAPTER	126
6.1.1 USING MY EXPERIENCE	127
6.1.2 GIVING SOMETHING BACK	127
6.1.3 HAVING A VOICE	132
6.2 BELONGING AGAIN	133
6.3 CROSSING BOUNDARIES	138
6.4 SUMMARY OF THE CHAPTER	147
<b>CHAPTER SEVEN: FINDING THE RIGHT SORT OF WORK</b>	<b>149</b>
7.1 INTRODUCTION TO THE CHAPTER	149
7.2 LEARNING FROM EXPERIENCE	151
7.2.1 VALIDATING WHO I AM	155

<b>7.3 REHEARSING FOR A NEW DIRECTION</b>	<b>158</b>
7.3.1 VISIONING MY FUTURE	160
<b>7.4. GETTING STUCK</b>	<b>162</b>
<b>7.5 FINDING THE RIGHT SORT OF WORK</b>	<b>167</b>
<b>7.6 SUMMARY OF THE CHAPTER</b>	<b>170</b>
<b>CHAPTER EIGHT: CONCLUDING DISCUSSION - EMERGING AS A WORKER THROUGH VOLUNTEERING</b>	<b>171</b>
<b>8.1 INTRODUCTION TO THE CHAPTER</b>	<b>171</b>
<b>8.2 SUMMARY OF THE EMERGENT THEORY - EMERGING AS A WORKER THROUGH VOLUNTEERING</b>	<b>171</b>
<b>8.3 FINDING AN ACCEPTABLE SELF-IDENTITY</b>	<b>176</b>
<b>8.4 FINDING AN OCCUPATIONAL IDENTITY</b>	<b>177</b>
<b>8.5 FINDING A SOCIALLY VALUED ROLE</b>	<b>179</b>
<b>8.6 ESTABLISHING A WORKER IDENTITY THROUGH VOLUNTEERING</b>	<b>186</b>
<b>8.7 SUMMARY OF THE CHAPTER</b>	<b>189</b>
<b>CHAPTER NINE: CONCLUSIONS AND RECOMMENDATIONS</b>	<b>190</b>
<b>9.1 INTRODUCTION TO THE CHAPTER</b>	<b>190</b>
<b>9.2 REFLECTIONS ON THE STUDY</b>	<b>190</b>
<b>9.3 REFLECTION ON THE AIMS OF THE STUDY</b>	<b>191</b>
<b>9.4 EVALUATING THE CREDIBILITY OF THE EMERGENT GROUNDED THEORY</b>	<b>192</b>
<b>9.4.1 REFLECTIONS ON RESEARCH DESIGN AND METHODS</b>	<b>194</b>
9.4.2 REFLECTIONS ON ANALYSIS	200
9.4.3 RELEVANCE	201
9.4.4 MODIFIABILITY OF THE EMERGENT THEORY AND FUTURE AREAS OF RESEARCH	201
<b>9.5 CONTRIBUTION TO KNOWLEDGE</b>	<b>203</b>
<b>9.6 RECOMMENDATIONS TO ENHANCE PRACTICE</b>	<b>211</b>
<b>9.7 Summary of the chapter</b>	<b>212</b>
<b>REFERENCES</b>	<b>213</b>
<b>APPENDICES</b>	<b>252</b>

## **TABLES**

Table 1	Database search strategy for the literature review
Table 2	Key stages in phase 1 and phase 2 study
Table 3	Table of participant demographics
Table 4	Table of volunteering settings
Table 5	An example of initial coding from phase 1 interview

## FIGURES

- Figure 1      Dimensions of hidden work
- Figure 2      Components of volunteering
- Figure 3      A theoretical framework for the study based on Crotty's Framework (1989)
- Figure 4      Diagram representing categories generated from the data in phase 1 and a tentative core category
- Figure 5      An early memo to support the category that was labelled Crossing boundaries from patient to volunteer
- Figure 6      Diagram showing the relationship between the categories and the core category
- Figure 7      Diagram demonstrating how one of the main categories was constructed '*Finding Meaning and Challenge within Volunteering.*'
- Figure 8      Diagram representing barriers (risks) to engaging with work
- Figure 9      Diagram demonstrating how one of the main categories was constructed '*Crossing boundaries from patient to volunteer*'
- Figure 10     Diagram demonstrating how one of the main categories was constructed '*Finding the right sort of work*'
- Figure 11     Learning from experience
- Figure 12     Diagram to explain the key elements of supported volunteering and how they influence the construction of Emerging as a worker through volunteering

## **APPENDICES**

Appendix i	Phase 1 Local Research Ethics Committee approval
Appendix ii	Local Research Ethics Committee amendment to consent form approval
Appendix iii	Letter to Sheffield Health and Research Consortium requesting change to methodology
Appendix iv	Sheffield Health and Research Consortium response and approval to change of methodology
Appendix v	Letter inviting phase 1 volunteers into the study
Appendix vi	Phase 1 study reply slip
Appendix vii	Phase 1 Participant information sheet
Appendix viii	Phase 1 Consent form
Appendix ix	Sheffield Hallam University Faculty Research Ethical approval
Appendix x	Sheffield Hallam University Faculty Research Ethical approval of amendment
Appendix xi	Phase 2 Recruitment flyer
Appendix xii	Phase 2 Participant Information sheet
Appendix xiii	Phase 2 Consent form
Appendix xiv	Phase 1 and Phase 2 Interview guide
Appendix xv	Example of interview transcript showing initial coding
Appendix xvi	Examples of how coding developed into categories
Appendix xvii	Examples of memos from phase 1 and phase 2
Appendix xviii	Reflection outlining links across phase 1 and phase 2
Appendix xix	Publications

## **CHAPTER ONE. INTRODUCTION TO THE STUDY**

### **1.1 Introduction to the chapter**

The aim of this thesis is to present a substantive grounded theory: *Emerging as a worker through volunteering*. The study presents a constructed identity of mental health service users through the accounts of people with enduring mental health problems who participated in volunteering activities. The research took place in England and comprised two distinct phases utilising in-depth semi structured interviews with a total of 19 volunteers. The first phase generated categories that were further explored and developed in phase 2 with the aim of saturation. A constructivist approach to grounded theory was used to explore the impact that volunteering had on personal recovery, which is the fundamental purpose of this study. This chapter provides a rationale for the research, introduces the research question and provides an overview of the research design and justification for the chosen methodology. The chapter concludes with an overview of the structure of the thesis.

### **1.2 A Conceptual Framework**

A conceptual framework is the researcher's map of the territory being investigated (Miles and Huberman, 1984). Lesham and Trafford (2007) describe it as a structure for organising and supporting ideas and a mechanism for organising abstractions. Thus the conceptual framework can be viewed as an overview of the intended research and the order within that process. Cohen and Manion (1994) describe it as the philosophical intent or motivation for undertaking a study. In this study, the conceptual framework is underpinned by a body of recovery literature, which provides the backdrop to the study. The researcher's map for this study offers only a departure point at this stage of this grounded theory study.

#### **1.2.1 Study methodology**

The study employed a constructivist grounded theory methodology. A grounded theory approach comprises several unique methodological elements for example

theoretical sampling, open and focused coding, constant comparative methods and diagramming (Mills, Bonner and Francis, 2006).

A comprehensive exploration of the literature was undertaken following data analysis. The research study was carried out over two phases. Phase 1 recruited participants from one UK NHS mental health Trust based in the North of England. All participants were engaged in volunteering in the Trust's User Volunteer Service (UVS) and were fully supported by mentors and the UVS. The second phase recruited participants who were volunteering in organisations outside the statutory healthcare sector. The findings from phase 1 informed the questions and theoretical sampling that took place in phase 2.

### 1.2.2 Preparatory work

Phase 1 study developed out of a study that was aimed at evaluating the experiences of service users and staff mentors supported through the User Volunteer Service. This study was funded by Sheffield Health and Social Care Consortium and a report was produced and disseminated at the Trust. At the start of the doctoral journey, a decision was made to move to a more expansive methodology. Approval from both Sheffield Health and Social Care Consortium and North Sheffield Local Research Ethics Committee was obtained, following an application for a substantial amendment. Following supervisory discussions at this early phase it was agreed that the focus of the doctoral research would be on the volunteers' experiences only and this would be followed up by a second, study. The purpose of this was to allow categories from phase 1 to be refined to saturation in phase 2 with new participants who were also volunteers.

### 1.2.3 Situating myself in the research - taking a reflexive approach

In this next section the first person will be employed to present the my perspective as an integral conductor of the research process. Reflexivity is essential in any qualitative research. Lincoln and Guba (2005, p.210) believe reflexivity is the process of reflecting critically on the self as researcher. It is a conscious experiencing of the self as both



inquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of research itself.

Therefore, this research demanded an on-going awareness of the relationship between myself, as researcher and analyst, and the volunteers who were the participants (Barker and Weller 2003, p210). Critical reflexivity relating to my presence and accountability in the research, my process of conceptualisation and interpretation of the data as well as the use of prior experiences and knowledge was therefore required (Clarke, 2005, p13). Reflexivity starts with my own personal values and beliefs about the area of research and an acknowledgement of my personal perspective, as an occupational therapist who worked with mental health service users for ten years, who had an interest in their vocational goals and who, since working in an academic field, has developed a scholarly interest in the area of vocational rehabilitation. This interest also included curriculum development for, and teaching on, a masters' course on vocational rehabilitation. Personal experiences of volunteering from my past are also relevant and shape who I am as a researcher.

### **1.3 Study Scope**

In this thesis reference is made to the term 'work', which is taken to mean a substitute for paid work that is, an activity that denotes productivity requiring physical and mental effort (Oxford English Dictionary [online], 2012). Reference to paid employment is discussed as necessary and as part of the spectrum of work opportunities for people with mental health problems.

The term 'enduring mental health problems' is used in this thesis to describe the population that is the focus of this research as opposed to describing discreet mental health diagnoses. This term has been chosen to describe a population that have mental health problems that are serious and impact on their lives over a period of time. The term also describes mental health when there is a significant functional impact for example sustaining employment. The term is one that is familiar to a mental health and recovery audience of clinicians and researchers.

A rationale for the study is outlined below which is expanded in chapter 2:

- There is little published research into the area of mental health and volunteering (Howlett, 2008) and the papers that seek to explain recovery in the context of volunteering are also sparse in number. In his review of volunteering and mental health, Howlett (2008) identified that there was not enough overlap between those researchers who specialised in volunteering and those who specialised in measurement of health benefits, and the nuances of volunteering had not been considered.
- A substantial number of service users with enduring mental health problems remain excluded from any mainstream paid work and are unable to fulfil a role linked to work activities.
- The dominance of the Individual Placement and Support (IPS) approach (Centre for Mental Health, 2009) within mental health services means that alternative approaches such as volunteering may go unrecognised and are worth considering.
- The role of mental health service users (with enduring mental health problems) as volunteers both in the services from which they received input and beyond has not been investigated in depth and will be a population from which to draw on.
- Recovery stimulates debate about what constitutes 'getting better' after a period of severe mental distress. This is not new but the meaning and quality of that recovery is a key focus of this study and, in particular, how volunteering contributes to the process of recovery.
- Blank and Haywood (2009) propose that it is possible to assist an individuals' recovery journey through applying a broader definition of employment as a meaningful, occupationally focused goal as traditional notions of 'work' and 'career' can marginalise and devalue the experiences of those who contribute through unpaid work activity.
- Gerwurtz and Kirsch (2007) propose that acknowledging the importance of doing and becoming are essential to the process of helping service users with enduring mental health problems to develop their ideas about their potential

for work and their work capacity for the future.

The study will not be addressing the following:

- The work does not intend to provide evidence of an alternative pathway to paid employment as this is not the focus of the study nor does it offer any economic evaluation of volunteering or objective outcome measures of success for those who volunteered.
- Although work is said to be determined by job control, including discretion and choice in work tasks on the part of the worker; the conditions under which some workers are currently exposed e.g. limited full time hours, zero contract hours and general work environments which may not be conducive to wellbeing, will not be a major focus of the present study. Whilst the volunteering environment is of interest contractual elements of paid employment will not be a focus.

#### **1.4 Aims of the research and research question**

Aims:

- To generate theoretical understanding of the experience of volunteering for mental health service users with enduring mental health problems in relation to their recovery.
- To contribute to knowledge that has application to practice and service development

Research Question:

How does volunteering impact on recovery?

## **1.5 Contribution to existing knowledge**

It is important and necessary that this doctoral study recognises that a significant contribution to knowledge is made. The PhD element of this work lies in the potential for new theory to be generated that will help to explain the interrelatedness of the conditions of volunteering and recovery. Specific contributions will include:

- Gaining new insight into how volunteering impacts on recovery, which is significant as previously little attention has been given to the phenomena of volunteering in a mental health context.
- Application of new theory in a practice context will provide evidence for volunteering as part of a vocational rehabilitation process.
- Evidence for the impact of volunteering will inform practice that supports recovery oriented mental health services.
- Dissemination of new mid-range theory to an academic and practice based community. This new knowledge contributes to and develops further ideas in the fields of recovery, occupation, volunteering and vocational rehabilitation.

## **1.6 Thesis Structure**

**Part One** - Chapter 1 provides an introduction and outlines the scope of the study. It proposes a conceptual framework and provides a rationale for the context and direction of the study. Chapter 2 considers a context for the study in terms of reference points within the literature with a backdrop of recovery. This chapter also highlights specific gaps in research. As is the practice within grounded theory approaches the literature referred to within this chapter is developed and extended in chapters 5, 6 and 7. Chapter 3 introduces the epistemological and ontological perspectives. It outlines the chosen methodological approach of constructivist grounded theory. Chapter 4 addresses methods employed in both phase 1 and phase 2 and ethical considerations are discussed which are fundamental to the trustworthiness and rigour of the study.

## **Part Two - Findings and Discussion**

Chapters 5, 6 and 7 present findings from the three key categories and are discussed in the context of extant literature. Chapter 8 presents a discussion to support the construct *Emerging as a worker through volunteering* and this integrates a synthesis of theoretical concepts to support this construct. Chapter 9 presents the conclusions of the study and makes recommendations for practice and further research. The chapter also includes a critical reflection of the study and processes within it.

### **1.7 Chapter summary**

This chapter has provided a context for the reader to examine the scope of the study that drives this research into how volunteering impacts on personal recovery and how my position as the researcher sits within this. The chapter also provides a rationale for the chosen qualitative methodological approach and offers a point of departure within a theoretical framework that informs a review of the literature in the area that is being studied. Finally the chapter offers a signpost to the reader outlining the structure of the thesis in total.

## CHAPTER TWO: AN INITIAL LITERATURE REVIEW TO PROVIDE CONTEXT

### 2.1 Introduction to the chapter

This chapter will provide a context to the study. Definitions of recovery are examined as is the relevance of work to people with mental health problems.

**Table 1. Database search strategy for the literature review**

Databases	Year parameters	Initial search term	Expanded search term
Cinahl	1998-2014	RECOVERY	Personal recovery
Medline		RECOVERY MODELS	Recovery and work
Pub Med		RECOVERY SERVICES	Recovery and
Web of Science		AND ORGANISATIONS	volunteering Recovery and occupation
		WORK AND MENTAL HEALTH THERAPEUTIC WORK AND MENTAL HEALTH	Work paid and unpaid and mental health Vocational rehabilitation and mental health
		UNPAID WORK VOLUNTEERING SUPPORTED VOLUNTEERING VOLUNTEERING AND HEALTH	Volunteering and unpaid work Volunteering and wellbeing Volunteering and mental health Service user volunteering

The issue of how and when to use existing literature, is one that has been the subject of continuing debate. Cutcliffe and Koehn (2007) asked how extensive the literature review should be and a range of grounded theory scholars have differed greatly in their response. Glaser and Holton (2007) propose a purist position in which a grounded theory researcher will enter the field with no preconceived ideas; this includes the literature review as well as interview protocols. Charmaz (2006, p126) states that 'extant concepts need to earn their way into the researchers narrative' and suggests

that delaying the literature search will help to avoid importing preconceived ideas and imposing them on the work and thus help the researcher to better articulate *his/her* ideas. Some of the literature that forms the contextual review was already familiar to the researcher due to its high profile as a body of knowledge and its relevance to her academic interests. Strauss and Corbin (1998) viewed the literature as another voice that contributes to the researcher's theoretical reconstruction in that it can provide examples of similar phenomena that can stimulate thinking that can then be used to examine the data. Stern (2007) expresses a need for honesty in the literature review that ensues from the emergent grounded theory and that it should be possible to demonstrate how the study builds on and contributes to knowledge in the field.

For the present study there was scrutiny of some relevant literature as this was necessary to develop a strong proposal at the initial and intermediate stages of the research process. The literature presented during these stages is used to motivate interest in the area of study and to demonstrate the worthiness of the problem and need for research (Hallberg, 2010). It is a starting point for this study, drawing on a range of literature and concepts in order to provide a context to the phenomena of volunteering and mental health recovery being studied. A literature review is a generic term that considers published materials that provide an examination of recent or current literature considered relevant to the study and can therefore cover a wide range of subjects, including research findings (Grant and Booth, 2009). In the present study analysis of the literature is presented thematically.

## **2.2. Recovery**

Recovery is a movement led by mental health service users and mental health practitioners; away from pathology, illness and symptoms towards a focus on strengths and wellbeing. This can mean continuing to live with or without symptoms such as psychosis (Roberts and Wolfson, 2004). Indeed people can experience wellbeing even within crisis (Roberts and Boardman, 2014). When an individual can step outside the sick role and become a less passive recipient of care then this is one of the most important indicators of progress (Shepherd, Boardman and Slade, 2008).

A review of British recovery literature by Bonney and Stickley, (2008) suggested that recovery concepts in the UK were built on legislative foundations of the disability rights, anti-discrimination and civil rights movements in the 1960's and 1970's. Recovery was seen as a political response to an unsatisfactory mental health system and can be viewed as a set of principles or a doctrine for change. The recovery paradigm rejects the assumption that being diagnosed with a mental illness should lead to a catastrophic outcome. One of the earliest recovery advocates had been the patients themselves and Pat Deegan (1988) a former patient and a clinical psychologist wrote about recovery as follows:

*Perhaps the phenomenon is elusive because it is so fundamental. Perhaps it is because the recovery process cannot be completely described with traditional, scientific, psychiatric or psychological language. Although the phenomenon will not fit neatly into scientific paradigms, those of us who have been disabled know that recovery is real because we have lived it. (p. 12)*

Recovery advocates have made two critical and interrelated claims. Firstly that recovery is a revolutionary new way of seeing mental illness and service delivery and secondly that the mental health system of the past was predicated on a false belief that mental illness was chronic, unremitting and had a life-long impact (Braslow, 2013). Anthony (1993) believed that the recovery concept gave people a vision for a revolution that would target the entire legitimacy of psychiatry.

Andreson, Oades and Caputi, (2003) define four components of the recovery process:

1. *Finding and Maintaining Hope*, believing in oneself, having a sense of personal agency and optimism about the future.
2. *Re-establishment of a positive identity*, finding a new identity, which incorporates illness, but retains core, positive sense of self.
3. *Building a meaningful life*, making sense of illness, finding a meaning in life, despite illness and being engaged in life.
4. *Taking responsibility and control*, feeling in control of illness and in control of life.



Later Andreson, Oades and Caputi, (2006), following extensive interviews with service users, identified five 'stages' of the recovery process.

1. Moratorium - a time of withdrawal characterised by a profound sense of loss of hopelessness
2. Awareness - realisation that all is not lost and that a fulfilling life is possible
3. Preparation - taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills
4. Rebuilding - actively working towards a positive identity, setting meaningful goals and taking control of one's life
5. Growth - Living a meaningful life, characterised by self-management of the illness, resilience and a positive sense of self.

Recovery is debated widely in mental health discourses (Bonney and Stickley, 2008; Shepherd, Boardman and Slade, 2008, Shepherd, Boardman and Burns, 2010; Leamy et al., 2011; Le Boutillier et al., 2011). Anthony (1993) defines recovery as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles and 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 purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery is defined as the reclamation of a fulfilling, meaningful and satisfying life, as defined by the individual themselves (Bradstreet and Connor, 2005). Hope is central to recovery and a belief in one's ability to recover is thought to be instrumental to recovery.

More recently Leamy et al.,(2011) put forward a conceptual framework for recovery, which resulted from a systematic review and narrative synthesis of literature relating to personal recovery. The framework identified five themes from the systematic review which addressed recovery and these were; values of recovery, beliefs about recovery, recovery promoting attitudes of staff, processes of recovery and stages of recovery. The authors perceive that these identified gaps in knowledge did support the underpinning philosophy of recovery. However, this is only in respect to personal

recovery, better understanding of the stages and processes of recovery and identification of valid measurement tools are still needed. These stages are not necessarily a linear process. They are seen as aspects of engagement with the recovery process but are helpful to determine interventions and evaluation strategies.

Research on the process of recovery and conceptualisations of recovery continues to emerge. Le Boutellier et al., (2011), provide a qualitative analysis of what recovery means in practice from an international perspective. They focused on recovery oriented practice guidance and conducted an inductive thematic analysis on 30 documents from six countries. Le Boutellier et al., (2011) found that building blocks for recovery-oriented practice had been proposed in International policy from the UK, US and New Zealand, in research literature and from personal accounts of recovery. They concluded that recovery was a nebulous concept and difficult to apply. However their review did identify common characteristics across the documents which resulted in the CHIME framework that is Connectedness, Hope and optimism, Identity, Meaning and purpose, and Empowerment and this provides a theoretical framework for personal recovery and a sound theoretical base for clinical practice and recovery research (Le Boutellier et al, 2011).

However recovery still remains a contested concept. Edgley, Stickley and Wright., (2012) recognise that recovery is fashionable and is in danger of being hijacked and distorted by policy makers and 'experts' in the field. They conclude that for the future of the recovery movement and the future development of mental health policy then it is for people with mental health problems to develop their own politics, policies and practices of recovery. Edgley, Stickley and Wright., (2012) believe that service users need protection from ideologically driven political interpretations of recovery and 'elite/ expert power' and so called scientific evidence.

Despite widespread support for the concept, Braslow (2013) argues that recovery has become an unquestioned over-arching principle in mental healthcare, further stating it to be '*a melange of beliefs and values that emerged from a number of disparate intellectual and social movements*' (Braslow, 2013). This lack of clarity also extends to

consumers (Aston and Coffey, 2012). To facilitate the translation of policy into practice, there is a need to operationalise personal recovery throughout mental health services, so it can be applied and evaluated within clinical and research settings. Confusion surrounding the meaning of recovery has also raised concerns that recovery has been co-opted by the system (Roberts and Hollins, 2007). This increased scepticism around recovery is common to both staff and consumers, where a number of different concerns have been raised, for example, recovery being the '*next new thing*' (Davidson et al., 2006), tokenism instead of genuine partnership and user involvement (El Enany Currie and Lockett., 2013), and a drive towards autonomy resulting in a withdrawal of support (Vandekinderen et al., 2012) have been expressed.

### 2.2.1 Recovery relationships

Recovery relationships and recovery inspiring role models include both service users and professionals. However, mental health professional's attitudes towards someone with an enduring mental health problem can both perpetuate stigma and create new barriers to receiving treatment. Stigma can originate from the very people in the mental health field who are expected to offer help to persons with enduring mental health problems. Professionals have very negative ideas about their patients and often talk in negative ways about them and have low expectations of them (Corrigan and Kleinlein, 2005). Cook, Jonikas and Razzano (1995) actually found the general public held more optimistic opinions about treatment outcomes for people with enduring mental health problems than were held by mental health professionals. Jorm et al., (1999) suggested that attitudes held by mental health professionals were influenced by the professionals' personal work experiences with clients and by prevailing attitudes of the profession and the professionals with whom they worked. Professional contact may improve general attitudes about people with enduring mental health problems but such contact was not helpful in changing negative attitudes about predicting prognosis and long-term outcomes (Cook, Jonikas and Razzano, 1995). Corrigan (2007), talks about service users adopting learned hopelessness as a result of negative clinical language.

There is criticism in Centre for Mental Health Briefing 47 (2013) that some health professionals do not believe that people with enduring mental health problems are capable of competitive employment Davidson et al., (2008), questioned if this negative outlook impacted on their practice and an assumed lack of hope and optimism was then being attributed to individuals. Sadly these negative attitudes may be conveyed to clients and their families and this may have an influence on their expectations and outcomes. Fear is the most prevalent emotion reported by mental health professionals regarding this population but some other secondary emotions including dislike, neglect and anger (Penn and Martin 1998) are also recognised. Fear is such a strong emotion that may perpetuate stigma by creating more labels that in turn influence clients' behaviours and symptoms. Whilst the recovery paradigm might be an inspiring concept, its links with citizenship and focus on the rights of people to live on equal terms in mainstream society by promoting social inclusion in the community challenges both traditional service structures and the professional narrative about responses to mental distress.

The concept of recovery provides a number of dilemmas about how to develop adequate services not least in the context of financial under-funding. Braslow (2013) asserts that the necessary scaffolding for a recovery-oriented system requires the inclusion of recovery beliefs, values and practices and this is a considerable challenge. Organisations that support recovery orientation need to demonstrate a commitment that in creating and maintaining a work environment and service structure are conducive to promoting recovery-oriented practice (Le Boutillier et al, 2011).

### **2.3 Work and mental health**

Work is important and recognised as a health issue and a major determinant of social inclusion for individuals who have enduring mental health problems (Boardman, 2011). Within mental health services, work has for many years been considered to have therapeutic benefits (Reed, Smythe and Hocking, 2013). There is a desire for practitioners in mental health services and communities to provide real work opportunities to promote social inclusion. This need is also influenced by political and economic drivers that prioritise paid work, leading to a reduction in the support of the

welfare state to those who are unemployed and in receipt of benefits due to their poor health (Garthwaite, 2011).

A report by the Social Exclusion Unit in 2004 demonstrated that only 24% of people with enduring mental health problems were in employment. Later, but prior to the recession, Marwaha et al., (2007) reported that employment rates of only 12.9% still existed, compared with 71% of the general population in the UK. A 2008 survey by the Healthcare Commission established that only 22% of people using specialist mental health services were in paid work or full time education. Richard Berthoud (2009) reported patterns of unemployment in order to assess the impact of the current recession on those disabled people who report themselves as having a limiting long-standing illness. This definition does not provide details of the exact nature or severity of impairments but it has been said to be a definition that exaggerates estimates of the number of disabled people in the working age population and underestimates the extent of the labour market disadvantage (Berthoud, 2009). The employment rate of people with severe and enduring mental health problem is the lowest of all disability groups at just 7.3% (Berthoud, 2009). In 2011, of the 1.18 million people who were in contact with secondary mental health services 136,000 had a serious mental health condition that would require some support to find and keep some form of work. This was reported by the National Mental Health Development Unit.

However the 2012 Care Quality Commission 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. Data on welfare benefit claims shows that the barriers experienced by people with enduring mental health problems are keeping large numbers of people out of the workforce. In February 2013 over 724,000 people were claiming employment and support allowance (ESA) because of mental and behavioural disorders (Centre for Mental Health, 2013).

It is noted that those identified as having an enduring mental health problem are associated with lower rates of workforce participation and higher rates of unemployment overall. They are often employed in occupations that are relatively lower skilled or lower income-earning than would be expected based on qualifications

(Cornwell et al., 2009). In addition to this, people with mental illness, such as anxiety disorders, mood disorders and psychosis and, who also have problems with substance use, have especially low employment rates (Drake et al., 2009) Disadvantage and discrimination associated with their mental health is common (Boardman, 2011, Wright and Stickley, 2013)

Social position and economic circumstances were affected by unemployment in those with depression (Butterworth et al., 2011). Rinaldi et al., (2008) identify individual and structural barriers as well as low expectations from healthcare professionals and a poorly developed vocational rehabilitation service in the UK as contributing factors to someone being able to find and keep work. Barriers to work for people with mental health include the episodic and fluctuating nature of mental illness, a disincentive to work due to fear of financial loss (Harris et al., 2014), stigma and stress in the workplace and fear of disclosure of mental ill health to employers (Bevan et al., 2013, Centre for Mental Health, 2013). Discrimination towards employees with mental health conditions can mean that access to paid employment is restricted and service users can feel alienated and marginalised. Danson and Gilmore (2009) found that employers were wary of employing someone with a mental health condition, fearing that their illness might lead to future difficulties that might result in financial pressure for businesses.

The economic climate that drives a reduction of dependency on the welfare system is a very real concern for people with disabilities. The government uses pejorative terms such as 'worklessness,' 'dependency/ 'workshy' and 'unwilling' when talking about those in receipt of sickness benefits (Garthwaite, 2011). This language stigmatizes an already excluded group and it suggests that work is being avoided.

In a review by Blank, Harries and Reynolds (2011) seven out of the thirteen papers reviewed identified barriers to work as perceived by service users. The stigma that mental health service users perceived was a barrier most commonly expressed (Boyce et al., 2008, Koletsi et al., 2009, Seeker et al., 2001). Seeker et al., (2001) did their survey on work barriers with a large group of service users in one large northern UK city. Seeker et al., (2001) findings, also reflected by Boyce et al., (2008), identified that

disclosure of a mental health problem and a disjointed work history were barriers. The study by Koletsi et al., (2009) again echoed these findings in that barriers to finding work were associated with mental health symptoms. The same study by Koletsi et al., (2009) also identified age, a lack of intrinsic motivation and a lack of work experience as barriers. Whilst these studies are of relevance to exploring barriers they are not all UK based and therefore aspects of the context is relevant primarily to healthcare systems in other countries e.g. US and Australia.

The right to work is enshrined in Article 23 of the United Nations Declaration of Human Rights, which states that 'everyone has a right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment' (The United Nations, Declaration of Human Rights).

However, the financial gain of paid work in an open employment market has not been attainable for everyone (Rinaldi, Montibeller and Perkins, 2011). There has been a strong and longstanding relationship between unemployment and mental health difficulties (Warr, 1987). Furthermore, Warner (1994) made associations between work and quality of life and mental health.

## **2.4 Work is good for you**

There has, for some time, been a body of evidence that supports the fact that work is good for you (Waddell, Burton and Kendall, 2008) and Melchoir et al., (2007), provided evidence that the right work is good for you. The benefits of work go far beyond financial reward. Work is central to the lives and wellbeing of most people and it is important in maintaining and promoting mental health. It is known that apart from financial gains, work when it is the right work for that person, can provide structure and routine, social status, social networks and has far reaching psychosocial benefits to a person, their families and their communities (Honey, 2004, Leufstadius, Elkund and Eriandsson 2009). Evans and Repper (2000) highlighted work as a way in which humans define themselves in the social world, as part of their social identity, but Fryers (2012) cautions that work identity can have conflicting values for many, as it is

not enduring and can be subject to threat from illness, disability, redundancy and retirement.

The Acheson report (1998) provided an evidence base, which outlined the consequences of unemployment and health that was instrumental in formulation of the Department of Work and Pensions (DWP) Green Paper (DWP. 2002). The work of Waddell and Burton (2000) was particularly influential as they focused on an evidence base for the main health conditions that resulted in long term sickness and absence from work. Later Waddell and Burton's (2006) work continued to be influential as their evidence review, commissioned by the DWP, titled: 'Is work good for your health and well-being?' was cited in later welfare reform policy documents (Freud 2007, Black 2008, and DWP 2008). The review synthesised 400 evidence sources relating to adults of working age who had common health problems, including mental health conditions, and the findings from this review have been a consistent and a major influence to validate government's health benefit claims associated with work.

(Waddell and Burton, 2006) concluded that overall:

- Work is beneficial to health and wellbeing.
- Lack of work is detrimental to health and well-being. The unemployed consult their GPs more often than the general population and those who have been unemployed for more than 12 weeks show between four and ten times the prevalence of depression and anxiety. Unemployment is also associated with increased rates of suicide.
- For people without work, re-employment leads to improvement in health and wellbeing and further unemployment leads to deterioration.
- For people who are sick or disabled, placement in work improves health and psychosocial status.
- The health status of people of all ages who move off welfare benefits improves.
- These benefits apply equally to people who have mental health problems including those with severe mental health problems. There is no evidence that work is harmful to the mental health of people with severe mental illness.



In contrast to musculoskeletal and cardiovascular conditions, literature and research relating to mental health has been less visible in DWP's (2002) Green Paper. However, this evidence has since had a stronger prominence in policy related documents, and two independent reports were commissioned by the DWP: 'Working for a healthier tomorrow', which was published in 2008 by Professor Dame Carol Black, the UK National Director for Health and Work and 'Realising ambitions: Better employment support for people with a mental health condition' by Perkins, Farmer and Litchfield (2009). It became apparent through these reports that more support for people with mental health conditions was required (Black 2008).

There has and continues to be a strong focus on the economic drivers for reducing welfare support for those people who do not work as a result of a health condition. The evidence for the right work being good for wellbeing is also acknowledged. However, there has been limited acknowledgment within welfare reforms and policy discourse about claimants' 'lived experience' of illness (Grant 2011, Garthwaite 2011) and the impact that unemployment, worklessness and the experience of receiving benefits has. For example, classic works by Charmaz (1983) and Bury (1982), among many others shows the significant disruption illness can bring to individuals' lives.

## **2.5 Welfare reforms**

People with enduring mental health problems are less likely to be in paid employment than the general population (Marwaha and Johnson, 2004; Rinaldi, Montibeller and Perkins, 2011). In 2006 there were nearly one million recipients of Incapacity Benefit due to mental and behavioural disorders. The Governments' aim was to reduce this number by 400,000 over the next ten years (Oxford Economics, 2007). There is a political, economic and moral imperative to focus the support that is given to service users with enduring mental health problems to include access to work. It has been frequently highlighted that individuals with enduring mental health problems are the fastest growing cause of long-term incapacity in the UK (Waddell, Burton and Kendall, et al., 2008) and the financial impact on the employer of mental health related sickness absence equates to £600 per employee (Centre for Mental Health, 2010).

There are many different measures of worklessness and no single agreed definition (Barnes et al., 2011). People are defined as 'workless' if they are involuntarily excluded from the labour market and in receipt of certain benefits. Separate statistical client groups (as agreed with DWP) have been grouped together to form the composite category of overall workless and include job seekers, those unable to work due to work-limiting illnesses, carers and lone parents (Barnes et al., 2011).

Over the course of this study there has been a change in government and a change in the political philosophy of how work is viewed between both Governments. In 2006, the UK Labour Government set a goal to reduce the number of people claiming Incapacity Benefit (IB) by one million (Fothergill and Wilson, 2007). This goal had high resultant costs associated with supporting this group, especially in terms of welfare benefits and the health-related support that is needed (Black, 2008). Consequently, the Government's welfare reform policies, both under Labour (1997-2010) and the Coalition (2010 onwards), have increasingly focused their attention on this group (Lindsay and Houston 2011, Garthwaite 2011).

The Labour Government viewed claimants to be largely unsupported, and therefore they become 'passive' and 'inactive' (DWP 2002). Thus the aim of these policies was to help restore claimants' motivation to work and reduce dependency (Wiggin 2012) and this ethos was present across both Labour and the Coalition leadership.

Themes underpinning the reforms are:

- ensuring claimants fulfil their moral duty as citizens and contribute to society , this comes along with the mantra of 'rights and responsibilities' and is associated with conditionality measures (Dwyer 2004),
- 'making work pay' by offering claimants financial incentives and
- simplifying the benefit system with the introduction of Universal Credit (Wiggin, **2012**).

At the time of the last Labour Government further justification for these reforms was promoted with the evidence that paid work was beneficial, not only for health and

well-being (Waddell and Burton 2006) but also as a way to reduce poverty and social exclusion (DWP 2002, Black, 2008). New Labour had a key initiative to tackle all forms of social exclusion (SEU, 2004). Their paper *A New Deal for Welfare: Empowering people to work* (DWP, 2006) set out its goal to reform the current welfare system by:

- increasing the number of people who remain in work when they fall sick or become disabled;
- increasing the number leaving benefits and finding employment;
- better addressing the needs of all those who need extra help and support.

The Welfare Reform Act, which came into effect in April 2008, had the intention to radically change the incapacity benefits (IB) system. It aimed to get one million people currently claiming IB back into employment through a mixture of support, incentives and conditionality. Both the current coalition government and the last Labour government have implemented 'conditionality' with respect to the long-term sick and disabled claiming benefits. Conditionality means that the receipt of welfare benefits are conditional on the claimant complying with set conditions. Conditionality measures intend to change peoples' behaviour (Gregg 2008) to ensure that claimants become "responsible citizens" (Dwyer 2004). Benefit sanctions are likely consequences of claimants' inappropriate actions i.e. failure to participate in employment programmes to which benefit claimants have been allocated.

In February 2013 according to Work Choice, over 724,000 people were claiming Employment Support Allowance (ESA) because of mental and behavioural disorders (DWP, 2013). Garthwaite (2011) has highlighted the numerous negative portrayals of people claiming benefits with expressions such as 'culture of worklessness', 'dependency', 'work-shy', and 'unwilling' (p.370). However, these constructions conflict with evidence that reveals that claimants with ill-health do express a desire to work (Beatty and Fothergill 2011). Nevertheless, it is clear that some of this group perceive their enduring mental health problems so negatively that it affects their ability to gain paid work (Beatty and Fothergill, 2011), and also that illness is a contributory factor in why some people are unable to maintain employment prior to claiming benefits (Kemp and Davidson, 2008) and re-enter the benefits system (Black

and Frost 2011). Therefore, claimants' health issues can present real barriers to employment, and health improvements can influence their progression into work (Davidson and Kemp 2010).

## **2.6 Vocational rehabilitation**

Vocational Rehabilitation (VR) as defined by Waddell, Burton and Kendall, (2008 p.10) is "*whatever helps someone with a health problem to stay at, return to and remain in work*".

The Department for Work and Pensions document *Building Capacity for Work: A UK Framework for Vocational Rehabilitation* (2004) put forward the following rationale that VR includes a wide range of interventions to help individuals with a health condition and/or impairment overcome barriers to work and so remain in, return to or access employment. For example:

- an assessment of needs which will look at motivations and barriers to work,
- re-training and capacity building for work,
- return to work management for employees that will support a successful re-entry into the work environment
- reasonable adjustments and control measures to support an employee and employer with specific health or disability needs,
- disability awareness for employers,
- condition management and medical treatment to assist the worker to know how to manage their condition in a work context.

What is implied is that vocational rehabilitation is not the remit of a single vocational rehabilitation specialist; rather it is the joint responsibility of a wide range of professionals and providers, including healthcare, social care, welfare and employment agencies (Waddell, Burton and Kendall, 2008). Furthermore, it is not simply concerned with maintenance or return to paid employment but has a wide remit to facilitate engagement in 'useful occupation' and, as emphasised by Waddell and Burton (2008) it should therefore include education, training, adult literacy, volunteering, unpaid work, caring roles, work placements, job search or other activities related to work.

In the past, people with enduring mental health problems were often referred to day-centres and sheltered workshops, which developed from the old long-stay psychiatric institutions. These were in effect an alternative to employment rather than a stepping-stone and were actually found to reduce people's confidence in believing they would ever regain an ordinary job (Seebohm & Scott, 2004).

Alongside the growth in services that now support a service user to return or remain in work there is a growing evidence base for supported employment particularly the Individual Placement and Support (IPS) model. A benefit of supported employment and in particular the IPS model was seen by policy makers to be the move away from service led provision to being part of a community that will genuinely increase chances of social inclusion.

The Individual Placement and Support (IPS) model is seen as the most credible approach leading to paid employment and the best way forward for those mental health service users who think they are ready for paid employment (Kinoshita et al., 2013, Rinaldi, Perkins, et al., 2008). The IPS model has achieved impressive results in terms of the numbers of people in open employment (Centre for Mental Health, 2013). IPS was developed in the US but has been successfully implemented in Norway, Denmark, Canada, New Zealand and Australia. A six-centre, randomised controlled trial (Burns et al., 2007) found that IPS was twice as effective as the best alternative vocational rehabilitation model available for achieving paid work outcomes. A European RCT demonstrated that IPS was successful at getting a significant 55% of people with mental health problems back into open employment (Burns et al., 2009).

The IPS has key ingredients, which are as follows (Centre for Mental Health, 2009):

- Support for anyone who wants to work
- A focus on real jobs in the ordinary labour market
- Early help to search for jobs
- Employment support from dedicated employment specialists based in clinical teams

- Tailored support in line with personal preferences
- On-going support for as long as needed
- Expert benefits advice

The model is yet to be fully established in the UK, but there are 13 sites of good practice identified that have fidelity to the evidence-based model (Centre for Mental Health, 2013). As many as 50% of England's secondary mental health services still have no IPS workers or teams in place and even the highest performing sites do not provide access to all service users (Briefing 47, Centre for Mental Health, 2013). Consequently in terms of access it is a postcode lottery. In a report, 'Doing What Works', from the Sainsbury Centre for Mental Health (2009) it states that everyone is eligible, but it would seem that the IPS model satisfies a specific population as referral criteria is to be work ready. Grove and Membrey, (2005) say that when someone says they are work ready then that is the time to start to work with him or her. They think that people will lose heart if they have to go through lengthy assessments, work preparation and interview practice.

Establishment of an IPS model has been a great improvement on increasing employment prospects over the past two decades, but it means that a meaningful work role for many still remains elusive for those not deemed ready for paid work. It is clear that this approach has been beneficial for many people but has this growing focus on IPS been to the detriment of any other approach or model that may support people back into work? Blank and Haywood (2009) propose that it is possible to assist an individuals' recovery journey with a broader definition of employment stated as a meaningful occupationally focused goal. It is by developing a sense of self through doing that people with mental health problems can begin to develop the capacity to consider a possible future. Involvement in meaningful work, whether paid or unpaid, has been recognised not just because of economic factors but also for social benefits including raised social status and better time use (Wilkinson 2005, Wilcock, 2006). Holmes (2007) recognises the worthwhile social and economic contributions that people can make outside the paid employment arena, e.g. volunteer role, carer role.

Vocational Rehabilitation is not simply concerned with maintenance or return to paid employment but has a wide remit to facilitate engagement in 'useful occupation' including volunteering (Realising Work Potential, Scottish Government, 2011) and one of the principles of a vocational rehabilitation service should be a pathway to identify appropriate placements in education and volunteering. A paper by Rinaldi et al., (2008) explores the evidence base for a range of interventions that have been aimed at supporting people with mental health problems back into work but volunteering, as a pathway is not acknowledged in any way.

Taking an occupational perspective, humans have an intrinsic drive to be active, to be able to participate in a satisfying daily routine which includes maintenance of self-care, engagement in leisure activities and to fulfil a need to be more productive and make a contribution to the world around us (Dowling and Hutchinson, 2008).

## **2.7 Concepts of work**

Biblical reference to work (Genesis 2: 15) relates to the Garden of Eden when man was placed there "to work it and take care of it." The cultural norm placing a positive moral value on doing a good job is a relatively recent development in society. It has been recognised since ancient times that work plays a central role in all people's lives. Paid work provides a monetary reward and is inseparable from economic productivity with its profits for the employer and its material benefits for society. As well as providing the monetary resources essential for material wellbeing, it links the individual to society (Schneider, 1998; Waddell and Burton, 2006).

The discourse that supports the sociological theme of work can be confusing. It talks about employment to mean open, paid employment in mainstream work and other forms or work have largely gone unrecognised (Glucksmann, 1995). This was largely as a result of a separation of the public and private spheres of work. The public sphere was the site of economically productive industrial labour and was traditionally male dominated, whilst the private sphere was seen as non-economic and the domain of women in the home. These activities were not seen as work and were in opposition to industrial labour (Glucksmann, 1995). The legacy of male industrial labour and the

notion that work and employment are synonymous has been a narrow view of peoples working lives (Taylor, 2004) before and after industrialisation.

Just as the mid nineteenth century encountered cultural and social change as a result of the industrial age then the late twentieth century was greatly influenced by the information age. Work now offered more discretion and choice in terms of workers being able to self-express themselves through their choice of work. This in turn offered more self-fulfilment and work satisfaction.

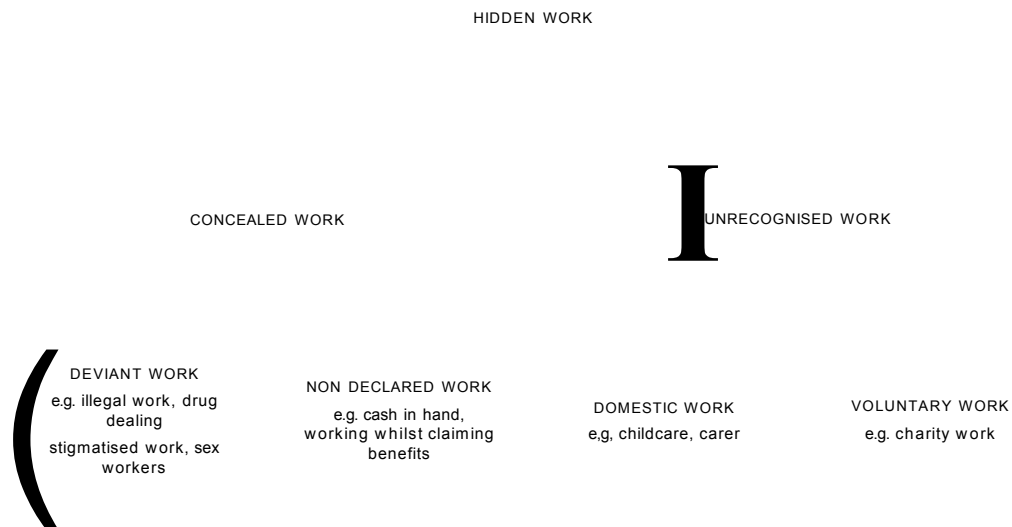
When considering job satisfaction there comes a core belief that the healthy, self-actualised worker will engage actively, mindfully and joyously with work; furthermore the healthiest worker will experience ongoing 'growth' i.e. strive for new challenges and experiences Maslow (2013). In industrial psychology, models of healthy and productive workmanship often define appropriate connections to work in terms of investment and interest, where both too much and too little are undesirable (Noon and Blyton, 2002). Workplace illness is described on a continuum from 'workaholism', described as a state of over- commitment to depression and burnout, described as 'detached concern' and 'distant attitude' towards one's work (Schaufeli et al., 2008

That said the greater proportion of our time is spent in informal economic activities rather than in formal employment (Williams and Nadin, 2012) and understanding how work is organised is important if the notion of work is to be fully comprehended. What constitutes an activity as 'work' whether it is paid or not usually involves the provision of a service to others or the production of goods for the consumption of others (Taylor, 2004)? Furthermore an activity is only deemed productive if it can be performed by someone other than the person who is benefitting (Taylor, 2004).



## 2.7.1 Hidden work

**Figure 1. Dimensions of hidden work (Noon and Blyton, 2002)**



Noon and Blyton (2002) describe 'hidden work' which includes activities that are 'concealed' because they are illegal or attract social stigma, or because the income derived from them is not declared for tax purposes. Hidden work also includes a variety of 'unrecognised' work, (see Figure 14 below) which is hidden because it does not attract payment, so this work is not recognised in an economic market but also it is not considered to be 'real work', and this includes volunteering. Conceptually volunteering can substitute for, compensate or complement paid work (Rochester et al., 2010). Tilly and Tilly (1994) recognise volunteering as one of the categories of work, the other three being labour markets, the informal sector and household labour. Volunteering is seen to sit alongside other work roles that an individual undertakes. It is distinguished from the labour markets and the informal sector as it is uncommodified and it is distinguished from household labour as it is freely undertaken. Tilly and Tilly, 1994 define volunteering in this context as 'unpaid work provided to partners to whom the worker owes no contractual, familial or friendship

obligation. Volunteering as work has a number of distinct elements apart from financial remuneration.

For many years, formal and informal economies were represented as separate realms and hostile worlds (William and Nadin, 2012). This is now being contested. Rather than perceiving formal, paid work to only have positive qualities and be progressive recent work practices, exemplified for example by zero hours contracts challenge this perception. Similarly informal economic work activities thought to have only negative economic qualities and always be regressive, for example volunteering is not only about reciprocity but it has positive, health affirming benefits to the volunteer and could be open to exploitation. Traditional notions of 'work' and 'career' can marginalise and devalue the experiences of those who contribute through unpaid work activity and render those who do not conform to a traditional paid work activity as invisible, thus limiting an understanding of their work identity and the practical realities of their working lives (Taylor, 2004).

## **2.8 An introduction to volunteering**

Defining volunteering is not without its challenges. It has been viewed as a mutually beneficial exchange, as social participation and unpaid but productive work. Formal volunteering is "an activity that involves spending time doing something that aims to benefit the environment, individuals or groups." (The Compact, 2008 p.4). The notion that volunteering is essentially altruistic is not universal as it is proposed that there is a mutually beneficial exchange relationship and it is something that provides benefits to the individual, be it enjoyment, skills, or the sense of having given something back. There is also recognition of the significant benefits for those who volunteer (Ellis, Hill and Rochester, 2010). A literal definition of 'formal' volunteering means '*unpaid work that benefits others to whom one owes no obligation*' (Wilson and Musick, 1997, p.695). Graham, (2004 p.16) warns there are "so many stereotypes have become attached to volunteering that they make it difficult to conceptualise and define".

A policy led definition of volunteering was developed for the United Nations, International Year of the Volunteer (2001), which identified 3 characteristics. Firstly, that there should be no financial reward although reimbursement of expenses is

permitted. Secondly the activity should be undertaken voluntarily according to the individuals' own free will. Thirdly the activity should be of benefit to someone else or to society at large. Conversely informal volunteering is any assistance given directly to individuals, which is not through a formal organisation, for example helping a neighbour or friend.

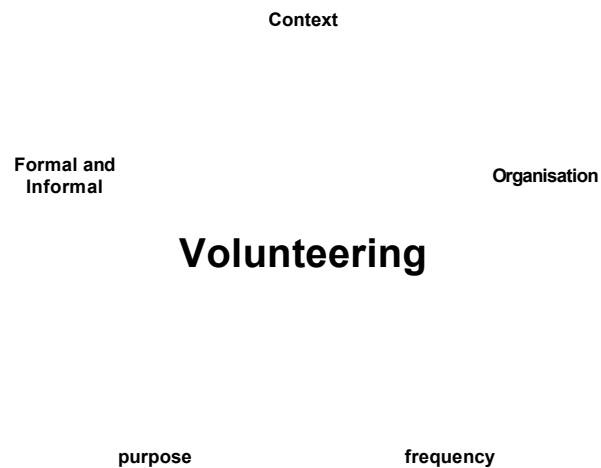
The notion that volunteering is essentially altruistic is not universal and Howlett (2008) recognises that it is a mutually beneficial exchange relationship and it is something that provides benefits to the individual, be it enjoyment, skills, or the sense of having given something back. Recognition of these benefits is outlined in The Russell Report (2005). There is no one lay definition of volunteering within and across countries but in an international study reported by Howlett, (2008) the links between social exclusion and volunteering the most commonly understood idea was that it was work without pay. The second most common notion was that it involved offering time and help to others and embedded in this view, was the perception that it involved a cost to the volunteer that was greater than any benefit they might receive from the activity. Interestingly a study by Handy et al., (2000), suggested that the public perception of volunteering is that those who participate have a net cost. Meijs et al., (2003), reported this in a study spanning eight countries. The authors conclude that the application of net-cost to understanding volunteering is helpful in defining who is a volunteer. The same study described the net-cost concept as the common denominator of all four dimensions of volunteering previously identified by Cnaan et al., (2010), these being based on a comprehensive review of the literature at that time and these are: free will; lack of material reward; benefit to others; and formal organisation.

### 2.8.1 Dimensions of Volunteering

Another way to try to make sense of the diversity of activities is provided by three broad perspectives, non-profit and civil society are the first two (Lyons, McGregor-Lowndes and Donoghue, 2006) and the third perspective is volunteering as serious leisure (Stebbins and Graham, 2004). Each of these three perspectives can be considered in terms of motivation, activities, organisational context and the

volunteers' roles. This figure presents different components that can be attributed to volunteering.

**Figure 2. Components of Volunteering**



There are different types of volunteering activities. The following typology was developed for the UN International Year of the Volunteer (2001). Four types have been identified which are related to the purpose of the activity:

1. **Self-help or mutual aid:** this is the oldest form of voluntary action in which people with shared problems, challenges and conditions work together to address or ameliorate them. This is sometimes described as 'by us for us/
2. **Philanthropy and service to others:** this typically involves an organisation recruiting a volunteer to provide a service to one or more third parties.
3. **Participation:** this is where volunteers are involved in the political or decision making process at any level, from participation in a user's forum to holding honorary office in a voluntary sector or community sector organisation.
4. **Advocacy or campaigning:** collective action aimed at securing or preventing change.

Ellis-Paine, Ockenden and Stuart, (2010) suggest a fifth addition; Expressive behaviours. This is involvement in an activity to fulfil a personal interest and passion e.g. the arts or sports sector.

Ellis-Paine, Ockenden and Stuart, (2010) questions whether there is a clear understanding of what volunteering is and whether the multiplicity of the activities it encompasses is recognised. It specifically highlights examples of when volunteering has been used to enhance health and wellbeing, or to develop skills and behaviour to enable the unemployed become more employable or as a way of overcoming social exclusion. That said the 'one size fits all' approach to how volunteering is supported by national agencies and what determines good practice is questioned (Howlett, 2010). It is recognised that if there is a better understanding of what constitutes 'good practice' across a wider range of volunteering activities then this can only be beneficial and might lead to a more inclusive definition of volunteering.

Concerns have been raised about developments within the policy and practice of volunteering. There is an on-going debate within the volunteering movement about the utility of volunteering. The term itself attracts a stereotype and volunteering is seen by some as not 'real work' and because there is no formal contract and so its value as work preparation can be problematic. However there is a recognition that volunteering is changing as is the context in which it takes place (Rochester, Ellis-Paine and Howlett, 2010). This is discussed later in this chapter.

Another way to classify volunteering activity is by the amount of time one spends volunteering and the work of Macduff (2005) and Hustinx, Cnaaan and Handy, (2010) who suggests that frequency of volunteering can be defined through the following categories:

- micro volunteering;
- episodic;
- serial episodic;
- short term episodic
- longterm and sporadic longterm volunteering.

Ellis-Paine, Ockenden and Stuart, (2010) suggest an additional three typologies to consider when categorising which are temporal dimensions of frequency (how often?), amount (how much?) and length (for how long?).

Another way to try to make sense of the diversity of activities is provided by three broad perspectives - non-profit and civil society are the first two and the third perspective is volunteering as serious leisure (Stebbins, 1996). Each of these 3 perspectives can be considered in terms of motivation, activities, the organisational context and the volunteers' roles. Ellis-Paine, Ockenden and Stuart, (2010) also highlight that historically volunteering has rarely been conceptualised as a field in isolation. More often it is taken from the perspective of a broader phenomenon such as work, leisure or participation. The concept of volunteering as participation underpins the current Government's policies that support volunteering, seeing it as an overtly pro-social activity (Evans, 2011). Volunteering is a way of getting more people involved and engaged with their community and allows them to participate in unpaid work that has meaning for them. This can lead to skills development and in some cases paid work.

When voluntary work is unpaid yet productive, volunteering can also be viewed through the lens of work (Rochester, Ellis-Paine and Howlett, 2010). It is a job people do for free, for the benefit of a community (Stebbins and Graham, 2004). Volunteering is a role that fits alongside others but for unpaid work there is no contractual obligation (Restall, 2005).

Howlett's review (2008) of volunteering and mental health found that there was a 'mushrooming of supported volunteering schemes' aimed at people with disabilities but people with mental health problems were under-represented as volunteers. It is not fully understood why this is the case, but Howlett (2008) put forward two options:

1. Organisations are not doing the right things to encourage people with enduring mental health problems to volunteer
2. Under representation may be due to personal circumstances of potential volunteers and motivations would be connected to mental ill health.

The social and financial impact of volunteering to support mental health service users should not be underestimated. Community Service Volunteers (CSV) a leading UK volunteering charity formed a partnership with Trusts and councils in London as part of a four year funded project, *Capital Volunteering*. Grants were given to volunteer projects to tackle social exclusion for people with enduring mental health problems and involved 150 volunteer opportunities. An evaluation report (Murray, Bellringer and Easter, 2008) highlighted benefits to skills attainment, social networks and a reduction in inpatient hospital stays and contact with health professionals. A significant proportion of the volunteers continued to make a contribution as volunteers once the project had ended. A report from CSV (2008) also demonstrated positive outcomes for mental health service users in an NHS Trust in the Midlands that worked with CSV in partnership to provide volunteering opportunities to 70 service users. In summary volunteering as a social phenomenon offers a number of definitions and typologies and is dependent on context and meaning. It is formal volunteering that is central to this study.

### 2.8.2 The different lenses of volunteering

Volunteering is complex, as discussed there is no one clear definition of volunteering and the way in which volunteering is carried out is diverse. The motivations of volunteers and the context in which they volunteer can be understood by a consideration of the different lenses through which volunteering can be viewed.

Volunteering can be viewed through the lens of work (Rochester et al., 2010) as a job people do for free, for the benefit of a community (Stebbins and Graham, 2004) where volunteering is a role that fits alongside others but for unpaid work there is no contractual obligation (Tilly and Tilly, 1994). A report by Bashir et al., (2013) found that disadvantaged groups including those with mental illness succeeded in assisting 22% of participants into paid work. This was a focused study concentrating on 15 volunteer centres across England in areas of economic deprivation. In the same report Bashir et al., (2013) suggests that volunteering is not a universal solution but it does conclude that volunteering can help people to progress towards the labour market and employment.

A second lens through which volunteering is viewed is philanthropy (Ellis-Paine et al., 2010). Volunteering is seen as one part of a spectrum which includes charitable donations and those who view volunteering in this way are often based in the non-profit sector where volunteering is a form of service provision. Volunteers are seen as a resource that can be utilised by organisations and as with volunteering as work there is a danger of commodifying the volunteers' involvement. However unlike work when volunteering is seen as a resource, it is also seen as a gift to the beneficiaries of the service they are providing. This evokes images of wealthy, privileged benefactors. Activities are almost exclusively formal and most often carried out in social welfare organisations that provide public services, which are more specifically likely to be large organisations and in the main well-resourced third sector organisations.

Volunteering in this context de-politicises volunteering, it is an act of charity rather than anything more activist. That said the current economic climate and pressure on voluntary organisations in the third sector are not without their political influences such as when volunteering can be viewed as covering up gaps in state provision of services and therefore an attack on people's human rights. For example volunteers that run food banks have been praised by the Coalition for their philanthropy, but criticised by others for masking the effects of government policy that create poverty and hunger (Agostino and Paco, 2012). Volunteering is something, which largely sits alongside the state directly, in partnership, or indirectly to deliver social welfare provision. However, when volunteering is there to support activism it can be viewed as acting in direct opposition to the state.

The third lens through which to consider volunteering is that of activism. This incorporates aspects of self-help, mutual aid, advocacy and campaigning. Rather than being seen as a resource to deliver a service volunteers are with the organisation to meet shared needs and address common problems (Rochester et al., 2010). Motivations are rooted in self-help and mutual aid and notions of management or even recruitment might be at odds or even an anathema. Instead there is an emphasis on roles emerging, developing and diversifying over time. When volunteering is utilised to support activism there is a gap in that research. There are likely to be clear mutual



benefits and the relationship between the volunteer and the organisation for which they volunteer is more symmetrical and equal. Motivations may be intrinsic and extrinsic or even mixed. Motivations such as solidarity, common causes, altruism, self-help and mutual aid are key drivers for volunteers and the organisations where they volunteer. For some large organisations activism might be one of the foci of volunteering but they may also have other volunteer roles, which meet other needs. Greenpeace, an organisation in which volunteers campaign for environmental causes using direct action, would be such an example.

Historically little attention has been given to volunteering within leisure studies although there are some exceptions. Stebbins and Graham's (2004) work argue that volunteering is leisure because it is unpaid and uncoerced. They would argue that the reason someone volunteers is because of the enjoyment and satisfaction they gain. Stebbins and Graham (2004) argue that although there is an element of obligation in volunteering, it is a flexible obligation and it is this that distinguishes it from work or personal obligation. Henderson (1984) sees motivations to be intrinsic. Stebbins and Graham, (2004) believes that there needs to be a clear distinction between volunteering and paid work. When it is seen as a productive output there is a danger that volunteers are viewed, assessed and valued in the same way as staff and this compromises their leisure experience. For some this trivialises volunteering when considered in leisure terms only as it ignores the personal sacrifice people make to volunteer. Also by viewing it only through the 'leisure' lens it omits the needs and impact it has on beneficiaries and society (Ellis Paine, Hill and Rochester, 2010).

Care includes paid care, care for family members and care for strangers, which can take the form of volunteering. Feminist scholars have paid attention to the exploration and development of ethics of care (Abma and Baur, 2014). Care is something to be celebrated as a human strength but is more often displayed by women but can be displayed by men as well. There are however, concerns of the value care is given and the lack of recognition that exists when an activity involves caring. (Zukewich, 2003) does not believe that volunteering which involves a care activity will be given the recognition it deserves until an objective measure can be made of the social and

economic costs and how this relates to an individual's capacity to engage with the workforce. Musick and Wilson, (2008) want to separate the concept of care from volunteering as they argue that the volunteer may have come into volunteering as a result of being a 'carer' for a relative or a person close to them or for a group. They believe that due to being part of an institutional structure, to carry out this specific function or role they have to detach themselves from the intimacy of a caring role. They argue this should be classified as care (work). The boundaries of care for a relative or a stranger further confuse the debate when trying to categorise volunteering.

Brodie, Cowling and Nissen, (2009) define public participation as engagement of individuals with the various structures and institutions of democracy e.g. being a councillor. Social participation refers to collective activities that individuals may be involved in as part of everyday life and that are statements of the kind of society they want to live in e.g. Fair trade consumption, greener energy.

The concept of volunteering as participation underpins the current Governments policy areas in support of volunteering, seeing it as an overtly pro-social activity. Volunteering is a way of getting more people involved and engaged with their community and allows them to participate in projects that are real for them. Theories of social participation, social capital and political engagement support this area. Ockenden, Hill and Stuart, (2012) provides evidence that volunteering can lead to an increased sense of belonging and it offers increased access to those excluded from other social spheres. It can be a form of positive social engagement. However there is evidence that volunteering can also replicate exclusionary features that can be found in work and politics.

Volunteering has been explored as an aspect of learning, training and development. Volunteering can provide a unique setting for specific learning to take place. Work by (Oakenden and Hill, 2009) links volunteering to lifelong learning. There has been considerable policy interest in the skills that can be developed both from the point of view of volunteering as general lifelong learning but also the association that volunteering has with training and retraining for the workplace (Russell, 2005). There is

much research to support skills development and learning through volunteering (Oakenden and Hill, 2009) but there is little theoretical underpinning that conceptualises volunteering in the context of learning (Ellis-Paine; Oakenden and Stuart, 2010). There is a caution that by viewing volunteering only through the 'learning lens' then it can reduce volunteering to just a means and not a valued end in itself.

By considering this range of lenses through which volunteering can be understood it provides insight into this multidimensional and complex field. It allows the reader to think about how volunteering as one social phenomena can be linked to other related social phenomena in order to enhance a broad conceptualisation of volunteering. It is also helpful to consider the different lenses of volunteering to gauge some of the motivations and expectations that are placed on volunteers. It is however important not to take the lens too literally as there is constant overlap between the lenses affirming the complexity that is volunteering.

### 2.8.3 Volunteering in the health and social care sector

It is within the context of health and social care and driven by a change to a coalition Government that this literature sits. The place of volunteering to support the Big Society (Evans, 2011) is potentially key to Governments aspirations to grow volunteering. The Big Society concept involves three key elements: 1. Opening up public services and thus enabling voluntary organisations, charities, social enterprises, and employee-owned co-operatives to compete to offer public services. 2. Social action through encouraging and enabling people to play a more active part in society. 3. Community empowerment by giving local councils and neighbourhoods more power to take decisions and shape their area. However it remains to be seen how the long-term impact will influence opportunities for volunteering and how more vulnerable groups will be supported.

It is estimated that at least 3 million people volunteer in the health and social care sector (Mundle et al, 2012) and it is more commonly evident in the public and third sectors. Broadly speaking women volunteer in this sector more than men and participation is higher in white groups compared to ethnic minority groups (Drever,

2010). Older people are more likely to volunteer on a regular basis in health and social care and this age group has attracted more research of their experiences and their contributions to volunteering (Morrow-Howell, (2010); Konrath et al, (2012); Gottlieb and Gillespie, (2008). Younger people will engage in irregular volunteering and those educated to degree level were more likely to be formal volunteers in the health and social care sector (Drever, 2010). In health and social care settings volunteer services have the possibility to be creative and responsive to local needs (Mundle et al, 2012).

Hard to reach groups and gaps in statutory provision are sometimes addressed through volunteering and national data sources suggest that for-profit organisations less commonly encourage volunteering. Hussein, (2001) thought the low numbers of volunteers in for-profit organisations was reflective of a philosophical objection for some volunteers to work in for-profit organisations.

In a study that looked at the volunteering that took place in social care (Hussein, 2011) it was found that volunteers represented approximately 1% of the workforce; that over 700 organisations indicated they had volunteers; and that most of these were placed in the voluntary sector (3.9%) rather than the private (0.2%) or local authority (0.1%). In voluntary sector health and social care agencies alone, volunteers accounted for 22% of the workforce and in those organisations that had more than one volunteer this constituted nearly a quarter of the whole workforce. Most volunteers were of white ethnicity and 13% of these had a disability; one third were male which is quite high compared to a predominantly female workforce and they covered the full age range spectrum, up to and over 65.

Whilst Hussein's (2011) study found that disabled volunteers were represented in social care, research into active service users volunteering although limited was a focus for George and Singer (2011) who looked into people with mild to moderate dementia and Farrell and Bryant (2009) focused on those with mental health problems. Overall those with disabilities are less likely to volunteer than the general population.

Volunteering roles in health and social care include for example: participation in planning, consultation, advice and research in health (Payne, 2011); service delivery (Buman et al, 2011; Paylor, 2011); and signposting for other service users or navigators

of the health system (Cook, 2011). Hussein, (2011) found that volunteers were offering counselling and peer-support, advocacy and advice to individuals and families. Casiday et al, (2008) focused their research on those volunteering to provide support and respite care and Sevigny et al, (2010) looked at how volunteers contributed by fundraising and providing administrative duties. Volunteers are offering their time and skills in a full spectrum of services across the health and social care sector. This includes hospices (Brodie et al, 2011) and home care, thus offering a 'fluctuating space' between formal and formal / private care and public settings (Sevigny et al, **2010**).

Kennedy et al, (2007, 2010) also researched the volunteering that took place in the health and social care sector but in non-NHS sectors. The value to those (patients, service users, carers) who benefit from volunteers in health and social care is multi-fold. However it must be noted that due to the complexity of this phenomena it is not always clear whether associated benefits of receiving support from a volunteer can be reliably attributed by causality in these studies. Increased self-esteem, improved disease management and acceptance were evident in a Department of Health study, (2011) and there was also a perception of improved relationships with professionals. Farrell and Bryant, (2009) and Sevigny et al, (2011) found that volunteering reduced social exclusion, isolation and loneliness and in a study by Week et al (2008) service users reported benefits of input from 'experts by experience' and were seen to be more independent outside formal support structures. Work by Morrow-Howell (2010) remains inconclusive about which groups benefit more from being a volunteer, but they did find that those with fewer social networks and social resources reported the most benefits.

A number of studies considered the health and wellbeing benefits of volunteering. A significant finding was that older retired volunteers, when compared to their non-volunteering peers, were found to have fewer incidences of depression, better cognitive functioning, higher reported mental wellbeing and life satisfaction (Morrow-Howell, 2010).

Volunteering was seen to provide roles and social ties leading to improved social integration and well-being, improved self-esteem and life skills (Farrell and Bryant, 2009). In studies by Paylor, (2011) and Brodie et al., (2011) volunteering was reported to have helped develop connections and networks, avoid boredom, keep fit and healthy and develop and improved sense of community. Mundle, Naylor and Buck, (2012) express caution about the validity of the strong associations made between volunteering and health and wellbeing and limitations of evidence in this area where volunteering per se was considered rather than specific roles (Casiday et al., 2008) must also be acknowledged.

A British survey of volunteers with enduring mental health problems reported that 'formal' volunteering can protect role identity and psychological wellbeing (National Centre for Volunteering, 2003) and that, furthermore, volunteering was thought to provide altruistic and egotistic motivations. Black and Living, (2004) in a mixed method UK study looked at the motivation of individuals with mental health problems in relation to volunteering. They found that individuals volunteered for altruistic and egotistic reasons and that as volunteers there were benefits to their mental wellbeing which translated into improved social functioning. Farrell and Bryant (2009) found conflicting and inconclusive evidence from their review of volunteering which was specific to mental health. Mundle et al (2012) found evidence that volunteers can become demotivated: if they cannot meet other patients' expectations; if opportunities for volunteering are of poor quality; and also, for some, if they experience 'burnout'. Problems also arise when there is a lack of clarity among professionals about the role of the volunteer (Cook 2011).

There have also been a number of studies carried out in the USA. Greenfield and Marks (2004) considered volunteering to have protective factors including protection from loss of role identity and that this was also linked to psychological wellbeing. The study was however limited to an older population. Again, although data is only available for a population of over 65's, Li and Ferraro, (2005) found that formal but not informal volunteering had a beneficial effect of on depression and Musik and Wilson (2003) reported that the benefits of volunteering are also experienced differently and at different times across the lifespan. They found that volunteering lowered

depression for over 65's but not for under 65's and also that when people were volunteering for religious reasons volunteering was perceived to be more beneficial than when volunteering for a secular cause. Sustained volunteering was found to be beneficial in both groups.

## **2.9 Chapter summary**

This chapter has presented a context for recovery in terms of its meaning, philosophy and values for an individual service user with enduring mental health problems. The chapter highlights and addresses some of the challenges that a recovery oriented system can present. The chapter helps to position this study within a recovery paradigm but draws on literature related to vocational rehabilitation and volunteering as a vocational pathway. This chapter also explores the literature in relation to work and mental health. It has acknowledged the place of work in society and the dimensions that reflect both paid and unpaid work. The place of vocational rehabilitation in contemporary mental health care is noted and key changes to welfare reform that have taken place over the course of this study have been highlighted to provide a political context. The chapter concludes with an exploration of definitions and typologies of volunteering. The range of lenses through which volunteering can be explored are also presented. This review of the literature provides a departure point for the study.

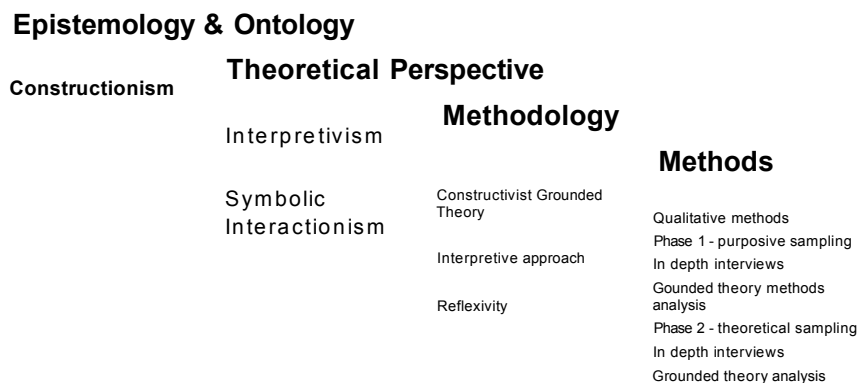
## CHAPTER THREE: METHODOLOGY

### 3.1 Introduction to the chapter

This chapter will present the methodology underpinning this study. It will consider the philosophical and theoretical perspective of the researcher and how it relates to the chosen area of study. Qualitative research and in particular constructivism will be examined. The chapter culminates with a short historical perspective on grounded theory and consideration of the chosen constructivist approach that has been adopted in this study.

The aim of this grounded theory study is to provide a theoretical interpretation of volunteering and its dynamic relationship with personal mental health recovery. A unique feature of grounded theory methods is theory building and this chapter provide a clear rationale for the study's philosophical perspective and subsequent research design decisions to support this approach.

**Figure 1. A Theoretical framework for the study based on Crotty's framework (1998)**





### 3.2. Epistemology and Ontology

Crotty (1998) distinguished between different frameworks of research on the basis of their grounding in epistemology. Epistemology according to Crotty (1998) is the theory of knowledge and this provides the foundation for research and on this the theoretical perspective is built. Methodology refers to the overall strategy for conducting the research and the methods to be used are selected accordingly. The strength of Crotty's framework is that it provides a format for the researcher to conceptualise and clarify the foundation for the research. Some authors, for example Cresswell (2007) prefer to discuss the interpretive framework that is relevant to this study in terms of 'knowledge claims', or even research methodologies (Neuman, 2000) rather than refer to paradigms. The use of different terms in different texts can lead to confusion.

#### 3.2.1 Social Constructionism

Social constructionism has its origins in sociology and first emerged some 30 years ago. It is associated with postmodern qualitative research. It takes an essentially anti-realist stance (Hammersley, 1992) and has a resonance with current approaches to grounded theory (Charmaz 2006). An understanding of its core concepts is important in evaluating its impact on the methodology employed in the present study.

The term constructionism has a social focus and the term constructivism proposes that individuals construct the world of experience through cognitive processes (Young and Colin, 2004). The constructivist researcher does not begin with a theory rather they generate or inductively develop a theory or pattern of meanings (Cresswell, 2007). By adopting a constructive approach I wanted to explore the worldview of mental health service users and their reality of volunteering and the impact this had on them in terms of their recovery and the processes involved. Charmaz (2006) recognises that as a researcher in grounded theory the researcher has guiding interests, in this case recovery and meaningful occupation. I also have a professional context of occupational therapy as well as experience as a volunteer. These concepts and positions are only a starting point and Blumer (1969) cited on Denzin (2004) says these concepts provide a loose framework, which is then sensitised through particular kinds of questioning.

Charmaz (2006) describes this as a departure point and the researcher then evaluates the fit between their initial research interests and their emerging data.

Sismondo (2004) claims that the vast majority of studies drawing on constructionist ideas adopt the mild or contextual form of analysis, where a distinction is maintained between what participants believe or claim about the social world and what is in fact already known.

Andrews (2012) summarised the approach by saying that a strict constructionist position has a scepticism about ontological claims of truth. They say that whilst the constructionist perspective does not deny the existence of reality it does maintain that the meaning of reality is socially constructed.

A further criticism of a social constructionist framework is the perceived inability to change things because there is nothing against which to judge the findings or research Bury (1986) and he further suggested that, as a consequence, a social constructivist framework results in the inertia and reluctance to make any recommendations from such research. Andrews (2012) maintains this is due to a misreading of the process, as social constructionists do not present their findings in objectivist terms through discrediting opposing arguments by a comparison to objective reality, but instead rely on the plausibility of their findings. They set out to present a convincing argument rather than arguing that their results are definitive. Far from being neutral, it can be argued that social constructionism generates debates that can lead to change.

In terms of social constructionism the arguments in relation to relativism are similar. Relativism signifies a belief in multiple realities mediated by the possibility of multiple interpretations of 'reality'. Craib (1997) in particular ridicules social constructionism for its alleged position on the realist-relativist argument, which he views as a comforting collective belief rather than a theoretical position. Because social constructionism can itself be seen as a social construct, then it has no more claims to be advanced as an explanation than any other theory. Thus there is no notion of what constitutes truth (Burr 1995). Hammersley (1992) refers to this as the self-refuting character of relativism and attempts to counter it with the notion of subtle realism. Subtle realism is a research position that assumes, that while there is an underlying

social reality, different researcher and different participant perspectives allow different and partial views of that reality and meaning can be somewhat fluid (Finlay and Ballinger, 2006).

Berger and Luckman (1991) maintain that change is brought about by human activity and those individuals and groups define their reality. People will present their version of events in such a way that it will prevail over other versions. (Burr, 2003) suggests that this is linked to power, as it is the most powerful who are successful at having their version of events dominate. Despite these issues, social constructionism continues to support the idea that people are agents of change.

Craib (1997), a strong opponent of relativist approaches, suggests that, like interactionism, social constructionism is no more than a coping mechanism for dealing with rapid change; social constructionists embrace change in order to avoid having to defend or justify their position on anything. Craibs' selective understanding of social constructionism arises from a partial understanding, and his assumption that all social constructionists hold a relativist position.

Social constructionism accepts there is an objective reality. It is more concerned about how knowledge is constructed and understood. Social constructionism places great emphasis on everyday interactions between people and how they use language to construct their reality. The focus of enquiry therefore is on the social practices that people engage in. Burr (2003) says when people talk to each other the world gets constructed. Our use of language can therefore be thought of as a form of action and some social constructionists take this 'performative' role of language as their focus of interest. Burr (2003) goes on to propose that concepts and categories are acquired by each person as they develop the use of language and these are reproduced every day by everyone who shares that culture or language. This means that the way a person thinks, together with these categories and concepts are part of a framework of meaning.

### **3.3 Theoretical Perspective**

Research has been described as a systematic investigation (Burns, 1997) or inquiry, whereby data is collected, analysed and interpreted in an effort to "understand,

describe, predict or control an educational or psychological phenomenon or to empower individuals in such context" (Mertens, 2005 p.2). The theoretical perspective or framework as opposed to a theory is sometimes referred to as a 'paradigm' and this influences the way knowledge is studied and interpreted (Mertens, 2005).

### 3.3.1 Symbolic interactionism

Symbolic Interactionism (SI) is a perspective conceived by George Herbert Mead (1863-1931). It has influenced modern thinking about the role of interpretation and meaning in the social world. Blumer, who formalised SI as a theoretical framework, summarised its basic tenets:

1. Human beings act towards things on the basis of the meanings they ascribe to those things.
2. The meaning of such things is derived from, or arises out of, the social interaction that one has with others and the society.
3. These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things they encounter (1969) cited in Denzin (2004).

As SI is a theoretical framework it isn't connected to specific methods. In general, SI emphasizes how people relate to each other, with a dynamic focus on actions and meaning and it addresses the active process through which people create and mediate meanings (Charmaz, 2006). Key concepts include identities, contextual definition of the situation and social roles (especially taking the role of the other). There is an assumption that social life consists of processes and, within this, individuals are creative, active and reflective (Charmaz, 2006). Fundamental to symbolic interactionism is the view that humans construct their own and each other's identities through everyday social interactions (Burr, 2003). The social world of volunteers is of interest to the researcher. All the volunteers have acknowledged they had a lived experience of mental health and the researcher wanted to know how they constructed and managed their identities within this role as volunteer. The researcher was interested in their reality of their world, the social interactions they made as

volunteers in the organisation in which they volunteered and the social networks they derived from volunteering.

### 3.3.2 Interpretivism

The interpretive paradigm has the intention of understanding the world of human experience, suggesting that reality is socially constructed (Mertens, 2005). Advocates of interpretive approaches question methodological processes and claims for objective knowledge because, in terms of progressing an understanding of human phenomena, they are limiting (Lincoln and Denzin, 2003). As a set of interpretive activities, qualitative research privileges no methodological practice over another (Denzin and Lincoln, 2003). Qualitative research is open to different ways of seeing the world (Krueger, 1998). In general, when engaging in a qualitative paradigm, the work tends to relate to social research from which the researcher relies on text, dialogue or visual data as opposed to numerical data. For many qualitative researchers this means asking open questions about phenomena as they occur in context rather than setting out to test a hypothesis (Schwandt, 2001).

Interpretive theory calls for the imaginative understanding of a study's phenomena and it assumes emergent, multiple realities (Charmaz, 2006). Interpretivists propose that the understandings they gain from their research recognises that they are part of the world that they are studying, rather than being external to it (Finlay & Ballinger, 2006). My aim is to generate theory that explains a process of mental health services users' social world through engagement with volunteering.

### 3.3.3 Qualitative Research

Qualitative research is a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live (Atkinson et al., 2001). Qualitative research is a situated activity that locates the observer in the world (Denzin and Lincoln, 2003). Qualitative inquiry is the appropriate approach when knowledge is sought concerning complex, little understood, personal, interpersonal and social processes. It is an ideal approach to help the understanding of the process of evolution of a given phenomenon. Finlay (2006) suggests that the process of

engaging with qualitative research is in the uncharted territory beyond the reach of quantitative instincts. There are many communities of practice in qualitative research offering different perspectives on cultural and interpretivist studies (Denzin and Lincoln, 2003).

The strong growth in interpretative approaches arises from dissatisfaction with the methods and procedures for producing scientific knowledge within a positivistic tradition. There is recognition of the limitations that positivist, objective methodologies offer. These limitations do not allow for the advancement of understanding of human and organisational phenomena (Sandberg, 2005). Conflict and tension between different schools of social science have existed for a long time. A positive approach was the focus in natural sciences and then was adopted by psychology and later sociology (Holloway and Wheeler, 2002). Positivism can be applied to the social world when there is an assumption that the social world can be studied in the same way as the natural world (Mackenzie and Knipe, 2006) but that would assume that the social world would be value free, and that explanations of a causal nature can be provided (Mertens, 2005). Positivists aim to test theory or describe an experience through objective measures (Mackenzie and Knipe, 2006). In contrast O'Leary (2004 p.6) provides a definition of postpositivism suggesting that "what might be the truth for one person or cultural group may not be the truth for another". Cresswell (2011) highlights concerns about the way positivists and interpretivist approaches are set against each other and says that descriptions of both should not be used as just negative labels but agrees it would be foolish to maintain there is no distinction between quantitative and qualitative research.

### **3.4 Methodology**

#### **3.4.1 The evolution of grounded theory**

Grounded theory is a methodology that seeks to construct theory about issues of importance in people's lives (Glaser, 1978; Glaser and Strauss, 1967; Strauss and Corbin, 1998). It does this through a process of data collection, which Morse (2001) describes as inductive in nature - the researcher has no preconceived ideas to prove or disprove. Several different types of grounded theory have been developed over the

last fifty years, with the different types being dependent upon the ontological and epistemological beliefs of key grounded theorists. The sociologists Barney G. Glaser and Anselm L. Strauss collaborated successfully during their study on dying in hospital (Glaser and Strauss, 1965, 1968; Strauss and Glaser, 1970). Their research looked at how terminally ill patients and professionals caring for them handled the news that they were dying and when this news was relayed to them and how. (Glaser and Strauss, 2009), reported that new analytic ideas were explored and as they constructed their analyses they developed systematic methodological strategies that social scientists could adapt to the study of many other topics. Their first book *The Discovery of Grounded Theory* (1967) set out an explanation for the strategies they employed and they advocated that, instead of deducing testable hypotheses from existing theories, their research was grounded in the data. This publication made a cutting-edge statement because it contested notions of methodological consensus and offered systematic strategies for qualitative research practice (Charmaz, 2006). The defining components of their grounded theory practice included: simultaneous data collection and analysis; constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses; making comparisons at each stage of the analysis; advancing theory development with each stage of analysis; memo writing to elaborate categories; sampling aimed at theory construction and not for population representativeness and conducting a literature review after independent analysis (Charmaz, 2006).

At the time of this revelation qualitative research in sociological studies was losing ground and the dominant quantitative tradition was more influential. The move towards quantification that supported systematic observation, replicable experiments and logically deduced hypotheses was aligned, with positivism, the dominant paradigm of enquiry in natural science.

Social researchers who adopted a positivist stance aimed to discover causal explanations and to make predictions external to a knowable world (Charmaz, 2006). As positivism grew in strength researchers concentrated on obtaining concrete information. This resulted in a connection between theory and logically deduced

hypothesis and extant theory was refined but research seldom led to new theory construction (Charmaz, 2006).

Glaser and Strauss wanted to move qualitative inquiry beyond descriptive studies into the realms of explanatory theoretical frameworks, thereby providing abstract, conceptual understanding of the studied phenomenon (Charmaz, 2006). They encouraged a delay in the literature review to avoid seeing the world through extant ideas. Glaser and Strauss, (1967), believed that a completed grounded theory should meet the following criteria: a close fit with the data; usefulness, conceptual density; durability over time; modifiability and explanatory power. Criticism of the analytical methods used by Glaser and Strauss includes the lack of accessible analytic guidelines, as these had previously only been relayed orally between researchers and their supervisors (Charmaz, 2006).

Glaser advocated building 'mid-range' theory. This consisted of abstract renderings of specific social phenomena that were grounded in data (Charmaz, 2006). Glaser permeated his grounded theory with dispassionate empiricism, rigorous coding methods and ambiguous, specialised language that echoes quantitative methods. It was not until 1978, when Glaser published *Theoretical Sensitivity*, that a statement of these methods was articulated (Charmaz, 2006).

Glaser and Strauss shared an interest in studying fundamental social and social psychological processes within a social setting or a particular experience, for example chronic illness and thus for them the resulting theoretical categories often demonstrated causes and conditions under which the process emerged and varied along with its subsequent consequences (Charmaz, 2006).

Glaser and Strauss subsequently took their grounded theory statements in somewhat divergent directions (Charmaz, 2000). Glaser remained consistent for many years with the original method and defined grounded theory as a method of discovery, treated categories as emergent from the data, relied on direct and often narrow empiricism and analysed a basic social process (Charmaz, 2006). Strauss however moved the method towards verification with his co-researcher and author Juliet M. Corbin. They clearly stated that they did not believe in an external pre-existing reality (Strauss and



Corbin, 1994). Their position was that the truth is enacted and this assumes a relativist ontological position that left behind Glaser's (1978) version which asserted that the truth is discovered and emerges from data that is representative of a 'real' reality. Different interpretations of their ontological nature ensued (Charmaz, 2000) and following an insightful book chapter (Corbin and Strauss, 1994) positioning them as relativist pragmatists - stating that 'theories are embedded' in histories (p.280). These historical epochs and eras are taken into account in the creation of revision and reformulation of theories.

Strauss and Corbins' version of grounded theory emphasised the constant comparative methods that distinguished earlier grounded theory strategies (Charmaz, 2006). Glaser (1992) contends that Strauss and Corbin force the data and analysis into pre-conceived categories which contradicts the fundamental elements of grounded theory. Their book *Basics of Qualitative Research* (1998) serves as a powerful statement of the methods used (Charmaz, 2006) and has been instrumental as instruction for student grounded theory researchers. This seemingly complex set of analytical procedures has been criticised (Melia, 1996 p. 376) as "the technical tail beginning to wag the theoretical dog". Mills et al., (2006) refer to a traditional (Glaser and Strauss) and an evolved (Strauss and Corbin) grounded theory process. The techniques that they use are tools for the researcher to draw on in the act of theory development. Corbin takes the position that "theorising is the act of constructing from data an explanatory scheme that systematically integrates various concepts through statements of relationships" (Strauss and Corbin, 1998 p.25) and also that theories themselves are interpretations made from a given perspective adopted or researched by researchers" (Strauss and Corbin, 1994, p.279).

The language used varies between that of post-positivism and that of constructivism and there is a reliance on terms such as 'recognising bias' and 'maintaining objectivity' (Mills et al., 2006) which describes the position of the researcher in relation to their participants. In relation to this MacDonald and Schreiber (2001 p.44) suggested that "people can find support in it (grounded theory) for any ontology that they wish." This does not negate the value of evolved grounded theory but rather it can be seen as

evidence of a struggle to move with the changing moments of qualitative research (Annells, 1997).

Strauss and Corbin acknowledge the importance of a multiplicity of perspectives and truths (Strauss and Corbin, 1989). They insist that theirs is interpretive work and that this 'must include the voices of the people who we study' (Strauss and Corbin, 1994 p. 274). Mills et al., (2006) propose that this position clearly implies that this perspective includes relating participants' stories to the world in which the participants live.

By 1990's grounded theory became known for its rigour and usefulness but also for its positivist assumptions (Charmaz, 2006). Grounded Theorists then started to move away from this positivist stance (Bryant, 2002; Clarke, 2005; Charmaz, 2006). Charmaz (2006) contends that basic grounded theory guidelines and twenty first century methodological assumptions and approaches can develop grounded theory further.

There are several key points of difference between an evolved grounded theory study and that of a traditional grounded theory approach. Theoretical sensitivity is a multidimensional concept that includes the researchers' level of insight in to the area of study and how attuned they are to the complexity and nuances of the participants' words and actions and their ability to construct meaning from the data generated (Mills et al., 2006). Traditional grounded theorists requires the researcher to enter a field with as few predetermined thoughts and as little prior knowledge of the area enabling them to remain sensitive to the data by being able to record events without first having them filtered through and squared with pre-existing hypotheses and biases" (Glaser, 1978 p.3). Clarke, 2005 reminds us of Glaser's claims that grounded theory must be a tabula rasa or a blank slate when entering a field of enquiry. Mills et al., (2006) state that researchers are not that naive as to think that this was possible. Charmaz extends a more flexible approach, originally offered by Glaser and Strauss (1967), and adds the caveat that, "Neither the observer nor the observed come to a scene untouched by the world. Researchers and research participants make assumptions about what is real, possess stocks of knowledge, occupy social status, and pursue purposes that influence their respective views and actions in the presence of each other" (Charmaz, 2006 p.15). It is for this reason that Charmaz (2006) defends a

reflexive stance in how the researcher conducts their research and how they relate to the research participants and how they are subsequently represented in any written reports. The researchers' scrutiny of their own experiences, decisions and interpretations influence their inquiry. Dunne (2011) reflects on this as a way of justifying engagement with extant literature early in the research process and says the researcher influences both the gathering and interpretation of data, primary or secondary and reflexivity forms a crucial part of the research process. Pidgeon and Henwood (1997) and Sandelowski (2000) suggest that if researchers are a product of their analysis that is a grounded theory, then this is a reconstruction of their own making. As alluded to in chapter 1 the area of literature and its uses are diametrically contested between traditional and evolved grounded theory (Mills et al., 2006). A traditional grounded theory stance is that there is no need to review any literature in the substantive area (Glaser, 1992). This is based on a fear of contamination, constraining, inhibiting or impeding the researchers' analyses of codes emergent from the data (Glaser, 1992). This situates the data as an entity separate from the participant and researcher (Mills et al., 2006).

Grounded Theory is often espoused as an effective strategy for topics where there is relatively little research and there is a paucity of knowledge (Payne, 2007). This leads to a practical dilemma that if no literature review is undertaken then how the researcher can assert this paucity of knowledge (Dunne, 2011). Without prior knowledge of the substantive area of study it is possible that the boundaries of the study may not be clearly defined (Dunne, 2011).

It is important therefore to articulate the benefits of an earlier literature review to present a cogent rationale for the study, including a rationale for the chosen research approach (Coyne and Cowley, 2006) and secondly it ensures the study does not already exist and that the literature will highlight pertinent gaps in knowledge (Cresswell, 2007). Thirdly it can help to contextualise and orient the researcher (Urquhart, 2007) and reveal how the phenomenon has been studied to date. The researcher has presented a literature review in chapter 2. It provides a context to the area of study and to the domain of recovery and work and mental health in which the literature situates this study. The review is not systematic and provides a relatively

narrow but clear overview which allows the reader an insight into the key areas of knowledge that currently exist about recovery and work.

Coffey and Atkinson (1996) remark "the open-mindedness of the researcher should not be mistaken for the empty mindedness of the researcher who is not adequately steeped in the research traditions of a discipline." (p.157). Dunne (2011) believes that collectively these arguments in favour of an early literature review in the substantive area before data collection and analyses are compelling. Strauss and Corbin (1998) found many uses for the literature and described it as another voice contributing to the researcher's theoretical reconstruction. Non-technical literature, for example reports or internal correspondence, provides contextual information within which the participant operates (Strauss and Corbin, 1998).

#### 3.4.2 Social Constructivism and Grounded Theory

It has been suggested that within grounded theory a traditionalist would take an objectivist stance that is dispassionate, and be the 'outside expert' described by Glaser and Strauss (1967). Glaser and Strauss (1967) also propose that the theory emerges from the data separate from the scientific observer or researcher and that this could indicate a positivist stance on qualitative research. Charmaz (2006) refutes this position and proposes that neither data nor theories are 'discovered', but that in fact researchers are part of the world in which they study and thus they co-create rather than collect data.

We can know about a world by describing it from the outside and yet to understand what living in this world means we need to learn about it from the inside (Charmaz, 2006). Strauss and Corbin's (1990, 1998) structured approach is questioned by Charmaz (2006) in that there is an attempt by the researcher to gain power in its use. By using an interpretivist, constructivist approach the researcher assumes that people create and maintain their world through dialectical processes of conferring meaning on their realities and acting within them (Denzin & Lincoln, 2003). Grounded theories are constructed through past and present involvement and interactions with people, perspectives and research processes. Charmaz (2006) believes that the researchers' position is fundamental to the interpretivist position.

Critics of constructivist grounded theory suggest that the approach acknowledges the researcher role but ask if the theory is truly grounded in the data? Willig (2007) suggests that it is discourse and language that shapes the construction of categories and this would then transform the method to such an extent that it may not in fact be grounded theory. Researchers in psychology have looked at the link between IPA (Interpretative Phenomenological Analysis) and grounded theory and here Smith (2007) suggests that they 'adopt a broadly similar perspective and they share much of the same analytic terminology. Consequently for psychological researchers IPA may be a preferred option.

The social constructivist aims to explore another worldview (Mertens, 1998). The researcher in the present study wants to explore the worldview of mental health service users and their experiences of volunteering and the impact this has had on them. Cultural norms operate for all the participants in the study. A researcher's own background shapes how they position themselves in the research. The researcher's personal, cultural and historical experiences are acknowledged with this study and any interpretation that is made will take this reflexive position into account.

### 3.4.3 Reflexivity

Reflexivity facilitates a critical attitude towards locating the impact of researcher context and subjectivity on the research design, data collection, data analysis and presentation of findings (Finlay and Gough, 2003). Morse, (2006) states that excellent qualitative research is inherently biased and Denzin and Lincoln (2003) says that there is no attempt to suggest that qualitative research is value-free. The researcher aims to be open about her reflexive position as an academic researcher who teaches occupational therapy and vocational rehabilitation and about the experience of working for a number of years in clinical practice. Throughout the qualitative research process the researcher will need to consider possible ethical dilemmas and reflect upon these. A full account of the researcher's reflexive position, when taking a constructivist approach to grounded theory in this study, is discussed in chapter 9.

### **3.5 Research Design and Methods**

Grounded theory strives to arrive at a theoretical understanding of psychosocial phenomena that is generated through the researcher from the data collected from the participants and that it is representative of their lives and contexts. Charmaz, advises that, as researchers, we should code for actions rather than themes in search of our theory. "When you theorise, you reach down to fundamentals, up to abstractions and probe into experience." (Charmaz, 2006 p.136). Charmaz' (2006) constructionist grounded theory approach (Charmaz, 2006) will be adopted for this study. A challenge can be about determining when saturation is reached. The main outcome of theory generation through a traditional grounded theory approach is a theory with specific components, central phenomena, strategies, conditions, context and consequences (Cresswell, 2007, p.68); this offers little flexibility and is prescribed. Charmaz's approach is more adaptable and she places value on views, values and beliefs, assumptions and ideologies but she also places emphasis on data collection, coding, memoing and theoretical sampling (Charmaz, 2006). This constructivist approach to grounded theory in this study is discussed in chapter 4.

### **3.6 Summary of the chapter**

This chapter has discussed the epistemological and ontological position that was selected for the study. The researcher is interested in the worldview of her participants, who are volunteers with a lived experience of enduring mental health problems. The social phenomena of volunteering is of interest to the researcher and a justification for location of this in the literature in the domain of recovery, work and mental health is explored with respect to a grounded theory approach. The researcher is taking a constructivist approach to the research and a subtle realist position assumes that the volunteers who participate in this study will have different realities of their role as volunteers. In relation to this position, a discussion and critique of social constructivism is presented. The chapter provides a rationale for the use of grounded theory using a constructive approach as the chosen methodology and the reflexive position of the researcher has been acknowledged. Grounded Theory is discussed in

relation to a historical perspective of the development of traditional, evolved and postmodern approaches to grounded theory.

## **CHAPTER FOUR: METHODS - PHASE 1 AND PHASE 2 STUDY DESIGN**

### **4.1 Introduction to the chapter**

Following on from the previous chapter's justification for the methodology chosen for this study, the methods that led from these methodological decisions will now be detailed. This chapter will present the grounded theory methods used to aid theory development across both phases.

### **4.2 Outline of the study**

The study was in two phases. An initial grounded theory analysis of the phase 1 study was used to develop theoretical sampling, generate categories and to refine and support further interviews and interview topics. Analysis of the Phase 2 data was then conducted as an iterative process to generate theory. The findings from both phases are therefore presented together in the findings chapters.

This chapter is structured to demonstrate how one study merged with the next. The methods used for both phase 1 and phase 2 studies will demonstrate how the phases differed subtly and also how they developed from one to the other. It will highlight the methods used to confirm rigour and provide the reader with a clear audit trail.

#### **4.2.1 Aims of Phase 1 and Phase 2 Study**

The role of mental health service users as volunteers both in the services from which they receive input and beyond has not been investigated in depth. It is this group of service users that will be the focus.

- To understand the experiences of services users who were volunteering in a mental health Trust and those volunteering elsewhere.
- To consider how volunteering as a phenomenon relates to personal recovery from the perspective of participants



#### 4.2.2 Timeframe for the study

**Table 2. Key stages in phase 1 and phase 2 study**

	Phase 1	Phase 2
Ethics and Governance	<p>Ethical approval from Local Research Ethics Committee (LREC) (22.2.2007)</p> <p>Subsequent amendment to LREC to request change to consent form approval received (30.7.2007)</p> <p>Notification to Sheffield Health and Social Research Consortium that study will form phase 1 of PhD (21.11.2007)</p> <p>Amendment to change methodology approval received from LREC (8.1.2008)</p> <p>Amendment to change methodology approval received from Sheffield Health and Social Research Consortium (12.1.2008)</p>	<p>Sheffield Hallam University Faculty Research Ethics Committee approval (2.8.2011)</p> <p>Amendment to request approval for telephone interviews approval (15.10.2012)</p>
Recruitment and data collection	July 2008 - June 2009	October 2011 - June 2013
Analysis phase 1	Commenced July 2008	
Analysis phase 2		October 2011 - September 2013

### 4.3 Planning the study - Phase 1

The research study design was planned with a reference group. This group consisted of two service users, an occupational therapist and the User Volunteer co-ordinator. The service user representatives were recruited through the Patient Council in the mental health Trust. Service user involvement enhances the credibility of research and ensures that findings are genuinely useful to the end-users, i.e. service users and carers (Stanizeska et al., et al. 2011). Users and carers can offer alternative perspectives and it was important to get a small group of stakeholders together because of their skills, knowledge and relevant experience to the context of the study. Read and Maslin-Prothero, (2011) state consultation related to researcher-led activities is passive consumer involvement (being consulted about the design process), as opposed to collaboration, which includes joint and equal partnerships. However involving service users at this early stage has the greatest potential for impact, as there is more flexibility to respond to service-users' views (Staley and Minogue, 2006). There is considerable variation in the role service-user members of steering groups are asked to play and therefore this impacts on the study (Staley and Minogue, 2006).

This group were consulted in terms of their ideas as well as for their opinions and feedback. The membership of the reference group included service users who already had research experience and so their contribution was valued and had real impact on the design. The group met approximately every 3 weeks over a six month period of time and members of the consultation group commented on and gave constructive feedback with respect to recruitment of participants, information sheets, consent forms and interview schedules. A series of meetings with the group took place up until data collection was completed. Brief notes were kept and shared following the meetings.

#### 4.3.1 Study context - Phase 1

The setting for Phase 1 was one NHS Mental Health Trust in England. The User Volunteer Service (UVS) was established in 1999, and its aims were to assist service users to engage in voluntary work within the NHS Trust. This was part of a local Trusts' strategy to support service users with employment and social inclusion and UVS was

part of the User Employment Service within the Trust (UES). The majority of service users had enduring mental health problems and may have been out of work for several years. The user volunteer service coordinator was an 'expert by experience', in that he was a service user with lived experience of enduring mental health problems, who had been a volunteer and was now in a paid position in the Trust and had a responsibility for co-ordinating the UVS. He was a credible role model for the volunteers. Staley and Minogue (2006) believes it is important to involve service users in service delivery as it starts to redress power issues that play out in the health service. The co-ordinators' active involvement as a service user and now as a paid employee goes some way to acknowledge the equal value of lived experience in the workplace.

The user volunteer service provided service users with volunteering opportunities in a range of areas around the Trust. Prior to taking up a volunteering placement, service users met with the volunteer co-ordinator and took part in a recruitment process similar to that of any other staff member, including providing references and undergoing an occupational health process as well as a vetting and barring checks (formerly criminal record bureau (CRB) checks) when necessary. Each placement was 'tailor made' around the volunteers' skills, experience and most importantly their aspirations. Each volunteer had a paid member of staff as a mentor, whose role was to support and develop the volunteer and to help them become a valued member of the team in which they were working. At the time of the phase 1 study the researcher was not aware of any projects elsewhere that focused to this extent on assisting people with enduring mental health problems to do voluntary work within mental health services. However over a period of time this position has changed.

The principles of the supported user volunteering service:

- A dedicated co-ordinator role ideally an 'expert by experience' who is leading by example
- Volunteering is part of an individual's vocational goal
- Standard employment processes are used e.g. application process, HR and disclosure and barring service processes
- A dedicated mentor is allocated in the workplace with time for supervision

- An honorary agreement is provided which outlines expectations of volunteers
- A role descriptor is provided and conduct, confidentiality, sickness absence and handling grievances processes are followed which are similar to that of any paid worker
- Access to appropriate training relevant to the role and also a standard induction to the organisation is provided
- A regular review and appraisal with volunteer is provided to ensure progress

Service users can be referred to the UVS by a health professional or they can self-refer. Volunteering is just one pathway that the UES offers alongside the Individual Placement and Support approach for those service users who are 'work ready'. The UES also provides employer support and the service is managed by a Consultant Occupational Therapist.

#### 4.4 Sampling - Phase 1

A decision to use convenience but purposive sampling rather than theoretical sampling in this phase was very much influenced by the initial focus on a specific user volunteer service as opposed to volunteering in general. Purposive sampling was employed as key features of the service user volunteers were of interest to the researcher. These volunteers were volunteering in the mental health Trust in which they had also received a service as mental health service users. They were volunteering because they had identified vocational aspirations. Purposive sampling demands that the parameters of this chosen population are considered carefully (Silverman, 2011).

Sampling allows the optimal experience of participants to be sought and heard.

Numbers of participants is a thorny issue in qualitative research and Starks and Trinidad (2007) suggest typical grounded theory studies can recruit between 10 and 60 participants. Sample size will depend very much on the success of wider recruitment and opportunistic and snowballing approaches may need to be used.

In phase 1 potential participants who could tell the researcher about their experiences of volunteering belonged to a discrete group and were the target for recruitment.

Purposive sampling was used to recruit a homogeneous sample of people who had all experienced the phenomena of supported volunteering. They were also a convenience sample because they were relatively easy to access and the researcher would interview all participants who fulfilled the inclusion criteria (see below). Convenience sampling is often used at the beginning of a grounded theory study to identify the scope, major components, and trajectory of the overall process (Bryant and Charmaz, 2011). There were some limitations to this sample in as much as there were a finite number of volunteers who could be invited into the study and at this stage no attempts were made to influence the sample by gender, age, ethnic group or volunteering experience. This is less problematic when adopting a grounded theory approach, as the main drive is theory generation as opposed to representativeness in a sample.

#### 4.4.2 Phase 1 recruitment and data collection

Inclusion criteria:

- Volunteers who had a volunteering placement in the Trust, and who were supported by the User Volunteer Service (UVS).
- Age 18 - 65 years
- Not in any paid employment

The researcher had no direct access to volunteers and all participants were recruited to the study through the user volunteer co-ordinator who acted as a gatekeeper. All volunteers who had accessed the service were contacted by the user volunteer co-ordinator and asked if they would like to participate in the study. They were sent a letter outlining the purpose of the study and some brief information about what they would be required to do (appendix v). Volunteers who were interested were asked to complete a form and return in a stamped addressed envelope (Appendix vi). In total 11 volunteers agreed to be interviewed.

All volunteers who expressed an interest were sent a participant information sheet (appendix v ii) and a consent form (appendix v iii) and were again given the

opportunity to contact the researcher if they had any further queries although verbal and written consent was taken at the time of the interview.

The researcher then contacted the volunteers to negotiate a time and venue for an interview, which was then confirmed by letter. All interviews took place on Trust premises which were familiar to the volunteers.

Informed and written consent was taken at the time of the interview. Interviews lasted between 35 minutes and 90 minutes. All interviews were recorded using a digital recorder. Demographic data was collected at the end of the interview and this included age and ethnic group. All reasonable travel expenses were reimbursed at the time of the interview and a ten pound shopping voucher was offered to all the volunteers who participated. This was possible as the researcher had gained some funding from Sheffield Health and Social Research Consortium.

#### 4.4.3 Phase 2 recruitment and data collection

The aim of phase 2 recruitment was to find volunteers who were not volunteering in a NHS Trust but who were volunteering in any other sector and in any other organisation.

Inclusion criteria:

- Male and Female
- Age 16 - 65
- Currently volunteering rather than in open employment
- Disclosure of mental health problem (self-reporting)
- Participating in either formal or informal volunteering.

Exclusion criteria:

- In open paid employment and volunteering
- Volunteering in an NHS mental health setting

Participants were initially recruited through *Your Voice*, a publication written, edited and published for mental health service users, carers and professionals working in mental health services. This is a Sheffield based publication available bi-monthly and a short piece about the research appeared in one of its editions and from this three people expressed an interest in the study. They contacted the researcher by phone and e-mail to discuss the study and following this a participant information sheet was sent out to them. After a short period of time the three participants responded to confirm they would like to take part in the study and interview times were set up at a venue and time that was convenient to the participants.

A number of key voluntary organisations that had access to large numbers of volunteers were contacted either by phone, e-mail or by arrangement of a visit. The researcher took the opportunity to tell the representative from the organisation about the study and a flyer (appendix xi) was also made available to advertise the study to potential participants. This was met with a varied amount of success and challenge of recruiting volunteers who would self-disclose a mental health problem was very much dependent on the views of the gatekeepers from the voluntary organisation that were contacted. This will be critically evaluated in chapter 9.

One of the organisations contacted was a drug and alcohol misuse service and the researcher was invited to a meeting to tell a number of Recovery Ambassadors about the research. The Recovery Ambassadors were in essence volunteers who were volunteering in drug, alcohol and homeless services across the city and they expressed an interest in the study and three eventually came forward to take part. Service user volunteers in higher education were also contacted and the remaining volunteers were recruited by snowballing. This is when the sample emerges with reference from one person to another (Denscombe, 2007). Volunteers who took part in the phase 2 study were asked to let other volunteers they knew who might fit the criteria to contact me if they were interested in taking part. This resulted in two more contacts who agreed to be interviewed. After a period of time 8 volunteers had consented to be interviewed. All volunteers in phase 2 were interviewed once and two consented to follow-up interviews to aid the generation of data to support a category. This is called selective coding and is used to when discriminate sampling helps to verify an emerging

theory and to further develop the categories that have not been well saturated (Draucker et al., 2007).

The interviews were arranged at a time and venue that was convenient for the participants. Venues included a library, university premises and a cafe. These were all private and quiet environments and were chosen because they enabled a convenient time for the interview to be held for the participant and also fitted in with the needs of the volunteers' organisation where they volunteered. Again all reasonable travel expenses were reimbursed and a ten pound shopping voucher was given to each volunteer. It is increasingly common for qualitative health researchers to compensate participants financially for taking part in their research study (Cook & Nunkoosing, 2008). The use of financial incentives has raised concerns about the potential impact of "buying" people's stories (Ensign, 2003), including the pressure on participants to produce a worthy narrative (McKeganey, 2001) and the commodification of sensitive and private information (Cook & Nunkoosing). The researcher did not feel that this token of appreciation was in any way an attempt to commodify their personal stories or incentivise them to take part. It was a way of acknowledging their valuable time and payment of reasonable travel expenses. It was important and ethical to ensure that there would be no financial disadvantage as a result of taking part in the study.

Interviews were recorded, transcribed and analysed using Grounded Theory methods, and in-depth interview questions were developed and changed in tandem with the theoretical analysis, rather than using a pre-formed topic guide. The interview process is discussed at length, later in this chapter. Interviews lasted between 50 and 90 minutes. Two volunteers were interviewed over the phone. All interviews were recorded using a digital recorder. Verbal and signed informed consent was taken at the start of the face to face interviews and written consent was collected by post for those volunteers interviewed over the phone. The details of mental health diagnoses were not collected in either phase. The service user volunteers in phase 1 were volunteering in the Trust they had received input from and so, by association, it was assumed they had a mental health problem. In phase 2 participants were recruited into the study because they self-reported a mental health problem. However during the course of the



interviews mental health diagnoses were disclosed and these included psychosis, depression, anxiety, personality disorder and substance abuse. Reflection on this as inclusion criteria is again discussed further in chapter 9.

The transcript was checked for accuracy against the audio recording after completion. In phase 1 and phase 2 all the transcripts were returned to participants, who were invited to check that they were happy in the way that they were being represented through the data. Bryant and Charmaz (2011) are advocates of this strategy being used by grounded theory researchers.

Transcripts included all original words irrespective of jargon, colloquialisms and other sounds. Only one participant in phase 1 asked for this to be cleansed and for a better grammatical version to be used. Again in phase 2 one of the participants corrected some of the grammar in the transcript. The researcher did not employ the volunteers as member checkers to validate actual findings. Birks and Mills (2011) argue that the process of concurrent data collection and data analysis subsumes the strategy of member checking in grounded theory and Charmaz (2006) agrees that grounded theory strategies make member checking redundant.

#### 4.4.4 Theoretical sampling

Theoretical sampling is pertinent to grounded theory and it is a form of sampling that allows the researcher to develop the properties of their emerging categories or theory (Bryant and Charmaz, 2011).

Categories from phase 1 informed an interview agenda and the following areas became of interest and required further exploration.

- What does mental health experience bring to volunteering?
- What impact has it had on recovery?
- Has volunteering impacted on skills or aspirations for future work?
- How does the service-user experience influence vocational goals?
- When do volunteers know that volunteering is right for them?
- How do working relationships in these areas influence recovery?

Whilst the research did not set out to understand transition into paid work it was within the context of the study to understand how volunteers perceived readiness to move into an option of paid work? The testing of an emergent theory is guided by theoretical sampling. This was directed by the evolving theoretical constructs in order to develop further the tentative theory that emerged from phase 1 which was summarised as *'supported volunteering allows volunteers to take positive risks that integrate an experience of mental health and provides a socially valued role'* Theoretical sampling will help to build on and develop the resulting theory so that it can be considered conceptually dense and grounded in the data.

**Table 3. Table of Participant Demographics**

Participant	Study		Gender	Age	Self-reported
	Phase	Pseudonym			Ethnicity
1	1	Terry	M	57	White British
2	1	Neil	M	45	White British
3	1	Luke	M	58	White British
4	1	Kevin	M	44	White British
5	1	Jana	F	46	White British
6	1	Karl	M	31	White British
7	1	Val	F	48	White British
8	1	Katie	F	27	White British
9	1	Dan	M	50	White British
10	1	Alice	F	18	White British
11	1	Nigel	M	29	White British
12	2	Eddie	M	29	White British
13	2	Louise	F	42	British Asian
14	2	Natalie	F	55	White British
15	2	Charles	M	42	White British
16	2	Bob	M	62	White British
17	2	Janet	F	32	White British
18	2	John	M	40	White British
19	2	Jim	M	64	White British

**Table 4. Table of participant volunteer settings**

Participant	Study		Pseudonym	Volunteering experience at time of interview
	Phase			
1	1		Terry	NHS setting: Supporting clients to engage with Therapeutic horticulture
2	1		Neil	NHS setting: Volunteers alongside community support workers
3	1		Luke	NHS setting: Supporting therapists to engage clients in group art sessions and helped to organise art exhibition with other service users and staff
4	1		Kevin	NHS setting: Patients council member, represents service user on interview panels
5	1		Jana	NHS setting: Supports clients to engage in therapeutic pottery groups in day service
6	1		Karl	NHS setting: Supports clients to engage in a computer group in community day service
7	1		Val	NHS setting: Supports day service staff to engage clients in a range of therapeutic groups in day service
8	1		Katie	NHS setting: Supports administrator in Trust headquarters
9	1		Dan	NHS setting: Supports chaplain in a range of activities
10	1		Alice	NHS setting: Supports administrator in community service
11	1		Nigel	NHS setting: Supports occupational therapist on acute in patient wards
12	2		Eddie	Higher Education sector: Contributes as an expert with lived experience into a range of health and social care courses
13	2		Louise	Voluntary sector: Provides counselling skills to voluntary sector organisations
14	2		Natalie	Church: Provides support at church to support disadvantaged groups in a range of activities
15	2		Charles	Voluntary and NHS sector: Recovery ambassadors that provide support to individuals and groups in substance use services
16	2		Bob	Higher Education sector: Contributes as an expert with lived experience' into a range of health and social care courses
17	2		Janet	Voluntary and NHS sector: Recovery ambassadors that provide support to individuals and groups in substance use services
18	2		John	Voluntary and NHS sector: Recovery ambassadors that provide support to individuals and groups in substance use services
19	2		Jim	Voluntary sector: Conservation volunteer in national park

#### 4.5 The interview

In depth interviews were the main means of data generation and an interview schedule was used in both phases to guide the interview and as a prompt when needed. A degree of flexibility was also needed during the interview process to ensure that the participant could talk about experiences as openly as possible and be able to move back and forth across areas of questioning. Care was taken not to over rely on the schedule but to allow the conversation to flow. Every effort was made to create an informal atmosphere and a genuine openness and to be sensitive to where the interview might go. Attempts were made to put the participants at ease at the beginning. Some specific open questions were asked with follow-up prompts to encourage further exploration of a particular story or experience. The interviewers' responsibility was to ensure that the conversation flowed naturally and to respond with additional questions, rephrase questions as necessary and clarify certain points or give prompts to open up a discussion about a certain topic, for example *'...please could you tell me a bit more about that?'*

The questions were chosen carefully to nurture the volunteers' reflections and to also reflect a symbolic interactionist perspective by learning about how the participants viewed events as volunteers (Charmaz, 2006). The questions were intended to study individual experience but during the interview it was also important to focus on organizational or social processes or collective practices first (Charmaz, 2006) and then elicit the individual's views on them. This study took a constructivist approach, it was important to create a sense of reciprocity between the researcher and the volunteers in the creation of meaning, and ultimately the theory that was grounded in the participants' and the researcher's experiences (Mills, Bonner and Francis, 2006). Karnielli-Miller, Strier and Pessach, (2009) wrote about the power relationships in qualitative research and proposed that there needs to be a balance between developing friendships and maintaining a distance from the research participants that will allow professional judgement which was also a view espoused earlier by Lincoln and Guba 1985). It was important to create an atmosphere that was informal yet also attentive, listening to the volunteers' stories, their perspectives and opinions. When relevant, gently probing questions were used to clarify meaning or context. There were

occasions when empathy, agreement and sharing of the researcher's own experience was appropriate and this helped to gain confidence and trust. In all the interviews, the participants were given the opportunity to ask questions. The researcher needed to be skilled to allow the interview to flow in such a way that the volunteers were able to express themselves and their thoughts, while at the same time the researcher needed to keep the interview focused without inhibiting the volunteers and allowing them space and time to express themselves. Charmaz (1991) cautions against interrogation and suggests that the interview is there to help exploration. It is important to ensure that the questions fit with the topic but also fit with the experience of the participant. Remaining attuned to what each participant was saying and how this related to developing theoretical sensitivity from one interview to the next was a challenge and required concentration and a connection with the participant that allowed exploration.

#### **4.6 Theoretical sensitivity**

Theoretical sensitivity is a concept that is intangible in nature (Birks and Mill, 2011) Corbin and Strauss (2008) refer to the concept of 'sensitivity' as a contrast to 'objectivity'. This was possibly employed as a strategy to diffuse Glasers (1992) criticism of their original discussion of theoretical sensitivity, where he suggested that the data is being forced. Birks and Mills, (2011) define theoretical sensitivity as the ability to recognise and extract from the data elements that have relevance for the emerging theory. Birks and Mills, (2011) highlight it as an important attribute and it is the ability to have theoretical insight, combined with the ability to make something of these insights. They suggest it has three characteristics:

1. It reflects the sum of personal, professional and experiential history
2. It can be enhanced by various tools and techniques
3. It increases as the research progresses

The techniques and tools for the researcher to draw upon support the act of theory development (Mills et al., 2006). Strauss and Corbin take the position that theorising is the act of constructing from data an explanatory scheme which systematically

integrates various concepts through statements of relationships (Strauss and Corbin, 1998) and that theories are made from the different perspectives as adopted or researched by researchers (Strauss and Corbin, 1994). Charmaz (2006) advises to code for actions rather than themes in the search for theory. Theorising means stopping, pondering and thinking anew. To gain theoretical sensitivity, Charmaz, (2006, p.136) says "we look at studied life from multiple vantage points, make comparisons, follow leads and build on ideas. When you theorise you reach down to fundamentals, up to abstractions, and probe into experience".

#### **4.7 Data Analysis Phase 1 and Phase 2**

The analytic process runs through the life of a grounded theory project (Forrester, 2010). It starts as soon as some data is available and continues until the report has been completed. Consistent with grounded theory techniques, initial coding, focused coding and constant comparative methods were key features of the analytic process to support theory development.

Practically, following each interview, notes were made to bring to mind immediate thoughts and observations about the interview. Listening to the recordings and making more notes and then transcribing them helped the researcher to become familiar with the data. Annotated notes were made on the transcript. 'Turn' units were used as a demarcation of what the interviewer said and what the participant said. Charmaz (2006) recommends that by listening to the participant's language you bridge their experiences with the research question. It is the work of Strauss and Corbin (1990, 1998) that provides a systematic, specific steps approach to analysis in grounded theory. Challenges can be determining when saturation is reached. Saturation is reached when a range of constructs that help to develop mid-range theory is represented within the data. This is a defining property of grounded theory. Grounded theorists do not specify a sample size (Glaser, 1998) but the use of theoretical sampling methods means that selective data was obtained to refine and support categories constructed from phase 1 and any new categories constructed in phase 2 and determined the next direction for data collection. The main outcome of theory

generation is a theory with specific components, central phenomenon, strategies, conditions, context and consequences (Cresswell, 2007, p.68). Pidgeon and Henwood (1997) recommend careful recoding and detailed documentation, of the research process. This detailed documentation again increases reflexivity. Charmaz's approach to coding was adopted by the researcher for the present study in that the researcher looked for social actions and processes in the data. There are however similarities with the coding strategies defined by Strauss and Corbin (1990). Transcripts were analysed using the principles described below.

#### 4.7.1 Initial coding - Phase 1

Initially, line by line coding provided a greater level of analysis than paragraph by paragraph coding, where the researcher may have tended to focus on possibly only one main point that caught their attention. However as analysis progressed, paragraph by paragraph coding was as helpful as the data became familiar and the researcher became more adept at coding. In phase 1 the depth of analysis from line by line coding compensated for the loss of breadth of the original data set as a result of the convenience sample. This is known as abbreviated grounded theory (Willig, 2001). Initial coding assigns conceptual labels on data extracts to denote meanings. It was important wherever possible to maintain participant meaning by using 'in vivo' codes. Paying attention to the language allowed some codes to be labelled literally as the participant had described. In vivo codes were still subject to on-going analysis but at times they did capture the essence of meaning or experience. In vivo codes are characteristic of the participants' social worlds and reflect organisational settings, allowing a deeper understanding of what is happening and what it means. Charmaz (2006) suggests these codes anchor the analysis in the participants' worlds. The purpose of early coding is to construct codes that then develop into categories that crystallise participants' experience. Charmaz (2006) highlights their relevance as part of a process to achieve and develop an inclusive analysis which interprets what is happening and makes relationships between processes and structures visible. In the example below the highlighted text is interpreted by the researcher in the right-hand column. Labels that denote a social or psychological process are noted as codes.



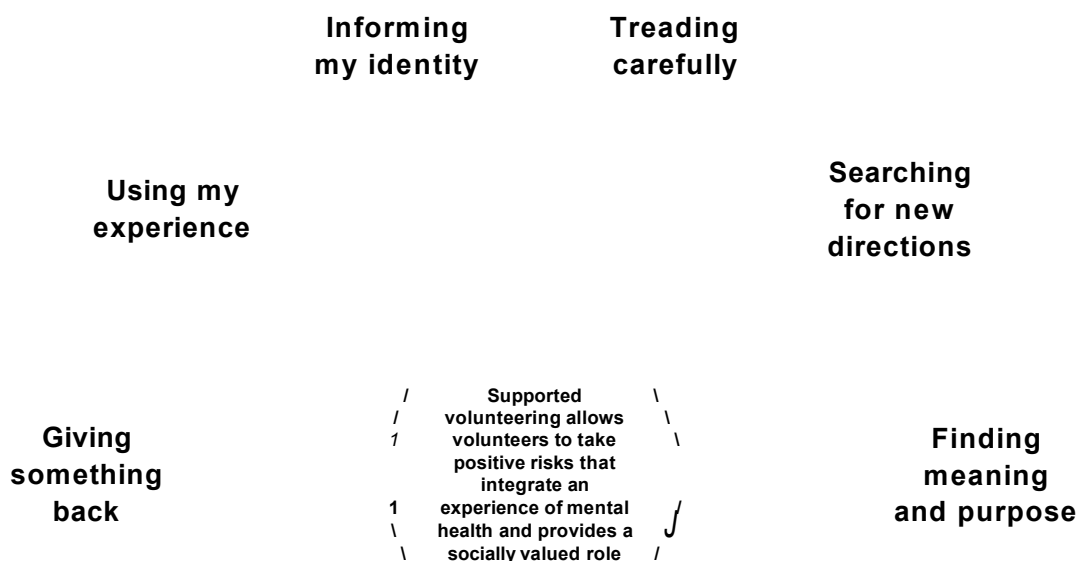
**Table 5. An example of initial coding from phase 1 interview**

32	Right. Yeah. OK. Thanks xxxx Um...can I ask how do you think volunteering and this experience of volunteering has changed you in anyway? Has it changed the way you think about yourself for example?	
33	Certainly from getting ill it's changed me a lot it's given me my confidence back. I mean it took a lot of things, and people, and appointments with psychiatrists and...what are the other ones? Psychologists that's the one! [LAUGHTER] So with all of that help I have come a long way but I think volunteering it was more um...self-driven, whereas the appointments I kept to because I felt it was what I had to do to get well again. Volunteering was much more about me and it was my commitment to come and volunteer. Um...it was my time I was taking to come and volunteer and it was about my own self-development rather than it being about my mental health. It was more about re-establishing myself in the work arena. So it was something I felt I did for myself rather than being...not forced but feeling I had to go to an appointment to see a psychologist.	<p><b>Internal motivation</b></p> <p>Motivation</p> <p>Self driven - internal locus of control linked to Worker role</p> <p><b>external motivation</b></p> <p>Role as service user not so self-driven - external locus of control</p> <p><i>Motivation is mentioned here again and the volunteering experience has been something this participant has done for herself. She compares it with the support she gained as a service user appreciating the help but the drive behind attending these appointments seemed external unlike her opportunity to be in a work role again.</i></p>
34	Do you see yourself differently then? Do you still feel like a service user when you volunteer or is it indistinguishable?	
35	Um...I suppose I haven't done for the last...for the last three or four months I have been really well, there was a time when I was coming in here and as well as volunteering I was speaking to xxxx quite regularly about things, what was going off at home and things like that. So I did feel there was a crossover of roles there where I felt yeah, I was a service user and...I was a volunteer, now since I volunteered down at xxxx my closest colleague knows I am a service user and she knows of my difficulties in the past with my mental health. But we are equals and I do everything that I am expected to do in my work role without this kind of tag or name of service user attached to me.	<p><b>Crossover of roles</b></p> <p><b>Relationships are evolving (equity)</b></p> <p><b>Disclosure</b></p> <p><b>Power change</b></p> <p><b>Identity transition</b></p> <p><i>Here the participant describes how at one point she felt like both a service user and a volunteer but more recently she has lost the tag of service user that she felt was attached to her and feels an equal to her work colleagues she has been able to disclose to.</i></p>
36	How does that feel?	
37	It feels great. In fact I have had a conversation with my social worker today about a CPA review and um...he said to me...I think we are going to need to discharge you and I said well great, does that mean I can lose the tag service user then? He said well yeah of course, you are not using the services anymore. So I was pleased. I am really pleased about that. I don't like to be put under a banner, I would much rather be known for...as my name you know, not because I am a service user.	<p><b>Losing stigmatising label</b></p> <p><b>Identity is transitioning</b></p> <p><i>Again she describes pleasure at losing service user tag. Dislikes banner of service user and prefers to be known for who she is - her name.</i></p>

#### 4.7.2 Focused Coding

Focused coding is the second major phase in grounded theory coding. Focused coding means using the most significant and / or most frequent codes. Focused coding requires decisions about which initial codes make the most analytic sense in order to categorise the data incisively and completely (Charmaz, 2006). Decisions were made about which initial codes made the most analytical sense and how they should be categorised. Sometimes initial codes would fit into more than one focused code and the descriptor that denoted a focused code had to be thought through carefully to establish a more analytical concept as opposed to a less passive descriptor. Data comparisons were made across the data sets. Through this process Charmaz (2006) says new threads of analysis become apparent.

**Figure 4. Diagram representing categories generated from the data in phase 1 along with a tentative core category**



#### 4.8 Phase 2 analysis

Data was analysed sequentially following each interview and modifications were made as necessary prior to each interview. Two of the volunteers in phase 2 were asked to participate in a second interview to explore further the development of concepts

around why people find it difficult to move out of volunteering. These volunteers Eddie and Natalie had expressed some challenges and frustrations about why they were finding it difficult to move on from volunteering and a second interview illuminated this further. This selective coding called for discriminate sampling in which data was gathered to verify the emerging theory and further develop the categories that had not been saturated (Draucker et al.,(2007).

Initial coding and focused coding took place as in phase 1 data analysis.

#### 4.8.1 Constant comparative methods

The constant comparative method is a method of analysis that generates more abstract concepts and theory through comparing data with data, data with category, and category with concept. Bryant and Charmaz (2011) say it is these comparisons that constitute each stage of the analytic development. Dey (1999) proposes that a virtue of constant comparison as a method in grounded theory is that it protects against the tendency to over interpret data. A systematic use of constant comparisons helped the researcher to challenge an inclination to focus on overly positive evidence, as the evidence to support codes and subsequent categories is found within the data using this method. The researcher found this very helpful in the early stages of analyses to prompt the exclusion of some codes because there was not sufficient evidence or depth of any theoretical relevance for some codes.

#### 4.8.2 Theoretical coding

Theoretical coding is an advanced level of coding that was introduced by Glaser (1978) as a conceptualisation of how the substantive codes may relate to each other as hypotheses to be integrated into a theory. Categories were developed from the decisions made about how and which focused codes were linked conceptually and what relationships there were between them. Theoretical coding aids precision and clarity. Analysis started to have depth of understanding and was coherent because the general context and specific properties of volunteering and its meaning for the participants in phase 1 became evident. Dimensions of these categories were

examined, who, what, when and how were questions that were asked of the data. A process that had temporal meaning for the volunteers became evident. Although the volunteers did not go through a process there was a starting point that was significant in terms of how they first engage with volunteering. Time was taken to review focused codes and consider whether some should be included or not. Their importance was relegated by other codes and subsequently into designated categories. Care had to be taken not to force data into preconceived codes and categories. Comparative methods were used at all analytical stages within and across all data sets. Theoretical coding looks at how codes relate to each other and visual diagrams eventually became a valuable tool to aid analysis. Charmaz (2006) supports the skilful use of theoretical codes to give the work a sharp analytic edge.

#### 4.8.3 Managing pre-conceptions when coding

Researchers are reminded not to force the data (Charmaz, 2006) and not to force our own pre conceptions of the data that is coded. Schutz, (1967) in Charmaz (2006) refers to this as 'common sense theorising/ Grounded theorists, like other researchers, can take a particular standpoint because of their own experiences. Preconceptions may be related to class, gender, race and an historical era may infuse the research but without the researcher's awareness. Charmaz (2006) says these preconceptions only become apparent when our taken for granted standpoints are challenged. Glaser (1978) favours that preconceptions earn their way into the analysis and Charmaz (2006) argues that preconceived concepts offer a starting point for looking at the data but they do not offer automatic codes for analysing the data. Charmaz (2006) went on to say that if extant concepts are not integral for understanding the data then they do not have a place in the codes or later analysis. A fine line exists between interpreting data and imposing a pre-existing framework. Both the constructivist and interpretivist approaches taken within this study meant that the researcher constructed meaning with the data provided by the volunteers through interviewing. The volunteers were co-actors in the interview process and both the researcher's interpretations and the volunteers' interpretations of their insights were examined during the interview process to confer agreement and clarity of the themes discussed. Finlay and Gough

(2003) suggest that both the researcher and the participant hold multiple T positions in the exchange of information as these various selves interact. The researcher has to attend to the micro level experience of the volunteer but also to the macro level of cultural and organisations discourse. This requires a reflexive level to be integral to the exchange between researcher and volunteer.

#### 4.8.4 Memo writing

A fundamental ingredient of data analysis is memo writing. Charmaz (2006) suggests that memo writing is crucial as it prompts the researcher to analyse data and codes early in the research process. It is the pivotal intermediate step between data collection and theory building. It is a precursor to writing drafts and will assist with sorting, that is finding logic for organising the analysis and subsequent writing. Memos are a tool that facilitates methodological practice but also the exploration of processes in a social world (Lempert, 2007). The use of memos as suggested by Charmaz (2006) was important as it helped to prompt and make associations with the codes identified in the early stages of data analysis. Memos helped to identify points of interest and commonality, and to aid identification of links between different categories. Each of the sub-categories highlighted and the main category has associated memos. An example is given in Figure 5 of a memo in its early stages as a category was constructed to support *Crossing boundaries from patient to volunteer*. Memo writing is the methodological link through which the researcher distils data into theory and ultimately it is the integration of these abstract analyses through memos that the researcher will share (Charmaz, 2006).

**Figure 5. An early memo to support the category that was labelled Crossing boundaries from patient to volunteer**

**Memo- Developing a socially valued role** - Identity is very important; due to MH there has been a change in how participants perceive themselves and how others perceive them. Participant's sense of identity and role were frequent themes that arose from the data in phase 1 and again in phase 2 but for some volunteers in phase 2 their identity was more established in some way. Role identity is important here. Papers by Peggy Thoits, looks at role identity and role salience, what roles are important and why. Some volunteers valued the fact that their experience as service users could be used in a positive way while others liked the anonymity of the volunteer role (see Katie and Alice). Stigma and labelling is relevant here Goffman says people control identity and information that may discredit them - spoiled identity. Many of the participants spoke about how they thought about themselves as a result of volunteering. 'Volunteer' was a more acceptable label, less stigmatizing; whilst others acknowledged that they would always be service users; there was it seems a transition that some volunteers went through. Service user > service user volunteer > potential worker in Trust. Occupational identity is also relevant, occupational identity is formed through everyday occupations. If volunteering provides a socially valued role then this will enhance an occupational identity. This new valued role also improved self-esteem and participants in phase 2 thought it gave out a message (positive one) about themselves to others (see Janet and Natalie).

#### 4.8.5 Theoretical sensitivity as an aid to theory building

Theoretical sensitivity is a key factor in theorising possibilities, making comparisons and building on ideas. It was important to be open to new or different ways of explaining what was happening in the data. Categories identified in phase 1 were explored with the benefit of new, additional data from phase 2 and labels, presented as gerunds suggesting enacted processes, were suggested and discussed with the researcher's supervisory team. Focusing the coding on actions assisted in the making of connections and sequences between each of the codes and then between the categories.

The researcher found it helpful at this point to use mind-mapping software to visualise these processes. It was important to make explicit the links and relationships between experiences and events.

During this part of the process the number of sub-categories was also refined as a result of re-examining the properties and dimensions of each category. Eventually the

researcher settled on three main categories, which contributed to an emergent substantive theory and which also are diagrammed to present the conditions and consequences related to the central phenomenon of volunteering (see Figure 6). The analytical process of constructing meaning and relationships is illustrated in the following diagram, which is a representation of a constructed identity for volunteers in this study. The diagram illustrates how the identity of *Becoming a Worker through Volunteering* is part of their personal recovery journey. This diagram does not attempt to offer a process, but rather a visual representation of how the emerging theory relates to key categories leading to a substantive core theory. The diagram presents properties and dimensions of each category and their relationship with the core category. Memo's supported the categories as they evolved. The inclusion of diagrams as another analytical tool is central to the theory generation in grounded theory. They create a visual display and bring order to the data and they can provide the researcher with a visual map which allows them to gain an analytical distance and then allow conceptualisation of the data in more abstract terms (Bryant and Charmaz, 2011).

#### **Key to Figure 6**

- The core category is represented by a large red circle
- The three main categories which link to the core category are represented by blue circles
- All other sub-categories are represented by orange circles.
- Red arrows show the relationship between the three main categories and the core category
- Blue arrows show linkages to demonstrate relationships within a category
- Orange arrows show a linkage between the sub categories in each of the main categories

TREADING  
CAREFULLY  
AT FIRST



#### **4.9 Ethics**

##### Ethical approval

A proposal for each phase of the study was submitted to Sheffield Hallam University ethics committee for scientific review and ethical approval.

Phase 1 study also required NHS ethics approval and this was granted from North Sheffield Local Research Ethics Committee on 08.01.2008.

Research within a qualitative paradigm that involves a direct relationship with participants will require attention to moral obligations to ensure no harm. Gregory (2003 p.30) describes the ethics of research as 'embracing moral issues arising out of the conduct of the research/

An attribution of vulnerability is often ascribed to people with enduring mental health problems and assumptions are made that the way the research is conducted may need to be different from the norm. Whilst accepting that there may be different needs, in terms of literacy, length of time needed to conduct the interviews, (so that the participant feels at ease and not rushed), and that there is a potential for an emotional response to areas of questioning, the researcher also does not want to undermine the value and importance of their contribution and indeed reinforce stereotypes about people who have a mental health diagnosis.

The process of health research ethics can be quite arduous with medical ethics in particular dominating and shaping research ethics policy. Social research ethics whilst rigorous is less socially and collectively developed. Self-regulation and personal conscience are paramount (Economic and Social Research Council, 2001, British Sociological Association, 2003).

In phase 1, an application was made for ethical approval from a local NHS Research Ethics Committee and the Trusts research and development department. This was granted subsequent to minor amendments of the participation information sheet and consent form and then a further amendment was requested to a change to the consent form plus a change to the analysis. Evidence of communication to support this process can be found in (appendix iii and iv)

In phase 2 Sheffield Hallam University (SHU) granted ethical approval. Following some challenges with respect to being able to recruit participants who fulfilled the inclusion criteria an amendment to the proposal was requested so that telephone interviews could be permitted. This could then extend the geographical area for recruitment and was approved by the SHU Faculty Research Ethics Committee (FREC). Two of the volunteers in phase 2 were interviewed over the phone. Evidence of this amendment can be found in appendix x

Ultimately, as a researcher, there was a duty to impart no harm on any participant and ensure that every question asked is related to the research topic area. It was important to maintain respect and trust and give a voice and ownership to the participants. The researcher was also aware that through the interview there would be the possibility of self-disclosures of sensitive or distressing experiences and confidentiality and anonymity were important to maintain. A health and safety proforma was completed and discussed with the supervisor about how to manage such situations. The researcher had a number of years of experience working in mental health services and the skills to manage situations if a volunteer became distressed.

As phase 1 interviews were conducted in Trust premises there were also other staff members available and on site. Had anyone become distressed in phase 2 interviews the researcher would have outlined a list of potential support agencies and established personal support networks that the volunteer could access. However this was not required and the interviews proceeded satisfactorily.

#### 4.9.1 Confidentiality and anonymity

All transcribed data was anonymised to maintain confidentiality and to ensure that no individual could be recognised in any subsequent report. All volunteers were allocated a unique identifying pseudonym. Paper based data was kept secure in a locked drawer and electronic data and information relating to this research was kept on a password-protected computer. This data will be kept for a minimum

of 7 years and according to SHU guidance. Anonymity will be maintained in this thesis and in any dissemination of the findings. There will be no identifying information in any subsequent dissemination or academic papers.

#### 4.9.2 Consent procedures

##### Phase 1

In phase 1 a copy of the consent form was supplied with the participant information sheet but written consent was taken at the time of the interview.

##### Phase 2

In phase 2 any participants who expressed an interest in being involved in the study were screened initially by telephone. This provided the researcher with an opportunity to check that potential participants fulfilled the inclusion criteria and also allowed them the opportunity to ask more questions should they have had any. Participants who continued to be interested in the study were sent a participant information sheet and a copy of the consent form. Written consent was taken at the first interview with each participant. Two participants were interviewed by phone and consent was given verbally at the time of the interview and followed up with written consent by post.

All participants had been made aware that should they wish to withdraw from the study they could do so and this would be respected without any detriment and any data related to them would be destroyed.

#### 4.9.3 Trustworthiness and Rigour

Trustworthiness is a means of viewing and checking issues around quality and rigour within qualitative research (Finlay and Ballinger, 2006). Qualitative researchers consider trustworthiness when a phenomenon is trying to be understood in a real world setting (Patton and Smith, 2011). To gain access to an individual's world the process of in- depth interviewing accesses inside knowledge

of that individual's thoughts and feelings about a given area of their life. Language is important as it can either promote validity through shared understanding or it can create a barrier. Validity issues are highlighted by what Mehan (1979) cited in Silverman (2013) refers to 'anecdotalism' which is a trap that researchers can fall into because they focus on just one or two well-chosen cases, resulting in a weakness of the findings presented.

How do we know that all instances and experiences are covered? Why do researchers leave out some instances and experiences? What is the justification for this? It was important to be aware of these traps and take steps to fully analyse all data and give justifications for what is and what is not presented. The selection of quotes from the interview just to fit into an ideal phenomenon should be avoided. However data is the researcher's evidence (Bryant and Charmaz, 2011) and it is this that allows the audience to participate in an unfolding analytical argument. Themes and ideas from the analysis should not be forced. Further issues of validity can be checked at all stages of data analysis. It is important that the data reflects the topic being studied and that the themes and questions constructed prior to the interview are enabling to the process and don't impose an agenda on the phenomena or situation being studied.

Validity should be identified confidently within the research report but it should be acknowledged that certainty is unlikely as the qualitative researcher strives for reality through a particular perspective. Hammersley (1992 p.50) supports this by considering that accounts represent reality but that they do not reproduce it.

The issue of reliability in a qualitative study means that the researcher documents their data analysis consistently. Lincoln and Guba (1985 p.316) make links between validity and reliability and state that "since there can be no validity without reliability then a demonstration of the former is sufficient to establish the latter." Patton (2001) supports this by describing reliability as a consequence of validity in a study. Lincoln and Guba (1985) identified evaluative criteria that

would assist qualitative researchers to determine rigour of their research and this has informed the rationale for decisions made to ensure trustworthiness and rigour in this study. These are: credibility, dependability, transferability, confirmability and each one is now discussed.

#### 4.9.4 Credibility

Credibility is the extent to which any research claim has been shown to be based on evidence (Silverman, 2010). It was important in this study to be consistent in the application of the grounded theory techniques, for example being consistent with the way the data was analysed and the process was followed across all data sets. This study has employed methods and approaches that align consistently with the constructivist approach selected. In this study the researcher undertook all the data collection and analysis; it is suggested that such an integrated approach is optimal for grounded theory studies due to the iterative data collection and analysis approach (Charmaz 2008a). 'Credibility' is associated with the familiarity of the setting, the adequacy of data to support the claims and evidence of systematic comparisons between data, codes and categories. Charmaz (2006) considers that a strong combination of originality that is the freshness of categories and the ability to offer new insights and original conceptual rendering of the data, as well as credibility increases the resonance, usefulness and ensuring value of the study's contribution. The contribution is also dependent upon a clear positioning within the context of relevant literature.

#### 4.9.5 Reflexivity

Reflexivity facilitates a critical attitude towards locating the impact of researcher context and subjectivity on the research design; data collection; data analysis and presentation of findings (Finlay and Gough, 2003). Morse (2006) states that excellent qualitative research is inherently biased and Denzin and Lincoln (2003) say there is no attempt to suggest that qualitative research is value-free.

Throughout the qualitative research process researchers need to consider possible ethical dilemmas and reflect on these. A full account of the researcher's reflexive position, when taking a constructivist approach to grounded theory in this study, is discussed in chapter 8.

#### 4.9.6 Confirmability

Through a reflexive position the documented procedures and critical reflections on methodological issues and decisions about the overall research design are presented in this thesis. In the previous chapter every effort has been made to present this overtly to the reader and a critical perspective of any research design limitations will be evidenced and discussed fully in chapter 9. Throughout the research process the supervisory team have supported the researcher to engage in different strategies to aid decision-making and check out ideas and concepts that help develop the theoretical stance of the study. A research diary has been used to record the researcher's own position and feelings at key stages of the study. Again this reflexive position will be presented in chapter 8.

#### 4.9.7 Dependability

Every effort has been made to clearly and openly give an account of the way in which the data was collected, from identification of participants as part of a convenience sample, the use of open interview questions to gain insight into the phenomena of volunteering and its meaning to the participants and recording and documentation of this data. Clear documentation of this process of enquiry in this thesis aims to provide the reader with the possibility of reproduction of this process if so desired.

#### 4.9.8 Transferability

The transferability of the study between the researcher and the volunteers as those being researched is evidenced by thick description that includes extensive details about context and participants in both phase 1 and phase 2. The qualitative

nature of the study means that rich descriptions of the social world under study is essential and extensive field notes accompanied all participant interviews and full consideration of the context in which the volunteering took place is also documented. This informed the richness of the data so it is detailed, focused and full (Charmaz, 2006). The use of memos and reflections were important so that thoughts and ideas informed by the data were recorded to help make decisions to progress the analytical stage of the study and there are, wherever possible, examples of these incorporated and provide evidence for transferability.

#### **4.10 Summary of the chapter**

This chapter has examined the research design and methods employed for this constructivist grounded theory study. It has considered how theoretical concepts have been developed and examples of the process of theory generation have been provided. A range of ethical processes and themes have been discussed and attention has been given to the rigour of the study and how this has been monitored and acted upon from data collection to presentation of emergent theory.

**PART TWO - FINDINGS AND DISCUSSION**



## **CHAPTER FIVE: FINDINGS - FINDING MEANING AND CHALLENGE**

### **5.1 Introduction to the chapter**

The previous chapters have introduced and set a context for this study. They have justified the methodological focus, and the design and research methods used to elicit the data and subsequent analysis using a constructivist grounded theory approach. As the researcher is a reflexive participant in the analysis of the data, it is this process that is presented.

This chapter starts to examine the categories that emerged from the data, and allow the volunteers voices to be heard as part of the analysis with supporting extracts from the original data set to illuminate meaning and interpretation.

The experience of volunteering has taken place for all participants over a period of time and similar to a journey, there is a temporal element to the experiences of the volunteers. Whilst the theoretical framework is not linear and no category is more important than any other they are ordered in such a way that offers a useful map for subsequent theory development.

The recovery process is not a linear one, it is not made up of successive achievements and it does not follow a straight course. Instead, it is an evolving process, one that sometimes spirals back on itself and it may result in a frustrating return to an active disorder (Ridgeway, 2001). Whitewell, (1999) refers to the myths of recovery as meaning being restored to a former state.

There are three broad emerging categories that will be discussed. Each key category will be discussed after the sub categories have been presented as an attempt to demonstrate how theory has developed through the categories and how one links with the next.

Chapter 5: Finding Meaning and Challenge within volunteering

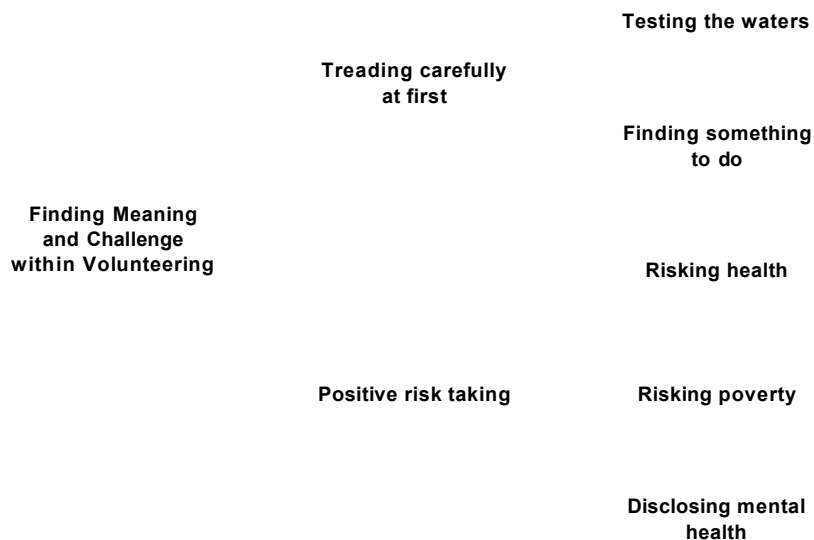
Chapter 6: Crossing boundaries from patient to volunteer

Chapter 7: Finding the right sort of work

These culminate in a substantive core theory generated from the data that is titled:

*Emerging as a worker through Volunteering*. Key supporting theories and concepts will be discussed in relation to this core category in chapter 8.

**Figure 7. Diagram demonstrating how one of the main categories was constructed 'Finding meaning and Challenge within Volunteering'**



The term that encapsulates this category is '*Finding meaning and challenge within volunteering*'. In terms of its place within a theoretical framework this category represents a starting point. This category is made up of two sub-categories *Positive risk taking* and *Treading carefully at first* which were significant in terms of the volunteers starting point and their approach to finding a place within volunteering that provided meaning and challenge. The volunteers expressed initial caution about volunteering

and this was linked to a perception of the barriers posed to service users. Barriers to work are highlighted as risks in this study. The label of risk has been designated to this category, as they were factors that posed a threat to the service users who were concerned about changing the status quo and who through volunteering, saw this was an opportunity to manage positively those same risks. People with enduring mental health problems have fewer opportunities to work due to prejudices and perceptions or even myths about their abilities in relation to work (Mental Health Foundation, 2002). Krupa et al., (2009) highlighted four assumptions underlying workplace stigma (1) Individuals lacked the competence to meet the demands of work, (2) people with enduring mental health problems are dangerous or unpredictable, (3) working is not healthy for people with enduring mental health problems and (4) providing employment for people with enduring mental health problems is an act of charity. These assumptions vary, being dependent on individual, organisational and societal factors (Brohan et al., 2010). These negative stereotypes impact on the social exclusion of individuals with enduring mental health problems.

The process of stigma producing prejudicial behaviour comprises three aspects: ignorance or misinformation, prejudice and discrimination (Thorncroft, Rose and Kassam, 2007). As a form of self-fulfilling prophecy it is not uncommon for people who experience stigma to also experience more somatic symptoms. It is more acceptable to talk about stomach-ache and fatigue than one's mental health problems (Walport 2001). Anticipation of negative responses from employers and fellow employees can also result in people withdrawing from or limiting their social or occupational functioning (Alexander and Link 2003). Boyce et al., (2008) highlights other factors that include stress, tiredness, control and flexibility to do other things that were significant to the participants in their study as potential barriers. Disincentives or barriers to work for people with mental health conditions have been attributed to loss of welfare benefits, stigma in the workplace and fear of disclosure of mental ill health to employers (Sayce 2000, Evans and Repper, 2000).

## **5.2 Treading carefully at first**

This term is used to express the approach that the volunteers were using to engage or re-engage with the world of work. People with enduring mental health problems are conscious of their impaired life position describing issues in their lives such as unemployment, divorce, housing problems, lack of money and social isolation. All the volunteers in this study had experienced a disruption to their working lives. This may have been due to a lack of or delayed starting point in their work history, which was a result of mental illness. This meant they were 'workless' for some time. A number of the volunteers had experienced paid work and successful careers, which was only disrupted when they became ill and they had to retreat from work. A number of the volunteers had periods when health was better and work was possible. However this had not been sustained and as a result of mental illness they had experienced difficulties engaging with work again or getting back into the labour market. Prior et al., (2013) found that how we understand an individual's readiness for a return to work is tentative and that there are considerable personal variations. Due to the nature of their mental health, a number of volunteers had diagnoses of severe and enduring mental health conditions that have fluctuating or deteriorating mental health symptoms together with associated physical health symptoms. They saw these as impacting on their ability to manage a paid work role with a formal contract and set hours. Volunteering allowed them to test this out. It was an opportunity to see how they could manage their mental health and physical health symptoms in a work environment and also an opportunity to see if they could commit to something without too much risk to their health. Diagnosis itself is a poor indicator of employability (Bond and Drake, 2008 Tsang et al., 2010a). Better indicators are work history and length of time employed (Grove and Membrey, 2005) which is again for some a barrier or risk identified in this study. Other studies suggest that it is higher levels of cognitive functioning, a stronger sense of self-efficacy and better work performance which are predictive of successful job outcomes (Tsang et al., 2010).

Alice was the youngest of the volunteers interviewed. Her risks were that she had no concrete work experience and, therefore, was less familiar with the workplace. She was unable to know what her physical capacity was for paid work; in terms of commitment to a set number of hours, time management and punctuality. She wanted to use volunteering as a way of building up experience for her curriculum vitae (CV).

***Alice (10):** For me personally one of the reasons I did volunteering was to test myself because...not in relation to the mental health side of things because I felt I had achieved and got over that hurdle but for me the physical demands of committing to a full-time or part-time job so volunteering for me meant that I could try working on a flexible basis and just see how much I could commit to.*

Previous research has indicated that a service users' own sense that they are ready for employment is a strong predictor of successful employment (Tsang et al., 2010a; Grove and Membrey 2005). Exposure to real work environments would allow them to better understand employers' expectations and to consider what type of working pattern may suit their needs (Kielhofner and Forsyth 2008). Thinking about the meaning of work from a temporal perspective is important (Reed, Hocking and Smythe, 2013), as individuals can see occupation including work related activities as a thread that runs through a lifetime, which suggests there is temporality which aids meaning. The temporal aspect is also important in terms of how people develop a work history or career over time and gaps in this work history have other meanings which may be attributable to mental illness (Reed, Hocking and Smythe, 2013).

**Figure 8. Diagram representing barriers (risks) to engaging with work from data analysis**



Time has shown that, although rewarding, re-entering the employment market after a serious mental illness can be daunting Rinaldi, et al., (2008). The onset of mental illness is disruptive to anticipated life paths and can sever social connections. Returning to work is valued as it provides several opportunities to meet instrumental, psychological and social needs that contribute to general wellbeing and quality of life (Warr, 1987). Getting and holding a job is an important measure of success and social approval (Nagle et al., 2002) and an indicator of personal recovery (Shepherd et al., 2008). It was in fact Freud cited in Hazan and Shaver (1990) who suggested that ability to love and work are the criteria of mental health. Work is valued for its normalising aspects and employment is viewed as means to gaining social approval, developing self-confidence and having a focus beyond disability (Nagle et al., 2002). There is clearly an important balance to be struck here between the dangers of forcing people back to work and the dangers of excluding them from it through a combination of ignorance, prejudice, and lack of effective help. Shepherd et al., (2008) believe that

even greater dangers still lie on the side of exclusion and that most people with enduring mental health problems want to work, if only they can be provided with the right kinds of help and support (Seebohm & Seeker, 2005). It should be noted that this study formed the qualitative arm of the EQOLISE study (Burns et al., 2009) and specifically explored Individual Placement and Support (IPS) and not work in more general terms.

### **5.3 Positive risk taking**

Bird et al., (2014) in their study discuss personal responsibility. Personal responsibility involves a degree of positive risk taking, particularly in the context of negotiated care planning and goal setting and it is helped when supported by health professionals. All the volunteers in the study were encouraged to take positive risks that helped to mitigate the concerns they had. Rinaldi et al., (2008) make the point that mental health professionals' fears about raising unrealistic expectations in their clients and exposing them to levels of stress that could exacerbate their enduring mental health problems can be unhelpful. Thus professionals' attitudes and lack of optimism about returning to work was viewed as another potential barrier.

The risks identified by the volunteers included deterioration in a mental health condition as well as a negative impact on their physical health condition. Changes to their finances and disruption to an established routine, even when not balanced, was a concern. Further concerns about relationships they would need to manage in the workplace as well as disclosure of enduring mental health problems were also perceived as risks. This category also determines some of the reasons why paid work was not the first choice or route that people wanted to take to get back into the labour market. This challenge was right for the volunteers at this time. Positive risk-taking is just the first step of a journey that starts with volunteering. The volunteers were able to make the decision to volunteer and they had control over that decision, it was at their discretion.

### 5.3.1 Risking health

The fear of managing a fluctuating mental health condition, and/ or a physical health problem was a real concern for the volunteers. Harris et al., (2014) recognise this as a key barrier to work. Natalie was a volunteer with her local church. She was in paid work but after a series of health related challenges she still felt she was unable at this time to commit to full time work. Volunteering was a way of helping her to know what she could commit to.

**Natalie (14)** *I would really love to work I would love to work sometime, but the problem I have been presented with to stop me doing that now, is in 2004 I was diagnosed with a cancer and then I went for chemo in 2009. But between 2004 and 2009 I was having some really bad periods, mental health problems so that kind of prevented me and then I had an accident last May, a car accident, I'm having real problems with my neck, shoulders and arm but I didn't have the energy to go to work and do full time work. I can't do it.*

Her main barrier was her physical capacity to do certain work tasks and she recognised that her current role, as a volunteer allowed her to discriminate between certain tasks, and that in this way she was managing risks around her physical health.

**Natalie (14)** *The work I do at the moment I could do that every day because there is no physical work involved that's the thing there is no physical work involved. It's pretty emotional but you don't have to do any major physical tasks. You see the reason I'm not cleaning anymore is because I can't physically do it anymore, so that's where I am at the moment.*

Finding a way to express occupational interests within the context of volunteering was an option for some. Volunteering was a way for Luke to try using his art skills in a work environment. It was a starting point and he was aware that his mental health symptoms still fluctuated. He was aware that volunteering could be demanding at times.



**CF:** *What advice would you give to another service user about volunteering?*

**Luke (3):** *Firstly, think about what capacity they want to volunteer; because it can be quite demanding particularly with mental health problems, it can have an impact on your own mental health.*

Luke then alluded in the interview to a reduction in his mental health support since volunteering. This might account for improvement in mental health symptoms based on several factors for example reduced stress, medication, support networks or an ability to cope better in this environment now as a volunteer.

CF: What has changed since you started volunteering?

**Luke (3):** *I have not seen my CPN for a while so I suppose it has helped me not need as much support.*

Luke's long terms plan is to find paid work that would allow him to use his art skills and he understands that further education may be required, so volunteering was the starting point. He was able to review his vocational goals with support from the user volunteer service.

Dan, like Luke wanted to try volunteering as something that was different to the work he had done in the past. Dan had weighed up the risk of doing volunteering from a health perspective. He wanted to try something that was less stressful than the work conditions he had experienced in the past. Dan also thought about finances, which for him was less of a risk, so this helped to sway his decisions to volunteer.

**Dan (9):** *I couldn't go back to doing what I did before which was working in a factory. That didn't help my condition at all you know, pressure of work and stress, so I said if I could I would like to get into helping in mental health somehow if I could you know. And without putting any stress of myself, I thought I would like to volunteer and I know there is no money in it but...it wasn't as if I was going out living the high life!*

It may be naive to think that Dan won't experience stress working in a mental health environment but Dan believed that, for him, it was stress related to the working environment he had in the past that he wanted to avoid, because it would not be conducive to his current mental health.

Karl initially volunteered with a computer group at a day service. He decided to do this as it was based on skills he had and previous experience of his time at college. He thought volunteering was a safer option as people knew him and understood his difficulties but he wanted this to be the start, doing something 'small' but helpful in terms of him looking for a job. Karl had worked from the age of 18-23 but then became ill. He saw volunteering as a 'stepping stone' towards paid work again. Work is important for Karl but he wanted to be ready and able to get a job and be able to hold it down without getting ill. He wanted to learn to be able to manage his illness. Karl had tried going to college but struggled because of his enduring mental health problems, feeling that people in college did not really understand and so he thought that volunteering in the Trust would be 'safer.'

***Karl (6):** Because I know I had problems going into college...in the past but, I thought if I could do something small where I felt a little bit safer, where I knew I had people around me who'd understand...then it helped, it helped me, then move on and get better.*

These findings reiterate the work of Honey (2004) when she speaks about people who have experienced mental health difficulties as 'weighing up work' (p.386), whereby they consider a range of factors that influence the decisions they make about wanting to return to work. Honey (2004) believes that people consider the benefits and drawbacks of work before deciding a course of action. When participants in Honey's study weighed up work they did this on two levels. First they assessed the benefits and drawbacks of being employed then they compared job types in terms of benefits and drawbacks to determine a course of action, which for some resulted in volunteering rather than paid work.

It is important that a sense of control is realised in order to enhance the experience of a life worth living with an enduring mental health problem (Hammell, 2004a).

Researchers note that individuals whose lives have been disrupted by illness or injury make a conscious decision to take control of their lives through reengagement in occupations they find personally meaningful (Vrkljan et al., 2001). A sense of control is achieved, along with biographical continuity, when individuals can choose, shape and orchestrate their daily occupations.

Central to the experience of quality of life is the ability and opportunity to enact choices and assert control over an individual's occupations and their aspirations.

### 5.3.2 Risking poverty

The financial gain of paid work in an open employment market is not attainable for everyone who has a serious mental health condition (Stolk et al., 2012). The risk and stress associated with a move away from welfare benefits should not be underestimated. Open paid employment can lead to an initial financial loss.

Discrimination against employees with enduring mental health problems can mean that access to paid employment is restricted and so individuals will continue to be marginalised and excluded (Perkins, Farmer and Litchfield, 2009). Unfortunately, despite the recognised benefits of employment, mental illness is associated with lower rates of workforce participation and higher rates of unemployment overall (Harries et al., 2014), with employment in occupations that are relatively lower skilled or lower income-earning than would be expected based on qualifications (Cornwell et al., 2009). People with mental illness, such as anxiety disorders, mood disorders and psychosis, and those who also have problems with substance use, have especially low employment rates (Drake et al., 2009). The benefits system supports those volunteers who are not able to engage with paid employment due to health problems (DWP, 2010). Volunteering allows some flexibility to do something different that is akin to working, but is less risky to their financial status.

CF: What stops you looking for paid work?

**Natalie (14):** *Because of that trap I am in with the benefits, that's the trap. It's a really big trap. It's got to me and got to me over the years so I think to myself I can apply myself voluntarily and in the same manner I'm giving something back to the community I'm gaining something from it and they're gaining something from it.*

A barrier to paid work for some is the financial risk of losing money initially when entering paid employment. The term 'benefits trap' is often used to describe the welfare system, that is when the system creates stronger incentives to continue claiming benefits rather than entering paid work (Lelliot et al., 2008). A fine balance exists between supporting people who cannot work and the existence of disincentives to returning to work for those who can (Boardman et al., 2003). Congruent with the policies of the current coalition government is that claimants perceive pressure from a feeling of being forced into work. Conditionality rules for receiving benefits mean benefit claimants, including those with enduring mental health conditions, must demonstrate that they are looking for work (Bambra, 2014). The consequence of not doing this is the possibility of their benefits being withdrawn if they are not judged to meet the requirements (Bambra, 2014) and this was a real concern for the volunteers.

Natalie had already considered her health to be a risk and here she looks at the financial risk she would have to take to change her financial status. Natalie had, over a period of time volunteered for a number of organisations. She worried about the commitment she would need to give to paid work. This was primarily because of the physical limitations she had, due to chronic back problems, and low energy after undergoing successful treatment for cancer. Whilst she did not want to return to paid work until she felt ready, she had resigned herself to the fact that she may be forced to return to paid work.

**Natalie (14):** *Everything is changing in the system so I'm not sure yet about how it will affect my volunteering...but if I had to go out and do paid work then I'd have to.*

In a recent British Academy report (Bambra, (2014) it was highlighted that the probability of returning to work after being in receipt of long-term health related benefits is just 2% annually (OECD, 2009). Most recipients who have not worked and who have been claiming benefits for more than 6 months only have a one-in-five chance of returning to work within 5 years (Waddell and Burton, 2006). The unemployment rate for those with chronic disabilities is around 40% (REF). Furthermore, people with health problems are also more than twice as likely to work part-time (OECD, 2009).

Janet is one of the volunteers interviewed in phase 2. She was an experienced volunteer who got involved with volunteering after leaving residential rehabilitation to support her substance misuse. She had a longer-term vocational goal to work as a support worker with other people who were receiving substance misuse services. Janet spoke about stages in her recovery; she had started this journey of volunteering in a small manageable way and had over time exposed herself to different types of volunteering. She had built up the length of time she volunteered over a period of time, gaining skills and evidence of training that would enhance her curriculum vitae (CV). Janet was motivated to work not least to enhance her financial status and was aware that she may need to look for paid work.

**Janet (17):** *I do know they are really tightening up on things with the benefits. I do 4 days (volunteering) currently and I would like nothing more than to get paid work, it would be another part of the back to work thing, that I'd actually achieved the next stage.*

It has been argued (Harris et al., 2014), that substance use problems may be less occupationally disabling than other mental illnesses. For example, Slade et al., (2009) reported that both depression and anxiety resulted in higher sickness absence

compared with substance use disorders, although employment outcomes may be worse for those with more severe dependence (Harbeck et al., 2005). However, substance use does not usually occur in isolation and Morgenstern et al., (2008) investigated the barriers to employability among welfare applicants with substance use problems and found that the overwhelming majority (95%) experienced significant difficulties with barriers that included mental and physical health and homelessness; with, for 70%, at least, one barrier was rated as severe. Additional barriers identified in accessing employment services among injecting drug users included appointments with drug agencies and criminal justice services, problems with maintaining contact with the employment services, illness (including mental illness), limited skills and work experience and stigma associated with drug use (Neale et al., 2008). People with mental illness and additional substance-use problems have lower rates of workforce participation than people with mental illness alone (Compton et al., 2005, Drake et al., 2008).

Whilst carrying out the study a number of changes to welfare reform were implemented. With respect to volunteering, most notably before 2010, there was an understanding that 16 permitted hours were allowed for a person to volunteer without this affecting his or her benefits. Subsequently conditional arrangements were implemented to maintain receipt of benefits, and for some this was seen as inevitable pressure to find paid work, even when they did not feel ready to embark on this. The current arrangements (DWP, 2010) for permitted work, which includes voluntary work, suggest that benefits will not be affected irrespective of the number of hours volunteering (DWP, 2010). However it also states that claimants must be actively looking for and be available for work. Welfare benefit caps and changes to benefit rules in recent times mean that anyone with a mental health condition who is unemployed and claiming benefits is highly likely to increase their income by entering paid employment, even where this is part time (DWP, 2010). Government policies over many years have disincentivised a life on benefits and vilified anyone considered to be capable of work for remaining unemployed (Centre for Mental Health, 2013).

A number of studies have considered the practical experience of benefit claimants and have found that clients had encountered a number of challenges in 'negotiating' the benefit system. A small number of UK studies have examined this issue in relation to adults with substance misuse problems (Bauld *et al.*, 20012). Problems identified included delays in moving from one benefit to another, for example from Job Seekers Allowance (JSA) to Employment Support Allowance (ESA); problems with medical assessments for eligibility for ESA or Incapacity Benefit (IB), delays in appeals; and issues to do with completing forms and obtaining information over the telephone. Professionals reported that delays or appeals concerning benefits had contributed to some of their clients relapsing to alcohol use as a means to cope with the stress resulting from the financial uncertainty they experienced.

Some interviewees in the Bauld et al., (2009) study were reluctant to leave the 'safety net' of benefits even if they were motivated to go into employment. This was particularly an issue for those accessing Disability living Allowance (DLA), who were concerned about moving onto JSA and losing access to the other related benefits (such as Housing Benefit) that accompany DLA. Service users in the same study also pointed out that the benefit system could serve as a financial disincentive to re-enter work, with fear of the 'benefit trap', (benefit payments being higher than household income in employment), being a feature for some interviewees, particularly those in supported accommodation. Research by Garthwaite (2013) describes how, for sick and disabled people, the familiar letter in the 'brown envelope' from the Department for Work and Pensions, that arrives in the post reflects 'the arbitrary, contradictory nature of welfare reform'. They also point out how such fears can cause a delay in opening the envelope, which in turn can hinder a successful ESA claim. The most common source of information about benefits and the disabled is the mass media, which is littered with scaremongering stories of 'lazy', 'work-shy' benefit cheats (Garthwaite 2011). The majority of people in a study by Garthwaite, (2013), reported that being on incapacity benefit was not a comfortable, agreeable lifestyle choice. Poverty and insecurity was a harsh and unavoidable reality for some, particularly in the case of people who were

living alone and managing on incapacity benefit as their sole income. Some benefit requirements (including availability, working hours, and levels of benefits), were seen to potentially hinder recovery and return to work. This is in direct contrast to media opinion and the opinion of the Coalition government.

Challenges to managing the benefits system were identified in a DWP report by Bauld et al., (2011). There was a real risk that initially individuals may find themselves to be significantly financially worse off as some benefit structures can pay better than minimum or less than minimum pay which, in some cases, is the financial alternative. In a survey of over 300 people receiving IB, Mind (2011) found that 51 per cent of people reported the fear of assessment had made them feel suicidal. Mind (2011) also suggests that 87 per cent of people told the charity that the prospect of reassessment had made them feel anxious and over a third said that this has led to them increasing their medication.

Despite the pressure to undertake paid work some of the volunteers in this study viewed this as a risk but also as inevitability, and this brought some concerns. Those volunteers who were working towards a vocational goal and were motivated by the prospect of paid work had been volunteering for some time. However for others who had started the process of volunteering they wanted to try out work, get used to it again, and see what they could do. They wanted to know how their mental and physical health could be managed. It was this latter group of volunteers for whom paid work was just too much of a risk at this stage of their recovery. Recovery is about being enabled to take risks. Risk was a catalyst for change and it can be painful and hazardous and it can also be rewarding (Rethink, 2005). Volunteering can provide an outlet that feels less risky, but which allows the individual to engage in an environment that still places demands and responsibilities on them. The current political climate and policies may be taking away individuals' control of their risk taking through volunteering by forcing them into a work environment or role that they so not feel able to do.



### 5.3.3 Positive risk taking - Disclosing mental health

The decision to disclose or not disclose is a complex one with a number of factors for consideration. The visibility of a stigmatised attribute is a key factor in how it influences the individuals' social identity. Sources of differences which are not immediately apparent, for example mental health problems, can be thought of as a concealable difference, although certain symptoms, or their behavioural manifestations, as well as medication side effects, can make mental health problems more visible and less concealable (Brohan et al., 2012). Their relative concealability means that these differences are often unobservable to potential employers and so job applicants and employees with a mental health problems have a level of choice regarding if and when to introduce this information.

Disclosure or self-disclosure can be defined as the process of communicating information about oneself verbally to another person (Brohan et al., 2012). Corrigan and Lundin (2001) describe the process of disclosure, like a journey. The metaphor suggests non-linearity and it has an element of the unforeseen. Mental health service users face difficulties in deciding whether to disclose a mental health problem in the employment context (Brohan et al., 2012). They fear that disclosure may lead to unfavourable treatment. They have concerns about the impact of disclosure in an employment setting and whether applicants will be treated unfavourably if it is known they have an enduring mental health problem. A review by Brohan et al., (2012) raised concerns about employers' perceptions of those who have disclosed a mental health problem. Brohan et al., (2012) reported that people did get turned down from jobs due to their mental health problem.

Volunteers in the study had concerns about disclosure but also, as they were volunteering in the Trust or services sensitive to their mental health, then disclosure as a risk was perceived more positively and something which could be managed.

Katie was a volunteer in the Trust and she had also recently applied for an administrative paid post in the Trust.

**Katie (8)** *I am not sure how clear it is to people when I have been along for interviews whether I am a service user or not, but everyone has been respectful and very welcoming.*

Charles had worked in the building trade for all of his working life. Due to an accident he thought he would be unable to return to the same sort of work. He had concerns about disclosing his substance use to employers. His decision to volunteer and aspire towards a paid role in substance use services modified his concerns about disclosure.

**Charles (15):** *Working in that field it's not a problem...! could disclose and I don't think that would be held against me. In other forms of work it probably would, it's not something I tell people unless there is some benefit in it...so if I was going to work in a supermarket I wouldn't necessarily disclose I had a problem with drugs a few years ago...so if I could use it to my advantage then I would but otherwise I probably wouldn't really mention.*

Although Charles did not worry about disclosure in the field of work he hoped to enter as a paid worker one day, the fear of being stigmatised and discriminated against, either in the process of job seeking or within employment, is common. A study of 949 people with mental health problems found that 53% reported some experience of discrimination and the areas in which this most frequently occurred included employment, housing and criminal justice system interactions (Corrigan *et al.*, 2003). A Mental Health Foundation (2009) study looking at return to work after sickness absence found almost half of employees off sick with physical health problems also experienced mild to moderate depression. Employees were however, more worried about telling their employer about their mental health issues than about their cancer or heart disease. Danson & Gilmore (2009) found that employers are wary of employing people with any health condition. They found that while employers had sympathy towards people with disabilities, mental health problems, or those who had

recovered from serious illness, they were also concerned that, as employees, their disability or illness might lead to future difficulties and financial pressures for the business. In a Joseph Rowntree Foundation report (Morris, 2011) the level of sickness of workers with mental health problems was raised as an issue, particularly in an economy dominated by small and medium sized companies. Morris (2011) also points out that a combination of anti-discrimination legislation and promotion of more positive attitudes to employees with disabilities may well improve opportunities for people who experience reasonable health and/ or who have a static impairment where adjustments can be made to overcome barriers. However this is not always the case with mental health conditions and, when an employer is faced with a choice of someone whose condition is associated with ill health and times when they cannot work, then such policies may seem futile.

#### **5.4 Finding meaning and challenge**

The recovery literature talks about 'meaningful activity/ Meaning is the process of making sense of the world and one's place in it (Christiansen, 1999) and has a number of functions. These functions are: *purpose*, that is it is pursued as a goal or fulfilment; *meaning* which imposes order whereby one must conform to one's own values and justifications; and *self-efficacy*, where one's actions can make a difference and where self-worth, provided through events and doing, is important for meaning to be made.

The volunteers were engaging in occupation that of Volunteering, that was right for them. Occupation is a broad construct that is meant to capture "how people do daily life," and it considers three broad categories to describe the occupations in which people participate: self-care, productivity, and leisure. Hammell (2004) described occupation as everything people do for themselves including looking at themselves (self-care) enjoying life (leisure) and contributing to the social and economic fabric of their communities. Depending on the cultural context, age of the individual, socioeconomic status and lifestyle, some occupations may be labeled leisure or productivity and this can be the case with volunteering. Pierce (2001) remarks that

occupation is solely the experience of the person performing it. It is his or her 'personally constructed, non-repeatable experience' (p.139). In terms of the location in which occupation takes place then Dickie et al., (2006) contend that occupation is contextual and exists in a transactional reality, where a person and his or her surrounding world are really part of each other, and that occupation in fact resides not at the individual level but as part of the situation in which the individual is an integral part (p.91).

Each category of occupation includes a broad range of activities which are defined by their central purpose and the ways in which they contribute to health. Productivity includes the range of activities in which people engage to support themselves and their families, and through which they contribute to their communities and society. In addition to paid employment, productivity includes education, parenting and home maintenance, volunteer work, and even the play of children (Krupa, et al., 2009). Some disability theorists would argue that by prioritizing productivity, which has economic implications, then these ideologies denigrate those deemed dependent or unproductive who are not able to be productive in the same way (Hammell, 2004). Indeed categorising the occupation of others is value-laden as they establish and justify self-worth (Hammell, 2004). The categorization of occupation into these three broad categories can be problematic as it excludes other meaningful activities, for example simply being with other people (Hammell, 2004).

Volunteering provided meaning and it was an expression through that occupation (time, energy, interest) of connectedness and sharing of oneself. A strength of the construct of occupation is that it is easily understood in lay terms and is relevant to most people, in that everyone knows something about what people do in daily life and why they do it. Yet this simplicity also masks the complexities of occupation (Krupa et al., 2009). Motivation, selection, experience, performance and contextual factors underlie participation in healthy occupations across the lifespan.

Working and having employment have been highly valued in Western societies for a long time. Work governs the patterns of daily occupation, which provides temporal structure and creates necessary routines for the individual and his / her family. However occupational apartheid is experienced by people with mental health difficulties due to stigma and discrimination, as they may be considered to have a different economic status, social status and social value to others and therefore may be marginalized, alienated or restricted in respect to occupation and work (Kronenberg and Pollard, 2008). Durocher, Gibson and Rappolt,(2013) viewed this from an occupational justice perspective, suggesting that each individual will have occupational aspirations dependent on their unique set of circumstances and capabilities, and that each individual will require different opportunities to flourish and utilize their talent. In this study this is exactly how many of the volunteers first became motivated to volunteer. There was a recognition of existing skills, their experience (which for many was a mental health experience) and the environmental context in which they volunteered was one that was familiar to them. This set of circumstances created an opportunity for the volunteers to flourish. Research by Farrell and Bryant (2009) viewed volunteering as a means to social inclusion and occupational justice. Occupational justice is a term coined by the occupational science community that defines people's rights, equity and power relations in daily life and that can be brought into the discourse about occupation and participation (Durocher, Gibson and Rappolt, (2013). Participation in life situations is invariably expressed through occupations. There is then a shift from the social world of social justice to a focus on occupational justice, which is the means to choose, organise and perform useful and meaningful occupations (Christiansen and Townsend 2004).

International research shows that as soon as people start to recover from mental illness they often express the wish to start working or return to their previous employment, because they perceive work to be a meaningful occupation in life (Honey, 2004)

For some individuals paid work is not the primary goal because, as has been argued before, it has been found to be too stressful or demanding in relation to their psychosocial functioning, and therefore prefer other types of occupation (Gewurtz and Kirsch, 2007). Certain daily patterns and routines seem to facilitate health and recovery. Work that corresponds to individuals' abilities can be an important factor in achieving such health promoting patterns (Flvalsoe and Josephsson, 2003). Honey (2004) investigated the benefits and drawbacks of work for people with serious and enduring mental illness and work was perceived as a meaningful activity that gave a feeling of contributing to society, social status and a feeling of being able to improve oneself. Kirsch (2000) also looked at perceived meaningfulness and it was found it led to structure, productivity and better health and this was perceived as normalising. Purposeful use of time has the potential to be both health maintaining and health regenerating and that position has been further developed over the years (Law, 2002). In the current occupational therapy debate, several concepts are used that form different facets of time use. In the study the volunteers often identified time use as a problem prior to volunteering.

**CF:** *What motivated you to look at volunteering?*

**Neil:** *I think reflecting back and seeing that not a lot has happened and realizing that life should not be about not a lot happening. I reached a point and thought I have got to do something. Life should be about things happening.*

Time use builds up temporal occupational patterns and daily rhythms. People normally organize and structure their days in such a way that a balance between the day-night cycle and the activity-rest cycle is maintained (Gallew and Mu, 2004; Larson and Zemke, 2003). The extent to which an occupational pattern is synchronized to time, is important for the functioning and health of the individual (Christiansen, 2005; Christiansen and Matuska, 2006; Leufstadius, Erlandsson and Eklund, 2006).

Occupations in daily life include activities that provide a means to organise time use,

meet personal goals, provide meaning and satisfaction, prompt human development, develop abilities, capacities and coping, and change oppressive experiences (CAOT, 2002). The actual "doing" of occupations is believed to be transformative, promoting adaptation, creating personal and social identities, connecting people to their communities and enabling ongoing personal growth and development.

It has been shown that time use among people with psychiatric disabilities tends to be more dominated by leisure and sleep than in other population samples (Krupa et al., 2003; Minato and Zemke, 2004) and in a healthy convenience sample. Hayes and Halford (1996) found that men with schizophrenia participated in less active leisure and social life, slept more, perceived less pleasure in "pleasant events," and reported more difficulty in social situations than both employed and unemployed men without known mental illness.

People with psychiatric disabilities are at risk of being under-occupied, with few occupational opportunities and a non-stimulating social environment, or over-occupied, with too much stimulation from an intrusive environment. In fact, these risks of occupational imbalance may be viewed as an aspect of the disability (Bejerholm and Eklund, 2007). Generally, under-occupation seems to constitute the greater risk.

*Katie: I wanted some structure to my day and I wasn't doing very much with my life and I was spending a lot of time at home feeling miserable.*

A number of volunteers in the present study did use their time in ways that were purposeful for them as some had carer duties and others had routine activities that they engaged with plus also their time was structured prior to volunteering with appointments and attendance at services supportive of the mental health conditions. This was pertinent to volunteers in phase 1. In phase 2 the volunteers were more established volunteers and generally their time use was very much structured around volunteering.

Spending more time in work/education and less on sleep has shown to be related to better health and functioning (Leufstadius et al., 2006; Eklund and Leufstadius, 2007), and an ongoing and high level of occupational engagement in general has been found to be associated with wellness (Bejerholm and Eklund, 2007). Moreover, having routines and a daily rhythm following the light-dark cycle has shown to be meaningful to individuals with psychiatric disabilities (Leufstadius, Erlandsson, Bjorkman and Eklund, 2008) and to promote social interaction and mastery (Leufstadius et al., 2006). Thus, occupational patterns characterized by work-related occupations, ongoing occupational engagement without longer periods of nothingness, and a daily rhythm are important. Also, quiet activities may be beneficial if they function as a break between activity peaks, but detrimental if they form the only or dominating alternative for filling time (Bejerholm and Eklund, 2006).

Findings regarding symptoms and time use are less conclusive. Leufstadius and Eklund (2008) and Bejerholm and Eklund (2007) found psychiatric symptoms related to variation in time use and engagement. In contrast, Harvey et al., (2006) did not find symptoms to be predictive of time spent in different occupations. Other research has emphasised that engagement in daily occupations depends on psychopathology and stage of illness (Nagle et al., 2002) and on length of illness (Harvey et al., 2006). Moreover, research has indicated that negative symptoms, cognitive disabilities and side effects of medication tend to restrict people with psychiatric disabilities from engaging in occupations and social life (Chugg and Craik, 2002). However, it has also been shown that engaging in occupations and psychosocial treatments decreases the severity of symptoms (Harvey et al., 2006). In all, it seems that the way people use their time has a relationship to diagnosis, symptoms and side effects, although the direction of that relationship is not clear.

Employment, job-related training, and studying have shown to be satisfying for people with psychiatric disabilities, and a lack of such occupations may cause an impoverished life style (Eklund, Hansson & Bejerholm, 2001; Leufstadius et al., 2006). Productive



activities create routines and balance during the day and help to organise time and other activities, such as self-care/self-maintenance, play/leisure and rest/sleep (Erlandsson & Eklund, 2003; Leufstadius, Eklund & Erlandsson, 2008). The meaning generated by work/education could be vital for motivating people with psychiatric disabilities to maintain a normal a daily rhythm (Leufstadius et al., 2006; Leufstadius & Eklund, 2008). Work has also shown to give spin-off effects in terms of engagement in other activities during other parts of the day (Leufstadius, Eklund and Erlandsson, 2009). Therefore, access to work or other meaningful productive activities is seen as vital for occupational balance and a beneficial daily rhythm for the target group.

One of the concepts related to time use is occupational balance, which can be defined as the way in which people satisfactorily organize their pattern of daily activities (Farnworth, 2003). Some researchers refer to a balance between work, rest and play measured in time (Farnworth, 2003), while others rather emphasise the person's experience of balance (Jonsson & Persson, 2006; Nagle, Cook & Polatajko, 2002). Christiansen (1996) questioned the over reliance on the concept of optimal balance despite it being a philosophical underpinning for occupational therapy and would be fundamental in terms of directing occupational therapy interventions. Stadnyk et al., (2010) defines this imbalance as the excessive time spent on one area of life at the expense of other areas. Wilcock (2006) argued that occupational imbalance can occur when occupations are out of alignment with personal or psychological needs. Another way of approaching occupational balance is to focus on the match between personal resources, tasks, and environmental demands (Moneta & Csikzentmihalyi, 1996). This has also been expressed as the person-occupation-environment fit (Law et al., 1996). Yet another view of balance considers people's lifestyle within a lifeline perspective, and suggests that the mix of occupations may need to shift between age stages in order to maintain occupational balance and a sense of meaning in life (Persson et al., 2001). However, maintaining some activities across the lifetime has also been proposed as important for perceptions of continuity, harmony and balance (Persson et al, 2001; Velde & Fidler, 2002). Wilcock (2006) went on to say that this imbalance can

have detrimental effects on health and highlights the economic, political and cultural structures that can be responsible for these situations of imbalance for example the distribution of paid employment. When these structures create or maintain an imbalance then this can result in occupational apartheid that is when opportunities are afforded to some individuals and not others based on the disability, gender, sexual orientation, religion or nationality (Kronenberg and Pollard, 2005).

The issue of occupational balance in this study and maintenance of a worker profile across a period of time was important to the volunteers. If balance is reflected on a match between the individual and the tasks they do as volunteers then for some they recognized that their time use leaned towards those activities that could be considered to be productive rather than always having a balance between work, rest and play.

*(Charles): Yes I am really busy, all the time and for me it's good. Yes I have got quite a lot of variety I do things at SASS and I have started at Fitzwilliam and there are no end of things I can get involved with there. I only started last week but literally everyday...it's a good place to get experience, it's mental health and drugs and alcohol all in one building...so yes I am busy. I am busy 7 days a week really. The last time I can't remember when I had nothing to do. When I had an unexpected day free I was sort of panicking, what am I going to do? I like to be busy all the time I have various things to do. I am as busy now as if I was back and work and getting paid.*

Nagle et al., (2002) wanted to know if other occupations could meet the needs traditionally met through competitive employment. Employment is valued for the opportunities it provides for individuals to meet instrumental, psychological and social needs that contribute to the wellbeing and quality of life (Warr, 1987). Getting and holding a job is an important measure of success (Stauffer, 1986). The most common reasons for pursuing work is having something to do and earning money. Work is also valued for its normalizing aspects. Employment is a means of getting social approval, to develop self-confidence and have a focus beyond disability (Nagle et al., 2002). Time has shown that entering or re-entering work is a profoundly meaningful goal, and also

**a daunting one.**

Individuals choose different occupations that have social, symbolic, cultural and spiritual significance to them. Work and the meaning it brings cannot be separated from the person and his / her social, familial and cultural contexts, since meaningful occupation is a dynamic relationship between the person, their occupation and their environment (Jonsson and Josphsson in Baum and Christiansen, 2005). The occupational science literature advocates and has advanced the respect for form, function and meaning of occupations (Hocking, 2009) and the author reminds us that it is the personal experiences of occupation and how these are interpreted by the individual, that is important.

Participants wanted to be careful because they often moved into volunteering after a period of relative inactivity, when their enduring mental health problems had restricted them from being able to engage fully in a spectrum of activities and roles. When the volunteers were supported to tread carefully at first they were enabled to find a route to occupation that provided meaning and challenge within volunteering. When volunteers made the decision to volunteer they would weigh up the risks involved. When volunteers took positive risks this resulted in them finding meaning and challenge within volunteering. Finding meaning and appropriate challenge from work is as important for those who volunteer as it is for those who are in paid work (Leufstadius 2009).

Volunteering had meaning and purpose but is dependent on its context. A number of the volunteers in phase 1 were motivated to volunteer in the Trust to give something back (see chapter 6). Working with other service users was a motivator, as was an opportunity to try a different work role which was motivated by negative experiences of past employment. By matching interests and experience to the volunteer role and setting, the volunteers were able to work in parts of the organisation or services where they could be most helpful /productive. This motivation to volunteer came about after

periods of inactivity and therefore the volunteers were supported to start thinking about what to do in a more productive and purposeful way.

***Charles (15): At the time I sort of caved in all at once, I had the accident lost my job and could not work, I lost my partner and became homeless all in the space of about 4 weeks.***

Charles describes a devastating time when for him all aspects of occupation in terms of roles, routine and his environment were disrupted. It was influential in terms of the next pathway he would take. In this study volunteering provided something to do for the volunteers and a sense of responsibility, structure, balance and meaning to the day, as well as job satisfaction. This section looks at the way participants attribute meaningfulness to volunteering.

A lot of the participants talked about the schedule they had during the week where they fitted in the volunteering and other activities. This is different to what they had been doing before so new challenges were presented through volunteering.

***Katie (8) I knew I wanted to go back to work and I thought a good route would be volunteering.***

Meaning is socially constructed and meaning can provide a dilemma when experiences cannot be interpreted as coherent and satisfying. When meaning is denied then this can impact on wellbeing. There are threats to meaning when: opportunities are denied or lost; goals are not achieved; relationships are broken or lost; and when injustices, displacement and / or social exclusion occur. Life situations, including illness and unemployment, can also threaten meaning. The devastation of mental illness, loss and disability present such a challenge. Meaning can be found in the roles we take on, and it is contextual. Carefully chosen occupations can be an antidote when there is a void in relation to meaning.

A study by Lahberte-Rudman (2002), which was based on the assumption that individual's perspectives about everyday activities can contribute to an in-depth

understanding of occupation, generated data that linked occupation and identity. Occupation appeared to be a means through which informants could express who they were to themselves and to others. A limitation of this sort of research that considers the links between occupation and identity is that, if occupations are limited then this may limit the way in which participants perceive themselves and manage their social identities. Opportunities for engagement in a broader range of occupations could lead to opportunities for growth and reconstruction (Lahberte-Rudman (2002). It should be noted that in this study participants had chosen to do volunteering as an activity that would provide meaning and purpose but it was not at the exclusion of other activities e.g. leisure activities, caring for relatives. In Lahberte-Rudman's (2002) study participants indicated that the inability to participate in school and work made it difficult for them to perceive themselves as 'normal' and socially useful.

Despite some hurdles Katie's journey through volunteering became easier. Here she highlights the importance of having a focus and being occupied within it.

**Katie (8)** *It was hard, there were days when I didn't want to come to work and I would be crying at home with my mum saying I don't want to go, I don't want to go. Urn...but she would say look it's for a couple of hours because that's all it was in the beginning probably once a week for two hours. Um...and I would have to make my way; because I wasn't driving at the time, I would have to make my way on two buses which was another big drama in itself. Because I didn't like public transport and was frightened that people were going to talk to me, things like that... so eventually I would get here and enjoy it and I would be fine if I was busy, if I had got something to focus on and keep myself busy I was just fine.*

Charles and Janet spoke about how the meaning and purpose of what they are doing as volunteers has impacted on their time structure in a positive way.

**Charles (15):** *I have gone from nothing to do to being busy depending on what stage of recovery or what state your mind is*

*you could take too much on and for some people that would be a problem for me it's been ok.*

**Janet (17):** *I would go stir crazy if I went to bed every night and didn't have a purpose to get up the next day. I mean when my alarm goes off about half seven in the morning I might think twice on that (laughs) but you know I still get up get myself ready and get to the bus stop at twenty past eight sometimes later. Other mornings I come out earlier but I like having things to do in the day. I get home have my tea, have a bath or shower and I'm sort of ready to settle down and watch telly for a couple of hours. I like having things to do in the day.*

Key studies within the occupational therapy literature explore the value of volunteering in terms of health and wellbeing. Black and Living (2004) reviewed the occupational therapy and occupational science literature to understand the relationship between volunteering and health and wellbeing. Their study reported benefits to both health and wellbeing as well as social functioning. Mental health benefits were reported as being fun, lifting the mood and being worthwhile and satisfying, with evidence of personal development. Volunteers gained confidence and a sense of achievement and being accepted and appreciated added to the experience.

Eddie had struggled with reoccurring mental health symptoms for a number of years but despite this maintained a commitment to volunteering. Here he talks about the sense of purpose he gained through volunteering. It would appear that Eddie's had ambivalence about how he perceived himself and how others did and so volunteering provided a meaningful occupation for him to gain affirmations about his skills.

**Eddie (12):** *It got me out of the house and there is absolutely no doubt that I would have felt a much greater depth of despair and emptiness. I'm often told that I connect with people really well but there is kind of maybe a denial about it that punctures the emptiness I feel as a person. It did make a big difference and you go home with a grin whilst still actually feeling quite depressed but it did undoubtedly, probably for the first time in years I think, it really kind of the first time I had any real deep sense of purpose about by myself... for a long time.*

Wilcock, (1998) says health is a complete sense of physical, mental, social, emotional and spiritual wellbeing. Research by Law et al., (1998) supported the value of occupation but indicated that factors such as choice, control, stress levels, boredom, intrinsic motivation and level of challenge and skill could hinder or, alternatively provide optimal conditions to benefit health. Research that has looked at the age of volunteers in particular has identified increased psychological wellbeing and life satisfaction for older adults who have reduced social and personal resources (Fengler, 1984). A study by Johnson et al., (1998) found that volunteering fulfilled intrinsic work values for younger people who were involved in their community. Studies into mediating factors including age, and number and range of volunteer roles. Social contact was an important factor and the volunteers said that it was like having another family and so many more friends'. Omoto (2000) again highlighted how volunteering can replace a lost role.

Employment as defined by the Oxford English Dictionary, is a 'state of having paid work' but Blank and Haywood (2009) argue that it is possible to assist an individual's recovery journey by defining employment more broadly, as a meaningfully occupationally focused goal. It is by developing a sense of doing that people with enduring mental health problems can begin to develop the capacity to consider a possible future.

Involvement in meaningful work whether paid or unpaid has been recognised as a major determinant of health, being related not just to economic factors but also to social benefits including social status and time use (Wilkinson 2005, Wilcock, 2006). Voluntary work confers positive attributes on the volunteer as it provides meaningful activity, builds structure and skills and, for some, will offer a step towards formal employment (Clark, 2003; Holmes, 2007; Bashir et al., 2003). In this study volunteering was perceived to be an acceptable occupation that had purpose and meaning. It also had therapeutic benefits in terms of pacing and grading of its different elements.

When we fail to consider an individual's life story we fail to confer meaning. A study by Nagle et al., (2002) highlighted that the participants all talked about past, present and future occupational choices in relation to their mental illness. The onset of illness forced them to abandon valued occupations and ongoing symptoms and relapse continued to affect their ability to be occupationally engaged and made it a struggle to determine a new life path. In summary: past occupations were engaged in because they were free from illness; current occupations were performed because they were feeling better and symptoms were managed; and future occupations were chosen to prevent relapse. This may be oversimplified as it was evident in this study that past occupations had been for some a contributing factor to their poor mental health and ability to cope in a paid work environment. Current occupations, including volunteering, were influenced by enduring mental health problems; occupations for the future were chosen in relation to maintaining a volunteer role and future work aspirations and, for some, to maintain a connection with mental illness that would still provide meaning and purpose. This will be explored further in chapter 7.

The significance of creating meaning through purposeful occupations has been explored widely by a number of theorists. Research does support the importance of engagement in purposeful occupations that are personally meaningful and valuable to the individual (Vrkljan et al., 2001; Hammell, 2004a). However, it is questioned whether engagement is enough to infuse life with meaning (Vrkljan et al., 2001).

Although it is not helpful to interchange meaning and purpose the association of these concepts are interlinked. Many qualitative studies have found that filling time with personally meaningful occupations restores a sense of value and purpose to life (Lahberte- Rudman et al., 2000). Mee and Sumison (2001) suggest that doing something purposeful is directly associated with the meaning of one's day and occupations that are personally meaningful convey a sense of purpose.

The social and cultural implications of having an enduring mental health problem, include unemployment and worklessness, which means that individuals may



experience exclusion from activities that provide meaning and purpose. For some individuals paid work may not be a primary goal because it has been found to be too stressful or too demanding in relation to their psychosocial functioning. Other occupations are then considered as meaningful activities e.g. community based activities and occupations at home. Volunteering as a positively meaningful occupation and its impacts on recovery are of particular interest. Christiansen, (1999) suggests that meaningful occupations are a way of providing a context that creates a meaningful life. Finding meaning and appropriate challenge from work (Leufstadius et al., 2009) is as important for those who volunteer as it is for those who are in paid work. Research suggests that volunteering can be a meaningful occupation for some individuals with mental health issues, enabling them to participate in the social life of their communities (Clark, 2003, Rebeiro and Allen 1998); they also perceive this occupation to have a positive effect on their mental health.

It is important that there is a good match between the person and factors in the volunteering environment such as the amount of noise, change in routines, whether it is a small unit or large building etc. Supported volunteering should provide an appropriate challenge to the volunteer and, as voluntary work can be graded this means that the service user can be exposed to increasingly challenging tasks and responsibilities that will support self-efficacy and growth in confidence. Law et al., (1998) argues that, for any occupation to be meaningful, factors such as choice, control, stress levels, boredom, intrinsic motivation and level of challenge and skill can provide optimal conditions to benefit health need to be understood. Black and Living (2004) found that mental health benefits that were reported included those where the activity was fun and where it lifted mood and was worthwhile and satisfying. The study also reported that there was evidence of personal development and that volunteers gained confidence and a sense of achievement and that being accepted and appreciated also added to the impact of the experience. In terms of social contact, participants described volunteering 'like having another family and so many more friends' and also that there were opportunities to meet other people and make friends

and that it was important to have a 'role'. Omoto et al., (2000), found that there was an opportunity to bring skills and experience to volunteering and that it can replace a lost role.

## **5.5 Summary of the chapter**

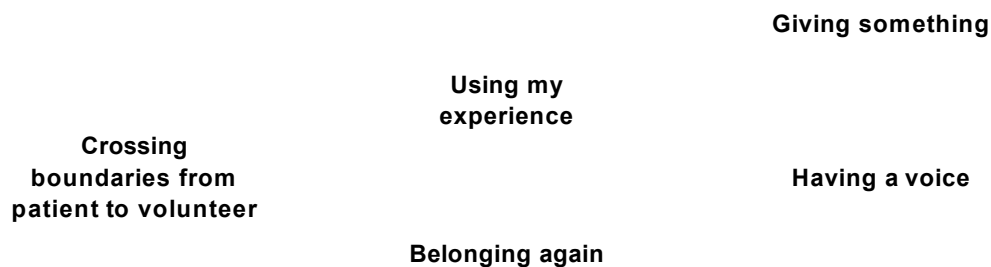
Many of the volunteers had fluctuating mental health symptoms and physical health symptoms, which they saw as impacting on their ability to manage a paid work role with a formal contract and set hours. This allowed the volunteers to practice self-management of their fluctuating symptoms, and recognise how this would impact on them and how they can cope in a work environment. Financial risks were a concern for a number of the volunteers even though paid work was the desired /future/ ultimate outcome. Concerns about changing the status quo of their financial situation was a risk that the volunteers wanted to manage and the way in which they did this was through positive risk taking by doing this in a timely way that was at their discretion and readiness. A number of the volunteers identified concerns about the relationships they would need to have with an employer if they were in paid work. This was linked to concerns about disclosure and having to commit in terms of their time. It was also linked to the dynamics of managing work relationships, some of which have already been experienced as a challenge while they were volunteers. For the volunteers in this study it is important to recognise that they had to '*tread carefully at first*'. It was their first big step back and, as such, was a significant part of their recovery into a world where they would re-engage with work. When volunteers had control and were able to make decisions about their vocational future in a way that they were 'ready' to do then this resulted in the volunteers finding a purpose and meaning through volunteering.

## CHAPTER SIX: CROSSING BOUNDARIES FROM PATIENT TO VOLUNTEER

### 6.1 Introduction to the chapter

This chapter illuminates the experiences of volunteers where they have gained a different status in the organisation in which they volunteer. This was something that was a new experience for them. Their views and opinions were heard and they could contribute. They were now in a role that could be inspiring for others recovering from mental health conditions. There was now recognition of the skills and experience they had gained as service users, which they could now apply in the context of volunteering. It was important for the volunteers to give something back for the support they had received or to make a difference and influence change for other users of a service. The chapter is structured in this way to allow the reader to understand how the categories emerged leading to the main category.

**Figure 9. Diagram demonstrating how one of the main categories was constructed**  
*Crossing boundaries from patient to volunteer*



### 6.1.1 Using my Experience

This category examines the experience of mental illness that connects all the participants in this study. It emerged as a category to describe how an experience associated with exclusion and stigma can become a positive force, an asset for those who went on to volunteer. The personal lived experience that the volunteers brought to this role was now of value and could be utilised in a productive way. They had crossed a boundary and they could provide a different perspective from that as a recipient of a service and thus volunteering had allowed them the forum to find a new way to 'fit-in' and have a voice.

This different perspective and position allowed them to experience new and different relationships, which promoted a sense of belonging. The contribution of people with lived experience can be illustrative, touching, challenging, inspirational, confrontational and supportive (Roberts et al., 2011). This personal contribution can have a powerful impact and help to shape attitudes and understanding amongst others.

### 6.1.2 Giving something back

For many of the participants in the study they wanted to '*give something back.*' The reasons for this and why it was possible through volunteering was, for some, part of the initial reasons that they volunteered. It brings volunteering to light as something that can be altruistic and reciprocal and for the benefit of others (Davidson, 2006). The notion that volunteering is essentially altruistic is not universal (Ellis-Paine, Ockenden and Stuart, 2010). It has been noted that there can be a mutually beneficial exchange relationship and that volunteering 'provides benefits to the individual, be it enjoyment, skills, or the sense of having given something back' (Institute for Volunteering Research 2004: p. 25).

Motivations to volunteer were influenced by the volunteers' recognition of an individual or of a particular service that been of help to them and through this they saw inspirational role models and wanted to be one too. This reciprocal relationship also extended to those participants that were also volunteering in non-clinical areas of a Trust. These volunteers wanted to 'give back' because of the support the Trust had given them. This extended also to those who wanted to give back to their community, and included the church and organisations that they had been supported by or services that they identified with because of their condition.

Reciprocity can be defined as a situation in which individuals are involved in mutual exchanges, based not on obligations linked to a contract, but on the willingness to build and to reinforce a social network of cooperation (Zamagni, 1995). "Doing good" for others develops trust among people, which, in turn, produces a feeling of security and reciprocal acceptance among volunteers and those who receive their help (Post, 2005).

The loss of reciprocity is significant in the process of service user involvement, as 'experiences of being discredited, embarrassed, ignored or otherwise devalued also contribute to the growing isolation of ill individuals and to their subsequent reappraisals of self' (Schneider & Conrad 1980, p. 211). The risk of potential discrediting is influential in the withdrawal from involvement in social activity and, is again replicated in involvement initiatives, whereby participating with no real power is experienced. This increases the disempowerment individuals face because of their identity and position in society (Kalathil 2013). Once a person is labelled with mental illness they must recover not only from severe emotional distress, but also from the role and identity of a person with mental illness (Deegan 1993). The label not only relegates people to a low status and diminished rights, but it also erodes a person's confidence and initiative to pursue a full life of one's own choosing. If positive images of self, reflected by even the briefest interaction, can help to maintain a positive self-

image, involvement of this nature can be a vehicle for those interactions. Volunteering was an opportunity for a reciprocal relationship to be re-established again.

*(Nigel): I've become a worthwhile person, not that I think I am hollow but subtly it's made changes to my self-esteem my sense of wellbeing so when mental health problems do come I can hang onto them thoughts although I feel completely worthless at the time and completely bad and all these things that attribute to what's going on in my mind there's always that sense that when you get to that depth I am really worth it, I have got self-esteem, people do like me, people do need me you know what I mean so there's always that under current.*

Generally, contemporary models of involvement within statutory services pay little regard to the identity of individuals beyond the 'service user' label and in doing so unwittingly perpetuate and sustain the negative impact of mental illness (Hutchinson and Lovell, 2013). An awareness of the disempowered status of many people with mental health issues is important for all professionals working with this group, particularly those with regular direct contact designed to enhance recovery (Hutchinson and Lovell, 2013).

The opportunity to 'give something back' should not be underestimated as it allowed the volunteers to use their new expertise as volunteers. They had experienced enduring mental health problems but were able to use this experience in a more positive way. This also gave context to a new sense of personal identity which was separate from previous experiences of illness, the sick role and dependency on care. Finding that you have 'something to give' as well as needing help is a powerful feeling that impacts on recovery (Bonney and Stickley, 2008). The literature related to reciprocity is yet to be established in the area of service user volunteering although, in the area of service user involvement, reciprocal relationships have been examined (Davidson et al., 2006).

These quotes from volunteers provide examples of how 'giving something back' would not just benefit the volunteers but would extend to the services in which they were volunteering.

**Terry (1):** *Being able to give something back, because I have had a lot of help from the mental health services over the years and it's nice to be able to help people who have sort of helped me.*

**Jana (5):** *It's nice to put something back because they have been ever so good to me.*

**Dan (9):** *I said well what I am interested in is working with the chaplains if the work with the mentally ill because what I have been through I know just how they feel.*

**Luke (3):** *Basically I wanted to put something back in, instead of it going one way.*

**Nigel (11):** *I don't think I would go and do volunteering just for me and be selfish. I think I would want to give something back, so you are not just taking.*

**Katie (8):** *It gives me a feeling of worth that I am giving back to society. It's always been really important.*

Volunteers saw themselves as positive role models who could support and help others who they identified with. They had empathy for people they worked with and had empathy with their new co-workers, who were in many cases health professionals and other staff employed in organisations that were sensitive to their needs. This sensitivity extended to the cultural and social context of a mental health experience. A meta-synthesis of community based mental health peer support (Lloyd Evans et al., 2014) found that positive benefits of peer support included improvements in self-rated recovery, hope and empowerment for the service user providing that support. However the authors also identified bias, including a lack of blinding of the assessors who completed the systematic review in five of the studies. It was also noted that some of the papers reviewed lacked outcome measures and therefore results were downgraded for risk of reporting bias.

Even though the authors did not look at volunteering specifically as the vehicle for peer support it did consider peer run support groups and peer support workers. The role of peer support workers as part of a recovery-oriented service is a growing area in the UK and the evidence in support of this role is developing (Repper and Carter, 2011, Repper, 2013). Repper, (2013) identified peer support roles as both paid and voluntary but with the specific function of, "*offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations.*" It would be unwise to extrapolate the findings from research on peer support workers but the working environments in which these studies are situated do have similarities in terms of training and supervision. Although peer-support experience provides the same environmental context for volunteers the volunteers in this study did not agree to volunteer based on a specific role descriptor of peer support worker and the range of volunteering opportunities and environments were more diverse.

Supportive peer relationships can be a powerful factor within service user run self-help or mutual support activities. Peer support, as a reciprocal relationship, can offer encouragement and hope (Davidson et al., 2006). Hope is central to recovery and can be enhanced through recognition of active control over the person's life and the ways in which they see others move forward for example, as educators, advisors or volunteers in a specific role (Jones and Evans, 2008). Service users who are volunteering in health and social care settings bring a unique service user perspective to volunteering. The experience of mental health and the 'expertise' it then affords can open up new options for service users in the world of work connected to their own enduring mental health problems e.g. peer support work, support time recovery workers, support worker roles.

It was interesting that for some of the volunteers their approach to volunteering was to work in those services that mirrored some of the services that they too had



received. Their expertise as former service users of that service was important and valued by the volunteers.

**Charles (15j):** *I had been through drug addiction myself and I had a chaotic lifestyle. I had not got experience as such but my experience is 'my life experience' and I wanted to put that into use to be supportive of others. I understand that with the right support you can make a lot of changes in your life. If I can be that little bit of support for somebody then it makes me feel good.*

He goes on to say,

**Charles (15):** *Well for this type of work I see it as a positive thing because I have gone through it and everything's back to normal now; well normal as in I am not living that sort of lifestyle.*

Charles was aware that he wanted to be part of this reciprocal relationship that he had also benefitted from himself. Service users and carers have a unique understanding of their own illness or that of their loved one and experience of being in the health and social care system. Users were traditionally portrayed as patients and as objects of the clinical gaze of mental health professionals (Pilgrim and Rogers, 1991). This perception has moved on and the personal contribution of service users can have a powerful impact and help to shape attitudes and understanding of those they work with, their family and carers.

### 6.1.3 Having a Voice

A number of volunteers expressed how volunteering had 'given them a voice' a place where their opinions and input could be valued. This is indicative of a shift in power and control.

Recovery is about taking back power and control and the recovery journey is undertaken through empowerment with gradual transfer of responsibility (Bonney and Stickley, 2008). A number of Trusts have promoted the 'lived experience' of mental

health service users as an asset. This is in an employment context and volunteering services are part of a vocational pathway that has been established in those Trusts (Cassinello and Bramley, 2012). These examples are underpinned with a supported volunteering model, which provides mentoring and training to support the volunteers in their roles.

**Janet (17):** *Yes I go into the staff meeting that they have at The Project and it makes me feel respected, you know my opinion matters and I am not going to talk a load of rubbish and I know what I am on about.*

Alice's voice and user experience is used to try to inform change.

**Alice (10)** *For me it is taking something that has been so wholeheartedly negative and actually quite damaging in my experience, hence the reason why I wanted to do it. It's like reflecting back and using it to implement changes I can see the positive impact that my involvement is having and thinking that if I wasn't at this meeting the meeting would have gone very differently.*

Importantly the debate in mental health has moved away from people being passive recipients of care to being experts of their own experience (Shepherd et al., 2008). It is through this experience that volunteers found their 'voice'. Service users and carers have a unique understanding of their own illness and experience of being in the health and social care system (Laws, 2011).

## **6.2 Belonging again**

Belonging is a sense of connectedness to other people, places, cultures, communities, and times. It is the context within which occupations occur and a person may experience multiple belongings at the same time. Relationships are essential to belonging, whether they be with a person, place, group, or other factor. A sense of reciprocity, mutuality, and sharing characterize belonging relationships, whether they are positive or negative (Haggerty, 1993).

Belonging is complex, as its emergence and integration as a theory occurred relatively recently. This has been credited to Hammell (2004), who identified it as a separate dimension that contributed to "a life worth living." However, she and others such as Bryant (2009) acknowledge Rebeiro et al. (2001) as the originator of the term in their study with mental health clients. Belonging has not been analysed as comprehensively as the other three dimensions of Doing, Being and Becoming which are seen as aspects of occupation (Wilcock, 2006; Rebeiro et al., 2001).

The volunteers in the study described belonging in a number of ways. They described volunteering as like being part of a family, as being valued team members and feeling the same as their colleagues.

*(Charles): Certainly the volunteers at SASS and the alcohol recovery community, it is like a big family really because there is always people there you can talk to if you're struggling and there is a lot of peer support and professional support and it is like a big extended family .1 guess depending what you own family support and situation is then you would probably get more support from that (volunteering community) than your own family.*

Perhaps unsurprisingly, most research into *belonging* occurs in group settings. For seniors attending an art class, the social aspects were just as important as doing, being, and becoming (Bedding & Sadlo, 2008). Another artistic occupation, circle dancing was also valued for the connectedness it offered to group members (Costa, 2012). While a non-competitive environment enhanced belonging in this case, healthy competition may also be beneficial in other circumstances. Group exercise provided both social and motivational benefits for people with enduring mental health problems (Alexandratos et al., 2012).

Formal settings can also support belonging, as demonstrated by the perceptions of Icelandic cancer survivors around their rehabilitation centre (Palmadottir, 2010).

Workplace relationships can enable new connections and relationships for people with

enduring mental health problems (Leufstadius et al., 2009), with consequences reaching beyond that particular environment. Other studies also affirm that social environments impact on occupational engagement by people with enduring mental health problems. Blank et al., (2014) found that work was a potent way to feel part of society and that despite having negative memories of work it was still a route to feeling included in the world.

Further evidence of the multifaceted nature of belonging is found in a study of carers for people at the end of life. These carers felt they belonged to both the dying person, and the health professionals who supported their caring (Pickens et al., 2010). Wada (2011) also highlighted the multidimensional nature of belonging, where, for example the societal expectations of Japanese culture must be fulfilled before a person is sanctioned as "belonging." Multiple belongings complicate attempts to categorize "where" a person belongs.

Recent contributions to an understanding of belonging have broadened the perspective on the term. The physical environment in belonging has also emerged, as a "place" for occupations (Huot & Rudman, 2010; Pickens et al., 2010). Stability, by its very own nature can support occupational engagement by providing a sense of home, and occupational therapy could support people to re-discover *belonging* when their environment has changed. Taylor (2008) called this locatedness, and suggests it exists in time, place, and body. It is therefore not that surprising that for the volunteers in this study environments and places that were familiar, where they already had some established connections and where they were now being valued for their input, helped to engender this sense of belonging.

Ockenden and Hill (2009) provides evidence that volunteering can lead to an increased sense of belonging and that it offers increased access to those excluded from other social spheres. It can be a form of positive social engagement. However Ockenden and Hill (2009) also found evidence that volunteering can also replicate exclusionary features that can be found in the workplace, such as harassment and bullying and

favouritism. In a recent study by Blank, Harries and Reynolds, (2014) the participants also found that engagement in non-work occupations instilled a sense of belonging. The way in which people belong is very much determined by them. They found ways of belonging that they valued and made them feel good.

Karl recognised he belonged because of the way he was engaging with colleagues and other service users in the service in which he volunteered. A more relaxed way of communicating suggested to Karl, that he fitted in.

***Karl (6):** I've actually fitted into it quite well. I still get a little bit offun from some of the other users or clients, just giving me a little bit ofjip and stuff like that but I find it alright*

Other volunteers reflected on belonging, in terms of equity with other staff members.

***Janet (17):** I do some of the same things as a staff member does, I am part of the team, and we are included like staff members. I belong there now.*

Wilcock's (2007) account of belonging identified it strongly with people's interpersonal relationships, with it being "the contextual element, of the connectedness of people to each other as they do and of the major place of relationships within health" (p. 5). This echoes other descriptions, which have highlighted social interaction, mutual support, and friendship, a sense of inclusion and affirmation from others as aspects of the relationship (Hammell, 2004; Lexell, Iwarsson, & Lund, 2011; Pickens et al., 2010). Reciprocity (giving as well as receiving, to share and contribute) is also important to belonging (Molineux & Baptiste, 2011). However, reciprocity was not an element of interpersonal relationships for Shank and Cutchin (2010), who stated that belonging refers only to a sense of being part of something bigger than oneself. They described the importance of the social context and its benefits. Partnerships that are conducive and supportive of recovery processes are those that are humanistic in approach and based on mutual trust. A recent study (Bonney and Stickley, 2008) into recovery

services highlights a need for external conditions in services, including partnerships, to facilitate a positive culture for recovery. In this study some mental health organisations, including the User Volunteer Service (UVS), had provided volunteering opportunities with staff in a range of departments within the service. The UVS was acting as a navigator, or facilitator of recovery, providing the means by which service users could explore work aspirations and new skills. Many of the volunteers could see a service that was familiar to them as a service user but from a different perspective. Relationships were formed that were different to those they had experienced when they were a recipient of care in the service. This was perceived to be a positive aspect of their experience as volunteers. Volunteers were experiencing a different relationship now, a good one that enhanced their volunteering experience and that could be considered a facilitating condition for personal recovery.

In their role as volunteers, the experience of relationships has been positive. For other volunteers there was an acknowledgement of a changing relationship and perspective with mental health professionals.

Janet describes how female relationships were important to her.

*Janet (17): Throughout any treatment service for drugs or alcohol, the percentage of women is always tiny compared to men who go there, so I did not have the opportunity to build relationships with other women. Now this has changed I might not necessarily go round to the staffs house for tea but I definitely have that opportunity to chat with other women, which I would not have if I was not here.*

Positive social support has been shown to reduce women's likelihood for relapse (Ellis-Paine; Ockenden and Stuart, 2004) and may play a more important role in recovery for women than men, as women's social supports are often closely tied to their substance use (Ellis-Paine; Ockenden and Stuart, 2004). Thus, gender-responsive treatment, positive abstinence and social support networks may support women's substance use recovery process.

Katie who had received support from the User Volunteer Service (UVS) talked about how a relationship had changed over time from one that was emotionally supportive to one that was more reciprocal in nature with the health professional in question having a different relationship with her.

***Katie (8):** She (health professional) was very supportive, and understood my emotional needs; I was very emotional all the time and she was supporting me through my redundancy with work, which I found very stressful. Now it's a much more casual relationship, we are much more friendly and I support her with admin stuff and she supported me finding work so it's developed the relationship but I don't think there is any crossover between the healthcare I received and the job that I am doing now.*

She reflects on the social impact volunteering has had.

***Katie (8)** Volunteering for me gave me an outlet to do that and to build on relationships as well, so I have made very good friends.*

Borg and Kistiansen (2004) identified key characteristics of the recovery-oriented practitioner. They identified the following: Openness; Collaboration as equals, a focus on the individuals' inner resources; reciprocity; and a willingness to go the extra mile. They went on to suggest that these general skills must be combined with a high level of relationship skills such as empathy, caring, acceptance, mutual affirmation, an encouragement of responsible risk taking, and a positive expectation for the future. Some people with enduring mental health problems find that not all relationships provide encouragement or are positive and supportive (Yanos et al., 2001) and, individuals may also continue to feel disempowered or stigmatised by their wider community.

### **6.3 Crossing boundaries**

Historically psychiatric services have been characterized by segregation and a pervasive 'them and us' mentality. Staff and service users have had very different

roles, rituals, control and privileges. Repper and Perkins (2006) propose that power differentials can impede relationships between service users and mental health staff. Traditional relationships have been founded on the assumption of an expert (professional) and a non-expert (patient/ service-user) (Repper, 2013). By volunteering in services where they had previously received a service, or in services that were sympathetic to their mental health difficulties, the volunteers were now in a different position with a new sense of agency as actors in a world that may have previously excluded them. Now they could see how things were done 'from the other side'. They had a different perspective and position and had crossed a boundary. They were now privy to a different set of working rules and rituals; and the power relationships with health professionals had changed.

This provided for them new cultural expectations and socialization into a world of work that they related to and that was familiar but was different to the way professionals worked in it. The volunteers had not adopted a privileged position but these two worlds were now overlapping.

**Charles (15):** *I think from a service users point of view I think they have more... what's the word I am looking for... in some ways they might get more out of it talking to someone who has been through it rather than someone who hasn't. That doesn't mean to say I don't think there should be professional people, there is a need for that but I think people can relate to you more if you've experienced what they're going through.*

Allport's Contact Hypothesis, (1954) identified 'in' and 'out' groups and is still very relevant today. It states that equalising the status between the two groups, (e.g. pursuit of a common goal), will promote direct contact and also that the familiarity offers an opportunity to disconfirm stereotypes and increases perceived similarity between the two groups (Pettigrew and Tropp, 2005). This was very much pertinent for the volunteers who worked in substance misuse services. Their volunteering role as recovery ambassadors in an integrated team with other service user volunteers



provided them with a different context to that they had known as users of the same service. They could empathise and identify both with substance users who used the service and with the health professionals who were supporting them. Within the UK, recovery policy aimed at substance use (Humphreys and Lembke, 2014) is at an early stage of development when compared to the mass of literature related to mental health recovery. Many of the interventions fostered by recovery-oriented policies have not been evaluated and therefore should be a major priority for future research. That said, there are some areas where rigorous research exists, for example in the SMART (Self-Management and Recovery) programme. This is a 4 point programme that focuses on: building and maintaining motivation; coping with urges; managing thoughts, feelings and behaviours; and living a balanced life. The research has shown that recovery-oriented interventions improve individuals' substance use and health outcomes in a cost-effective fashion, thus supporting the value of recovery-oriented public policy initiatives (MacGregor and Herring, 2010).

Charles talks about how he views this position as someone who has crossed a boundary. He was someone who completed a SMART programme and was now helping to facilitate the same programme to others. He was a volunteer with a specific role known as a recovery ambassador.

**Charles (15):** *I volunteer at a place called the xxxxx Alcohol Support Service so I am fairly involved there I used to do a lot of drop-ins and things and I work as a recovery coach, an unpaid recovery coach. I facilitate a SMART recovery meeting there.*

**Charles (15):** *I can see how it can be frustrating for the professionals depending on the clients I mean they all have different needs but it has been quite an eye opener.*

**Charles (15):** *I can sort of relate to both sides. I can relate to how the person, the service user might be feeling in some ways and also how the workers are feeling.*

It could be argued that service user volunteers now belonged to an 'in' group with their peers, as they too had inside knowledge of lived experience but were from an 'out' group when receiving mental health support from services, where they were different and less powerful to the health professionals. Now that they straddled this boundary their social identity had changed.

Tajfel (1972) defines social identity as the 'individual's' knowledge that he belongs to a certain group that has some emotional value and significance and Tajfel and Turner (1979) developed the concept of social identity into Social Identity Theory (SIT). Individuals are predetermined to social groups that structure society, and membership predicts certain behaviours. Positive social identity is sought through seeking out others from their social group (the in-group) in order to improve self-esteem and as a drive for self-determination. The original SIT was developed in relation to social positioning of ethnic minority groups (Tajfel and Turner, 1979) but this theory is applied in a number of different contexts including people with disabilities (Aviram and Rosenfield, 2002) and those with mental health problems (Ison and Kent, 2010). Tajfel coined the term 'minority' as referring to a devalued social position, and, in his original work, this included service users who had problems with substance misuse. They had a social position that was devalued by society. When applying SIT to mental health it can be said that people with enduring mental health problems belong to a low status minority group (Ison and Kent, 2010) with negative characteristics attributed to them and, as a result, society can view this group negatively.

Tajfel and Turner (1979) proposed that membership of social groups form part of a person's self-concept and predict that people are positively biased towards their own group (the 'in' group). This theory brings together two fundamental cognitive concepts by which people, events and objects are placed in categories and mechanisms of comparison, by which people compare their group with other groups. The product of this classification is known as 'social identification' and this has an impact on self-esteem.

Self-esteem increases when there is a positive effect from the individuals' social identification with that group, (the 'in group') leading the person to incorporate the group membership as part of their self-image. At the same time a negative bias is predicted towards other groups (the 'out' group). This bias can result in discrimination leading to low self-esteem among 'out' group members and a negative self-image (self-stigma). The volunteers in the study reported increased self-esteem through the process of volunteering and association with mental health services.

In this study the volunteers were originally members of an 'out' minority stigmatised group (service users) and found they crossed a boundary to be new 'in' members of a societally valued staff group that before they would have seen as the 'out' group? It could also be argued that their status in the 'out' group (members include other service users) has in fact been enhanced because of the position they now have as volunteers. Some volunteers reported this raised self-esteem but for others it resulted in role and identity conflict.

**Katie (8):** *I did feel there was a crossover of roles there where I felt yeah, I was a service user and...I was a volunteer, now since I volunteered down at xxxxx my closest colleague knows I am a service user and she knows of my difficulties in the past with my mental health. But we are equals and I do everything that I am expected to do in my work role without this kind of tag or name of service user attached to me.*

The opportunity to cross a boundary was not without some challenges to the volunteers. Eddie had volunteered for some time, mainly in the voluntary sector, but now had some experience of volunteering in the Trust and contributing to health and social work courses in the University. He had struggled initially with working relationships but had used volunteering to try to learn to manage work relationships.

**Eddie [12]:** *I'm very friendly and able to make therapeutic relationships with clients but if it was something like paperwork or staff conflict I just had to retreat into myself and would then start ruminating.*

Eddie also worried that he sometimes disclosed too much about himself when volunteering but blamed this on his mental health condition. He again tried to reflect on this in the workplace and with the social relationships that he had built as a result of volunteering.

***Eddie (12):** Because of my OCD I'll sometimes say things that are a bit taboo. I have this weird balance as I have to say everything that's going on in my head. I'm learning now to rein this in.*

Terry spoke about the boundary around confidential information. He struggled knowing how to manage this and asked his mentor for advice.

***Terry (1)** Yes, at first it was a little bit difficult because, when I was inside the office and staff were talking about people who I knew, I found it difficult sometimes being inside there. You know, listening to it and I didn't know whether to leave or stay and I talked to my mentor and he kind of said that if you want, if they want me to leave they will ask me to leave but that's only if it's someone that I really, really know well, like one of my friends.*

Recovery from mental illness is a social process (Schon et al., 2009) in which the helping factors are related to the quality of social relationships. These factors include opportunities to create accepting and enabling social environments (Tew et al., 2011).

As a volunteer within mental health organisations, there is an opportunity to develop and be exposed to new relationships beyond those of the patient-professional relationship and this process can be empowering. In any work environment we learn to manage and negotiate relationships with a range of people. The opportunity for a co-worker relationship for a volunteer working with staff members may assist in reducing power imbalances or disempowering paternalistic relationships.

Carlson et al., (2001) carried out a research study in New Zealand in which they considered the growing number of mental health service users who were seeking employment as mental health support workers. They identified three potential barriers

to this being a successful transition but also proposed ways in which these barriers could be addressed. The barriers identified were:

1. Dual Relationships - being both a provider and consumer of a service;
2. Role Conflict and Confusion - a new blurring between 'the sick' and 'the well' working in the same environment, when previously there has been a clear delineation and
3. Confidentiality - although there was no empirical evidence that confidentiality would be breached by a consumer of the service.

These were factors that volunteers in this study also identified and could relate to. Carlson et al., (2001) argued that the benefits of employing service users as mental health support workers outweighed the perceived barriers and proposed the following solutions: clear policies and job descriptions; creations of support structures and opportunities to express feelings; and support that provides quality supervision, mutual peer groups and training. These elements were available to the volunteers in phase 1 through the User Volunteer Service, which was part of the Trust's User Employment Service. It is less clear how these factors were incorporated into the experiences of all the volunteers in phase 2 but for the recovery ambassadors there was a strong link to these supportive elements.

One of the volunteers' insights into the human side of his co-workers is demonstrated here.

**Karl (6);** *Before I used to think that some of the staff were all goody goodies, that's a good word to use, goody goodies but now I think differently in this role and you see them in a completely different light.*

He then went on to explain how this also impacted on him now that he had a different relationship with his co-workers.

**Karl (6):** *Like, there's not as many boundaries and looking at it from a different point like when you told a joke they'd probably tell you off for being sexist or racist or...pull you up on something, for being cheeky or something like that.*

It is interesting how Karl has identified an example of when he feels the boundary between the volunteer and the staff members is relaxed and could be considered as less professional. His previous relationships with staff had been ones that put them in an authoritative, controlling position. It appeared that there was one rule for service users and another rule for staff. A study by Eriksen et al., (2013) looked at the challenges that service users had relating to mental health professionals. Participants identified three different levels of connectedness; 1) being detached; 2) Being cautious; and 3) Being open and trusting. Relationships are crucial for a coherent sense of self and identity, as this develops in recognition of the other, and in being recognised by others. It is important therefore that this new relationship with staff is based on openness and trust. It is important to remember too that the position and perspective of the health professional has also changed. An earlier study by Erikson et al., (2012) described how service users in community mental health services reported using different tactics in their efforts to relate to professionals. There was a dynamic tension between sharing openly with professionals and at the same time feeling a need to conceal aspects of their experience and keep professionals at a distance. If recovery is to have an impact for individuals, then professionals need to be sensitive and 'not take over.' Roberts and Wolfson (2004) suggest that professionals should offer their professional skill and knowledge but they also need to learn from and value the patient, who is an expert by experience. When individuals volunteer in a mental health service that is familiar to them the power in relationships can be shared, and clinicians are 'on tap and not on top' (Repper and Perkins, 2003, Shepherd et al., 2008), which helps volunteers move through the transition from service user to volunteer. Borg and Kristiansen (2004) identified that high levels of relationship skills required by health professionals when working alongside service users. These skills include empathy, caring, acceptance, mutual affirmation, and encouragement of

responsible risk taking, and also a positive expectation for the future. Perkins (2007) also identified 'hope inspiring relationships' at the heart of her prescription for recovery-oriented practice. Volunteers in this study identified individuals that had inspired them and who were influential in their choice of volunteering.

**Charles (15):** *When I started the SMART recovery, using the group as a service user so to speak well that gave me a lot of inspiration and I learnt a lot from the guy facilitating the group and then I became a facilitator and he was a big part of it.*

They also recognised the benefits they gave to other service users as a result of seeing someone they could identify with in a volunteering role.

**Kevin (4):** *Because one of the benefits of the service user volunteer service is that it helps other service users see another service user in a different role and developing, and moving forward.*

**Charles (15):** *there's also the recovery side of it. If they can see someone who has been where they are and have got better and have moved on...you know...it can sort of let that person know how they get on and dealt with the problems and issues...and it gives them hope for the future really.*

As has been asserted, hope is central to recovery and active control over an individual's life and ways in which he or she sees others moving forward is important (Repper and Perkins, 2003). Service users recognised that volunteering was a positive activity that acted as one that was an impetus to take small risks and do different things. Recognition of achievement and a new sense of self-value provided hope to the volunteers. These achievements were recognised by the volunteers themselves but also validated by others.

There has been controversy about whether it benefits people to volunteer within the health and social care services, including the service they have been attending. There is some evidence to suggest that mental health service users prefer to volunteer in

services sensitive to their mental health needs (National Centre for Volunteering, 2003) and that there is a barrier to progression from this to other volunteering opportunities due to perceived discrimination and stigmatisation (Yanos et al., 2001). Thus, service users can be 'ghettoised' into like-minded organizations and then get stuck in environments that may be difficult to break away from (Farrell and Bryant, 2009) rather than being able to see volunteering as a stepping-stone to other things. This study confirms the first view but provides no concrete evidence to support the latter. Volunteering was a salient role for the volunteers. In this study there were examples of how some volunteers were 'stuck' and did find it difficult to move on. This is discussed in the next chapter. However many volunteers also identified vocational goals including education, more volunteering to gain different work experience or paid work as the next stage. One volunteer had in fact gained paid work at the time of her interview. The researcher endorses the fact that the volunteer is in a like-minded service but this is just the starting point, a tentative step into the world of work. It is important to view volunteering in mental health organisations as part of a broader vocational experience and that volunteers should be encouraged to apply for paid posts in these organisations that view their mental health history and experience positively.

#### **6.4 Summary of the chapter**

This chapter has examined the category '*Crossing Boundaries from patient to volunteer*' which is a key aspect of the experience of volunteers who offer their services to organisations that are sensitive to their mental health needs. The opportunity to bring lived experience to the volunteering role has benefits for the volunteer and other service users they now work with. The chapter also discussed the volunteers' experiences when they have crossed boundaries and become part of the service from which they may have previously received some support or to one known to be sensitive to their needs. The familiarity of this social environment should not be underestimated. The chapter has considered the experience of the volunteers and the



impact, both positive and challenging, of a different relationship they now have with staff and the sense of belonging that is instilled from their experiences as volunteers.

## CHAPTER SEVEN: FINDING THE RIGHT SORT OF WORK

### 7.1 Introduction to the chapter

*Nigel (11): I suppose that's to do with the journey that I am on in my life. I want different things out of it.*

Volunteering was an opportunity to 'rehearse for a new direction' a different journey and pathway to that which the volunteers had experienced in the past. It allowed them to reconsider their future as workers.

Volunteers used the volunteering experience to test out old skills and develop new ones that they would use in the future. It allowed them to develop their capacity in terms of their stamina, managing health conditions and establishing routine and structure. Volunteers had learnt, from past experience of work, what was conducive and not conducive to their mental health and wellbeing and were able to apply these lessons to their volunteering role. Volunteering was an opportunity to do something different, to experience different work skills and environments to those that they had been used to. For some of the volunteers this was their first work experience and so for those volunteers it was important again not only to see how they would manage but also to use it as a way to develop and gain experience to put on their curriculum vitae (CV).

The various decisions that a volunteer makes along their volunteering pathway', (including the decision to stop volunteering), are influenced by many factors, some of which are very personal, whilst others are determined by the experience they have gained as volunteers. These experiences then inform the next stage of their vocational pathway.

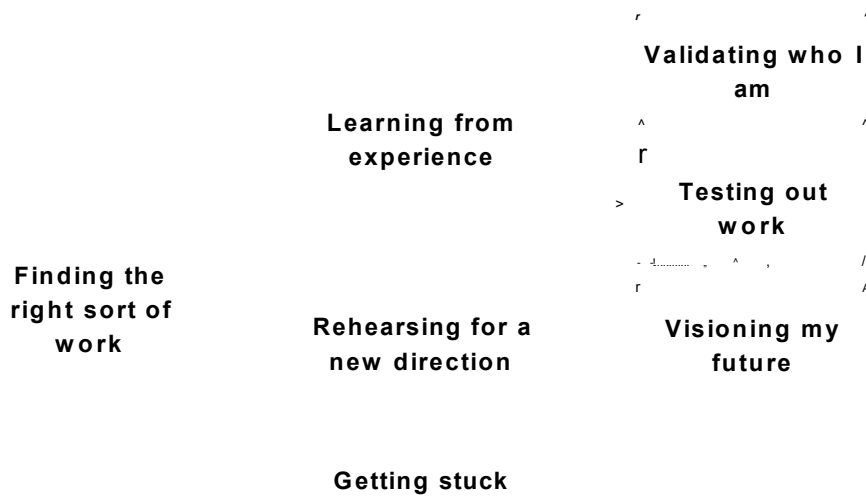
This chapter considers the trajectories that volunteers take that will allow them to follow a path to more productive roles linked to work. All the volunteers in phase 1 had identified a vocational goal, and so, with that knowledge and through analysis, an assumption has been made that this is where a link with work is important.

In phase 2 the volunteers in most cases were further along a journey of recovery and, whilst many did still volunteer in services that were sympathetic to their mental health, their trajectories towards paid work or education were clear. At this point it is important to highlight that one of the volunteers in phase 2 volunteered outside of mental health services. He volunteered in more than one organisation that was reflective of his interest in conservation. He had found the right sort of volunteering for him although he could be considered a negative case rather than a true outlier which Bryant and Charmaz (2011) describe as a serendipitous error. Jim was the oldest of the volunteers and his mental health difficulties resulted in him taking early retirement from a management role in the public sector. He fulfilled the criteria for the study but his vocational aspiration was to maintain his mental wellbeing by volunteering something which he did while he was in work. This is a factor which differentiated him from the other volunteers. As a negative case Jim did not respond in a way that was anticipated and his experiences were somewhat different so it is important to determine these differences.

Through volunteering the volunteers developed an insight or awareness of what productive work would suit them and what was an option for them. The task for volunteers and for those that support them is to find a path that suits them. Volunteering has allowed the volunteers to explore a work role which was authentic, even though there was no monetary recompense, and they were also able to decide whether it was right for them.

This was important as it informed new directions or trajectories, new skills and training and preparation for a future around work.

**Figure 10. This diagram demonstrates how one of the main categories was constructed *Finding the right sort of work***



## **7.2 Learning from experience**

This category is about 'learning' and it reflects the interplay of three different types of learning:

- how the volunteers used this opportunity of volunteering to learn about work.
- how they used the opportunity to reflect on previous work - what they liked and did not like
- how through volunteering they learned about themselves and integrated their mental health experience into this learning

**Figure 11. Learning from Experience**

**Learning from and  
how to integrate a  
mental health  
experience**

**Learning from  
volunteering  
(new)experiences**

**Learning from  
previous work  
(past)experiences**

Self-stigma and self-efficacy are key psychological phenomena that affect people with enduring mental health problems. Self-stigma is an internal evaluation process whereby people judge themselves negatively and it can impact upon recovery and confidence to take part in mainstream social interactions (Perlick et al., 2001). These judgements can be related to societal norms of mental illness and the challenges that come with that. This judgement decreases self-esteem, as a person tells him or herself that he or she does not fit in or is not good enough to live up to the expectations that others impose on a person (Blankertz 2001; Corrigan, 2004). Self-efficacy has an impact on the belief that one can perform adequately and, consequently, confidence in one's future is greatly reduced when self-efficacy is poor. Those volunteers in the study who had negative work experiences in the past were cautious about repeating those experiences and wanted to avoid that work situation again. Their self-esteem and self-efficacy were decreased and impeded. The opportunity to do voluntary work

can challenge this self-stigma, allowing the volunteers to experience feelings of value and self-worth and recognition of the skills they either once had or want to develop.

**Katie (8):** *It gave me an outlet, somewhere for me to recognise my skills. I didn't know what I was capable of after I had been ill, I didn't know whether I had lost the ability to be organised, be able to be responsible, I had no confidence so it was a case of could I rebuild those skills?*

A number of the volunteers felt that this experience allowed them to learn from their past and to do things differently in a work context. Previous experiences of work for some have been stressful, limiting or too physically demanding and had had a detrimental effect on their mental health.

**CF:** *Tell me about your past experience of employment?*

**Terry (1):** *Bloody hell, last count I'd had 37 paid jobs.... I have been at firms for like one day or buggered off after a week you know what I mean I have walked off jobs because I have tantrums, I need to calm down. If it's not going right I get frustrated there's a pressure point and I walk out.*

**Katie (8):** *It's definitely still important to me but I have realised it's not the be all and end all. I have realised that it's not a good thing if I am spending seventy hours in the week at work, that there is more to life. I recognise now that you have to spend time for yourself, outside of work to collect your thoughts, to rest, to enjoy life, whereas before my work was everything. And I spent a lot of time there, now I do a lot stricter hours basically.*

**Terry (1):** *Well I mean it's like the gardening group, you can see something for your efforts and I get involved with other people. At one time I would stay in my van but someone came to fetch me and helped me and now I stay here.*

**Alice (10):** *That's been invaluable in learning my own kind of strengths and weaknesses. As I say when I go into paid employment I can apply for jobs where that won't be so much of an issue, or I can make my employer aware of those issues that have come up through volunteering.*

All the volunteers were thinking about themselves in a work context. A noteworthy point that arose from the data across phases 1 and 2 was that some volunteers were able to identify realistic goals for their future work in health and social care. Through volunteering they were able to take the opportunity to gain relevant experience and training to enhance the skills needed in this sector. Several volunteers found the experience helped them develop insight into a different way of thinking about themselves and their skills which could be new skills and / or skills they felt they may have lost. This had a positive effect on how they viewed their future and the experience of mental illness had led to an evaluation of their work role.

Janet spoke about her time volunteering. She could see that it was potentially risky as she is with people who still use drugs and she might be tempted to get involved. However, Janet says the environment is helpful for her, as it is a reminder of what she has been through and she does not want to return to that life again, and so she is managing this risk. She feels her choice of career is therefore very important to maintain her wellbeing.

**Janet (17):** *I suppose in an ideal world I would like to work in one of the drug services, but also I am going to look at things like hostels or other organisations possibly to support street workers and things like that.*

The evaluation of the work experience and skills that the volunteers highlighted is likely to have been informed by the volunteer's preparation and enactment of volunteering. This provided a comparison for the volunteers, in that it was very different to their previous work experience, which had been stressful or too demanding.

It might also be possible that the experience of having an enduring mental health problem was an opportunity to have time-out to re-evaluate what might have contributed to this traumatic experience, and that brought about this realisation. Bradshaw et al., (2007) identified three recovery phases that their participants

experienced over a three-year period. The first phase was characterized by demoralization, being overwhelmed by disability and the attempt to get some sort of control over the illness. This was followed by a period where the participants developed mastery and coping with the consequences of illness, and it is feasible that volunteering provides this opportunity.

The third phase was characterized by reintegration into their community.

### 7.2.1 Validating who I am

Volunteering provides an opportunity for self-reflection and personal learning about themselves as people and also about personal attributes and skills they would need to use in a work environment.

**Jana (5):** *I learned to work with a group because normally I am better doing things on my own. But it really got me to work as a group.*

**Natalie (14):** *While I have been doing the volunteering I have learned the skills as well, because it's not just about experience but it's about applying yourself in a professional manner in an ethical manner. The worlds not revolving around your experience but seeing other people's experiences and applying my experience and a professional and ethical code so that's how it is...but I have learned those skills as I have gone on in years and I take voluntary work as extremely skilled and it is my work.*

**Alice (10):** *Well, I don't know if it has its just the stuff that I have learnt about myself through it, which I have touched on...just in terms of managing and being more open about problems rather than dealing with them internally, in that sense because you have got a commitment to an employer. You have got to be open to a certain degree which is something personally I find difficult. So...it's helped me overcome that. I think that's probably the main thing that I view a bit differently.*



Volunteering was an opportunity to gain more skills and to engage with training that would make them attractive as potential employees. Using volunteering to enhance or build on a work history was seen to be important. All the volunteers in both phases of the study talked about the skills that they had developed through the opportunity to volunteer and the training that had been provided. This was viewed as positively helping the volunteers to feel validated because of these skills. Again their contribution to a CV was of interest to the volunteers

**Charles (15):** *Since I fell off the roof (laughs) I've done quite a lot of things to build my CV up. Some computer training, some business admin training I have done quite a lot. To be honest I have been keeping really busy with training and volunteering which is good because I need to build a CV up and mine only had building related things on and that was pretty much all that was on it.*

**Karl (6):** *I've been sent on some courses, I did diversity training, which was good, I did mental health training I actually had to do a full course for that but I've also done things like race relations and equal opportunity training and stuff like that.*

**Charles (15):** *I've done a lot of training at xxxxx - motivational interviewing, basic things like confidentiality and boundaries and that kind of thing that you have to do in all kinds of support work. I've done level 2 counselling skills and other bits and bobs. I've also done the xxxxx training scheme from xxxxx drug and alcohol action team which I've now got a place on. We'll have to see how things go I hope it opens up a few doors to paid work eventually.*

**Eddie (12):** *It was not as harsh as it is now where budgets are just being really reined in so I took up an awful lot of training about anti oppressive practice and racism and various other things as well as going to in-house training so in a way I kept a CV and have been someone that was on the ball and made a note of things I have quite an impressive CV in terms of someone who's just worked in the voluntary sector.*

### 7.2.2 Testing out work

The onset of an enduring mental health problem can lead to an underestimation of existing abilities and to a devaluation of the whole person (Hammell, 1998; Reynolds, 2003). When individuals are engaged in personally valued, meaningful activities they have perceptions of competence, capability and feeling valued (Rebeiro, 2004; Vrkljan et al., 2001). The importance of a competent self lies not only in perceptions that the individual has of themselves but also in what others think of them (Reynolds, 2003). The importance of being able to be reciprocal in relationships fosters perceptions of value, competence, connections and belonging (Rebeiro, 2004; Reynolds, 2003). The experience of volunteering has provided an opportunity for volunteers to test out these skills and 'test out work' and receive feedback in ways, which enhance their self of self now. Volunteering has provided the space and experience for the volunteers to re-evaluate themselves as workers. Work is an important yardstick of recovery (Shepherd 1989 cited in Rinaldi et al., 2008) and so it is important that the skills and abilities of service users are not underestimated. Volunteering may provide a less risky re-entering or exposure to a work environment because it has been 'tested out' first.

Janet expressed pride when she thought about herself now working as a volunteer and the impact it would have on her family relationships.

*Janet (17): Throughout my 13 years when I used heroin I think I worked two of those years. So I have found something to put down on an application form because it wasn't looking good. But I'm proud of myself because I have got something now and it's nice to be able to speak to my sister who has always had a really good career...you know instead of ringing her up and telling her how bad my life is...and I need some money and I am lying to her because it's not really for what I am saying it is. I can ring her up and have a genuine conversation and tell her what training I am doing, or ask her for some advice regarding application forms.*

Definitions from practice link doing with participation in activities of work, school, self-care, and leisure. However, Wilcock (2006) cautioned that classifications of *doing* prevent a holistic approach by arbitrarily compartmentalising experiences into artificial categories, falsely suggesting mutual exclusivity. Other definitions have been put forward, for example that the concept of doing involves purposeful, goal-oriented activities and doing has also been the preoccupation of occupational therapy thinking (Hammell, 1998 cited in Wilcock, 2006). The ability to do provides structures, an affirmation of competence, and enhanced feelings of self-worth through a sense of being valuable and capable (Hammell, 2004). Developmental<sup>^</sup>, previous doing is understood to provide skills and abilities for future doing (Stagnitti, 2012). Attempts to define doing may be futile, as Crabtree (2003) notes that language captures many varieties (i.e., acting, behaving, participating, and performing). However he highlights that occupational therapists specify *doing* in a way which is uniquely meaningful to the person.

Another cited feature of doing is purpose. Alexandratos et al. (2012) found that *doing* exercise for people with serious mental illness was a purposeful and constructive use of time. However, the question becomes "whose purpose?" Occupations can be meaningful without necessarily being purposeful (Hammell, 2004). Participants acknowledge that occupations that involved skill development or new knowledge development linked to new attributes and discovery of new aspects of oneself. This concept should be considered in isolation but in with discussions in chapter 5 Finding Meaning and Challenge through Volunteering.

### **7.3 Rehearsing for a new direction**

Katie, who is volunteering in an administrative role, talks about her plans for paid work in the future. She had been volunteering in admin as this was closely linked to the work skills and work preferences she had prior to becoming ill. However Katie saw a new direction for herself, as she realised that now she wanted to work more closely

with people and she saw this as a start of a journey that would help her to change direction in terms of work.

***Katie (8):** I am really enjoying it but there is a part of me that wants to get more involved with clients. I love admin and I think the clinic administrator job I have got is a good compromise between seeing clients which I have to meet and greet them and make sure they have got appointments and things. The admin work I enjoy doing, but I think... I would quite like to be an STR worker, a support time recovery worker, and I touched on it briefly with xxxxx yesterday and she said there are some jobs coming up in the New Year. So I think.../ think with a little bit more encouragement, and a bit of support I would go for one of those jobs. I remember the STR worker I had and she was really lovely.*

Conceptually volunteering can substitute for, compensate or complement paid work (Rochester et al., 2010). This has several implications, not least that in this situation motivations are extrinsically driven (Deci and Ryan, 2000); that is motivations may be driven by reward, which could be praise; compliance to please someone else; or they are self-endorsed because there is an acceptance of the value of the activity, for example a way to use time more productively.

An individual's skills and social ties can shape their participation in volunteer activities. In the present study the volunteers' social ties had already been established in services supportive of their mental health difficulties. The opportunity to volunteer enriched these social ties as the volunteer's status and position changed. The skills they gained through a lived experience of mental illness and the skills they developed through volunteering were the ones they perceived to be desirable for their desired job. For some this job was solely based on these skills together with their valuable experiences but for others the desirable job was one within mental health services working with other services users.

### 7.3.1 Visioning my future

Volunteering provided opportunities or transition points that influenced other decisions. The volunteers had aspirations to use the skills they had developed during volunteering opportunities and to take them forward into some sort of end point, be it in paid employment, education for a professional role, further education to support leisure interests to develop opportunities for work or into an entrepreneurship role. Those volunteers who did not want to make changes to their volunteer status are discussed in the next sub chapter.

**Charles (15):** *I've got nothing to lose by trying but yes I would like to get some paid work maybe as a drug worker or a key worker or along those lines.*

**Janet (17):** *I am going to give myself 6 months and then seriously start looking for work.*

**Nigel (11):** *I worked for the Royal Mail, a bit of warehouse work, delivery driving, difficult to settle after military life so this is the first time I have experienced job satisfaction since my military days, which was fourteen years ago. That's the first box I wanted to tick.*

The opportunity to volunteer opens doors and participants started to see opportunities and think about what they wanted to do and develop goals for their future. Volunteers who aspired to work in mental health settings identified roles they would aspire to such as support worker, support time recover worker, mental health professional.

The attitudes and perceptions of youths volunteering were studied and 87% of employers think that volunteering can have a generally positive effect on career progression for people aged 16-25. However, nearly 30% felt that volunteering was irrelevant when considering a particular job application. A further 30% felt that volunteering was only relevant if linked directly to the field of work (Youth Volunteering: Attitudes and Perceptions, 2008). A review of literature on behalf of the

Kings Fund (Mundle, Naylor and Buck, 2012) found that research shows that individuals have a range of motivations for volunteering which can be both philanthropic and self-oriented. Several theoretical frameworks have been developed for understanding these motivations more deeply (Yeung, 2004). By considering motivations for volunteering it is possible to see how these can then support a trajectory to a future visioned role, which may be more volunteering, paid work or education.

Some volunteers were able to identify realistic goals for the future, within the Trust or outside, in terms of additional training and work experience. This had a positive effect on how they viewed their future. Through volunteering, the experience of an enduring mental health problem also informed, and lead to an evaluation of their future work role.

Within the paradigm of occupation 'becoming' is an important construct and there is a discourse on the process of becoming in the occupational therapy and occupational science literature. Becoming is the dimension related to change and development. In occupational therapy literature, it relates to changes over time within therapeutic relationships, but it is also an ongoing progression across a person's lifetime (Wilcock, 2006). Becoming is a process (Cutchin, Aldrich and Bailliard, 2008), with cycles of achieving goals and aspirations before setting new ones.

Wilcock provides a definition of this term. Becoming is "to become (somehow different), to grow, for something to come into being" (Wilcock, 2006, p. 148). This describes a perpetual process of change, driven by evolving goals that inspire, guide and assist occupational engagement. In an occupational therapy context, it is captured as "situatedness" within an ongoing life (Lala & Kinsella, 2011).

Individual becoming has also been defined as goals themselves; a person's stated hopes and aspirations for the future (Nunn, 2007 in Hitch, et al., 2014). Others have described it as a dynamic and emergent perspective on identity, embodied by the

changing self (Shank & Cutchin, 2010). In common with being, becoming reflects the person's self-concept, self-creation, and desire to experience competence, efficacy, and consequence and it focuses on individual strengths and difficulties in all areas of life (Wilcock, 2006). However, becoming is not always about improvement. In some circumstances, managing and maintaining is a legitimate form of becoming. While Van Huet (2011) expected little improvement in the physical state of people experiencing chronic pain, managing symptoms to the best of their ability enabled becoming through other aspects of their occupational being. Therefore, wellbeing requires opportunities for ongoing "becoming," which exist outside of health and illness contexts (Aldrich, 2011). Wilcock (2006) challenged therapists to not compromise their professional becoming by offering services focused on coping, management, or risk elimination, all of which can stymie true becoming.

#### **7.4. Getting Stuck**

A number of volunteers found it difficult to move out of volunteering. None of the volunteers interviewed in this study had given up volunteering and it was still very important to them but they had all struggled to move on, to take that next step or reach the next stage of their vocational journey. This was despite several having clear and positive visions of their future. It would seem that the aforementioned risks are still perceived as high for these volunteers. When the volunteers did 'get stuck' in like-minded organisations this was because of complex factors often related to the individual's personal feelings of safety and readiness. However when the volunteers had vocational goals and these were supported, as was the case for volunteers in phase 1 and for the recovery ambassadors in phase 2, volunteering was a stepping stone, a chance to find the right sort of work, learn new skills and test out old ones. Through the analysis process a number of the volunteers in the study have been denoted the label of '*career volunteers*' and it is these volunteers that seem to be stuck. This label is provided because of the length of time they have volunteered in services that are supportive of their enduring mental health problem. Despite this they

have moved from one organisation to another, demonstrating a level of control over their situations.

The volunteers did not always view their 'getting stuck' in a negative sense but it did, at times, raise frustrations, as it was personal intrinsic factors sometimes related to their mental health condition that seemed to impede this progress, despite some improvements in self- confidence, self-esteem and self-efficacy. Despite this when volunteers remained in volunteering they saw the opportunity to further develop their skills, social networks and training opportunities.

*Jana (5): I don't want to leave here, that's my comfort zone.*

*Natalie (14): It has almost become like a glove or a slipper; it's comfortable and you're right...it's been a pattern I have gone through for years and years and I know it and it's a comfort.*

*Eddie (12): I'm still toying with applying for nursing for next year but I've really got to get my butt into shape and get on with it and I still have severe doubts about how much I can turn myself around in the next...year basically. I still have that dual fear what if I get turned down, but what if I actually applied and get on there? You know how crushing the rejection would be when a lot of people have said you'd be really good including professionals.*

Eddie then gave an apt metaphor '*it's like the flow of the tide*' for his cognition about moving forward and making a decision that will lead to the next stage of his journey. He worried about the time being right but also realised that he may have regrets if he did not do something to advance his goals. Eddie also linked these challenges with his personality, which as he has indicated in other parts of the interview is linked to his mental health condition, so remaining a risk for him.

*Eddie (12): What I do periodically is it's like the flow of the tide, I come in a lot, and the tide coming in is my metaphor for being close to the shore and thinking I'll go for something, and then I go out again and I tend to have these periodical, I need to go for something, the time is right. I've got to go for something and I don't want to reach 60-65 and*



*be bitter with myself, and I know with my personality there is never going to be a perfect time.*

Self-efficacy was a barrier for Eddie. It was impacting on his belief that he could perform fully in a work environment, and consequently his confidence in his future achievements is greatly reduced when self-efficacy is poor. Individuals may internalise an identity that dehumanises them. When individuals do not live up to their identity they have feelings of inferiority, self-hate and shame that diminishes self-esteem and causes self-doubt as to whether one can live independently, hold a job, earn a livelihood and find a life mate. Self-esteem is another area that is affected by stigma, which is often confused with self-efficacy. Self-esteem is defined as a person's appraisal of himself or herself at an emotional level and stigma can be detrimental to self-esteem.

**Eddie (12):** *I'm still toying with applying for nursing for next year but I've really got to get my butt into shape and get on with it and I still have severe doubts about how much I can turn myself around in the next...year basically. Urn...and I still have that dual fear what if I get turned down, but what if I actually applied and get on there? You know how crushing the rejection would be when a lot of people have said you'd be really good including professionals. Not all but quite a few, and then if I got turned down, even got as far as an interview or application then how would I deal with that.*

Negative stereotypes associated with the stigma of an enduring mental health problem can have a serious impact on self-esteem (Blankertz, 2001). Stereotypes are an important part of an underlying belief system so they endure across many different settings. This influences recovery as well as other areas of one's life (Sadow et al., **2010**)

Research by Provencher et al., (2013) attributed a profile 'recovery as uncertain' to those who struggled to manage their enduring mental health problems and were less well supported by family and friends. They had a sense of needing to protect a vulnerable self by maintaining the status quo and work was not seen to be able to help

with self-development. For those with a profile of 'recovery is seen as a challenge' then work is seen as a route to self-actualisation, improving abilities and providing opportunities to meet challenges and have social connections. Young and Ensing (1999) cited in Eklund (2006), described recovery as overcoming 'stuckness' or inertia before individuals move into vocational activities and from here participants then strive for a more challenging activity to allow them to reach a new potential.

*(Natalie): There's something in voluntary work, you don't have to do it but it's something I love to do and I'm loyal in it and I'm faithful in it. I'll probably continue as long as I can.*

Natalie alludes to loyalty and wanting to continue to volunteer as long as she can. Resilience was an important attribute that those volunteers in phase 2 had in particular. It is popular to view resilience as the absence of psychological problems, such as mental health problems. Resilience has been described variously in the literature as: an individual's capacity for maintenance, recovery or improvement in mental health following life challenges; as successful adaptation following exposure to stressful life events and as an individual's capacity for transformation and change (Werner, 2002). It has also been classified (Masten, Best & Garmezy, 1990) into three classes:

- 1) as a predictor of good outcome in high-risk groups,
- 2) as a moderator able to enhance or reduce the effect of adversity,
- 3) as a pattern of recovery from trauma.

Contemporary resilience research has progressed beyond purely descriptive issues to focus on the underlying processes by which all factors critical to adjustment and adaptation exert their influence, with the main foci being on self-regulatory (emotion, arousal, behavior) processes, stress responses and the ability to capitalise on support structures (interactions and relationships).

The volunteers in the study demonstrated resilience despite their mental and physical health symptoms and other personal factors which challenged them. Even those

volunteers designated with the term 'career volunteers' appeared to display a sense of resilience, as they had demonstrated adaptation following stressful life events and were able to capitalize on the support structures and relationships available to them as volunteers. Researchers have concluded that each person has an innate capacity for resilience and that resilience is not a fixed personality trait, but is rather the process of doing what is necessary to survive in different contexts. Resilience is determined by complex interactions between genetic makeup, previous exposure to stress, personality, coping style, availability of social support and so on (Bonanno et al., 2010).

It is important to look at the support that was offered to the volunteers across both phases. Phase 1 volunteers had a formal support network whilst in phase 2 this was variable. The WORKS (Cassinello and Bramley, 2012) is a framework adopted by a UK mental health Trust that supports service users into employment and helps support them once in work. It recognizes that volunteering with the Trust is a pathway that can be helpful. The WORKS framework comprises three elements, *Getting Started*, *Keeping Going and Moving Forward* and *Growing*. This framework was reflective of the context in which phase 1 volunteers were supported. In phase 2 the recovery ambassadors were also supported in a similar way. Their volunteering placements rotated so they gained experience across a sector, which included voluntary organisations that supported drug and alcohol misuse and homelessness. They were supported with relevant training and ongoing support from mentors. Other volunteers in phase 2 had a less formal support network from the organisations in which they volunteered. Those volunteers who were in phase 2 and who had a less supported volunteering experience did not express strong dissatisfaction with their current personal scenarios. Therefore it can be questioned whether these volunteers were able to progress as part of a vocational pathway if that support was not available. Adequate support would have helped them to navigate and access services that would aid a journey towards paid work, training or education, if that was what they desired. It was also those volunteers that the researcher identified as career volunteers who were 'stuck' in volunteering that appeared to have a less structured and goal orientated support from

the organisation. It would be interesting to know how the voluntary organisations viewed the potential output of volunteering as something that can support a vocational trajectory into work or education for their volunteers.

Volunteers that were supported valued encouragement from mental health professionals and colleagues and these relationships were important. However work is not always important in the recovery of people with enduring mental health problems and the value of other occupations should not be underestimated. An expressed desire to work is consistent with Western values around work (Noon and Blyton, 2002) and for some this may not be that conducive to wellbeing. The current discourse linked to welfare benefits is in danger of deflecting attention away from a need to participate in occupations that are good for health and wellbeing (Blank, Harries and Reynolds, 2014).

### **7.5 Finding the right sort of work**

Marie Jahoda in 1958 developed the theory of Ideal Mental Health. Through her work Jahoda identified five categories, which she said were vital to feelings of well-being . These were: time structure, social contact, collective effort or purpose, social identity or status, and regular activity (Johnson and Lipscomb, 2006). She maintained that the unemployed were deprived of all five, and that this accounted for much of the reported mental ill-health among unemployed people. In the 1980s, when unemployment levels were again high, this approach was influential. She also found that unemployed people do not exploit the extra time they have available for leisure and social pursuits. Their social networks and social functioning decrease, as do motivation and interest, leading to apathy. People with enduring mental health problems are especially sensitive to these negative effects of unemployment (SEU, 2004). The social exclusion that they experience as a result of mental ill health is reduced by work and aggravated by unemployment (SEU, 2004). Fryer emphasised the role of poverty as a cause for unemployment distress, arguing that financial

deprivation severely frustrates the human desire for agency and self-directedness, which further impedes social inclusion (Fryer, 2006).

Research by Gewurtz and Kirsch, (2007) supported the value of occupation and indicated that factors such as choice, control, stress levels, boredom, intrinsic motivation and level of challenge and skill could provide optimal conditions to benefit health. Factors that seem to contribute to vocational success and the recovery of people living with mental illness are often related to a positive fit between the worker, the tasks and the workplace (Gewurtz and Kirsch, 2007). Certain daily patterns and routines seem to facilitate health and recovery. Work that corresponds to an individual's abilities can be an important factor in achieving such health promoting patterns (Hvalsoe and Josephsson, 2003)

It was important for the volunteers to think about the type of work they wanted to do in the future and what was right for them now, given the enduring mental health problems they had been through. The term 'authentic' is used to describe volunteering work in this study as it is real, not copied or simulated. Their motivations to volunteer were also influential in terms of finding the right sort of volunteering. When the volunteers were motivated by a desire to work in health and social care then volunteering allowed them to test out the fit between them as a worker, and the working environment. The option to volunteer allows these motivations to be tested out first. Moran et al., (2013) used self-determination theory to examine the intrinsic motivation of peer support workers. Moran et al., (2013) said that external motivation included generic occupational goals and getting away from a negative work experience. Internal motivations corresponded with autonomy and reflected as freedom to discuss and find work which was consistent with personal values. The volunteers in this study had a need to demonstrate competence in work they hoped would be right for them. It was not possible to access volunteering on just a vocational outcome alone as this was too risk laden but the volunteers needed to try to find the right sort of work for them.

Moran's study (2013) identified that for peer support workers their extrinsic motivation for that role was to do something different from previous work experiences. Their intrinsic motivations favoured a role where there was a freedom to disclose and use personal experience to help others.

This is illustrated in part of the interview with Janet who has a history of drug and alcohol use. Janet was very keen to use the lived experience she had had to help influence her future work directions. She was very aware that ideally she needed to find structure and routine that was conducive and influential on her mental wellbeing, as well as it providing a role around work.

**Janet (17):** *I had been through drug addiction myself and I had a chaotic lifestyle. A lot of the clients...not all of the clients have issues with drugs and/or alcohol and they have a certain lifestyle and for myself for the majority of my adult life I'd not got experience such as in a career. My experience is 'my life experience' and I wanted to put that into use to be supportive of others.*

*If I was told I had to take a job maybe say stacking shelves at Asda. Well with my mental health that would do me no good at all. I know I would have something to get up for and I would be out all day but I need to keep my mental health as positive as possible because if that starts to go that's maybe when thoughts creep in about using again and that's the danger. I suppose in an ideal world I would like to work in one of the drug services, but also I am going to look at things like hostels or other organisations possibly to support street workers and things like that.*

Boyce et al., (2008) focused their research on the views of users of mental health employment agencies who had successfully returned to work, in order to identify what had been successful. Job satisfaction was one of these key themes. Factors associated with job satisfaction included the right balance for the individual between work demands and sufficient challenge, a sense of achievement, and using and expanding work skills. Similar to the feelings of the volunteers in this study, a supportive workplace was also important. Less positive views identified in the same study were

discrimination and lack of support, which impacted on mental health problems at work.

Volunteering provided an appropriate challenge to the volunteers and, as voluntary work could be graded, this meant that the service user could be exposed to increasingly challenging tasks and responsibilities that supported self-efficacy and growth in confidence.

## **7.6 Summary of the chapter**

This chapter has discussed the impact that volunteering can have on the volunteers future work identity, work potential and work aspirations. Volunteering provided a forum to compare and contrast work tasks and duties to previous work experiences which was often negative. It allowed the volunteers to apply lessons they had learnt from their previous employment and use volunteering as a vehicle to do something very different. Volunteering allowed the volunteers to build and develop new skills and test old ones. It allowed them to learn and apply the social skills required for work. This had practical implications in that the volunteers could add to a CV in preparation for the next stage of their vocational journey, which may be paid work or education. A number of the volunteers were '*stuck*' in volunteering and their experiences have been highlighted. Self-efficacy and symptoms, as well as a dependency on the organisation where they volunteer, have been attributed to this. Despite this, in terms of recovery all volunteers were able to identify progress of their attributes for work which they had gained during their time as volunteers. Finally the chapter stresses that not all work is experienced as being beneficial and consideration of what constitutes the right sort of work for people with an enduring mental health problem is key as well as the relevance it has on their recovery.

## **CHAPTER EIGHT: CONCLUDING DISCUSSION - EMERGING AS A WORKER THROUGH VOLUNTEERING**

### **8.1 Introduction to the chapter**

The aim of this study was to generate a substantive theory that explained how volunteering impacted on personal recovery. The preceding three chapters examined the findings and how they related to three main categories 1. *Finding Meaning and Challenge within Volunteering*, 2. *Crossing Boundaries from Patient to Volunteer* and 3. *Finding the Right Sort of Work*, drawing in conceptual literature to substantiate them.

In this chapter, a synthesis of the key theoretical concepts will be discussed in relation to the emergent substantive theory of *Emerging as a worker through volunteering*. The researcher will also discuss the emergent theory in the context of personal, social and vocational recovery.

### **8.2 Summary of the emergent theory - Emerging as a worker through volunteering**

Recovery is not a linear process and these findings and the substantive theory provide a theoretical interpretation and not a logical process of volunteering or recovery. However, volunteering was initiated by positive risk taking, when volunteers were supported to tread carefully at first and at their discretion. When they were supported to make some decisions and take control of their vocational aspirations then volunteering was the impetus, a starting point towards vocational recovery. The risks as perceived by the volunteers and the process of finding meaning and challenge through volunteering are outlined in chapter 5. The volunteers were engaging with this occupation at their own discretion. They were not volunteering to avoid paid work or because it was important to someone else, but because it was their choice. This allowed the volunteers to find meaning and challenge through volunteering, which helped to affirm their readiness for work related activities.

Moran et al (2013) considered how motivation impacted on recovery. External motivation included generic occupational goals and getting away from a negative work experience. Internal motivations corresponded with autonomy, which was reflected as



freedom to discuss and find work with personal values. Competence needs were met and were reflected in the use of personal experience to help others. At their best humans are agentic and inspired, striving to learn, extend themselves and master new skills and apply their talents responsibly (Ryan and Deci,2000). Volunteers in this study discovered a degree of self-efficacy in the work they were doing, and a combination of beliefs and abilities supported their confidence, which then started to have an influence over their own situations.

A number of recovery oriented researchers emphasise that recovery involves a resurgence of a coherent sense of self and personal responsibility for one's own state of being in the process of social reintegration (Roberts et al., 2006). Bradshaw et al., (2007) suggest that, as well as gaining control over one's life, it is important to negotiate a valued and satisfying place in the world. Jacobsen and Greenley (2001) state that empowerment emerges from inside oneself, although it may be facilitated by external conditions. In the present study volunteering is an example of an external condition, which provided a focus for the volunteers. The actual work that the volunteers did, and the relationships that they established, were part of their personal, social and vocational recovery.

Volunteers in both phases were able to give something back to the services that had previously supported them or that were sympathetic of their enduring mental health problems. They recognised that they now had a voice. Their experience as volunteers with a lived experience was validated and this is discussed in chapter 6. Volunteering helped to establish a new and socially valued role and the volunteers had relationships that were positive and they experienced a sense of belonging again. As service user volunteers in the Trust they had the opportunity to work in the service that had been integral (irrespective whether they had a positive or negative experience) to their mental health support. Despite a long tradition of support for service user involvement, there is still little evidence that service user volunteering is an integral, embedded part of statutory mental health services. User involvement continues to

take a more passive form with the emphasis frequently on suggestion boxes, patient satisfaction surveys or consultation.

Although evidence of personal impact on those involved as service users exists, the nature of this impact is not well researched, and there is little consideration of how these forms of involvement and recovery impact on the 'self. Where the effectiveness of user involvement has been limited, it is the validity of 'user involvement' that has been the focus of debate rather than attention to the process, how it was implemented or how the different agendas influence that process (Stickley, 2006).

The involvement of service users as volunteers in a service that is supportive of mental health is not uncommon. Voluntary work has regularly been encouraged to enable people to recover their mental health and to promote their social inclusion. There is a belief that, like open employment, voluntary work can provide involvement in a meaningful activity, build structure and skills and for some offer a step towards paid employment (Holmes, 2007).

Volunteering provided an opportunity to be socially committed in terms of time and responsibility. Whilst paid employment has implications for construction of an occupational identity the researcher would suggest this extends to volunteering. As a lack of employment led to reduced self-esteem and self-efficacy (Dunn et al., 2010), volunteering was a way to rebuild this. In terms of the social value of volunteering, the relationships that were formed through volunteering with peers, other service users and professionals allowed for reciprocity, and a sense of belonging. This had benefits for the volunteers in terms of their evaluation of themselves, and it also enhanced how they were viewed by others. Whilst volunteering can provide many of the latent aspects of work (Jahoda, cited in Bernad et al., 2010) e.g. routine, structure and identity, a lack of income (which is synonymous with paid work) did not diminish the overall value and benefits that were being derived from volunteering.

Volunteering provided an opportunity to learn from experience. This included the experience that they brought with them as mental health service users but also they

were able to use skills they already had and learn through the development of new ones. These skills were then going to be an asset in a workplace. The volunteers were motivated by the opportunity to enhance their curriculum vitae (CV) to influence future employment. Volunteering was a chance to try something completely different from previous work experiences and this again informed learning about how the volunteers wanted to satisfy future work aspirations. Finding the right sort of work was important and as result of volunteering an authentic experience of work was provided. The volunteers were able to confirm to themselves and others what their capabilities were. The volunteers were able to rehearse for new directions that included education, paid work or other volunteering opportunities. Getting stuck in volunteering was problematic but this was based on both intrinsic and extrinsic factors, for example fear of failure and rejection or a need to maintain the current situation. This is discussed in chapter 7.

Emerging as a worker through volunteering is a construct of identity. Social constructionists view identity as an active process involving person-environment interactions. Concepts about identity depict individuals as continually involved in interpreting, constructing and reconstructing their personal and social identities as part of a complex interaction with their environments (Giddens, 2013). Mental health related identities are significant and Schwartz (2005) said that mental health becomes a lens that people see themselves through following a diagnosis of mental illness and that this new label impacts on how mental health service users are seen as people and also that this damaging effect on identity is concordant with views on psychiatric labelling through diagnosis. Charmaz (1995. p.659) defines identity as a way in which a person 'defines, locates and differentiates the self from others' which implies that the evaluation of social interactions with others is key to identity formation.

Whilst it was important that the volunteers were recognised for their lived experience of mental health. It was also important that the label of service user could be discarded in preference to the one of volunteer. The assignment of labels in the context of mental health can be damaging and further impacts on identity as, for

example the terms 'lunatic' or 'insane' (which can be traced back in history) and those associated with these labels were persecuted. That said, some marginalised groups have used 'identity' politics to reframe their devalued identities by using a collective approach. Work done by the Mental Health Foundation (2013) found that some have more negative connotations than others. For example, the term service user is the most commonly used term to describe people who use mental health services. The term represents a move away from an era of institutionalisation to a consumerist tradition that started in the 1990's and to the democratic tradition of developing participation to ensure the suitability of services (McLaughlin, 2009, p.1106). The term is also entrenched in the identity of the service user movement, which Wallcraft, (2010, p.3) describe as "numerous individuals who speak out for their own rights and those of others, and local groups and national organisations set up to provide mutual support or to promote the rights of current and former mental health service users to have a voice."

The term service user has been criticised because it homogenises a group and denies complexity and diversity amongst that group (McLaughlin, 2009) and also it privileges just one aspect of a person's identity and neglects other identities. The term is deeply engrained into some of the volunteers psyche and no matter what they would eventually do they thought they would always be a service user. This may in fact be correct due to the fluctuating nature of some enduring mental health problems and they would require the use of the services available to them. However a number of the volunteers interviewed felt differently and they expressed dissatisfaction with the term service user, preferring to be known as a volunteer.

*(Katie): I don't like to be put under a banner I would much rather be known for...as my name you know, not because I am a service user.*

*(Alice): Even when I was a service user because obviously I am an ex-service user now, it was almost like a personal thing for me to go and prove and show them.*

*(Val): I don't like being marginalized into being a service user and therefore, all the other things that I bring to the table are lost almost because you are...lumped into that category.*

### **8.3 Finding an acceptable self-identity**

Finding an acceptable identity was important to the volunteers and their identity as volunteers was a valued one. Identity and stigma have a dynamic relationship. There are several current theories about the construct of stigma. Famously Goffman in 1963 discussed how stigmatised people form a virtual social identity when they become disfavoured or dishonoured in the eyes of society and then become outcasts. Goffman coined the term 'spoiled collective identity' to describe people who were stigmatised and whose identity as a whole was brought into question. People with enduring mental health problems are often judged by their behaviours but this does not reflect their whole being. Stigma arises when an actual social identity falls short of a societally defined ideal identity. Establishing a social identity or group identity is important in establishing a social power structure. People with enduring mental health problems are bombarded with messages that suggest that society's expectations of them falls short. This is evidenced in the media and the derogatory language that is used to describe people with enduring mental health problems.

The loss of self with respect to an enduring mental health problem is an established theme in literature, which presents much debate about the impact of mental health on identity, with some suggesting that identity issues are a causal factor of mental illness (Baker, Proctor and Gibbons, 2009). People who have been diagnosed with an enduring mental health problem often find that their self-image and confidence is sacrificed by living under pressure and the negative expectations generated by that stigma. Thesen, (2001) said people with enduring mental health problems felt like they lacked a life of their own, in that they felt that others were making choices and setting goals for them. This reflects an underlying attitude, which contributes to a lack of self-

efficacy. The volunteers in this study felt that they had some control over the vocational decisions and directions that they wanted to take. By volunteering the identity information that they could offer about themselves, offered a new and valued dimension to their overall identity, that was now an extension and beyond that of service user.

Conversely some people develop stigma resistance by maintaining social relationships outside the mental health system. Given the emerging research into 'stigma resistance' (Thoits, 2011), it is important to develop social interventions where a person is not engulfed in a devalued 'illness' identity and be enabled to maintain roles and contacts with wider social networks. The researcher respects these findings but, this study suggests that some stigma resistance can be developed by having a different role in mental health services. The volunteers had a different identity and the role they had was of value to themselves and others. Their social network was different in terms of the relationships that were extended beyond that of service user and health professional.

The internalisation of stigma within ones self-identity has been shown to act as a barrier to recovery, as it undermines self-esteem and hope and the self-confidence and self-efficacy necessary to take part in mainstream social interaction (Yanos et al, 2008; Kleim et al, 2008 and Perlick et al, 2001). If paid work is classed as mainstream and seen as risky by the volunteers then volunteering provides a social, less risky outlet which allows them to present themselves not in an illness context but as individuals with skills, hopes and attributes of value. In this environment relationships can be developed and maintained and a wider social network emerges.

#### **8.4 Finding an occupational identity**

Individuals appeared to make occupational choices and carry out occupations in ways that allowed them to maintain a sense of personal identity, that was acceptable and satisfying (Laliberte Rudman, 2002). An acceptable self-identity was often linked to

maintaining a continuity of that identity and thereby maintaining that they were the same person that they had been earlier in life prior to onset of disabilities. This is the case to some extent in this study but it is linked to such things as work ethic, feeling useful, wanting to have routine and coping better when there is structure. In this study the discovery of a new self is related to a new occupation, that of volunteering. It is the volunteering that is now fulfilling choice, acceptability and satisfaction but in a context that is influenced by a mental health experience. Having an acceptable social identity can be described using occupation and this can in turn be perceived to be socially valued as a means of working towards or achieving a higher social status. Volunteering was a pathway for some that was intended to lead to paid work and thus improving a financial status. The volunteers were able to be socially useful and continue to be productive in a volunteering role. They were socially recognised by others for their skills and the assistance they could provide.

Baumeister (2011) recently identified three conceptual roots through which it is possible to understand the self - (a) the self as a knowledge structure in which a person stores information about himself or herself; (b) the self as an interpersonal being, emerging out of social relationships, and (c) the self as an agent with executive function. Taken together these concepts show that the self is born out of social relationships and self-reflexivity; that the self encompasses and organises one's thoughts, emotions, identities, values and attributes; and that the self is an agentic force that is expressed while interfacing with the outside world (Carlson et al., 2012). The relationship between what people do, which is labelled as occupation, and the expression of identity have been addressed to some extent in the literature (Christiansen 1999, Bury 1982). Volunteering supported the expression of an identity that integrated an enduring mental health problem in a positive way.

Occupation provides a person with a means of expressing their identity when faced with disruption in their lives, which have been due to ill health (Crabtree, 1998). Studies that link occupation to identity cite Crabtree (1998) who proposed "occupation provides persons facing apparent insurmountable odds a means of expressing their

identity." (p.213); this was true of the volunteers in the present study as volunteering provided an authentic experience for them to express a worker identity.

Christiansen proposed that "any threat to the ability to engage in occupations and present ourselves as competent people becomes a threat to our identity" (p.553). A number of small case studies have demonstrated the value of occupation being used to express identity and that it is central to the identity reconstruction process following the onset of disability. One such study is that by (Rebeiro and Allen, 1998) who explored identity reconstruction through volunteering. Also Ludwig (1998) examined the everyday tasks of older women and found that the participants described themselves in terms of their occupational abilities and disabilities and they sought to engage in occupations that reflected personal identity. Ludwig (1998) proposed that self-identity was created through everyday occupations. Occupations appear to be a means by which informants can express who they are to themselves and others. The volunteers in the present study were able to present a different more capable self, different to the one that others may have been seen when they were distressed or when their mental health symptoms were less controlled.

Having a sense of control over occupation is an important mediator of the relationship between occupation and its contribution to people's lives (Lahberte-Rudman, 2002). It is still not clear which occupations shape identity and how identity is shaped by occupation. The present study makes an attempt to understand the occupation of volunteering as one that promotes a work identity and how individuals engage in this.

### **8.5 Finding a socially valued role**

In symbolic interactional theory, role identities are definitions of the self in terms of the social roles that one holds and enacts (Mead, 1934 cited in Stryker and Burke, 2000). Role identities are answers to the question 'Who am I? In this context role identity also links to role relationships (Thoits, 2012). Roles are positions in the social structure to which behavioural expectations, including reciprocal rights and obligations, are attached (e.g. employee) Thoits, (2012). Stryker and Burke (2000)



propose that individuals obtain classifications of themselves as social objects and evaluation of themselves as worthy and competent social actors through taking the role of the other and accepting others categorisations and appraisals of them as self-descriptive. This was an important element of the findings from the present study, in as much as the volunteers were all too aware of how volunteering validated not only themselves as people but also their skills and capabilities. They could see this for themselves but it was important that they were validated by others too. The role they assumed as volunteers was one that was socially valued and this engendered a sense of value and pride in the volunteers.

*(Janet): You know you can be on the bus and get off and walk back to your house or flat whatever and you haven't got a sign above your head saying 'I volunteer my time.' It's like the feeling I get there should be a sign saying this 'girls alright, she supports our homeless project's.*

Role identities provide meaning and purpose in life as well as behavioural guidance, which in turn promote emotional and bodily wellbeing (Thoits, 2012). Because roles indicate to individuals who they are in their own and others eyes and why and how they are expected to behave, roles protect against anxiety and existential despair (Thoits, 2012).

Competent role identity performance also fosters a positive self-appraisal (Rosenberg, 1979) and belief in one's ability to achieve desired goals (a sense of control or mastery over one's life). The achievement of a socially valued role through volunteering is a move away from a service user label. It is an example of how volunteering in services that are recovery promoting can be empowering. Because individuals hold multiple identities theorists assume that some role-identities are more salient than others. Here salience is taken as being the subjective importance or value that persons attach to the various roles that they accept as self-defining (Thoits, 2012).

This is similar to McCall and Simmon's (1978) concept of identity prominence (cited in Thoits, 2012) where some identities are subjectively more central, prominent or important than others. Factors that affect the salience of an identity are the investment of time, effort and material resources in the role; intrinsic and extrinsic rewards from the role performance; and the amount of validation and support for the role from significant others (McCall and Simmons, 1978).

**(Natalie):** *Yes it's the spring of life for me, it's actually the spring of life, it keeps me sane it keeps me stable, it keep me from being held in by this situation I am in and without it I would die, literally I would die, because it's made me who I am and even if the situation was so bad that I will fall into a despondency and all of those things I know I would come up again, I'm known as the emotional scrapper.*

There are many examples in the data from the present study where the volunteers have provided testimony as to when they have felt their volunteering role to be important. They refer to the time it takes, to the amount and types of volunteering that they do and the rewards they gain from volunteering. As a role it holds some importance and the volunteers used it as a benchmark to compare it to other roles they had. For example, Natalie is talking about the role and how important it is to her as it gets her out of the house where she is trying to manage family problems as well as caring for a spouse with enduring mental health problems and these could have had a detrimental effect on her own mental health but volunteering has helped to protect that.

Thoits (2013) posited that if social roles provide purpose, meaning, and guidance in life then important role identities should be more potent sources of these assets than roles viewed by the person to be of lesser importance. Thoits (2012) also suggests that the greater the salience accorded to role-identity then the greater should be the

beneficial effects on wellbeing. Thoits (2012) researched the role identity of volunteers and salience in a US study. The more important a role identity is to a person then the more he or she has a sense of purpose and meaning in life and this is further associated with physical and mental health advantages. The US study was carried out with volunteers who themselves had experienced heart surgery and who were then volunteer visitors for others experiencing a similar predicament. Thoits (2012) suggests that this position of someone who has an appreciation of the support given to them when they were ill is a motivating factor. Thoits (2012) points out that the rewards from being a volunteer can underestimate the importance of the identity and meaningfulness that the voluntary work provides and of any subsequent wellbeing over time. Therefore associations with salience, identity and sense of purpose and wellbeing influence the volunteer and the recipient dynamically over time.

Longitudinal studies show reciprocal effects between volunteer role enactment and identity salience (Li and Ferraro, 2006). A limitation of Thoits's (2012) study is that it is a subjective interpretation of role identity gained through volunteering and it is unclear if the same would hold true for obligatory roles (e.g. spouse, daughter).

Tew (2012) sees personal and social recovery as mutually reinforcing. Volunteering helped the volunteers structure their lives, with a meaningful occupation and reciprocal relationships that impacted positively on their identity. Recovery can be about rediscovering a sense of personal identity, separate from illness and disability (Shepherd, Boardman and Slade, 2008). Having experienced enduring mental health problems there is a shift in one's self concept and people may need to redefine their identity (Repper and Perkins, 2003; Roberts and Wolfson, 2004). Some may need to reconstruct a sense of self in light of their mental health experience (Mezzina et al., 2006). Bonney and Stickley (2008) in their review record that the recovery journey can actually result in improved functioning, as this now incorporates personal growth, healing and often a change in attitudes and values (Repper and Perkins, 2003). This was evident in the data from the present study, where it is seen that the volunteers were taking the opportunity to volunteer as a way of testing themselves for a new

direction. They had reflected and learnt things about themselves and their work identity as a result of mental illness and this learning was taken into the volunteering environment and informed other decisions about their future work aspirations. This is discussed in chapter 7. It was the enabling and supportive environments that were key to the experiences of the volunteers. Slade (2012) suggests recovery begins when the individual can relate to something or someone and that the job of the system is to support this relationship, maintaining an organizational commitment to recovery and promoting citizenship amongst individuals in recovery. The role of volunteering was this 'something'. The volunteers in the main were volunteering in services that were familiar to them and the personal relationships they developed were encouraging and supportive. This helped to facilitate feelings of achievement and capability and it impacted on their social recovery.

Our social identities may be ascribed, achieved or managed (Tew, 2012). They may be given to us (ascribed) based on factors such as gender or mental health status. They may be achieved on the basis of specific social interaction, opportunities and performances or they may be managed by individuals creating the 'right impression' in order to be accepted, which in turn impacts on the way they have influence in particular social contexts (Cote, 1999 cited in Tew, 2012).

Identities give currency in relation to wider social participation and allow membership to a sub-cultural a group, which is a key to inclusion and a form of bonding or bridging capital (Tew, 2012). This is highlighted in the present study, as the volunteers cross the boundary between service user and volunteer. Their group membership has changed and they now belong to a different cultural group although they provide a valued perspective and this provides opportunities for growth of their identity capital. Their value as volunteers is now socially recognized within that group and their internalized sense of self-esteem is a resource that helps them operate in new situations with confidence.

Although there is a complex relationship between internal and external aspects of identity it can be assumed that the opportunity to take on identities that are socially valued and recognized is a positive thing. However there are some potentially overlapping issues that can affect the taking up of identity and these may deplete the effectiveness of identity capital. Identity may feel out of control and there may be a disconnection from any sense of who they previously were (Tew, 2012). Tew talks about socially inferior identities and uses examples of being 'black' or 'gay' which are then further compounded through the additional social stigmatization of an identity of being 'mentally ill' (Corrigan and Phelan, 2004). This often disrupts existing social, personal and economic relationships and can have a damaging effect on an individual's self-esteem. The volunteers in this study had identity issues that were viewed negatively by society and included being identified as drug abusers and / or being work shy as benefits claimants. Although these are external aspects of identity they still present additional challenges to identity management. Developing identity capital is fundamental to recovery. The process of creating a 'new me' can be liberating but has to be negotiated within that which is expected and ascribed to a particular social context (Ridge and Ziebland, 2006). Crucial to identity is being able to demonstrate an identity that is reflective of a capable person with something to offer. In this study volunteering was able to confirm the volunteers' capabilities about the work that they were doing. Volunteering was a way of confirming capability in term of skills and about themselves as workers within a volunteering context

Self-advocacy can be defined as people's beliefs about their capability to achieve designated levels of performance, and self-efficacy is influenced by negative cognitions and low self-esteem (Blankertz, 2001). When individuals with an enduring mental health problem can see that they do not have a support system and are dehumanised they have a lower level of self-efficacy. When people with a mental illness see that people who constitute their support systems are judging them this also affects feelings of mastery and makes their assessment of their functioning difficult. Stigma imposed by others creates the expectation that people with enduring mental health problems

are unable to live up to the responsibilities that are part of everyday living (Corrigan and Watson, 2002). The social context of volunteering in services that were sympathetic or understanding of the needs of people with mental health conditions is a significant factor in this study. The volunteers were given the space and time to allow their 'own resources and capabilities to come into play' as suggested by Schon (2009, P.345) and these experiences had allowed them to exert some control and influence over their life. When a more capable identity emerges this then has an impact on the individual's social environment and can open up access to wider networks (Tew, 2012). The volunteers' capabilities provided a confidence in both themselves and in others and this in turn gave evidence for them to move onto more challenging roles. It provided them with the capital to either become volunteers or to move forward and take a direction that would help them to achieve their vocational aspirations.

Personal capital is an internalization of constructive ways of seeing ourselves and engaging with the wider world and comprises components of personal resilience (Mancini, 2007), and learned optimism (Seligman, 1991)

Any motivation to recover is predicated on an emergence of a coherent sense of self that is able to assume control of one's intention to move forward (Tew, 2012). This may depend on establishing a sufficiently congruent 'shell' of self-identity, a fledgling position that one can occupy (identity capital) and from which individual drives can be developed and flow. A key enabler is likely to be an environment that offers recognition and acceptance (known as relationship and social capital). Once a more viable sense of 'I' emerges, the individual can reconnect with aspects of their emotional and social world (Tew, 2012). It is then possible to work more directly at enhancing efficacy and capability, supporting and reinforcing tentative acts of initiative, and continuing to identify internal and external barriers that need to be overcome to move forwards.

Maintaining a presence in some social network or settings may be achieved but this might be at the cost of having to adopt a position of inferiority or deference, or of

having to hide behind a 'false identity' in order to fit in, perhaps fearing that one may be found to be 'mentally ill' (Tews, 2012). Social contacts that are non-stigmatising and offer acceptance are crucial to recovery. The opportunity to be a service-user volunteer and to volunteer in a Trust with a mentor who is supportive of this role is recovery enhancing. When volunteers are volunteering in other organisations that can still provide meaningful occupation, including volunteering, this offers a sense of fellowship and belonging or a combination of both (Mezzina et al., 2006).

However Putnam (2001) finds that social connectedness rather than human or physical capital is a far better predictor of altruistic behaviours, including volunteering. Putnam (2001) argues that the web of social relationships and institutions allows dilemmas of collective action to be resolved by facilitating co-ordination and communication. The perceived benefits for volunteers are more likely to accrue for those individuals who are more embedded in the community through social networks and those with more social networks are more likely to volunteer than those with fewer networks. (Lee and Brudney, 2009). In other words the cost-effectiveness of volunteering increases with the relationships an individual has with his or her community, including a network of friends, membership of formal organisations and citizenship (Slater and Tonkiss, 2001 cited in Lee and Brudney, 2009). All the volunteers in the study had already established networks. These networks were their prior or current contacts within mental health services and organisations that were supportive of their enduring mental health problems. It is not known but these may be the more significant networks in the volunteers' lives. These networks were familiar and as such it is entirely reasonable that the volunteers should want to maintain and develop relationships within a mental health community if they are conducive to their recovery and provide social capital.

## **8.6 Establishing a worker identity through volunteering**

Establishment of a worker identity is the key construction in this study. Volunteering allowed the volunteers to express this identity of 'worker' in situations where they could volunteer. The literature presents much debate about the impact of mental

health on identity with some suggesting that identity issues are a causal factor of mental illness (Hemsley, 1998). Regardless of the impact, there is a profound loss of self (Proctor and Gibbons, 2009). Identity is not perceived to be a singular, essential and static property of the individual but is perceived as something that is fluid and that intersects with other identities (Kowitz, 2010). Feminist social constructionists argue that identity is created out of political, cultural, historical and social contexts (Reynolds and Wetherall, 2003).

Sayce (2001) and Perkins and Repper (1996) consider that the loss of socially valued roles, for example employment, leads to a loss of social networks and social exclusion. Worker role identity can be defined as an aspect of identity and self-definition that is tied to participation in the activities of work and / or membership in work related groups, occupations, professions or organisations (Dutton et al., 2006 p.266).

Fryers (2006) on considering the impact of chronic illness on a person's identity, suggests that there are two key facets that have negative connotations that may impact on identity. Firstly there is a deficit as a result of the lack of possibility of identity that results from not having a profession, a job, and a trade or worker status. Secondly there is a stigmatising identity that may result in negative perceptions of that individual as 'disabled', 'schizophrenic', 'depressive'.

These labels convey no real meaning about work potential or competence and have no value in a context of work other than helping to fuel discriminatory views and actions. The choice of occupations, be it conscious or unconscious, carries with it the unique stamp of the person's self. Vocational choices reflect the public aspect of one's identity and leisure occupations tend to reveal the private identity (Unruh, 2004). It is important to note that there was a strong interest in the present study from the participant volunteers whose aspiration was to first volunteer and subsequently work in a health and social care setting. This choice of occupation appeared now to be a conscious choice as a result of an enduring mental health problem and this experience was now part of that individual's unique stamp.



Donnelly (2000) was cautious about the advantages of volunteering to support people back into work if it was to become a 'substitute for work' and it may have negative long-term effects; however they had no evidence to substantiate this. Wilson and Musick (2003), whose work is the most rigorous in this area, allay these fears that too much volunteering can be counter-productive. They assert that two measures of volunteering, range and length show a linear effect; in that the more respondents volunteered the less likely they were to be depressed. In the case of volunteer hours, the positive effect is slightly stronger among those who work less than forty hours (Wilson and Musick, 2003). This study applied to those over the age of 65 and for those volunteers below that age the amount of time volunteering had no effect. Musick and Wilson (2008) highlight that when people view their volunteering as unpaid labour their motivation to volunteer shifts to the productive aspects of their role. Volunteers in the present study spoke about how their time dedicated to volunteering had increased over time. They described being 'busy' as volunteers and often had more than one place in which they volunteered.

The concept of work in its widest sense allows a discourse to develop about what is work and for whom and when. Allowing a broader definition of what constitutes work (paid and unpaid) ensures that a population of volunteers are recognised and the value given to the work they do and the sociological and psychological impact of that work does not go unrecognised.

The volunteers had aspirations to use the skills that they had developed during volunteering to take forward into some sort of end point be it paid employment or more volunteering to gain experience for a future work role or education. The majority valued and aspired to competitive employment, but volunteering at this time is what met their occupational, social and recovery needs. On a pragmatic level, volunteers could as a result enhance their CV for future evidence of work skills. They had used this experience to evaluate what work meant for them and this would inform future vocational choices. Volunteering facilitated an evaluation of their readiness as a worker, which would support their next vocational steps and their vocational recovery.

The nature of the relationship between volunteering and mental health is complex and the research does not distinguish between different contexts. Howlett's review of the literature in 2008 concludes that it is remarkable that there is not much research from the UK.

Volunteering is one of a number of productive behaviours, which an individual may or may not pursue depending upon a particular context. This context is relevant to service users where the motivation is a vocational goal. Viewing volunteering as a primarily productive activity focuses attention on the value of that productivity and on strategies to increase it. This is important as it has led to an increased focus on volunteer management but it can also reduce the nature of this value to productive outputs only and ignore the wider holistic benefits of volunteering. The nuances of volunteering are important. The idea of a volunteer workforce is closely aligned with the public health goal of generating social capital through civic participation.

### **8.7 Summary of the chapter**

This chapter has provided a synthesis of concepts to support the emergent theory - Emerging as a worker through volunteering. It has nested the emergent grounded theory with extant literature of identity and role theory drawing in an occupational and recovery orientated perspective to help locate the theory within a practice context. The final chapter will now provide a conclusion to the thesis; an evaluation of the credibility of the study and it will synthesise the contribution it has made and will put forward recommendations for practice and further research.

## **CHAPTER NINE: CONCLUSIONS AND RECOMMENDATIONS**

### **9.1 Introduction to the chapter**

The aim of this thesis was to present a substantive grounded theory: *Emerging as a worker through volunteering*. This two-phase study presents a constructed identity of mental health service users through the accounts of people with enduring mental health problems who participated in volunteering activities. Using a constructive grounded theory approach the aim of the thesis was to present a research journey supported by extant literature to examine the impact of volunteering on personal recovery. The emergent theory is the result of a rigorous application of grounded theory methods. This chapter reflects on the research process and theoretical interpretations. The implications for practice as well as the limitations of the study will form part of that reflection. Finally opportunities for further development of the emergent theory are also presented.

### **9.2 Reflections on the study**

This section will be presented in the first person as it is my own personal account and reflections on this research journey. Finlay and Gough, (2003) suggest that reflexivity means turning a critical gaze towards ourselves and Finlay and Gough (2003) define reflexivity as 'The project of examining how the researcher and intersubjective elements impact on and transform research' (p.4). This has been an important part of the evolution of qualitative research. Doing qualitative research is by nature a reflective process. Reflexivity in research is built on an acknowledgement of the ideological and historical power dominant forms of inquiry exert over myself as the researcher and the researched. Self-reflection upon the constraining conditions is the key to the empowerment 'capacities' of research and the fulfilment of its agenda. In this chapter I will critically reflect on aspects of this research process.

Charmaz (2006) suggests that a reflexive position will allow the reader to assess how and to what extent my interests, positions and assumptions influence this inquiry. The process of reflexivity is an attempt to identify, do something about, and acknowledge the limitations of the research: its location, its subjects, its process, its theoretical context, its data, its analysis, and how accounts recognise that the construction of knowledge takes place in the world and not apart from it. Being reflexive in doing research is part of being honest and ethically mature in research practices that requires researchers to 'stop being shamans of objectivity' (Ruby, 1980 p.154 cited in Morley, 2008). To not acknowledge the interests implicit in a critical agenda for the research, or to assume value-free positions of neutrality, is to assume 'an obscene and dishonest position' (Shacklock and Smyth, 1998 p. 6). My personal bias has been considered in chapter 1 in terms of my professional experience and interests and in chapter 3 where an open account of the interview process and subsequent analysis is offered.

### **9.3 Reflection on the Aims of the Study**

In this section I will reflect on each of the aims of this study.

- To generate a theoretical understanding of the experience of volunteering for mental health service users in relation to their recovery.
- To contribute to knowledge that has application to practice and service development

At the start of this journey there was a negligible amount of rigorous research available into the experiences of service user volunteers and this was of interest to me.

The aims of the study were informed by an identified gap in the literature. This in turn was driven both by my personal interest into vocational pathways to support people with enduring mental health problems who wanted to return to work and also

influenced by the experiences of volunteers who were volunteering back into a NHS Trust where they had received a service. This study goes some way to present a co-constructed theoretical interpretation of volunteering in this context. Data generated in phase 2 allowed me to consider a second group of volunteers again with enduring mental health problems but who were volunteering in organisations in the voluntary sector. This allowed me to consider the experience of two groups of volunteers who had some similar and also some different attributes as a population to draw upon. Recovery is not uni-dimensional and volunteering is just one social phenomenon that has been studied. The emergent substantive theory can only offer some further insights into volunteering for this group, which have largely been ignored by other social researchers who are adept at research into either volunteering or recovery.

#### **9.4 Evaluating the credibility of the Emergent Grounded Theory**

Charmaz (2006) asks researchers to look back into the researcher journey and also forward to imagining how the endpoint appears to readers or viewers. Researchers are immersed in the research process but Charmaz (2006) cautions that for the reader the lines become blurred between process and product. I was keen throughout this research process to be open but at times I struggled to see the wood from the trees. I relied on establishing a consistent approach to my grounded theory analysis. I constantly checked and questioned the data as the coding became more sophisticated and I developed increased theoretical sensitivity as the research progressed to aid my theory building towards a substantive theory that I was happy and confident to present. It was important that despite the experience and any pre conceptions I brought to this study my data analysis was grounded by the data I had collected and co-constructed through the interview process.

Grounded theory offers conceptual strength to the researcher, facilitating the abstraction of qualitative data into conceptual theory (Glaser 2003). Ultimately, however, a methodology is only as good as the researcher employing it. Challenges

that I experienced were in determining when saturation was reached. In grounded theory approaches the term theoretical saturation refers to 'the point at which gathering more data about a theoretical category reveals no new properties or does not yield any further theoretical insights about the emerging grounded theory' (Charmaz, 2006 p.189). Theoretical saturation in some categories was stronger than others, for example 'giving something back' provided dense saturation. I did make every effort to follow up all the categories and the tentative theory that came out of phase 1 by employing theoretical sampling of these categories into phase 2.

I employed considerable effort to increase theoretical sensitivity by reading literature pertinent across several fields of knowledge but it is important to acknowledge that I am in the relative early stage of a career as a researcher and this may have limited the breadth, depth and interpretation of multiple theoretical codes.

The research process has allowed me to achieve familiarity with the context of recovery, volunteering and work and their inter-relationships for people with enduring mental health problems. It was important for me to maintain a theoretical focus drawing on areas beyond the immediate substantive literature to ensure connections were made to demonstrate convergence or non-convergence of ideas. However it was also important not to be enticed by other interesting but less relevant bodies of work that would ultimately draw me away from the area of study. The use of literature for the literature review outlined in chapter 2 was a challenge. Charmaz (2006) warns that the place of the literature review is both disputed and misunderstood. Glaser (1998) maintained that grounded theorists should be uncontaminated by extant ideas. It was difficult to find a balance that could be presented as a review in this thesis. The reality was that the overall research process meant delving in and out of the literature throughout and weaving this into all findings chapters in order to create a dialogue to advance how this work fits in or extends the relevant literature. As an academic in occupational therapy it was important to be aware of contemporary literature and so this did inform the literature review but other extant literature both current and historical became familiar only through the analysis phase and subsequent writing.

With this in mind a decision was made to provide a context and structure to the study area in chapter 2 which helped to situate myself as the researcher within the domain of mental health recovery, vocational rehabilitation and a considered review of work concepts in which volunteering as unpaid paid is central.

#### **9.4.1 Reflections on research design and methods**

I chose to work with a research reference group for phase 1 of the study but this did not occur in phase 2. Again on reflection this may be an inherent flaw in the study design. At the time I did not think it was essential to the phase 2 study. In phase 1 where the volunteering context was so integral to the mental health Trust, the value that a service user informed reference group could offer was important. Phase 2 was aimed at recruiting volunteers from multiple sectors although in reality apart from one volunteer from a conservation setting who agreed to be interviewed all the other volunteers that came forward were in fact volunteering in organisations that were supportive of mental health. This had unexpected consequences. It did in fact improve the theoretical sensitivity derived from theoretical sampling as the categories that emerged from phase 1 could now be examined through the gaze of volunteers with very similar experiences. However a diversity of volunteering settings was elusive which raises questions again about how volunteers with enduring mental health problems can get access to volunteering opportunities other than in those services that will readily support them because they are sympathetic to their mental health needs. The present study identifies this as problematic and this has been highlighted in previous research but from the data generated I would like to offer a different perspective which is outlined later in the chapter.

The decision to use purposive sampling in phase 1 rather than theoretical sampling was very much influenced by the focus on a specific user volunteer service as opposed to volunteering in general. Purposive and convenience sampling is not an unusual sampling method when a grounded theory study gets underway. My use of purposive

sampling and the fact that I only approached each participant once for interviewing may have constrained the analysis. I endeavored to consider data from within and across all data sets through a series of coding, constant comparative methods, memo writing and diagraming. Another limitation of this study was that there were fewer participants from different ethnic backgrounds. This was not in any way intentional but rather a result of the sample available at the time, identifying themselves as Caucasian and British. It does mean that these findings are not transferable to a different ethnic population. Cultural diversity is always a concern in qualitative research. It is assumed, the more diverse populations that are represented in a sample, the better. With this in mind, a broader sample of culturally diverse volunteers may have resulted in more in-depth appreciation of volunteering but an argument could be made that this grounded theory represents a population where volunteering is a social norm; and although I did approach African-Caribbean, Asian and Chinese community groups represented in the City's voluntary sector to aid recruitment to phase 2 it only resulted in one volunteer who fulfilled the inclusion criteria to come forward. In the United Kingdom there are higher rates of mental health problems in BME (Black, Minority and Ethnic) communities compared with the national average. People from BME communities with mental health problems are reported to be more likely than others to receive a diagnosis of severe and enduring mental illness, to experience involuntary treatment, and to enter mental health services via the criminal justice system (Rugkasa and Canvin, 2011). It may be the case then that volunteering in those communities is not prolific. However it may be more likely that a barrier may have been created resulting in a reluctance to be part of a study that is led by a myself as researcher from a dominant white community, rather than their own community.

The interpretation of inclusion criteria appeared to be more significant in phase 2 and in particular, asking potential participants to self-report a mental health problem. With hindsight this criteria was potentially problematic for a number of reasons. The criteria was neither designed to exclude anyone who did not have a formal diagnosis nor was it there to discriminate between people who had a diagnosis but were unsure exactly



what that was. Exact diagnosis was not important in this study. My idea then to ask potential participants to self-report a mental health problem had the intention to remove these uncertainties and let the individuals identify themselves with respect to their mental health. This could have been seen to be an ambiguous statement to include and lacked clarity. I may have attracted more participants had a distinct diagnosis been used as inclusion criteria although this would immediately have narrowed the range of organisations that I could have approached to those that exclusively supported people with mental health conditions for example Rethink.

When I made contact with organisations that had access to volunteers who might be interested in the study it aroused some sensitivity about the gatekeeper being able to support the study because of the mention of mental health as an inclusion criterion. I had not expected this to be such an issue, which may have been naive. The way in which gatekeepers carry out their role can "facilitate, constrain or transform the research process and the production of the data" (Sanger and Thapar-Bjorkert, 2008, p. 558). Most of the gatekeepers for example the project managers or volunteer coordinators, recognized the importance of the study but a number who could have given me access to large numbers of volunteers felt uncomfortable asking volunteers to consider a study that was related to mental health or by promoting it through a flyer for the same reasons. The terminology 'recovery' also highlighted some issues for one gatekeeper and this e-mail extract demonstrates a perspective that I had not fully considered although the concerns raised were also somewhat contradictory. It is presented here as a critical incident during phase 2 recruitment.

*I'm really sorry to appear so uncooperative but looking at the sheet I don't feel able to pass it onto our volunteers. Firstly mental health recovery feels like a very clinical term and it rather anticipates that one is getting better, whereas I suspect for many they are handling an ongoing issue, or one that comes and goes maybe and where volunteering is part of helping, to feel more up for more of the time. In any case it feels presumptuous to suggest that recovery has taken place especially as it's not something we talk about (unless the volunteer raises it themselves) so we don't know. Also there is*

*something very freeing to be away from this label, they have no requirement to disclose and we are fearful of suggesting to them that we view them in this way. All of which does not help you get more subjects but we are keen to understand the needs of people with mental health issues so we can do our best by them.*

*(Gatekeeper for a large organization that has access to many organizations that support volunteers)*

I found it interesting that the gatekeeper was trying to protect the volunteers and felt that my invitation to take part in this research was in some way stigmatising, when in fact the research was trying to find out just what the gatekeeper wanted to know. Although this scenario was isolated the way in which recovery and enduring mental health problems are conceptualised for an external audience less familiar with this field was something I had underestimated. The discourse around mental health is jargon-filled and whilst I made attempts to recruit using language that was clear and not value laden the notion of recovery is less clear. Facilitating research can also put a strain on small organisations with limited budgets. There might be limited time and resources available for involvement in additional work, particularly if there are no obvious or direct benefits to the organisation or the people it supports.

Whilst sample size was not over important in this study; recruitment to phase 2 to allow theoretical sampling to get underway was a challenge for a time. All the interviews were in depth and so the richness of the data across the nineteen interviews between phase 1 and phase 2 seems adequate, had the quality of the data been impaired in any way then this would require the sample size to increase. Morse (2000) addresses this by suggesting that if only shallow data is available then she recommends a number of 30-60 participants to obtain the richness required for qualitative data analysis. There is no clear viewpoint on sample size and so in order to gain theoretical sensitivity of the concepts arising from the data that is theoretically sampled then I was also aware of the use of shadowed data (Morse, 2000). This was when in addition to talking about their own experiences to myself as the researcher

the volunteers also talked about the experience of others. This was important as it allowed me to investigate experiences beyond the single participant experience with respect to the phenomena being studied. Shadowed data provided direction for me. When I interviewed one of the recovery ambassadors he spoke about one of the other recovery ambassador volunteers who was also taking part in phase 2. I was then able to verify and explore the data by interviewing this volunteer and thus theoretically sampling to help develop further categories across phase 2 during analysis. Had the volunteer talked about someone who was not taking part in the study this had the potential so raise some ethical issues around confidentiality.

During the interviews a number of dilemmas arose. There were a couple of occasions where I knew the participants from previous therapeutic contacts with them when I was an occupational therapist working in that Trust. Although this was quite a long time ago this was acknowledged, as it would have seemed futile and unfriendly not to acknowledge a previous relationship. However I did feel that this influenced the interview, the participant assumed I knew people and services they spoke about and sometimes I did but not always and so clarification had to be sought rather than allow the volunteer being interviewed to think that I had assumed something. I had to be careful to distance myself from an interview style that could have been considered more like that of a counsellor or one that was over familiar and just chatty. My unique contribution and that of the participants in a study makes us inseparable parts of the final creation (Karnielli-Miller, Strier and Pessach, 2009). Participants feel involved because of the personal experiences they can contribute and I had an aspiration to understand them. A feeling of informality was developed fuelled by an anti-authoritative, unstructured atmosphere, and there was an attempt to engender trust from the volunteers. This had the intention of democratising any power relations of control sharing (Karnielli-Miller, Strier and Pessach, 2009). An attempt to do this was by sharing the transcribed transcripts with the volunteers post interview. Karnielli-Miller, Strier and Pessach, (2009) says there is no correct or optimal relationship in qualitative research but that the relationship changes according to the researcher's

world view, ethnic and social background and perceptions derived from the researchers professional background.

I made the decision early on to use the term volunteer when writing about the participants rather than the term participant. This was to balance the control and power that I had over the data, even though the analysis was constructed by me, the volunteers' data were integral to that process. The term volunteer described key and important attributes of those being interviewed and the label participant somehow distanced them further from the analytical process. I then became the storyteller who recasts that story in a new historical and cultural context (Karnielli-Miller, Strier and Pessach, 2009).

In this study I shared the transcribed interviews with each volunteer, for them to amend as they saw fit. Forbat and Henderson (2005), question this and say whilst it is motivated by a desire to empower the volunteers in this study it could be seen as threatening as it would expose any ungrammatical styles and may prompt worry over how they were presented. As discussed in chapter 4, one participant did make grammatical changes and sent the transcript back to me but it is not clear about how it made them feel. I wanted the volunteers in the study to see that I had a level of openness and trustworthiness. I did not include the volunteers in the analysis or share any of the analysis leading to categories. I had not agreed this through the process of ethical approval and a number of volunteers interviewed in phase 1 were all volunteering for the same Trust and so identification of participants might have been possible even though they would have been anonymised. In light of these constraints, qualitative research oscillates between the desire to offer a less hierarchical and more open and transparent process and the need to respect methodological discipline of qualitative principles (Rugkasa and Canvin, 2010).

#### 9.4.2 Reflections on analysis

Data analysis was as expected, overwhelming and yet exciting. A decision was made to not use qualitative software e.g. Nvivo despite having some training. There was something about being able to engage with the data creatively on paper that helped me with coding. I used many strategies (paper based and electronic mapping tools) and a downside was changing my mind about which was the best one so an eclectic approach was taken although the actual process of initial, focused and theoretical coding was used consistently and interpreted in the same way across the study.

As the data analysis gradually gathered momentum and became purposeful, I became embedded in this process. I have always been surprised throughout the analysis about how long it takes to move through the abstractions from codes to categories to theory. It was pleasing to be aware of how my analytical skills became more refined as the study progressed and I was aware of theoretical sensitivity to the core categories. The final stage of writing the thesis was an important part of the research journey and as I began to articulate the emergent theory I was able to reflect and to review the detail of this construction. The process of writing helped me to refine and clarify my theory. It has been important to get across key arguments and also to present the data through quotes from the volunteers to add weight to these arguments. As I integrated the quotes to support the narrative, this helped to challenge and question my assumptions. Decisions made about how to present my theory were based on the categories and theory that was generated. During the final writing phase some of the sub-categories were collapsed into other categories in an attempt to present a more cohesive category that defined a social action or process more clearly, which could also be supported and grounded in the information provided by the volunteers. Finally, it was important to reflect the voice of the volunteers as well as my own voice through word choice, tone and rhythm. Charmaz (2006) suggests the researchers' voice has to be compelling. Silent authorship can assume neutrality and objectivist pretensions (Charmaz and Mitchell 1996).

### 9.4.3 Relevance

Relevance or usefulness (Charmaz, 2006) refers to the importance of the core concern in the substantive area, and (Glaser 1978,1998) describe this as the 'grab' of the emergent theory. If a theory is relevant, then it captures sufficiently a significant concern for participants. It will be my responsibility to disseminate the emergent theory to a range of stakeholders and importantly volunteers so that they can make sense of it in their everyday worlds. A generic aspect of the theory might be of interest to the lived experience of peer support workers as the work environment is somewhat similar and it relates to the substantive area of research. The study will inform and extend the recovery literature.

Relevance has been supported in this study by ensuring the systematic and rigorous application of coding and constant comparison methods leading to successive levels of abstraction and theoretical sampling, which progressively refine the emerging theory. I have tried to be careful not to force my preconceptions on the data. This has been aided by delaying a fuller engagement with the literature and also engaging in memo writing throughout the different stages. I am confident that core categories leading to the emergent theory that was constructed are reflective of the data from which they were derived.

### 9.4.4 Modifiability of the emergent theory and future areas of research

Modifiability refers to the ability of the grounded theory to be altered in response to comparison of new relevant data (Glaser, 1978). In this study new ideas would not refute the emergent theory but would increase its density and scope by adding further variation. Further theoretical sampling of volunteers with enduring mental health problems who are volunteering in different sectors or who are accessing volunteering in different ways would increase the density of the theory, for example sampling through the local City council, the voluntary sector outside of mental health where

different support strategies might be employed. The conceptual scope of the theory could be developed, by exploring completely different lenses of volunteering. As the integration of extant literature has demonstrated, this is a potentially common concern that will span several domains in which people engage with volunteering for example, other areas of healthcare, welfare agencies, social work or higher education. Different demographics of age, gender and ethnic groups would also illuminate and enhance the theory.

To advance this research, a longitudinal study would add weight to the emergent theory if some of the concepts could be examined overtime. A longitudinal study that uses mixed methods to establish the trajectory of volunteers over a period of time, including objective outcomes of quality of life, vocational skills attainment and how preparation for future work roles are gained through volunteering would provide further evidence of the potential for volunteering as a vocational pathway. This is put forward as a recommendation.

Constructivism as an ontological perspective reflects that individuals construct meaning out of social contexts, it emphasises the value of an individual's interpretation and unique experiences (Crotty, 1998). When applied to grounded theory methods, it gives a voice to the participants but it also embraces the input of myself as researcher (Charmaz, 2012). My professional journey and discourse undoubtedly influenced the analytical decisions that I made. The data was rich with potential analytical themes, which was part of the intrigue yet also a dilemma that required careful decisions to be made. I am sure others will look at my work and see different things and place a different emphasis on the construction of categories and the subsequent emergent theory. However this constructivist grounded theory approach fitted well with the aims of this study. Other methodological approaches for example phenomenology or narrative research might also have provided an interesting perspective on the lived experience of volunteers in the study but this emergent theory will inform practice and hopefully add to the ongoing debates about

volunteering for people with enduring mental health problems and what helps them on their personal recovery journey.

### **9.5 Contribution to knowledge**

This study aimed to make a contribution and generate knowledge of how volunteering helps someone with a mental health problem to recover. The key contribution to knowledge that I make through this thesis relates to the following areas:

- Identity construction through volunteering for people with enduring mental health problems
- Volunteering as occupation
- Volunteering as part of a pathway to support recovery
- Volunteering within health and social care

Positive risk-taking is just the first step of a journey that starts with volunteering. The volunteers were able to make the decision to volunteer and they had control over that decision, it was at their discretion. Volunteering can provide an outlet that feels less risky, but which allows the individual to engage in an environment that still places demands and responsibilities on them. The current political climate may be taking away individuals' control of their risk-taking through volunteering as it may be interpreted as a readiness for paid work. Over the course of conduct of this study the domain of recovery and vocational rehabilitation has had a prominent position within mental health services (Shepherd et al., 2008; Sainsbury Centre for Mental Health, 2007, 2009, 2010). In 2010 the new coalition Government made changes to the way people can claim welfare benefits if they are out of work as a result of their health condition or a disability. The Welfare Reform Act (2012) has posed and continues to pose some challenges for people with enduring mental health problems. The expectation to do paid work is not an unrealistic one but for many there may be fears about what they can do and how quickly they will be expected to work, as fear of losing welfare benefits are real ones. Volunteering may be recognised as part of the approach to providing voluntary or mandatory work experience for people claiming



Employment Support Allowance (ESA) and so its value, prominence and potential has never been greater. The aims of this study were therefore both relevant and significant to this political context.

Prior to volunteering, the volunteers in the study experienced limitations in occupation and this could have in turn limited the ways in which they perceived themselves and managed their social and vocational identities. Engagement in an occupation like volunteering has the potential to lead to opportunities for growth and reconstruction (Laliberte Rudman, 2002). In the present study volunteering as occupation provided meaning, challenge and a purpose. It helped the volunteers to establish a new occupational identity that was synonymous with a vocational role that was recognised as socially valuable. It was interesting for me to see that for many of the volunteers in this study the continuity they wanted to maintain through occupation, especially those that were work related, was related to their enduring mental health problems. They had acquired knowledge and skills through this experience that could now be used in a more productive way and volunteering was allowing them to do this. Their worker identity was still important but now, due to an enduring mental health problems they were able to integrate this but in a positive way. They now had mental health knowledge and experience that could be seen as essential criteria for some types of employment. The volunteers in the present study used volunteering as a way of presenting a less passive identity, one that was productive, skill enhancing and reciprocal. This reconstruction of a worker identity through volunteering was one that could be viewed in a more positive light by the person themselves and also by others. Kelhofner (2008) defined occupational identity as a 'composite sense of who one is and wishes to become as an occupational being and this is generated from one's history of occupational engagement' (p.106). Research suggests that people maintain a sense of identity that is acceptable to them and that following illness or disability they strive to achieve a sense of continuity with their previous lives (Unruh, 2004). The volunteers in this study had had diverse and rich occupational histories that were part of their current identity and was influencing their occupational choices now and would

continue to influence them in the future. The volunteers in the study also had experiences of an enduring mental health problem to offer and this was now part of that richness. Volunteering as occupation was fundamental in allowing the volunteers to develop a new socially valued role and identity. Christiansen (2004) supports the fact that people become who they are through what they do. Blank, Harries and Reynolds (2014) assert that occupation is one of the building blocks of an evolving identity.

The development of user support services within mental health Trusts is consistent with a recovery-focused drive. These services continue to grow but there is no consistent or equitable access to such services across England (Centre for Mental Health, 2013). There are a number of benefits to a recovery-focused service that can be provided through a volunteer scheme. There are gains for both professionals and other service users by the very presence of volunteers in the mental health workforce. Benefits specific to other mental health service users are that service user volunteers can help them to navigate through an often frightening and complex system. They can provide an 'expertise' that service users can learn from and can identify with. In these ways volunteers complement the roles of health and social care professionals.

A strength of the volunteering experience was seen to be the ability to 'give something back', as this provided an opportunity to have a mental health lived experience valued by others. It gave the volunteers a voice which validated their own enduring mental health problem through experience as a volunteer and not as a patient. The volunteers recognised a need to be valued for what they do and also that their relationship with others was now reciprocal. In the present study it was evident that service user volunteers identified changes in their sense of self, who they were now, and how they felt about themselves, as a result of volunteering and as a result of their enduring mental health problems. The opportunity to do voluntary work helped the volunteers challenge the stigma they experienced by allowing them to have feelings of value and self-worth and to be recognised for the skills they either once had or wanted to

develop. The integration of their experience of an enduring mental health problem was important and it was a benefit from volunteering in services that were supportive of mental health. Similar findings can be found in other studies (Arthur et al., 2009) where individual's optimism about paid work as well as voluntary work resulted in mobilising their hopefulness and resilience towards stigma. There is evidence (Bird et al., 2014; Roberts and Boardman, 2014) that it is possible to find supportive relationships in the presence of other recovering individuals. This then provides an opportunity for learning and the prospect to regain control over one's life and become independent. In recovery people learn to understand and accept the challenges posed by their condition. This may be part of a journey where recovery is facilitated by supported volunteering.

There is some evidence to suggest mental health service users prefer to volunteer in services sensitive to their mental health needs (National Centre for Volunteering, 2003) but also that there is a barrier to progression from this to other volunteering opportunities due to perceived discrimination and stigmatisation. An impetus for this present study was a paucity of literature in relation to the changing role of service users as volunteers and the impact this has on personal recovery. It had been suggested that volunteering was important as it is an agent for recovery and that volunteering is a journey towards a new and valued sense of identity, role and purpose but more research was needed (Lloyd et al, 2007). It is hoped that this study has gone some way to help understand the construction of the identity change that volunteers go through as they move from service user to volunteer. Farrell and Bryant (2009) provide evidence that service users can be 'ghettoised' into like-minded organizations and then get stuck in these environments and it could be questioned whether it is helpful for volunteers to stay within a restricted mental health sector. Roberts and Boardman, (2014) stress that people live in society and not in mental health services, and that it is not uncommon for people with enduring mental health problems to have their lives centred on contacts with fellow service users, staff and mental health facilities. Some volunteers in the present study did get stuck but that was as a result of

intrinsic and extrinsic factors and not solely as a result of being restricted by the 'ghetto' of mental health services. The researcher proposes that, when volunteers are supported to enhance and progress their vocational aspirations, volunteering in a mental health sector may be just part of a longer vocational journey.

It was interesting that, for many of the volunteers in this study, the continuity they wanted to maintain through occupation, especially if it was work related, was related to their mental health experience. They had acquired knowledge and skills through this experience that could now be used in a more productive way and volunteering was allowing them to do this. Their worker identity was still important but now due to an experience of mental ill health, they were able to integrate this in a positive way. They now had mental health knowledge and experience that could be seen as essential criteria for some types of employment.

In health and social care settings, volunteer services have the possibility to be creative and responsive to local needs (Mundle et al, 2012). The place of volunteering on UK Government policy agendas has rarely been more prominent and 'the weight of expectation' about its potential contribution to individual development, social cohesion and addressing social need has never been greater (Rochester et al., 2010). Hotchkiss et al (2009) say it is important to recognise the financial value of volunteers and suggest monitoring the number of hours they provide as a way of avoiding the potential for exploitation. Volunteering should not take the place of paid work or provide cover for what should be a paid professional role (Buckingham 2012). However, where volunteering is offered and is supported, the volunteer workforce is then more able to reach its full potential. The concept of recovery provides a number of dilemmas about how to develop adequate services, not least in the context of financial under-funding. Braslow, (2013) asserts that the necessary scaffolding for a recovery-oriented system requires the inclusion of recovery beliefs, values and practices and that this is a considerable challenge. Organisations that support recovery orientation need to demonstrate a commitment that the work environment and service structures are conducive to promoting recovery-oriented practice (Le Boutillier

et al., 2011). These structures would include a comprehensive user support service that provides a spectrum of support for work and work related activities that would enhance identity and roles. This would include volunteering: support for volunteering; peer support worker roles, integration of recovery colleges (Perkins et al., 2012) led by service users; and other opportunities to embed people with lived experience of mental health into the workforce.

A service which values service user volunteers alongside service users in paid positions can promote a culture focused on recovery. It can help change mind-sets by having a focus on what people can do and achieve rather than their symptoms. Mental health services are in a unique position to build partnerships with service users to support their recovery and their journeys toward employment by providing opportunities for volunteering. The role of peer support workers and the evidence supporting this role continues to emerge (Repper, 2011; 2013) although Lloyd-Evans et al.; (2014) highlight a need for more evidence of the effects of these roles for people with enduring mental health problems. They state that the evidence provided so far does not indicate any statutory or strategic requirement to implement these roles as part of a recovery focused service. The researcher therefore proposes that volunteering for service users would seem a logical step that would prepare someone for a paid peer support role and would make a positive contribution to this ongoing debate.

Whilst the recovery paradigm might be an inspiring concept, its links with citizenship and the focus on the rights of people to live on equal terms in mainstream society, by promoting social inclusion in the community, challenges both traditional service structures and the professional narrative about responses to mental distress. Mental health professionals could also engage in practices that support service users' journeys towards full citizenship by continuing to hold a broader understanding of the causes of distress that goes beyond the ideology of the biomedical model. An awareness of the impact of a loss of role as a worker is key. For mental health professionals there is a need to ask 'the work question'. This would then allow them to gain an insight into the service user as an occupational being who maybe has a rich history of employment and

who for no fault of their own has been thwarted in their desire to develop a vocational identity due to their enduring mental health problems. As Davidson (2008) has argued, if mental health professionals can be more aware of the oppressive social structures that impact on service users' status this would reduce the conditions placed on their citizenship. When mental health professionals practice within the key domains for supporting recovery: working relationships; supporting personally defined recovery; organizational commitment; and promoting citizenship (Le Boutellier et al., 2011), they continue to support service users strengths and resourcefulness which helps them to overcome the shame and demoralisation associated with being labeled.

Mental health professionals, particularly occupational therapists, have the opportunity to recognise that through volunteering, occupation can have an impact on social recovery and positive identity formation. When mental health professionals view their practice through a framework that promotes citizenship of service users, they too are using their political power to support service users on their journeys towards full citizenship that is acceptable to the individual and not just that demanded by society.

Professionals need to be aware of the potential for exploitation of volunteers in terms of finances, time and any unethical practices. In services where the workforce is often stretched there may be a danger that volunteers are used to 'plug a gap' in service provision. The current economic downturn may prove even more challenging for vocational rehabilitation interventions including Individual Placement and Support (IPS). Perkins (2009) talks about time limited internships and time limited voluntary work. These opportunities are more important at a time when there is limited open and competitive paid work.

Volunteering should not take the place of paid work or provide cover for what should be a paid professional role. However, where volunteering is offered and is supported, and it is recognized as part of a pathway towards paid work, there are benefits both to the volunteers and to the services in which they volunteer.

The recovery paradigm clearly requires a rethink about the way services are organized and delivered. An individual approach to recovery requires professionals to facilitate a

process whereby service users feel empowered to become autonomous and self-sufficient but even with this the proper care and support resources are not always available. It can also be argued that recovery can be viewed as the way the system could cope with the increased demands whilst in an economic climate of cut-backs and financial savings. This view is echoed within the literature, where there is a concern that recovery will be misused as a post-hoc justification for reducing and cutting services (Fernando, 2010; Roberts and Hollins, 2007). This increased scepticism about recovery also raises the question as to whether such concerns are a by-product of individuals coming into contact with mental health services that are not currently recovery focussed, with the result that staff and system-level concerns about recovery are communicated to consumers. It is important therefore that any supported volunteering service is ethical and prioritises the needs of the service user, which is to support recovery. In the UK there exists a network of mental health support groups designed to provide individuals who have enduring mental health problems with opportunities for social support and positive social interaction, for example Hearing Voices Network (Romme, 2009). Such groups provide an opportunity for individuals to identify with other members who share an enduring mental health problem. There is a role here for volunteers with lived experience which is outside statutory secondary services.

Whilst this thesis has put forward a view that is overall in favour of supported volunteering the thesis has not focused on the financial costs of setting up such a service or the objective vocational outcomes that a service would be expected to provide. However adequate resources are required to maintain the support networks that are needed in a supported volunteering scheme. The volunteering environment allows a service user to gauge readiness for work by testing out their capabilities over a period of time. Recovery services are clearly focused on opportunities for people with enduring mental health problems to influence services. The research raised a number of questions about how volunteers are supported and whether the way in

which some of the participants volunteered was something more than volunteering e.g. internship or work placement. This would warrant further investigation.

## **9.6 Recommendations to enhance practice**

**Recommendation 1** - Volunteering is meaningful occupation. When supported it provides an authentic work experience which: fosters positive risk taking; confirms capabilities for work; and affirms a readiness for work. A worker role and identity can be strengthened through volunteering.

**Recommendation 2** - Mental health professionals are in an influential position to work in partnership with service users to help them explore their vocational aspirations through volunteering. Awareness raising and training should be provided to give health professionals the necessary skills to support volunteers in their role.

**Recommendation 3** - Volunteering within services that are supportive of mental health is a starting point for those who want to volunteer and mental health organisations should explore the range of opportunities that exist in order to embed volunteering as part of their role in aiding recovery? All recovery focussed services should develop an effective infrastructure that both promotes and supports volunteering.

**Recommendation 4** - A longitudinal study is recommended that uses mixed methods to establish the vocational trajectory of volunteers over a period of time. This should include objective outcome measures of: quality of life; vocational skills attainment; and how preparation for future work roles is gained through volunteering. A cost benefit analysis should also be considered. This would provide further evidence of the potential for volunteering as a vocational pathway.

**Recommendation 8** - Providing authentic work experience is important for service users as part of a vocational pathway. It is recommended therefore that studies that compare and contrast different models of work experience should be undertaken with the aim of identifying the advantages of each approach and to establish which works best.



## 9.7 Summary of the chapter

This chapter has situated the emergent substantive theory *Emerging as a worker through Volunteering* within relevant extant literature. The chapter provides an insight into how a worker role and worker identity is constructed through volunteering in services where a lived experience of mental health is valued. Volunteering has had a positive impact on self-stigma and a case is put forward for volunteering as a way of maintaining the positive outcomes of recovery whilst working as a volunteer in a mental health environment. The key benefits of volunteering have been presented and the new contribution this makes to the territory of recovery. The chapter includes a critical reflection on the credibility of the substantive theory and the overall research process. A series of conclusions and recommendations are put forward that will inform recovery-focused practice and recovery focused services.

## REFERENCES

- Abma, T. A., & Baur, V. E. (2014). User involvement in long-term care, towards a relational care-ethics approach. *Health Expectations*,
- Adnoy Eriksen, K, Arman, M., Davidson, L, Sundfor, B., & Karlsson, B. (2013). Challenges in relating to mental health professionals: Perspectives of persons with severe mental illness. *International Journal of Mental Health Nursing*,
- Agostinho, D., & Pafo, A. (2012). Analysis of the motivations, generativity and demographics of the food bank volunteer. *International Journal of Nonprofit and Voluntary Sector Marketing*, 17(3), 249-261.
- Aldrich, R. M. (2011). A review and critique of well-being in occupational therapy and occupational science. *Scandinavian Journal of Occupational Therapy*, 18(2), 93-100.
- Alexander, L, & Link, B. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, 12(3), 271-289.
- Alexandratos, K, Barnett, F., & Thomas, Y. (2012). The impact of exercise on the mental health and quality of life of people with severe mental illness: A critical review. *The British Journal of Occupational Therapy*, 75(2), 48-60.
- Andresen, R, Caputi, P., & Oades, L (2006). Stages of recovery instrument: Development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry*, 40(11-12), 972-980.
- Andresen, R, Oades, L, & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australasian Psychiatry*, 37(5), 586-594.
- Andrews, T. (2012). What is social constructionism. *The Grounded Theory Review*, 11(1), 39-46.
- Annells, M. (1997). Grounded theory method, part I: Within the five moments of qualitative research. *Nursing Inquiry*, 4(2), 120-129.

- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11.
- Arthur, B., Knifton, L., Park, M., & Doherty, E. (2009). 'Cutting the dash'—experiences of mental health and employment. *Journal of Public Mental Health*, 7(4), 51-59.
- Aston, V., & Coffey, M. (2012). Recovery: What mental health nurses and service users say about the concept of recovery. *Journal of Psychiatric and Mental Health Nursing*, 19(3), 257-263.
- Aviram, R. B., & Rosenfeld, S. (2002). Application of social identity theory in group therapy with stigmatized adults. *International Journal of Group Psychotherapy*, 52(1), 121-130.
- Baker, A. E., Procter, N., & Gibbons, T. (2009). Dimensions of loss from mental illness. *J.Soc. & Soc. Welfare*, 36, 25.
- Bambra, C. (2014). Tackling health-related worklessness: A 'health first' approach. // *You could do One Thing....*, 62.
- Barker, J., & Weller, S. (2003). Geography of methodological issues in research with children. *Qualitative Research*, 3(2), 207-227.
- Barnes, H. (2011). Does mental illness have a place alongside social and recovery models of mental health in service users' lived experience? Issues and implications for mental health education. *The Journal of Mental Health Training, Education and Practice*, 6(2), 65-75.
- Barnes, H., Garratt, E., McLennan, D., & Noble, M. (2011). Understanding the worklessness dynamics and characteristics of deprived areas.
- Bauld, L., McKell, J., Carroll, C., Hay, G., & Smith, K. (2012). Benefits and employment: How problem drug users experience welfare and routes into work. *Journal of Social Policy*, 41(04), 751-768.
- Baumeister, R. F. (2011). Self and identity: A brief overview of what they are, what they do, and how they work. *Annals of the New York Academy of Sciences*, 1234(1), 48-55.

Beatty, C., & Fothergill, S. (2011). *Incapacity Benefits in the UK: An Issue of Health Or Jobs*,

Bedding, S., & Sadlo, G. (2008). Retired people's experience of participation in art classes. *The British Journal of Occupational Therapy*, 71(9), 371-378.

Bejerholm, U., & Eklund, M. (2006). Engagement in occupations among men and women with schizophrenia. *Occupational Therapy International*, 13(2), 100-121.

Bejerholm, U., & Eklund, M. (2007). Occupational engagement in persons with schizophrenia: Relationships to self-related variables, psychopathology, and quality of life. *American Journal of Occupational Therapy*, 61(1), 21-32.

Berger, P., & Luckman, T. (1991). *The social construction of reality*. London: Penguin Books.

Berthoud, R. (2009). *Patterns of Non-Employment, and of Disadvantage, in a Recession*,

Bevan, S., Zheltoukhova, K., Summers, K., Bajorek, Z., O'Dea, L., & Gulliford, J. (2013). Life and employment opportunities of young people with chronic conditions. *Life*,

Bird, V., Leamy, M., Tew, J., Le Boutillier, C., Williams, J., & Slade, M. (2014). Fit for purpose? validation of a conceptual framework for personal recovery with current mental health consumers. *The Australian and New Zealand Journal of Psychiatry*,

Black, C., & Frost, D. (2011). *Health at work - an independent review of sickness absence* Department for Work and Pensions. TSO.

Black, W., & Living, R. (2004). Volunteerism as an occupation and its relationship to health and wellbeing. *The British Journal of Occupational Therapy*, 67(12), 526-532.

Blank, A. A., Harries, P., & Reynolds, F. (2014). 'Without occupation you don't exist': Occupational engagement and mental illness. *Journal of Occupational Science*, (ahead-of-print), 1-13.

Blank, A., Harries, P., & Reynolds, F. (2011). Mental health service users' perspectives of work: A review of the literature. *British Journal of Occupational Therapy*, 74(4)

- Blank, A., & Hayward, M. (2009). The role of work in recovery. *British Journal of Occupational Therapy*, 72(7)
- Blankertz, L. (2001). Cognitive components of self esteem for individuals with severe mental illness. *American Journal of Orthopsychiatry*, 71(4), 457.
- Boardman, J. (2011). Social exclusion and mental health-how people with mental health problems are disadvantaged: An overview. *Mental Health and Social Inclusion*, 15(3), 112-121.
- Boardman, J., & Shepherd, G. (2011). Putting recovery into practice: Organisational change and commissioning. *The Journal of Mental Health Training, Education and Practice*, 6(1)
- Boardman, J., Grove, B., Perkins, R., & Shepherd, G. (2003). Work and employment for people with psychiatric disabilities. *The British Journal of Psychiatry: The Journal of Mental Science*, 182, 467-468.
- Bonanno, G. A., Brewin, C. R., Kaniasty, K., & La Greca, A. M. (2010). Weighing the costs of disaster consequences, risks, and resilience in individuals, families, and communities. *Psychological Science in the Public Interest*, 11(1), 1-49.
- Bond, G. R. (2004). Supported employment: Evidence for an evidence-based practice. *Psychiatric Rehabilitation Journal*, 27(4), 345-359.
- Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An update on randomized controlled trials of evidence-based supported employment. *Psychiatric Rehabilitation Journal*, 31(A), 280.
- Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, 15(2), 140-153.
- Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health*, 13(5), 493-505.
- Borg, M., & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health*, 17(2), 129-140.

- Borg, M., & Kristiansen, K (2008). Working on the edge: The meaning of work for people recovering from severe mental distress in Norway. *Disability & Society*, 23(5), 511-523.
- Boyce, M., Seeker, J., Johnson, R, Floyd, M., Grove, B., Schneider, J., et al. (2008). Mental health service users' experiences of returning to paid employment. *Disability & Society*, 23(1), 77-88.
- Boyle, M. (2014). Occupational performance and self-determination: The role of the occupational therapist as volunteer in two mountain communities. *Australian Occupational Therapy Journal*,
- Bradstreet, S., & Connor, A. (2005). Communities of recovery. *Mental Health Today (Brighton, England)*, 22-24.
- Bradshaw, W., Peterson Armour, M & Roseborough, D. (2007). "Finding a place in the world: The experience of recovery from severe mental illness." *Qualitative Social Work* 6(1),27-47
- Braslow, J. T. (2013). The manufacture of recovery. *Annual Review of Clinical Psychology*, 9, 781-809.
- Brodie, E, Cowling, E, & Nissen, N. (2009). *Understanding Participation: A Literature Review. Pathways through Participation. United Kingdom: NCVO and Institute for Volunteering Research (IVR)*,
- Brohan, E, Henderson, C, Wheat, K, Malcolm, E, Clement, S, Barley, E A., et al. (2012). Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC Psychiatry*, 12, 11-244X-12-11.
- Brohan, E, Slade, M., Clement, S, & Thornicroft, G. (2010). Experiences of mental illness stigma, prejudice and discrimination: A review of measures. *BMC Health Services Research*, 10, 80-6963-10-80.
- Brohan, E, & Thornicroft, G. (2010). Stigma and discrimination of mental health problems: Workplace implications. *Occupational Medicine*, 60(6), 414-415.

Brown, G., Marshall, M., Bower, P., Woodham, A., & Waheed, W. (2014). Barriers to recruiting ethnic minorities to mental health research: A systematic review. *International Journal of Methods in Psychiatric Research*,

Brown, L. D., Shepherd, M. D., Merkle, E. C., Wituk, S. A., & Meissen, G. (2008). Understanding how participation in a consumer-run organization relates to recovery. *American Journal of Community Psychology*, 42(1-2), 167-178.

Bryant, A. (2002). Re-grounding grounded theory. *Journal of Information Technology Theory and Application (JITTA)*, 4(1), 7.

Bryant, A., & Charmaz, K. (2007). *The sage handbook of grounded theory* Sage.

Bryant, W. (2009). Creating opportunities for participation within and beyond mental health day services. *International handbook of occupational therapy interventions* (pp. 413-421) Springer.

Buman M, Giacobbi P, Dzierzewski J, Aiken M, McCrae C, Roberts B, Marsiske M (2011). 'Peer volunteers improve long-term maintenance of physical activity with older adults: a randomized controlled trial'. *Journal of Physical Activity & Health*, vol 8 suppl 2, pp S257-S266.

Burningham, K., & Cooper, G. (1999). Being constructive: Social constructionism and the environment. *Sociology*, 33(2), 297-316.

Burns, T., Catty, J., Becker, T., Drake, R. E., Fioritti, A., Knapp, M., et al. (2007). The effectiveness of supported employment for people with severe mental illness: A randomised controlled trial. *The Lancet*, 370(9593), 1146-1152.

Burns, T., Catty, J., White, S., Becker, T., Koletsi, M., Fioritti, A., et al. (2009). The impact of supported employment and working on clinical and social functioning: Results of an international study of individual placement and support. *Schizophrenia Bulletin*, 35(5), 949-958.

Burr, V. (2003). *Social constructionism* (2nd ed.). London: Routledge.

- Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health & Illness*, 4(2), 167-182.
- Butterworth, P., Leach, L S, Strazdins, L, Olesen, S C, Rodgers, B, & Broom, D. H (2011). The psychosocial quality of work determines whether employment has benefits for mental health: Results from a longitudinal national household panel survey. *Occupational and Environmental Medicine*, 68(11), 806-812.
- Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment*, 6, 65-72.
- Care Quality Commission. (2012). *The state of health care and adult social care in england in 2011/12* The Stationery Office.
- Carlson, M., Park, D. J, Kuo, A., & Clark, F. (2012). Occupation in relation to the self. *Journal of Occupational Science*, (ahead-of-print), 1-13.
- Carson, J., McManus, G., & Chander, A. (2010). Recovery: A selective review of the literature and resources. *Mental Health & Social Inclusion*, 14(1), 35-44.
- Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies and methods in qualitative research. *Qualitative Health Research*, 17(10), 1316-1328.
- Casiday, D. R, Kinsman, E, Fisher, D. C., & Bambra, D. C. *Volunteering and health: What impact does it really have?* Volunteering England.
- Cassinello, K, & Bramley, S (2012). Keeley's journey: From service user to service provider. *Work (Reading, Mass.)*, 43(1), 91-97.
- Castillo, H, Ramon, S, & Morant, N. (2013). A recovery journey for people with personality disorder. *International Journal of Social Psychiatry*, 59(3), 264-273.
- Centre for Mental Health. (2010). *The economic and social costs of mental health problems in 2009/10*



Centre for Mental Health. (2013). *Barriers to employment: What works for people with mental health problems* No. Briefing 47) Centre for Mental Health.

Charmaz, K (1983). Loss of self: A fundamental form of suffering in the chronically ill. *Sociology of Health & Illness*, 5(2), 168-195.

Charmaz, K (2014). *Constructing grounded theory*. Sage.

Charmaz, K (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.

Christiansen, C., & Baum, C. (2005). The complexity of human occupation. *Occupational Therapy: Performance, Participation, and Well-being*, 3, 3-23.

Christiansen, C. (2000). Identity, personal projects and happiness: Self construction in everyday action. *Journal of Occupational Science*, 7(3), 98-107.

Christiansen, C. H. (1999). Defining lives: Occupation as identity: An essay on competence, coherence, and the creation of meaning. *American Journal of Occupational Therapy*, 53(6), 547-558.

Christiansen, C. H., & Matuska, K. M. (2006). Lifestyle balance: A review of concepts and research. *Journal of Occupational Science*, 13(1), 49-61.

Christiansen, C., Baum, C. M., & Bass-Haugen, J. (2005). *Occupational therapy: Performance, participation, and well-being* Slack Incorporated.

Christiansen, C., & Townsend, E. A. (2004). *Introduction to occupation: The art and science of living* Prentice Hall Upper Saddle River, NJ.

Chugg, A., & Craik, C. (2002). Some factors influencing engagement for people with schizophrenia living in the community occupational. *The British Journal of Occupational Therapy*, 65(2), 67-74.

Clark, S (2003). Voluntary work benefits mental health. *A Life in the Day*, 10(A)

Clarke, A. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Sage.

- Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction*, 26(4), 553-576.
- Cnaan, R. A., Jones, K. H., Dickin, A., & Salomon, M. (2010). Estimating giving and volunteering: New ways to measure the phenomena. *Nonprofit and Voluntary Sector Quarterly*,
- Cohen, L., & Manon, L. (1994). *Research methods in education 4th* (4th ed.) Routledge.
- Cook J (2011). 'The socio-economic contribution of older people in the UK'. *Working with Older People*, vol 15, no 4, pp 141-6.
- Commission for the Compact. (2009). *The compact commission for the compact*. Birmingham:
- Cook, J. A., Jonikas, M. J. A., & Razzano, L. (1995). A randomized evaluation of consumer versus nonconsumer training of state mental health service providers. *Community Mental Health Journal*, 31(3), 229-238.
- Corbin, J., & Strauss, A. (1994). Grounded theory methodology. *Handbook of Qualitative Research*,, 273-285.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* Sage.
- Cornwell, K., Forbes, C., Inder, B., & Meadows, G. (2009). Mental illness and its effects on labour market outcomes. *The Journal of Mental Health Policy and Economics*, 12(3), 107-118.
- Corrigan, P. W., & Kleinlein, P. (2005). The impact of mental illness stigma.
- Corrigan, P. W., & Lundin, R. (2001). Don't call me nuts. *Coping with the Stigma of*,
- Corrigan, P. W., & Phelan, S. M. (2004). Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal*, 40(6), 513-523.
- Corrigan, P. W., River, L. P., Lundin, R. K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., et al. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, 27(2), 187.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, 9(1), 35-53.

Corrigan, P., Markowitz, F. E, Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior*, , 162-179.

Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work*, 52(1), 31-39.

Corrigan, P. W., Angell, B., Davidson, L., Marcus, S. C., Salzer, M. S., Kottsieper, P., et al. (2012). From adherence to self-determination: Evolution of a treatment paradigm for people with serious mental illnesses. *Psychiatric Services*, 53(2), 169-173.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 1(1), 16-20.

Costa, Ana Lucia Borges da. (2012). Circle dance, occupational therapy and wellbeing: The need for research. *The British Journal of Occupational Therapy*, 75(2), 114-116.

Crabtree, J. L (1998). Occupational therapy: Building skills or transforming selves? *British Journal of Occupational Therapy*, 54(11), 504-508.

Crabtree, J. L (2003). On occupational performance. *Occupational Therapy in Health Care*, 17(2), 1-18.

Crabtree, J. W., Haslam, S. A., Postmes, T., & Haslam, C. (2010). Mental health support groups, stigma and self esteem: Positive and negative implications of group identification. *Journal of Social Issues*, 55(3)

Craib, I. (1997). Social constructionism as a social psychosis. *Sociology*, 31(1), 1-15.

Cresswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, California: Sage.

- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), 124-130.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process* Sage.
- Cutchin, M. P. (2013). The art and science of occupation: Nature, inquiry, and the aesthetics of living. *Journal of Occupational Science*, 20(4), 286-297.
- Cutchin, M. P., Aldrich, R. M., Bailliard, A. L., & Coppola, S. (2008). Action theories for occupational science: The contributions of dewey and bourdieu. *Journal of Occupational Science*, 15(3), 157-165.
- Cutchin, M. P., & Dickie, V. A. (2013). *Transactional perspectives on occupation* Springer.
- Cutcliffe, J., & Koehn, C. (2007). Hope and interpersonal psychiatric/mental health nursing: A systematic review of the literature-part two. *Journal of Psychiatric and Mental Health Nursing*, 14(2), 141-147.
- Danson, M., & Gilmore, K. (2009). Evidence on employer attitudes and EQUAL opportunities for the disadvantaged in a flexible and open economy. *Environment and Planning C: Government and Policy*, 27(6), 991-1007.
- Davidson, J., & Kemp, P. A. (2008). Sickness benefits in a polarised labour market. *Benefits*, 16(3), 225-233.
- Davidson, L. (2003). *Living outside mental illness: Qualitative studies of recovery in schizophrenia* NYU Press.
- Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57(5), 640-645.
- Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 32(3), 443-450.

- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4), 459-470.
- Davis, L., & Brekke, J. (2014). Social support and functional outcome in severe mental illness: The mediating role of proactive coping. *Psychiatry Research*, 215(1), 39-45.
- Deci, E., & Ryan, R. M. (2011). Self-determination theory. *Handbook of Theories of Social Psychology*, 1, 416-433.
- Deegan, P. E. (1993). Recovering our sense of value after being labeled mentally ill. *Journal of Psychosocial Nursing and Mental Health Services*, 31(4), 7-11.
- Denscombe, M. (2008). Communities of practice a research paradigm for the mixed methods approach. *Journal of Mixed Methods Research*, 2(3), 270-283.
- Denzin, N. Lincoln, (2003). introduction: The discipline and practice of qualitative research. N.Denzin & y.Lincoln (Eds.) *The Landscape of Qualitative Research. Theories and Issues*,, 1-45.
- Denzin, N. (2004). Symbolic interactionism. *A Companion to Qualitative Research*,, 81-87.
- Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research* Sage.
- Department for Work and Pensions. (2004). *Building capacity for work: A UK framework for vocational rehabilitation* TSO.
- Dickie, V., Cutchin, M. P., & Humphry, R. (2006). Occupation as transactional experience: A critique of individualism in occupational science. *Journal of Occupational Science*, 13(1), 83-93.
- Dickson, E., & Taylor, J. (2012). Supporting service users into employment: A literature review. *Mental Health Practice*, 16(4), 15-18.
- Dictionary, O. E. (2012). *Online Version June 2012*,
- Donnelly, S. M., Michael. (2000). Work, rehabilitation and mental health. *Journal of Mental Health*, 9(2), 199-210.

Dowling, H., & Hutchinson, A. (2008). Occupational therapy-its contribution to social inclusion and recovery. *A Life in the Day*, 12(3), 11-14.

Drake, R E, & Bond, G. R (2008). The future of supported employment for people with severe mental illness. *Psychiatric Rehabilitation Journal*, 31(4), 367-376.

Drake, R E, & Bond, G. R (2008). Supported employment: 1998 to 2008.

Drake, R E, Skinner, J. S., Bond, G. R, & Goldman, H. H. (2009). Social security and mental illness: Reducing disability with supported employment. *Health Affairs (Project Hope)*, 28(3), 761-770.

Drever, E (2010). 2008-09 citizenship survey: Volunteering and charitable giving topic report.

Duff, C. (2012). Exploring the role of 'enabling places' in promoting recovery from mental illness: A qualitative test of a relational model. *Health & Place*, 18(6), 1388-1395.

Dunn, E C., Wewiorski, N. J., & Rogers, E S (2010). A qualitative investigation of individual and contextual factors associated with vocational recovery among people with serious mental illness. *American Journal of Orthopsychiatry*, 80(2), 185-194.

Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology*, 14(2), 111-124.

Durocher, E, Gibson, B E, & Rappolt, S (2013). Occupational justice: A conceptual review. *Journal of Occupational Science*, (ahead-of-print), 1-13.

DWP. (2002). *Pathways to work*. London: The Stationery Office.

DWP. (2008). *Working for a healthier tomorrow: Dame carol black's review of the health of Britain's working age population*. TSO.

DWP. (2013). *Improving health and work: Changing lives* JSO.

Dwyer, P. (2004). Creeping conditionality in the UK: From welfare rights to conditional entitlements? *The Canadian Journal of Sociology*, 29(2), 265-287.

**Economics, 0. (2007). Mental health and the UK economy.**

Edgley, A., Stickley, T., Wright, N., & Repper, J. (2012). The politics of recovery in mental health: A left libertarian policy analysis. *Social Theory & Health, 10*(2), 121-140.

Eklund, M. (2006). Occupational factors and characteristics of the social network in people with persistent mental illness. *American Journal of Occupational Therapy, 60*(5), 587-594.

Eklund, M., Erlandsson, L., & Persson, D. (2003). Occupational value among individuals with long-term mental illness. *Canadian Journal of Occupational Therapy, 70*(5), 276-284.

Eklund, M., Hansson, L., & Bejerholm, U. (2001). Relationships between satisfaction with occupational factors and health-related variables in schizophrenia outpatients. *Social Psychiatry and Psychiatric Epidemiology, 36*(2), 79-85.

Eklund, M., & Leufstadius, C. (2007). Relationships between occupational factors and health and well-being in individuals with persistent mental illness living in the community. *Canadian Journal of Occupational Therapy, 74*(A), 303-313.

El Enany, N., Currie, G., & Lockett, A. (2013). A paradox in healthcare service development: Professionalization of service users. *Social Science & Medicine, 80*(0), 24-30.

Ellis Paine, A., Hill, M., & Rochester, C. (2010). *A Rose by any Other Name... Revising what Exactly is Volunteering Question,*

Eriksen, A. K., Arman, M., Davidson, L., Sundfer, B., & Karlsson, B. (2013). Challenges in relating to mental health professionals: Perspectives of persons with severe mental illness. *International Journal of Mental Health Nursing, May*

Evans, J., & Repper, J. (2000). Employment, social inclusion and mental health. *Journal of Psychiatric and Mental Health Nursing, 7*(1), 15-24.

Evans, K. (2011). 'Big society' in the UK: A policy review. *Children & Society, 25*(2), 164-171.

Evans, J., & Repper, J. (2000). Employment, social inclusion and mental health. *Journal of Psychiatric and Mental Health Nursing, 7*(1), 15-24.

Evans-Lacko, S., Brohan, E., Mojtabai, R., & Thornicroft, G. (2012). Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. *Psychological Medicine*, 42(08), 1741-1752.

Farnworth, L. (2003). Time use, tempo and temporality: Occupational therapy's core business or someone else's business. *Australian Occupational Therapy Journal*, 50(3), 116-126.

Farrell, C., & Bryant, W. (2009). Voluntary work for adults with mental health problems: A route to inclusion? A review of the literature. *British Journal of Occupational Therapy*, 72(4), 163-173.

Fengler, A. P. (1984). Life satisfaction of subpopulations of elderly: the comparative effects of volunteerism, employment, and meal site participation. *Research on Aging*, 6(2), 189-212.

Finlay, L., & Gough, B. (2008). *Reflexivity. A practical guide for researchers in health and social sciences* John Wiley & Sons.

Finlay, L., & Ballinger, C. (2006). *Qualitative research for allied health professionals: Challenging choices*. London: John Wiley and Sons.

Forbat, L., & Henderson, J. (2005). Theoretical and practical reflections on sharing transcripts with participants. *Qualitative Health Research*, 15(8), 1114-1128.

Fothergill, S., & Wilson, I. (2007). A million off incapacity benefit: How achievable is Labour's target? *Cambridge Journal of Economics*, 31(6), 1007-1023.

Freud, D. (2007). Reducing dependency. *Increasing Opportunity: Options for the Future of Welfare to Work, DWP*,

Fryer, D. Posted in blog posts, professional development on December 3, 2012 0.

Fryer, D. (2006). Insecurity, the restructuring of unemployment and mental health. *Unemployment and Health: International and Interdisciplinary Perspectives*, 21.

Gallew, H. A., & Mu, K. (2004). An occupational look at temporal adaptation: Night shift nurses. *Journal of Occupational Science*, 11(1), 23-30.



- Garthwaite, K. (2011). 'The language of shirkers and scroungers?' Talking about illness, disability and coalition welfare reform. *Disability & Society*, 26(3), 369-372.
- Garthwaite, K. (2013). Fear of the brown envelope: Exploring welfare reform with long-term sickness benefits recipients. *Social Policy & Administration*, n/a-n/a.
- George, D. R., & Singer, M. E. (2011). Intergenerational volunteering and quality of life for persons with mild to moderate dementia: Results from a 5-month intervention study in the united states. *The American Journal of Geriatric Psychiatry*, 19(A), 392-396.
- Gewurtz, R., & Kirsh, B. (2007). How consumers of mental health services come to understand their potential for work: Doing and becoming revisited. *Canadian Journal of Occupational Therapy*, 74(3), 195-207.
- Gibson, R. W., D'Amico, M., Jaffe, L., & Arbesman, M. (2011). Occupational therapy interventions for recovery in the areas of community integration and normative life roles for adults with serious mental illness: A systematic review. *The American Journal of Occupational Therapy*, 65(3)
- Giddens, A. (2013). *Modernity and self-identity: Self and society in the late modern age* John Wiley & Sons.
- Glaser B, S. A. (1967). The discovery of grounded theory.
- Glaser, B. G. (1992). *Emergence vs forcing: Basics of grounded theory analysis* Sociology Press.
- Glaser, B. G., & Holton, J. (2007). Remodeling grounded theory. *Historical Social Research/Historische Sozialforschung. Supplement*, 47-68.
- Glaser, B. G., & Strauss, A. L. (2009). *The discovery of grounded theory: Strategies for qualitative research* Transaction Publishers.
- Glazier, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Glucksmann, M. A. (1995). Why 'work'? gender and the 'total social organization of labour'. *Gender, Work & Organization*, 2(2), 63-75.

Goffman, E (1963). *Notes on the management of spoiled identity*. Harmondsworth, Middlesex: Penguin Books.

Gottlieb, B. H., & Gillespie, A. A. (2008). Volunteerism, health, and civic engagement among older adults. *Canadian Journal on Aging/La Revue Canadienne Du Vieillissement*, 27(04), 399-406.

Graham, M. (2004). Volunteering as heritage/volunteering in heritage. *Volunteering as leisure/leisure as Volunteering: An International Assessment*,, 13-30.

Grant, A. (2011). Fear, confusion and participation: Incapacity benefit claimants and (compulsory) work focused interviews. *Research, Policy and Planning*, 28(3), 161-171.

Grant, A. (2013). Welfare reform, increased conditionality and discretion: Jobcentre plus advisers' experiences of targets and sanctions. *Journal of Poverty and Social Justice*, 21(2), 165-176.

Grant, M. J., & Booth, A. (2009). A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal*, 26(2), 91-108.

Greenfield, E., & Marks, N. (2004). Formal volunteering as a protective factor for older adults' psychological well-being. *Journal of Gerontology*, 59(5), 258-264.

Gregg, P. (2008). *Realising Potential: A Vision for Personalised Conditionality and Support*, Department for Works and Pensions,

Griffiths, C. A. (2009). Sense of coherence and mental health rehabilitation. *Clinical Rehabilitation*, 23(1), 72-78.

Grove, B., & Membrey, H. (2005). Sheep and goats: New thinking on employability. *New Thinking on Mental Health and Employment*. Radcliffe Publishing, Oxford,, 3-11.

Grove, R., Seeker, J., & Seebohm, P. (2005). *New thinking about mental health and employment* Radcliffe Publishing Ltd.

- Gruhl, K L R (2005). The recovery paradigm: Should occupational therapists be interested? *Canadian Journal of Occupational Therapy*, 72(2), 96-102.
- Hagerty, B. M., Lynch-Sauer, J., Patusky, K L, & Bouwsema, M. (1993). An emerging theory of human relatedness. *Image: The Journal of Nursing Scholarship*, 25(4), 291-296.
- Haines, G. (2013). Using documentary evidence to explore the interwoven strands of self-concept and happiness through work: Findings and reflections. *Australian Journal of Career Development*, 22(36), 36-44.
- Hallberg, L (2010). Some thoughts about the literature review in grounded theory studies. *International Journal of Qualitative Studies on Health and Well-being*, 5(3)
- Hallett, C., Klug, G., Lauber, C., & Priebe, S (2012). Volunteering in the care of people with severe mental illness: A systematic review. *BMC Psychiatry*, 12(1), 226-226.
- Hammell, K R W., & Iwama, M. K (2012). Well-being and occupational rights: An imperative for critical occupational therapy. *Scandinavian Journal of Occupational Therapy*, 19(5), 385-394.
- Hammell, K W. (2004). Dimensions of meaning in the occupations of daily life. *Canadian Journal of Occupational Therapy*, 71(5), 296-305.
- Hammersley, M. (1992). *What's wrong with ethnography?: Methodological explorations* Psychology Press.
- Handy, F., Cnaan, R A., Brudney, J. L, Ascoli, U., Meijs, L C., & Ranade, S (2000). Public perception of " who is a volunteer": An examination of the net-cost approach from a cross-cultural perspective. *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, 11(1), 45-65.
- Harding, E, Brown, D., Hayward, M., & Pettinari, C. J. (2010). Service user perceptions of involvement in developing NICE mental health guidelines: A grounded theory study. *Journal of Mental Health (Abingdon, England)*, 19(3), 249-257.

Harris, L M., Matthews, L R, Penrose-Wall, J., Alam, A., & Jaworski, A. (2014). Perspectives on barriers to employment for job seekers with mental illness and additional substance-use problems. *Health & Social Care in the Community*; 22(1), 67-77.

Harvey, C., Fossey, E, Jackson, H., & Shimitras, L (2006). Time use of people with schizophrenia living in north london: Predictors of participation in occupations and their implications for improving social inclusion. *Journal of Mental Health*, 15(1), 43-55.

Hayes, R L, & Halford, W. K (1996). Time use of unemployed and employed single male schizophrenia subjects. *Schizophrenia Bulletin*, 22(4), 659-669.

Hazan, C., & Shaver, P. R (1990). Love and work: An attachment-theoretical perspective. *Journal of Personality and Social Psychology*, 59(2), 270.

Henderson, K (1984). Volunteerism as leisure. *Nonprofit and Voluntary Sector Quarterly*, 13(1), 55-63.

Henderson, K A. (1981). Motivations and perceptions of volunteerism as a leisure activity. *Journal of Leisure Research*, 13(3), 208-218.

Hitch, D., Pepin, G., & Stagnitti, K (2014). In the footsteps of wilcock, part two: The interdependent nature of doing, being, becoming, and belonging. *Occupational Therapy in Health Care*,

Hocking, C. (2009). The challenge of occupation: Describing the things people do. *Journal of Occupational Science*, 16(3), 140-150.

Holley, L C., Stromwall, L K, & Bashor, K E (2012). Reconceptualizing stigma: Toward a critical anti-oppression paradigm. *Stigma Research and Action*, 2(2)

Holmes, J. (2007). *Vocational rehabilitation* Blackwell Publishing.

Honey, A. (2004). Benefits and drawbacks of employment: Perspectives of people with mental illness. *Qualitative Health Research*, March

Howlett, S. (2008). Volunteering and mental health: A literature review. *Voluntary Action*, 6(2 Spring)

Howlett, S. (2010). Developing volunteer management as a profession. *Voluntary Sector Review*, 1(3), 355-360.

Humphreys, K., & Lembke, A. (2014). Recovery-oriented policy and care systems in the UK and USA. *Drug and Alcohol Review*, 33(1), 13-18.

Huot, S., & Rudman, D. L. (2010). The performances and places of identity: Conceptualizing intersections of occupation, identity and place in the process of migration. *Journal of Occupational Science*, 17(2), 68-77.

Hussein, S. (2011). Volunteers in the formal long-term care workforce in England. *Social Care Workforce Periodical*, (13)

Hustinx, L., Ram, C. A., & Handy, F. (2010). Navigating theories of volunteering: A hybrid map for a complex phenomenon. *Journal for the Theory of Social Behaviour*, 40(4), 410-434.

Hutchinson, A., & Lovell, A. (2013). Participatory action research: Moving beyond the mental health 'service user' identity. *Journal of Psychiatric and Mental Health Nursing*, 20(7), 641-649.

Hvalspe, B., & Josephsson, S. (2003). Characteristics of meaningful occupations from the perspective of mentally ill people. *Scandinavian Journal of Occupational Therapy*, 10(2), 61-71.

Ikiugu, M. N. (2005). Meaningfulness of occupations as an occupational-life-trajectory attractor. *Journal of Occupational Science*, 12(2), 102-109.

Ison, J., & Kent, S. (2010). Social identity in eating disorders. *European Eating Disorders Review*, 18(6), 475-485.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4), 482-485.

Johnson, J. V., & Lipscomb, J. (2006). Long working hours, occupational health and the changing nature of work organization. *American Journal of Industrial Medicine*, 49(11), 921-929.

Jones, G. H., & Evans, A. (2008). Hope, help and recovery: Gerwyn Jones and colleagues describe how service users were encouraged and supported by mental health staff and partner organisations to tell their personal stories about recovery from psychosis, the project culminated in a joint conference presentation. *Mental Health Practice*, 11(8), 32-37.

Jonsson, H., & Persson, D. (2006). Towards an experiential model of occupational balance: An alternative perspective on flow theory analysis. *Journal of Occupational Science*, 13(1), 62-73.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry*, 33(1), 77-83.

Kalathil, J. (2013). 'hard to reach'? racialised groups and mental health service user involvement. *Mental Health Service Users in Research*, 121.

Karnielli-Miller, O., Strier, R., & Pessach, L. (February 2009). Power relations in qualitative research. *Qualitative Health Research*, 19(2), 279-289.

Kemp, P. A., & Davidson, J. (2010). Employability trajectories among new claimants of incapacity benefit. *Policy Studies*, 31(2), 203-221.

Kennedy, A., Reeves, D., Bower, P., Lee, V., Middleton, E., Richardson, G., et al. (2007). The effectiveness and cost effectiveness of a national lay-led self care support programme for patients with long-term conditions: A pragmatic randomised controlled trial. *Journal of Epidemiology and Community Health*, 61(3), 254-261.

Kennedy L (2010). 'Benefits arising from lay involvement in community-based public health initiatives: the experience from community nutrition'. *Perspectives in Public Health*, vol 130, no 4, pp 165-72.

Kielhofner, G., & Forsyth, K (2008). Therapeutic reasoning: Planning, implementing and evaluating the outcomes of therapy. *Model of Human Occupation: Theory and Application*, 143-154.

Kinoshita, Y., Furukawa, T. A., Kinoshita, K., Honyashiki, M., Omori, I. M., Marshall, M., et al. (2013). Supported employment for adults with severe mental illness. *Cochrane Database of Systematic Reviews*, 9

Kirsh, B. (2000). Factors associated with employment for mental health consumers. *Psychiatric Rehabilitation Journal*, 24(1), 13-21.

Knapp, M., Patel, A., Curran, C., Latimer, E., Catty, J., Becker, T., et al. (2013). Supported employment: Cost-effectiveness across six european sites. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, 12(1), 60-68.

Koletsis, M., Niersman, A., van Busschbach, J. T., Catty, J., Becker, T., Burns, T., et al. (2009). Working with mental health problems: Clients' experiences of IPS, vocational rehabilitation and employment. *Social Psychiatry and Psychiatric Epidemiology*, 44(11), 961-970.

Konrath, S., Fuhrel-Forbis, A., Lou, A., & Brown, S. (2012). Motives for volunteering are associated with mortality risk in older adults. *Health Psychology*, 31(1), 87.

Korsbek, L. (2013). Disclosure: What is the point and for whom? *Journal of Mental Health (Abingdon, England)*, 22(3), 283-290.

Kronenberg, F., & Pollard, N. (2005). Introduction: A beginning. *Occupational Therapy without Borders: Learning from the Spirit of Survivors*, 1-13.

Krupa, T., Fossey, E., Anthony, W. A., Brown, C., & Pitts, D. B. (2009). Doing daily life: How occupational therapy can inform psychiatric rehabilitation practice. *Psychiatric Rehabilitation Journal*, 32(3), 155-161.

Lahberte-Rudman, D. (2002). Linking occupation and identity: Lessons learned through qualitative exploration. *Journal of Occupational Science*, 9(1), 12-19.

- Lala, A. P., & Kinsella, E. A. (2011). A phenomenological inquiry into the embodied nature of occupation at end of life. *Canadian Journal of Occupational Therapy*, 78(4), 246-254.
- Larson, E. A., & Zemke, R. (2003). Shaping the temporal patterns of our lives: The social coordination of. *Journal of Occupational Science*, 10(2), 80-89.
- Laws, J. (2011). Work, madness and an ethics of relation. *Value of Work*, 23.
- Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services*, 62(12), 1470-1476.
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry: The Journal of Mental Science*, 199(6), 445-452.
- Lee, Y., & Brudney, J. L. (2009). Rational volunteering: A benefit-cost approach. *International Journal of Sociology and Social Policy*, 29(9/10), 512-530.
- Leshem, S., & Trafford, V. (2007). Overlooking the conceptual framework. *Innovations in Education and Teaching International*, 44(1), 93-105.
- Leufstadius, C., & Eklund, M. (2008). Time use among individuals with persistent mental illness: Identifying risk factors for imbalance in daily activities. *Scandinavian Journal of Occupational Therapy*, 15(1), 23-33.
- Leufstadius, C., Eklund, M., & Erlandsson, L. (2009). Meaningfulness in work-Experiences among employed individuals with persistent mental illness. *Work: A Journal of Prevention, Assessment and Rehabilitation*, 34(1), 21-32.
- Leufstadius, C., Erlandsson, L., Bjorkman, T., & Eklund, M. (2008). Meaningfulness in daily occupations among individuals with persistent mental illness. *Journal of Occupational Science*, 15(1), 27-35.
- Leufstadius, C., Erlandsson, L., & Eklund, M. (2006). Time use and daily activities in people with persistent mental illness. *Occupational Therapy International*, 13(3), 123-141.



- Li, Y., & Ferraro, K F. (2005). Volunteering and depression in later life: Social benefit or selection processes? *Journal of Health and Social Behaviour*, 46, 68-84.
- Li, Y., & Ferraro, K F. (2006). Volunteering in middle and later life: Is health a benefit, barrier or both? *Social Forces*, 85(1), 497-519.
- Lincoln, Y. S., & Guba, E G. (1985). *Naturalist inquiry*. Beverly Hills, CA: Sage,
- Lindsay, C., & Houston, D. (2011). Fit for purpose? welfare reform and challenges for health and labour market policy in the UK. *Environment and Planning-Part A*, 43(3), 703.
- Lloyd, C., & Waghorn, G. (2007). The importance of vocation in recovery for young people with psychiatric disabilities. *British Journal of Occupational Therapy*, 70(2), 50-59.
- Lloyd-Evans, B., Mayo-Wilson, E, Harrison, B, Istead, H, Brown, E, Pilling, S, et al. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*, 14(1), 39.
- Ludwig, F. M. (1998). The unpackaging of routine in older women. *American Journal of Occupational Therapy*, 52(3), 168-175.
- Lyons, M., McGregor-Lowndes, M., & O'Donoghue, P. (2006). Researching giving and volunteering in australia. *Australian Journal of Social Issues*, the, 41(A), 385.
- MacDonald, M., & Schreiber, R S. (2001). Constructing and deconstructing: Grounded theory in a postmodern world. *Using Grounded Theory in Nursing*,, 35-54.
- Macduff, N. (2005). Societal changes and the rise of the episodic volunteer. *Emerging Areas of Volunteering*, 1(2), 49-61.
- MacGregor, S, & Herring, R (2010). The alcohol concern SMART recovery pilot project final evaluation report. *Middlesex, UK: Middlesex University Drug and Alcohol Group*,
- Maclver, D., Prior, S, Forsyth, K, Walsh, M., Meiklejohn, A., Irvine, L, et al. (2013). Vocational rehabilitation: Facilitating evidence based practice through participatory action research. *Journal of Mental Health*, 22(2), 183-190.

Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in Educational Research*, 16(2), 193-205.

Mancini, M. (2007). The role of self efficacy in recovery from serious psychiatric disabilities. *Qualitative Social Work*, 1(49), 74.

Mancini, M. A. (2007). The role of self-efficacy in recovery from serious psychiatric disabilities: A qualitative study with fifteen psychiatric survivors. *Qualitative Social Work*, 6(49)

Marwaha, S., & Johnson, S. (2004). Schizophrenia and employment. *Social Psychiatry and Psychiatric Epidemiology*, 39(5), 337-349.

Marwaha, S., Johnson, S., Bebbington, P., Stafford, M., Angermeyer, M. C., Brugha, T., et al. (2007). Rates and correlates of employment in people with schizophrenia in the UK, France and Germany. *The British Journal of Psychiatry: The Journal of Mental Science*, 191, 30-37.

Maslow, A. H. (2013). *Toward a psychology of being* Start Publishing LLC.

Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology*, 2(04), 425-444.

McLaughlin, H. (2009). What's in a name^client'/patient'/customer'/consumer'/expert by experience'/service user'—what's next? *British Journal of Social Work*, 39(6), 1101-1117.

Mee, J., & Sumsion, T. (2001). Mental health clients confirm the motivating power of occupation. *The British Journal of Occupational Therapy*, 64(3), 121-128.

Meijs, L. C., Handy, F., Cnaan, R. A., Brudney, J. L., Ascoli, U., Ranade, S., et al. (2003). *All in the eyes of the beholder?* Springer.

Melchior, M., Caspi, A., Milne, B. J., Danese, A., Poulton, R., & Moffitt, T. E. (2007). Work stress precipitates depression and anxiety in young, working men and women. *Psychological Medicine*, 37, 1119-1129.

Melia, K. M. (1996). Rediscovering glaser. *Qualitative Health Research*, 6(3), 368-378.

Mertens, D. (2005). Research methods in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods.

Mertens, D. M. (1998). *Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches*. Thousand Oaks, California: Sage.

Mezzina, R, Davidson, L, Borg, M., Marin, I., Topor, A., & Sells, D. (2006). The social nature of recovery: Discussion and implications for practice. *Archives of Andrology*, 9(1), 63-80.

Michalos, S. (2010). Linking career theories to volunteering. *Career Planning and Adult Development Journal*, 26(3)

Miles, M. B., & Huberman, A. M. (1984). Qualitative data analysis: A sourcebook of new methods. *Qualitative data analysis: A sourcebook of new methods; qualitative data analysis: A sourcebook of new methods*. Sage publications.

Mills, J., Bonner, A., & Francis, K (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice*, 12(1), 8-13.

Mills, J., Bonner, A., & Francis, K (2008). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5(1), 25-35.

Minato, M., & Zemke, R (2004). Occupational choices of persons with schizophrenia living in the community. *Journal of Occupational Science*, 11(1), 31-39.

Molineux, M., & Baptiste, S (2011). Emerging occupational therapy practice: Building on the foundations and seizing the opportunities. *Role Emerging Occupational Therapy: Maximising Occupation Focused Practice*, 3-14.

Moneta, G. B., & Csikszentmihalyi, M. (1996). The effect of perceived challenges and skills on the quality of subjective experience. *Journal of Personality*, 64(2), 275-310.

Moran, G. S., Russinova, Z, Yim, J. Y., & Sprague, C. (2014). Motivations of persons with psychiatric disabilities to work in mental health peer services: A qualitative study using self-determination theory. *Journal of Occupational Rehabilitation*, 24(1), 32-41.

- Morley, C. (2008). Critical reflection as a research methodology. *Knowing Differently: Arts-Based and Collaborative Research Methods*, 265.
- Morris, J. Rethinking disability policy November 2011.
- Morrow-Howell, N. (2010). Volunteering in later life: Research frontiers. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, 65(4), 461-469.
- Morse, J. M. (2000). Determining sample size. *Qualitative Health Research*, 10(1), 3-5.
- Morse, J. M. (2006). The politics of evidence. *Qualitative Health Research*, 16(3), 395-404.
- Mueser, K., & McGurk, S. (2014). Supported employment for persons with serious mental illness: Current status and future directions. *L'Encephale*,
- Mueser, K T., & Cook, J. A. (2013). From tragedy to healing. *Psychiatric Rehabilitation Journal*, 36(2), 63-64.
- Mundle, C., Naylor, C., & Buck, D. (July 2012). *Volunteering in health and care in England*. The Kings Fund.
- Murray, J., Bellringer, S., & Easter, A.,. (2008). Evaluation of capital volunteering.
- Musick, M., & Wilson, J. (2008). *Volunteers: A social profile*. Indiana: Indiana University Press.
- Musick, M., & Wilson, J. (2003). Doing well by doing good. *The Sociological Quarterly* 44 3; 433-450, 44(3), 433-450.
- Nagle, S., Valiant Cook, J., & Polatajko, H., J. (2002). I'm doing as much as I can: Occupational choices of persons with a severe and persistent mental illness. *Journal of Occupational Science*, 9(2), 72-81.
- National Centre for Volunteering. (2003). *Volunteering for mental health: A survey of volunteering by people with experience of mental ill health*. Institute for Volunteering Research.

Neale, J., Allen, D., & Coombes, L (2005). Qualitative research methods within the addictions. *Addiction, 100(11)*, 1584-1593.

Nelson, G., Lord, J., & Ochocka, J.,. (2001). Empowerment and mental health in community. *Journal of Community and Applied Social Psychology, 11*, 125-142.

Neuman, W. L (2000). Social research method. *University of Wisconsin at Whitewater,*

NHS Scotland, (2011). Realising work potential defining the contribution of allied health professionals to vocational rehabilitation in mental health services: the way forward

Noon, M., & Blyton, P. (2002). The realities of work palgrave (chapter 10 'Unfair discrimination at work').

Ockenden, N., & Hill, M. (2009). A gateway to work? the role of volunteer centres in supporting the link between volunteering and employability. *The Institute for Volunteering Research,*

Ockenden, N., Hill, M., & Stuart, J. (2012). 12. The big society and volunteering: Ambitions and expectations. *The Big Society Debate: A New Agenda for Social Policy?*, 149.

Omoto, A. M., Snyder, M., & Martino, S. C. (2000). Volunteerism and the life course investigating age related agendas for action. *Basic and Applied Social Psychology, 22(3)*, 181-97.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31(1)*, 9-22.

Oxley, C. (1995). Work and work programmes for clients with mental health problems. *British Journal of Occupational Therapy, 58(11)*

Paine, A. E., McKay, S., & Moro, D. (2013). Does volunteering improve employability? Evidence from the British household panel survey.

Paine, A. E., Ockenden, N., & Stuart, J. (2010). Volunteers in hybrid organizations: A marginalised majority? *Hybrid Organizations and the Third Sector: Challenges for Practice, Theory and Policy*, 93.

Palmadottir, G. (2010). The role of occupational participation and environment among icelandic women with breast cancer: A qualitative study. *Scandinavian Journal of Occupational Therapy*, 17(4), 299-307.

Patton, N., & Smith, M. (2011). Envisioning visual research strategies. *Creative spaces for qualitative researching* (pp. 115-124) Springer.

Paylor J (2011). *Volunteering and Health: Evidence of impact and implications for policy and practice*. London: Institute for Volunteering Research.

Perkins, R. (2007). First person "you need hope to cope". *Enabling recovery: The principles and practice of rehabilitation psychiatry* (). London: Gaskell.

Perkins, R., & Farmer, P. (2009). *Realising ambitions: Better employment support for people with a mental health condition* DERECHO INTERNACIONAL.

Perkins, R., Repper, J., Rinaldi, M., & Brown, H. (2012). 1. recovery colleges.

Perlick, D. A. (2001). Special section on stigma as a barrier to recovery: Introduction. *Psychiatric Services (Washington, D.C.)*, 52(12), 1613-1614.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., et al. (2001). Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services (Washington, D.C.)*, 52(12), 1627-1632.

Pettigrew, T. F., & Tropp, L. R. (2005). Allport's intergroup contact hypothesis: Its history and influence. *On the Nature of Prejudice*, 262-277.

Pickens, N. D., O'Reilly, K. R., & Sharp, K. C. (2010). Holding on to normalcy and overshadowed needs: Family caregiving at end of life. *Canadian Journal of Occupational Therapy*, 77(4), 234-240.

- Pidgeon, N., & Henwood, K (1997). Using grounded theory in psychological research.
- Pierce, D. (2001). Untangling occupation and activity. *American Journal of Occupational Therapy*, 55(2), 138-146.
- Pilgrim, D., & Waldron, I. (1998). User involvement in mental health care development: How far can it go? *Journal of Mental Health*, 7(1), 95-104.
- Pollard, N., & Kronenberg, F. (2008). *A political practice of occupational therapy* Elsevier Health Sciences.
- Post, S. G. (2005). Altruism, happiness, and health: It's good to be good. *International Journal of Behavioral Medicine*, 12(2), 66-77.
- Prior, S., Maciver, D., Forsyth, K, Walsh, M., Meiklejohn, A., & Irvine, L (2013). Readiness for employment: Perceptions of mental health service users. *Community Mental Health Journal*, 49(6), 658-667.
- Procter, N., Baker, A., Grocke, K, & Ferguson, M. (2014). Introduction to mental health and mental illness: Human connectedness and the collaborative consumer narrative. *Mental Health*,, 1.
- Provencher, H. L., & Keyes, C. L (2013). Recovery: A complete mental health perspective. *Mental well-being* (pp. 277-297) Springer.
- Putnam, R (2001). Social capital: Measurement and consequences. *Canadian Journal of Policy Research*, 2(1), 41-51.
- Read, S., & Maslin-Prothero, S. (2011). The involvement of users and carers in health and social research: The realities of inclusion and engagement. *Qualitative Health Research*, 21(5), 704-713.
- Rebeiro, K, & Allen, J. (1998). Voluntarism as occupation. *Canadian Journal of Mental Health*, 65(5), 279-285.

- Reed, K, Hocking, C., & Smythe, L (2010). The interconnected meanings of occupation: The call, being-with, possibilities. *Journal of Occupational Science*, 17(3), 140-149.
- Reed, K, Smythe, L, & Hocking, C. (2013). The meaning of occupation: A hermeneutic (re) view of historical understandings. *Journal of Occupational Science*, 20(3), 253-261.
- Repper, J. (2013). Peer support workers: Theory and practice. *Centre for Mental Health and Mental Health Network, NHS Confederation*,
- Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), 392-411.
- Repper, J., & Perkins, R (2003). *Social inclusion and recovery: A model for mental health practice*. London: Bailliere Tindall.
- Restall, M. (2009). Volunteering and legal issues. *Volunteers in Hospice and Palliative Care: A Resource for Voluntary Service Managers*, 99.
- Reynolds, F. (2003). Reclaiming a positive identity in chronic illness through artistic occupation. *Otjr Occupation Participation and Health*, 23, 118-127.
- Reynolds, J., & Wetherell, M. (2003). The discursive climate of singleness: The consequences for women's negotiation of a single identity. *Feminism & Psychology*, 13(A), 489-510.
- Ridgway, P. (2001). Restorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, 24(A), 335.
- Rinaldi, M., Montibeller, T., & Perkins, R (2011). Increasing the employment rate for people with longer-term mental health problems. *The Psychiatrist*, 35(9), 339-343.
- Rinaldi, M., Perkins, R, Glynn, E, Montibeller, T., Clenaghan, M., & Rutherford, J. (2008). Individual placement and support: From research to practice. *Advances in Psychiatric Treatment*, 14(1), 50-60.
- Roberts, G., & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment*, 10, 37-49.



- Roberts, G., & Boardman, J. (2014). Becoming a recovery-oriented practitioner. *Advances in Psychiatric Treatment*, 20(1), 37-47.
- Roberts, G., Good, J., Wooldridge, J., & Baker, E. (2011). Steps towards 'putting recovery at the heart of all we do': Workforce development and the contribution of "lived experience". *The Journal of Mental Health Training, Education and Practice*, 6(1), 17-28.
- Roberts, G., & Hollins, S. (2007). Recovery: Our common purpose? *Advances in Psychiatric Treatment*, 13(6), 397-399.
- Roberts, G. (2007). *Enabling recovery: The principles and practice of rehabilitation psychiatry*. London: Gaskell.
- Rochester, C., Paine, A. E., Howlett, S., & Zimmeck, M. (2010). *Volunteering and society in the 21st century* Palgrave Macmillan Hampshire.
- Roets, G., Roose, R., Claes, L., Vandekinderen, Van Hove, G., & Vanderplasschan, W. (2012). Reinventing the employable citizen: A perspective for social work. *British Journal of Social Work*, 42, 94-110.
- Rogers, A., & Pilgrim, D. (1991). 'Pulling down churches': Accounting for the British mental health users' movement. *Sociology of Health & Illness*, 13(2), 129-148.
- Rugkasa, J., & Carvin, K. (2011). Researching mental health in minority ethnic communities: Reflections on recruitment. *Qualitative Health Research*, 21(1), 132-143.
- Russell, I. (2005). *A national framework for youth action and engagement: Report of the russell commission*. London: The Russell Commission.
- Ryan, R. M., & Deci, E. L. (January 2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68-78.
- Sainsbury Centre for Mental Health. (February 2009). *Briefing 37. Doing what works: Individual placement and support into employment*

Sandelowski, M. (2000). Focus on research methods-whatever happened to qualitative description? *Research in Nursing and Health*, 23(4), 334-340.

Sayce, L. (2000). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion* St. Martin's Press.

Schaufeli, W. B.; Taris, T. W., & Van Rhenen, W. (2008). Workaholism, burnout, and work engagement: Three of a kind or three different kinds of employee Well-being? *Applied Psychology*, 57(2), 173-203.

Schneider, J. W., & Conrad, P. (1980). In the closet with illness: Epilepsy, stigma potential and information control. *Social Problems*,, 32-44.

Schneider, J. (1998). Models of specialist employment for people with mental health problems. *Health & Social Care in the Community*, 6(2), 120-129.

Schon, U. K, Denhov, A., & Topor, A. (2009). Social relationships as a decisive factor in recovering from severe mental illness and disability. *International Journal of Social Psychiatry*, 55

Schwartz, S. J. (2005). A new identity for identity research. *Journal of Adolescent Research*, 20(3), 293-308.

Seeker, J., Membrey, H., Grove, B., & Seebohm, P. (2010). Recovering from illness or recovering your life? implications of clinical versus social models of recovery from mental health problems for employment support services. *Disability and Society*, 17(4), 403-418.

Seeker, J., Grove, R., & Seebohm, P. (2001). Challenging barriers to employment, training and education for mental health service users: The service user's perspective. *Journal of Mental Health*, 10(4), 395-404.

Seebohm, P., & Scott, J. (2004). *Addressing disincentives to work associated with the welfare benefits system in the UK and abroad*. London: Social Enterprise Partnership GB.

Seligman, M. E. *Learned optimism*, 1991. AA Knopf, New York,

- Sevigny, A., Cohen, S. R., Dumont, S., & Frappier, A. (2010). Making sense of health and illness in palliative care: Volunteers' perspectives. *Palliative and Supportive Care*, 8(03), 325-334.
- Shank, K. H., & Cutchin, M. P. (2010). Transactional occupations of older women aging-in-place: Negotiating change and meaning. *Journal of Occupational Science*, 17(1), 4-13.
- Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality* Sainsbury Centre for Mental Health London.
- Shepherd, G., Boardman, J., & Burns, M. (2009). *Implementing recovery: A methodology for organisational change* Sainsbury Centre for Mental Health.
- Shepherd, G., Boardman, J., & Burns, M. (2010). *Implementing recovery. A Methodology for Organisation Change*. London: Sainsbury Centre for Mental Health,
- Silverman, D. (2010). *Qualitative research*. Sage. Publications Limited.
- Silverman, D. (2011). *Interpreting qualitative data*. Sage. Publications Limited.
- Silverman, D. (2013). *Doing qualitative research: A practical handbook* SAGE Publications Limited.
- Sir Donald Acheson. (1998). *Independent inquiry into inequalities in health report*. The Stationery Office.
- Sismondo, S. (2004). *Social studies of science*.
- Slade, M. (2012). Everyday solutions for everyday problems: How mental health systems can support recovery. *Psychiatric Services*, 63(7), 702-704.
- Smith, J. A. (2007). *Qualitative psychology: A practical guide to research methods* Sage.
- Smyth, J., & Shacklock, G. (1998). Behind the "cleansing" of socially critical research accounts. *Being Reflexive in Critical and Social Educational Research*, 1-12.
- Social Exclusion Task Force. (2006). *Reaching out: An action plan on social exclusion*. London: The Cabinet Office.

Social Exclusion Unit. (2004). *Mental health and social exclusion*. London: Office of the Deputy Prime Minister.

Stadnyk, R., Townsend, E A., Wilcock, A., Christiansen, C., & Townsend, E (2010). Occupational justice. *Introduction to Occupation: The Art and Science of Living*, 2, 329-358.

Stagnitti, K (2012). Play. *Occupational Therapy and Physical Dysfunction Enabling Occupation*,, 371-390.

Staley, K, & Minogue, V. (2006). User involvement leads to more ethically sound research. *Clinical Ethics*, 1(2), 95-100.

Staniszewska, S, Adebajo, A., Barber, R, Beresford, P., Brady, L, Brett, J., et al. (2011). Developing the evidence base of patient and public involvement in health and social care research: The case for measuring impact. *International Journal of Consumer Studies*, 35(6), 628-632.

Stanton, M. C. (2014). Constructing individuals' lived experiences in shaping social inclusion: Voices of persons in recovery from mental illness. *Society for Social Work and Research 18th Annual Conference: Research for Social Change: Addressing Local and Global Challenges*,

Starks, H, & Trinidad, S B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372-1380.

Stebbins, R A. (1996). Volunteering: A serious leisure perspective. *Nonprofit and Voluntary Sector Quarterly*, 25(2), 211-224.

Stebbins, R A., & Graham, M. (2004). *Volunteering as leisure/leisure as volunteering: An international assessment* Cabi.

Stern, P. N. (2007). On solid ground: Essential properties for growing grounded theory. *The Sage Handbook of Grounded Theory*,, 114.

Strauss, A., & Corbin, A. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* Sage.

- Stryker, S., & Burke, P. J. (2000). The past, present, and future of an identity theory. *Social Psychology Quarterly*, 284-297.
- Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. *The Social Psychology of Intergroup Relations*, 33(47), 74.
- Taylor, J. A. (2008). *The Construction of Identities through Narratives of Occupations*.
- Taylor, R. F. (2004). Extending conceptual boundaries: Work, voluntary work and employment. *Work, Employment & Society*, 18(1), 29-49.
- Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *British Journal of Social Work*, 42(3), 443-460.
- Thesen, J. (2001). Being a psychiatric patient in the community-reclassified as the stigmatized "other". *Scandinavian Journal of Public Health*, 29(4), 248-255.
- Thoits, P. A. (2011). Resisting the stigma of mental illness. *Social Psychology Quarterly*, 74(1), 6-28.
- Thoits, P. A. (2012). Role-identity salience, purpose and meaning in life, and well-being among volunteers. *Social Psychology Quarterly*, 0190272512459662.
- Thoits, P. A. (2013) "Self, Identity, Stress, and Mental Health" Pp. 357-377 in *Handbook of the Sociology of Mental Health, Second Edition*, edited by Carol S. Aneshensel, Jo C. Phelan, and Alex Bierman. Dordrecht, The Netherlands: Springer.
- Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry*, 19(2), 113-122.
- Tilly, C., & Tilly, C. (1994). Capitalist work and labour markets. In N. Smelser, & R. Swedberg (Eds.), *Handbook of economic sociology* (pp. 283-313). Princeton: Princeton University Press.
- Townsend, E., & Wilcock, A. A. (2004). Occupational justice and client-centred practice: A dialogue in progress. *Canadian Journal of Occupational Therapy*, 71(2), 75-87.

Tsang, H. W., Leung, A. Y., Chung, R. C., Bell, M., & Cheung, W. M. (2010). Review on vocational predictors: A systematic review of predictors of vocational outcomes among individuals with schizophrenia: An update since 1998. *The Australian and New Zealand Journal of Psychiatry*, 44(6), 495-504.

Unruh, A. M. (2004). Reflections on:"So... what do you do?" occupation and the construction of identity. *Canadian Journal of Occupational Therapy*, 71(5), 290-295.

Urquhart, C. (2007). The evolving nature of grounded theory method: The case of the information systems discipline. *The Sage Handbook of Grounded Theory*,, 339-359.

Van Huet, H. (2011). Living and doing with chronic pain: Clients' and occupational therapists' perspectives.

Vandekinderen, C., Roets, G., Roose, R., & Van Hove, G. (2012). Rediscovering recovery: Reconceptualizing underlying assumptions of citizenship and interrelated notions of care and support. *Scientific World Journal*,, 496579.

Velde, B. P., & Fidler, G. S. (2002). *Lifestyle performance: A model for engaging the power of occupation* Slack Incorporated.

Vrkljan, B., & Miller-Polgar, J. (2001). Meaning of occupational engagement in life-threatening illness: A qualitative pilot project. *Canadian Journal of Occupational Therapy*, 68(4), 237-246.

Wada, M. (2011). Strengthening the kawa model: Japanese perspectives on person, occupation, and environment. *Canadian Journal of Occupational Therapy*, 78(4), 230-236.

Waddell, G., & Burton, K. (2000). *Concepts of rehabilitation for the management of common health problems* Department for Work and Pensions. TSO.

Waddell, G., & Burton, A. K. (2006). *Is work good for your health and well-being?* The Stationery Office.

Waddell, G., Burton, A. K., & Kendall, N. A. (2008). *Vocational rehabilitation-what works, for whom, and when? A report for the vocational rehabilitation task group*. TSO.

Wallcraft, J. (2010). The service user as a person in health care-service users organising for self empowerment. *International Journal of Integrated Care*, 10

Walsh, R (2011). Lifestyle and mental health. *American Psychologist*, 66(7), 579.

Warner, R (1994). *Recovery from schizophrenia: Psychiatry and political economy* (2nd ed.). London: Routledge.

Warr, P. (1987). *Work, unemployment and mental health* Oxford University Press.

Werner, E E, & Johnson, J. L (2002). Can we apply resilience? *Resilience and development* (pp. 259-268) Springer.

Wheat, K, Brohan, E, Henderson, C, & Thornicroft, G. (2010). Mental illness and the workplace: Conceal or reveal? *Journal of the Royal Society of Medicine*, 103(3), 83-86.

Whitwell, D. (1999). The myth of recovery from mental illness. *Psychiatric Bulletin-Royal College of Psychiatrists*, 23, 621-622.

Wiggan, J. (2012). Telling stories of 21st century welfare: The UK coalition government and the neo-liberal discourse of worklessness and dependency. *Critical Social Policy*, 32(3), 383-405.

Wilcock, A. A. (2006). *An occupational perspective of health*. Thorofare, NJ: Slack.

Wilcock Ann A. (2007). Occupation and health: Are they one and the same. *Journal of Occupational Science*, 14(1), 3-8.

Wilkinson, R (2005). *The impact of inequality: How to make sick societies healthier*. London: Routledge.

Williams, C. C., & Nadin, S (2012). Work beyond employment: Representations of informal economic activities. *Work, Employment & Society*, 26(2), 1-10.

Willig, C., & Stainton-Rogers, W. (2007). *The SAGE handbook of qualitative research in psychology* Sage.

- Wilson, J., & Musick, M. (1997). Who cares? toward an integrated theory of volunteer work. *American Sociological Review*, , 694-713.
- Wright, N., & Stickley, T. (2013). Concepts of social inclusion, exclusion and mental health: A review of the international literature. *Journal of Psychiatric and Mental Health Nursing*, 20(1), 71-81.
- Yanos, P., Rosenfield, S., & Horwitz, A. (2001). Negative and supportive social interactions and quality of life among persons diagnosed with severe mental illness. *Community Mental Health Journal*, 37, 405-419.
- Yeung, A. B. (2004). The octagon model of volunteer motivation: Results of a phenomenological analysis. *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, 15(1), 21-46.
- Young, R., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of Vocational Behaviour*, 64(3), 373-388.
- Zamagni, S. (1995). *The economics of altruism* Edward Elgar Pub.
- Zukewich, N. (2003). Unpaid informal caregiving. *Canadian Social Trends*, 70, 14-18.



## Appendix i Phase 1 Local Research Ethics Committee approval

**NHS**

**North Sheffield Ethics Office**

1st Floor Vickers Corridor

Direct Line: 0114 271 4894 or 271 4011

Fax: 0114 256 2469

Email: sue.rose@sth.nhs.uk

**Northern General Hospital**

Herries Road

Sheffield

SS 7AU

22 February 2007

Ms Colette Fegan  
Senior Lecturer  
Faculty of Health and Wellbeing  
Sheffield Hallam University  
11-15 Broomhall Road  
SHEFFIELD  
S10 2BP

>

Dear Ms Fegan

**Full title of study:** What is the impact of a user volunteer project on Mental Health Service Users and Staff

**REC reference number:** 06/Q2308/178

Thank you for your letters of 28th January and 19th February 2007, responding to the Committee's request for further information on the above research [and submitting revised documentation].

The further information has been considered on behalf of the Committee by the Chairman.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised].

**Ethical review of research sites**

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

**Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

***The following is also a condition of approval:***

***The introductory letters are no longer appropriate as it has been confirmed that the consent form will not be enclosed with the information sheet, consent will be face to***

**rzzza**

**National Research Ethics Service**

**North Sheffield Local Research Ethics Committee**

1st Floor Vickers Corridor  
Northern General Hospital  
Herries Road  
Sheffield  
S5 7AU

\_\* - i: '- - : \* -  
-a < 31\*4 2S€ 2\*5S

08 January 2008

Ms Colette Fegan  
Senior Lecturer  
Robert Winston Building  
Faculty of Health and Wellbeing  
11-15 Broomhall Road  
SHEFFIELD  
S10 2BP

Dear Ms Fegan

**Study title:** What is the impact of a user volunteer projecti on health service users and staff?  
**REC reference:** 06/Q2308/178  
**Amendment number:** 1  
**Amendment date:** 18 December 2007

The above amendment was reviewed at the meeting of the Sub-Committee of the REC held on 07 January 2008.

**Ethical opinion**

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

**Approved documents**

The documents reviewed and approved at the meeting were:

Document	Version	Date
Protocol	3	18 December 2007
Notice of Substantial Amendment (non-CTIMPs)		18 December 2007
Letter from R & D Consortium		03 December 2007

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority  
*The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England*

## Appendix iii Letter to Sheffield Health and Research Consortium requesting change to methodology

November 21st 2007

ZE55: An investigation into the experiences of service users and staff who have been involved in a volunteering service

Dear Dr Dixon,

Following discussion with my academic supervisors, I am writing to you as Chair of the Scientific Review Panel to inform you that I am planning to use grounded theory analysis for my study. I discussed this situation with Dr Jonathan Boote recently and he advised me to contact you.

In my original submission to the Panel I had looked at grounded theory but took on board the Panels response and suggestion to use Framework Analysis as they thought I would not have sufficient time to conduct grounded theory analysis.

Since that time I have made the decision to study for a PhD that will look at the impact volunteering has on recovery for service users with mental health problems.

Findings from this first study will inform a second study and I intend to use constructivist grounded theory methodology. I feel that I do have sufficient time left to analyse my data using grounded theory and no longer feel that framework analysis is appropriate.

I am aware that there are several limitations in using this form of analysis but would like you to consider this change to the proposal. The study has been conducted to date as per the original proposal and has recently been subject to audit.

Thank you for your help and advice with this matter.

Yours sincerely

Colette Fegan  
Principal Investigator

**Appendix iv Sheffield Health and Research Consortium response and approval to  
change of methodology**

**SHSRC A-iJLzJ**

\*

**Sheffield Health & Social Research Consortium**

**Fulwood House  
Old Fulwood Road**

12 February 2008

Ms Collette Fegan  
Office of the Pro Vice-Chancellor  
Sheffield Hallam University  
City Campus  
Howard Street  
Sheffield S1 1WB

**Tel: 0114 271 8804  
Fax: 0114 271 6736  
Email: shsrc@sct.nhs.uk  
www.shsrc.nhs.uk**

Dear Ms Fegan,

**Consortium Reference: ZE55**  
**Project Title: An investigation into the experiences of service  
users and staff who have been involved in a  
volunteering project.**

**Proposed Amendment dated 18 December 2007**

Thank you for your letter of 21 January 2008 with details of the above proposed amendment.

On the assumption that this amendment relates exclusively to the change described in your letter to the Consortium of 21 November 2007, I can confirm on behalf of Sheffield Care Trust that you have research governance approval from this Consortium to implement the above amendment, for which I note you have received a favourable opinion from an NHS REC.

For the benefit of our partner organisation research lead to whom I am copying this letter, I summarise the essential change as follows:

- Change in analysis to use constructivist grounded theory methodology

Yours sincerely,

Robert Dixon  
Consortium Manager

Cc Dr Tom Ricketts  
Project File  
Dr Jonathan Boote

A multi-agency consortium of  
Trusts, Universities, and  
Social Services in Sheffield

la<sup>2</sup>J A

TRENT RDSU

Z:\Projects\ZE Files\ZE55\12.02 2008\Yb ZE55 approval for amendment doc

Appendix v Letter inviting phase 1 volunteers into the study

Dear

I am writing to you to inform you about a study that is being conducted that looks at **Service User Volunteers experience of Volunteering**

You have been invited to take part in the study because you are or have been a volunteer.

The research is being conducted by Colette Fegan a researcher from Sheffield Hallam University. Any identifiable information which is collected about you during the course of the research will be kept strictly confidential.

Enclosed is an information sheet that outlines what can be expected if you choose to take part in this study and a reply slip.

If you feel you would like to take part in this research please return the reply slip. We will then contact you to make arrangements for a time to be interviewed. You will be asked to sign a consent form before the interview commences.

In the meantime if you have any questions about the study please do not hesitate to contact me Andrew Wright (User Volunteer Co-ordinator) 271 8929 or Sally Bramley (Consultant Occupational Therapist in Vocational Rehabilitation in Mental health) 271 8122

Yours sincerely

Andrew Wright  
User Volunteer Co-ordinator  
Tel: 2718929

**Appendix vi Phase 1 study reply slip**

Reply slip to be returned in stamp addressed envelope to:

User Volunteer Service  
St Georges Community Centre  
Winter Street  
Sheffield

I would like to take part in the study:

**An investigation into the experiences of service users and staff who have been involved in a volunteering project**

I would like you to contact me about the study

**Name**

**Contact no**

**Appendix vii Phase 1 Participant information sheet**

Version 4 February 18th 2007

**Participant Information sheet for staff**

**Ref 06/Q2308/178**

**An investigation into the experiences of service users and staff who have been involved in a volunteering project**

Dear

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. Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or if you would like more information.

Thank you for reading this.

**Part 1**

**What is the purpose of the study?**

The User Volunteer Project was set up by occupational therapy staff at Limbrick Day Service to provide service users with the opportunity to gain work experience in a variety of settings. We would like to hear what your thoughts and feelings are about the User Volunteer Project and your experience of being a member of staff who works or has worked alongside a volunteer. The study will look at the impact of volunteering in the Trust on services users who were volunteers and also the impact it had on staff who worked with volunteers.

The research is part of a doctorate educational project.

**Why have I been invited?**

You have been chosen to take part in the study because you are a member of staff who works or has worked alongside a volunteer. Other staff members who work or have worked with volunteers will also be asked to take part as well as service user volunteers.

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

**What will happen to me if I take part?**

You will be asked to take part in an interview about your experiences of working alongside a volunteer. The interviews will last no more than 60 minutes and will be conducted by a researcher from Sheffield Hallam University.

We would like to audio tape the interviews or make notes but only if you agree to this. The interviews will take place at a venue of your choice. A day and time will be arranged that is convenient for you.

**What are the possible benefits of taking part?**

The study has no intended clinical benefit. The research will help us to see how the user volunteer project has impacted on service user volunteers and the staff they worked with. It will help to inform any need for changes in this service but will also consider how it felt to be a member of staff working alongside a volunteer and what this experience was like for you.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

**Part 2****What will happen if I don't want to carry on with the study?**

You can withdraw from the study at any time. If you choose to withdraw any interview tapes, notes or transcripts will be destroyed and that data will not be included in the study.

**What if there is a problem?**



If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. This is Colette Fegan

Tel 0114 225 2581

If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from St Georges Hospital.

### **Harm**

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Sheffield Hallam University but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

### **Will my taking part in the study be kept confidential?**

Yes, all information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it.

All tapes used in the research will be destroyed upon completion of transcripts. You are welcome to see and comment on a copy of your transcript.

Transcripts and any notes about the interviews will be kept in a locked cupboard in a locked office at Sheffield Hallam University Research Centre for a period of 10 years. This is in line with the University governance of research data.

Direct quotes from the interview may be used in a report but no identifiable information will be made available.

### **What will happen to the results of the research study?**

A report will be available upon completion of the study. The researcher will use the results as part of her thesis and in publications. Anyone who takes part in the study will not be identified in any way.

**Who is organising and funding the research?**

The research is being conducted by a researcher from Sheffield Hallam University in collaboration with staff and service users from Sheffield Care Trust. The research is funded by Sheffield Health and Social Care Consortium.

**Who has reviewed the study?**

The study has been reviewed by North Sheffield Research Ethics Committee

If you would like to take part in the study please complete the reply slip and return in stamp addressed envelope or if you would like to speak to someone about the research please call Colette Fegan 225 2581 or Andrew Wright (User Volunteer Co-ordinator) 271 8929

Thank you for reading this.

Yours sincerely

Colette Fegan

Researcher

Sheffield Hallam University

Tel 0114 225 2581

*email* c.m.fegan(a)shu.ac.uk

Appendix viii Phase 1 Consent form

Study Number: 06/Q2308/178

Participant identification number:

**CONSENT FORM**

**Title of Project:** An investigation into the experiences of service users and staff who have been involved in a user-volunteering project.

**Name of Researcher:** Colette Fegan

**Please initial box**

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3.1 agree to be interviewed, and for the interview to be recorded.

|

4.1 do not wish the interview to be recorded but agree to notes being taken.

T]

5.1 understand that direct quotes from the interview may be used in a report but no identifiable information will be made available. \_\_\_\_\_

l j

6. I understand that this research may be subject to inspection by my supervisors; and regulatory bodies for audit purposes for monitoring of the quality of the research.

7. I agree to take part in the above study.

8.1 would like to see a copy of the transcript of my interview for comment.

| '

---

Name of Participant

---

Date

Signature

---

Name of Person taking consent  
(if different from researcher)

---

Date

Signature

---

Researcher

---

Date

Signature

Copies: 1 for participant; 1 for researcher

**Faculty of Health and Wellbeing Research Ethics Committee  
Health & Social Care Research Ethics Review Group  
Report Form**

Title: **Change and Transformation through Volunteering - Phase 2 Study**

Principal Investigator: Colette Fegan

Recommendation:

Acceptable:

Not acceptable, see comments:

Acceptable, but see comments:

Comments:

Signature: ..... Date:..

Appendix x - Sheffield Hallam University Faculty Research Ethical approval of amendment for phase 2

Sheffield  
Hallam  
University

**Centre for Health  
and Social Care  
Research**

15 October 2012

Colette Fegan  
Sheffield Hallam University  
Robert Wilson Building  
Room F426  
Collegiate Crescent Campus

Dear Colette

This letter relates to your research proposal

**Change and Transformation through Volunteering**

and the amendment received on 8th October 2012

This amendment to your proposal was submitted to the Faculty Research Ethics Committee for review. It has been reviewed by an independent reviewer on behalf of the Committee and is now passed as satisfactory. You may need to get further permission for the amendment from other governance bodies, such as R&D departments or NHS ethics committees.

The documents we reviewed were:

Protocol  
Participant Information Sheet  
Participant Consent Form

Good luck with your project.

Yours sincerely

Peter Allmark  
Chair Faculty Research Ethics Committee  
Faculty of Health and Well-being  
Sheffield Hallam University  
32 Collegiate Crescent  
S10 2BP

0114 225 5727  
p.allmark@shu.ac.uk

Centre for Health and Social Care Research  
Faculty of Health and Wellbeing | Montgomery House | 32 Collegiate Crescent | Sheffield | S10 2BP UK  
Telephone +44 (0) 114 225 5854 | Fax +44 (0) 114 225 4377  
chscr@shu.ac.uk | www.shu.ac.uk/chscr



**Appendix xii - Phase 2 Participant Information sheet**

Participant information sheet

Study title: Change and Transformation through Volunteering  
Chief investigator Colette Fegan  
Telephone number 0114 225 2581 or e mail c.m.fegan@shu.ac.uk

**Study Sponsor: Sheffield Hallam University**

**I would like to invite you to take part in a research study. The study is about your experiences of being a volunteer and what impact if any it has on mental health recovery.**

**Before you decide I would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish. Ask me if there is anything that is not clear.**

Participant name:

You will be given a copy of this information sheet to keep



## 1. What is the purpose of this study?

The purpose of this study is to find out more about peoples experiences of being a volunteer and how it impacts on their recovery. The study forms part of the researcher's PhD.

## 2. Why have I been invited?

You have been invited to take part in this study because you are currently a volunteer, not in paid employment and consider yourself to have a mental health problem.

## 3. Do I have to take part?

Your decision to take part in this study is entirely voluntary. You may refuse to participate or you can withdraw from the study at any time. Your refusal to participate or wish to withdraw would not influence any other support or treatment you are receiving.

## 4. What will happen to me if I take part?

If you participate in the study you will be invited to participate in an informal interview with the researcher. The interviews will last no more than one hour and will take place at a venue that is convenient to you and the researcher. After the researcher has analysed the interview they may ask you to discuss their findings and may ask for a second interview to check out some things further.

All reasonable travel expenses will be paid

## 6. What are the possible disadvantages and risks of taking part?

The interview will involve discussing your experience of being a volunteer and it may mean that you think about your own experiences of mental health.

The interview is not intended to cause any distress, but every care will be taken to be sensitive to your needs during the interview.

## 7. What are the possible benefits of taking part?

By taking part in the study you will have the opportunity to discuss your experiences of volunteering. The researcher would like to find out more about volunteering and mental health recovery and your participation will help to do this

## 8. What if there is a problem or I want to complain?

If you have any queries or questions please contact:

Principal investigator: Colette Fegan

c.m.fegan(5)shu.ac.uk

Telephone: 0114 225 2581

Sheffield Hallam University, Faculty of Health and Wellbeing

**Alternatively**, you can contact my supervisor: Dr Sarah Cook

s.p.cook(a)shu.ac.uk

Telephone: 0114 225 5672

If you would rather contact an independent person, you can contact

Peter Allmark:

p.allmark(a>shu.ac.uk

Telephone: 0114 225 5727.

He is a member of the relevant University ethics committee.

### **9. Will my taking part in this study be kept confidential?**

The interview will be recorded and then written up word for word. The researcher will check that the recording and the written transcript are the same. She will then erase the recording. The transcript will be kept on a password-protected computer. Identifying details will be taken out of any final report and any publication so people reading these will not be able to identify you. The written transcripts will be kept for 5 years after the project and then destroyed.

The documents relating to the administration of this research, such as the consent form you sign to take part, will be kept in a folder called a project file. This is locked away securely. These documents will be destroyed five years after the end of the study.

### **10. What will happen to the results of the research study?**

Results of this study will form part of a thesis. The researcher will also plan to publish papers about the research to share her findings with various networks.

### **11. Who is sponsoring the study?**

The sponsor of the study has the duty to ensure that it runs properly and that it is insured. In this study, the sponsor is Sheffield Hallam University.

## **12. Who has reviewed this study?**

All research based at Sheffield Hallam University is looked at by a group of people called a Research Ethics Committee. This Committee is run by Sheffield Hallam University but its members are not connected to the research they examine. The Research Ethics Committee has reviewed this study and given a favourable opinion

## **13. Further information and contact details**

If you have any queries or questions please contact:

Principal investigator: Colette Fegan

[c.m.fegan@shu.ac.uk](mailto:c.m.fegan@shu.ac.uk)

Telephone: 0114 225 2581

Sheffield Hallam University, Faculty of Health and Wellbeing

Alternatively, you can contact my supervisor: Dr Sarah Cook

[s.p.cook@shu.ac.uk](mailto:s.p.cook@shu.ac.uk)

Telephone: 0114 225 5672

If you would rather contact an independent person, you can contact Peter Allmark

[p.allmark@shu.ac.uk](mailto:p.allmark@shu.ac.uk)

Telephone: 0114 225 5727.

He is a member of the relevant University ethics committee.

**Appendix xiii - Phase 2 Participant consent form**

Participant consent form

Study title: Change and Transformation through Volunteering  
Chief investigator Colette Fegan  
Telephone number 0114 225 2581

**Participant name**

**Please read the following statements and put your initials in the box to show that you have read and understood them and that you agree with them**

**Please initial each box**

- 1 I confirm that I have read and understood the information sheet dated **date** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 2 I agree that any interview with me can be recorded.
- 3 I understand that my involvement in this study is voluntary and that I am free to withdraw at any time, without give any reason and without my medical care or legal rights being affected.
- 4 I understand that some of the data collected during the study may be looked at by responsible individuals from the Sponsor and my research supervisor. I give permission for these individuals to have access to my records.
- 5 I agree to take part in this study

**To be filled in by the participant**

I agree to take part in the above study

Your name

Date

Signature

**To be filled in by the person obtaining consent**

I confirm that I have explained the nature, purposes and possible effects of this research study to the person whose name is printed above.

Researcher

Date

Signature

Filing instructions

1 copy to the participant

1 original in the Project file

## Appendix xiv Phase 1 and Phase 2 Interview guide

**Phase 1** : demographic data collected at the end to include age and ethnic group, gender, volunteering setting(s)

The researcher proposes the following as interview questions but will be very much guided by the interviewee.

- How did you become involved in the User Volunteer Project?
- Tell me about your experiences as a volunteer?
- Can you tell me about the working relationships you have?
- What are your plans for the future in terms of volunteering or work?

2018 වසරේ ප්‍රධාන අරමුණු

2018 වසරේ ප්‍රධාන අරමුණු

2018 වසරේ ප්‍රධාන අරමුණු

REHEARSING FOR NEW DIRECTIONS	TREADING CAREFULLY AT FIRST	DISCOVERING MY NEW SELF	USING MY EXPERIENCE	EXTENDING RELATIONSHIPS	GETTING STUCK	BELONGING	THE RIGHT SORT OF VOLUNTEERING
Can you tell me why you wanted to become a volunteer?	Was open paid employment ever an option for you?  What are your feelings about this in the future?	How did you feel when you were volunteering?  Do you think of yourself differently?	Did your mental health experiences influence or impact on your time as a volunteer?	Can I ask you about whether there are any significant relationships you have made that have either influenced you to be a volunteer or have been important during your time as a volunteer?	Have you ever wanted to move away from volunteering into something else e.g. paid work  What are the barriers if any?  How does this feel?	'Like a family'  Sense of belonging?  Explore this more in phase	Is this the right sort of Volunteering?  What would not be the right sort of volunteering and was this your experience?









19 20  
5 11  
5 W 11  
2 2

41 42  
X X  
X X  
X X

18  
80

18  
80

x

18 19  
X X  
X X  
X X

18 19  
X X  
X X  
X X

18  
80

18  
80

18  
80

20

P I ?  
X S  
X S

18 19  
X X  
X X  
X X

18  
80

18  
80

18  
80

x

18 19  
X X  
X X  
X X

18  
80

18 19  
X X  
X X  
X X

24

මා මුද්‍රාණයක් ලෙසට පිටපත් කළේ නම් මෙහි  
 ලාභය ඔබටම අයත් වේ. මෙහි අලුත් පිටපතක්  
 1. මුද්‍රාණයක් ලෙසට පිටපත් කළේ නම් මෙහි  
 ලාභය ඔබටම අයත් වේ. මෙහි අලුත් පිටපතක්  
 මුද්‍රාණයක් ලෙසට පිටපත් කළේ නම් මෙහි  
 ලාභය ඔබටම අයත් වේ. මෙහි අලුත් පිටපතක්

සාධකයක්

ලාභය

සාධකයක්

ලාභය

ලාභය

25

ලාභය

26

මුද්‍රාණයක් ලෙසට පිටපත් කළේ නම් මෙහි  
 ලාභය ඔබටම අයත් වේ. මෙහි අලුත් පිටපතක්  
 මුද්‍රාණයක් ලෙසට පිටපත් කළේ නම් මෙහි  
 ලාභය ඔබටම අයත් වේ. මෙහි අලුත් පිටපතක්

මුද්‍රාණයක් ලෙසට පිටපත් කළේ නම් මෙහි  
 ලාභය ඔබටම අයත් වේ. මෙහි අලුත් පිටපතක්  
 මුද්‍රාණයක් ලෙසට පිටපත් කළේ නම් මෙහි  
 ලාභය ඔබටම අයත් වේ. මෙහි අලුත් පිටපතක්

## Appendix xvi Examples of how initial coding developed into categories

Examples of Initial codes	Examples of Focused codes	Sub categories	Main category
Altruism Recognising benefits to others Helping those who have helped me Putting something back into the system	GIVING SOMETHING BACK IS IMPORTANT	GIVING SOMETHING BACK HAVING A VOICE BELONGING AGAIN	<b>FINDING MEANING AND CHALLENGE WITHIN VOLUNTEERING</b>
A sense of belonging Awareness of team cultures Empathy towards others and staff Integrating with staff	A SENSE OF BELONGING	POSITIVE RISK TAKING USING MY EXPERIENCE INFORMING MY IDENTITY	
Anonymity Identity crisis Service user label Managing barriers Developed coping strategies Learned from past experiences of work Increased self-worth and confidence My opinion counts again New plans and goals Rehearsal for the real world of work	IMPACT ON IDENTITY GAINING PERSONAL INSIGHTS	TREADING CAREFULLY AT FIRST SEARCHING FOR NEW DIRECTIONS REHEARSING FOR NEW DIRECTIONS	<b>FINDING THE RIGHT SORT OF WORK</b>
Aspiration of paid work in mental health services Work instability	CROSSING BOUNDARIES AND NEW DIRECTIOND	FINDING MEANING AND PURPOSE	<b>CROSSING BOUNDARIES FROM PATIENT TO VOLUNTEER</b>
Volunteering as a meaningful activity Introduce balance and time use Impacted of self efficacy Links to other meaningful activity Has therapeutic values	VOLUNTEERING PROVIDES MEANING AND PURPOSE	GETTING STUCK LEARNING FROM EXPERIENCE EXTENDING RELATIONSHIPS THE RIGHT SORT OF VOLUNTEERING	
Career volunteers Readiness to change Fear of change Safer to stay as 1am Disclosure Taking risks	DIFFICULTY MOVING ON		

## **Appendix xvii - Examples of memos from phase 1 and phase 2**

### **Memo to support category - Finding meaning and challenge (phase 1 and 2 )**

For some participants the value of volunteering was clearly identified as a sanctuary different from past work experiences and now there were different reasons to 'work' as a volunteer rather than for financial incentives. The security of benefits was acknowledged yet volunteering still provided something to do, a sense of responsibility, structure, balance and meaning to the day as well as job satisfaction. Spending more time in work/education and less on sleep has shown to be related to better health and functioning (Leufstadius et al., 2006; Eklund and Leufstadius, 2007), and an ongoing and high level of occupational engagement in general has been found to be associated with wellness (Bejerholm and Eklund, 2007). Volunteering provided participants with a way to expand previous interests in a meaningful way. The impact it had on them and their social networks was acknowledged. Volunteering was perceived to be an acceptable activity that also had therapeutic benefits in terms of pacing and grading different elements of it. Having routines and a daily rhythm following the light-dark cycle has shown to be meaningful to individuals with psychiatric disabilities (Leufstadius, Erlandsson, Bjorkman and Eklund, 2008) and to promote social interaction and mastery (Leufstadius et al., 2006). Thus, occupational patterns characterized by work-related occupations, ongoing occupational engagement without longer periods of nothingness, (see time use studies). Also, quiet activities may be beneficial if they function as a break between activity peaks, but detrimental if they form the only or dominating alternative for filling time (Bejerholm and Eklund, 2006).

### **Memo to support the category - Getting stuck (phase 2)**

Volunteering had an element of safe risk taking, participants seem to balance that risk but some were 'stuck'. Is volunteering safe and open employment not? Volunteering was a safe risk in terms of some people's recovery. Is the risk getting ill again? Research by Provencher et al., (2013) attributed a profile 'recovery as uncertain' to those who struggled to manage their enduring mental health problems and were less well supported by family and friends. They had

a sense of needing to protect a vulnerable self by maintaining the status quo and work was not seen to be able to help with self-development. Is this linked to a readiness for change?

For some participants the risk around work was linked to 'being managed' disclosure of mental health, having to be somewhere at a certain time and stay for a certain amount of time. These seem to be risky, and is what kept some participants 'stuck'. This group I want to call 'career volunteers'. However what is striking is that they do all stay within a health and social care, church focused organisation or contribute to higher education training of students. This is their preferred environment. Negative stereotypes associated with the stigma of mental illness can have a serious impact on self-esteem (Blankertz, 2001). Stereotypes are an important part of an underlying belief system so they endure across many different settings. This influences recovery as well as other areas of one's life (Sadow et al., 2010)



## Appendix xviii - Reflection outlining links across phase 1 and phase 2

Conceptual Framework from Phase 1 is proposed that *supported volunteering can enhance recovery because it fosters positive risk taking and gives individuals a valued identity that integrates their mental health experience.*

Core theory going forward is that volunteering is about validation of yourself as a worker. Saturation of categories that support; giving something back, finding meaning and rehearsing for a new direction.

The experience of volunteering has taken place for all participants over a period of time/ similar to a journey there is a temporal element to the experiences of the volunteers.

The core category is one of validation. It is a process. There is validation of the self that is who they are now and this also includes their skills and the personal changes that have been acknowledged by themselves and others.

It is a validation of their experience from a place that was seen as negative influenced by a diagnosis of mental ill health, trauma or vulnerability sometimes in environments that were unfamiliar and frightening. Through volunteering this negative experience of ill health allows the participants to recognise changes that support their individual recovery.

Volunteering validates people's qualities and strengths as well as the specific skills they bring to the role. The experience of volunteering helps people to feel valued and examples of how they have taken on responsibility and additional duties are highlighted.

Volunteers feel they are 'heard' in the organisations they work. They can make a positive contribution and within that role they can move forward in terms of a role they have - be in work, a productive role, a contributing role, or a 'giving' role.

For some participants the value of volunteering was clearly identified as a sanctuary different from past work experiences and now there were different reasons to 'work' as a volunteer rather than for financial incentives. The security of benefits was acknowledged yet volunteering still provided something to do, a sense of responsibility, structure, balance and meaning to the day as well as job satisfaction.

Volunteering provided participants with a way to expand previous interests in a meaningful way. The impact it had on them and their social networks was acknowledged. Volunteering was perceived to be an acceptable activity that also had therapeutic benefits in terms of pacing and grading different elements of it.

Volunteering was identified as a stepping stone, a rehearsal for the real world of work. It would enhance curriculum vitae and would allow the volunteers to test out new skills and refresh old ones. For several participants the opportunity to volunteer allowed them to

consider a change in direction, to consider working in the Trust, to test the water in an environment that they were familiar with but also one in which they felt they could contribute to positively both as a volunteer and then possibly as a paid worker. Other participants felt that this experience allowed them to learn from their past and to do things differently, to have different types of relationships with mentors and other staff and to be more open in their communications with their mentors. Some volunteers were able to identify realistic goal for the future either within the Trust or outside in terms of additional training and work experience. Several volunteers found the experience helped them develop insight into a different way of thinking about themselves, their skills new ones and ones they felt they may have lost. This had a positive effect on how they viewed their future. The experience of mental illness leads to an evaluation of their work role.

Volunteering had an element of safe risk taking, participants seem to balance that risk. Is volunteering safe and open employment not, volunteering was a safe risk in terms of some people's recovery. Is the risk getting ill again? For some participants the risk around work was linked to 'being managed', disclosure of mental health, having to be somewhere at a certain time and stay for a certain amount of time. These seem to be risky and is what kept some participants 'stuck'. This group I want to call 'career volunteers'. However what is striking is that they do all stay within a health and social care, church focused organisation or contribute to higher education training of students. This is their preferred environment. Their experience through mental health is the reason they stay there. They can give to others in the same boat, they can empathise with someone who is going through something similar, they can support and share coping strategies they have, they can provide an 'authentic' experience. Their experience also allows them to inform the organisation and share in decision making and ideas. There seems to be a fit between voluntary work that is positive and the individual. They have the relevant skills and experience for these volunteer posts. However there are some challenges - expectations of others, disclosure of mental health difficulties, some relationships strained (in phase 2 volunteers had felt let down, exposed and not supported by some individuals) it is this perception of what paid work would be like that is also impacting on them moving into paid work.

For participants in phase 2 validation is still key if anything more so. Participants are treading with more confidence. They have autonomy in terms of taking on a volunteering role(s). There is recognition of their place as a volunteer and the value they add. Risks that are taken are around more responsibility in that role of the acceptance of their contributions and ideas and the opportunities that they take to develop themselves and their skills. Their sense of self as someone who can make a valuable contribution, influence and feel validated was important. All participants in phase 2 describe their resilience in terms of the life events, mental illness, poor relationships they have endured yet despite this they see their future positively. They have overcome adversity. Volunteering does seem to provide opportunities or transition points that have influenced other decisions. For volunteers in phase 2 the chance to volunteer is implicit in who they are and how they function with evidence of it maintaining wellbeing and allowing that

individual to be who they want to be e.g. giving to their community, self-determination towards a work role.

Resilience appears to be key to this process of change, sticking at it despite setbacks, learning from the setbacks and growing in confidence. Improved self-esteem and self-efficacy through the process of volunteering continues to validate the person. This process of change is characterised by tentative, safe steps at first. Volunteering allows the participants to try new areas of work, some which are directly linked and congruent with their experience of mental ill health. This experience allows the volunteers to be empathic and be a positive role model to others. As service user volunteer they have an inside and outside view of services and their experience is one that is authentic and valuable to a service and other service users. The experience of mental ill health, which is integral to the volunteers experience is used positively as a volunteer, their relationship with professional staff in services changes and there is a diminishing of power. (This power differential just changes from one that was previously as a service user to one that is now possibly more equal but different power difference as a service user volunteer) There is an acceptance of their contribution to work with professionals and the contribution they can make.

Motives for volunteering were varied but for many doing this was altruistic: for some it felt important to give something back to the mental health services that had supported them, to put something back in the system. For others it was about empathy with other services users and wanting to help them. Their experience as service users was identified as relevant and important as they had empathy with other service users and as recipients of a service could reflect back and inform the service based on their own experience. This can be tokenistic so needs to be the right sort of volunteering.

As a result of the experience of mental ill health can influence life choices. Identification with vulnerable groups based on volunteers experience.

The work role seems important in the study. Participants compared how they felt about previous or lack of work experiences and the experiences they gain as a volunteer. As a service user volunteer with new skills and experience to put back into a system that they had used and been part of 'from the other side'. The participants felt that when the volunteering was the right type for them then this was positive. The work role they were in now suited them better, it had meaning and direction for them.

This rings true in phase 2 the volunteers have aspirations to use the skills they have often developed during volunteering opportunities to take forward into some sort of end point (be it education for a professional role, entrepreneurship role to use skills outside the volunteering).

Volunteering provides a validating identity for self. Many of the participants spoke about how they thought about themselves as a result of volunteering. 'Volunteer' was a more acceptable label, less stigmatizing; whilst others acknowledged that they would always be service users; there was it seems a transition that some volunteers went through - service user > service user volunteer > potential worker in Trust. The term volunteer can be seen as a preferable label.

Interestingly participants in the study were being socialised into a mental health culture demonstrated in the language and skills they spoke about, (Professionalisation of service user - positive and negative). Several participants commented on their own personal journey in terms of how far they have come. A positive impact on mental health was identified along with an increase in confidence and self-worth as well as personal attributes in terms of increased self-awareness, a more caring attitude and more tolerance were also identified. Participant's sense of identity and role were frequent themes that arose from the data. Some volunteers valued the fact that their experience as service users could be used in a positive way while others liked the anonymity of the volunteer role.

Many participants spoke about how they thought about themselves as a result of volunteering. Feeling validated not only linked to specific work skills but also to psychological attributes - being heard, views respected, self-worth, increased self-esteem, patience, social skills.

In terms of coping, improved coping strategies, increased structure in terms of time allowing time for other things but also different view about how they structure their time. A lot of the participants talked about the schedule they had during the week where they fitted in the volunteering and other activities. Some volunteers recognised how they coped previously in paid work and did not want to go back there because of the impact it had on their mental health. Relationships with employers, reduced flexibility and disclosure were concerns.

Volunteering is way to validate relationships. Some relationships can be positive and are influential, these relationships stand out and influence and act as a motivator for volunteers. For other volunteers there was an acknowledgement of a changing relationship and perspective with mental health professionals. Volunteers were able to see things differently, it helps them to gain insight into a service. A number of volunteers described 'belonging' like a family

As service users who were volunteering in an organisation from which they received a service, this raised a number of issues for the participants in the study. For several volunteers the change in role and relationship with other service users and the perception that other service users had of them was a challenge. They acknowledged their service user role as part of their identity. Having contact with service users in a different way sometimes raised anxieties for a minority of the participant volunteers in case they said 'the wrong thing' or found other people's emotions distressing.

For the volunteers in phase 2 the participants identified concerns about the relationships they would need to have with an employer if they were in paid work, this was linked to disclosure, having to commit in terms of their time, managing a fluctuating mental health problem in paid work as well as the dynamics of managing work relationships some of which have already been experienced as a challenge while volunteers

## Appendix xix - Publications

1.

Fegan, C, Cook, S (2014). The therapeutic power of volunteering. *Advances in Psychiatric Treatment*, 20(3), 217-224.

Article focused on the therapeutic benefits of volunteering and provided suggestions how volunteering can be integrated into recovery focused services. As first author C. Fegan had primary responsibility for writing the article, submission and responding to the Editor regarding changes:

### Abstract

There is growing evidence from smaller evaluative studies in the USA and anecdotal papers in the UK that supported volunteering can help recovery and can be a pathway into paid work for people with serious and fluctuating mental health conditions. It allows the person to take risks and test out a working environment. This opportunity can integrate their experience of mental illness into a valued identity and provides opportunities to engage with a world of work. We recommend that mental health professionals consider ways of providing volunteering opportunities as part of a recovery-oriented service within their organisations.

2.

Fegan, C, Cook, S (2012). Experiences of volunteering: A partnership between service users and a mental health service in the UK. *Work: A Journal of Prevention, Assessment and Rehabilitation*, 43(1), 13-21.

Article submitted to a special edition with a focus on mental health and partnerships. As first author C. Fegan had primary responsibility for writing the article, submission and responding to the Editor regarding changes:

### Abstract

The aim of the study was to investigate how people with serious mental illness perceived the experience of volunteering for the health care organisation in which

they had received a service. The study took a qualitative approach and in phase one, eleven service user volunteers were purposefully sampled and interviewed. In depth interviews were analysed using grounded theory. This paper describes the findings from phase one, and highlights the following themes to represent the volunteering experience: 1) rehearsing for a new direction; 2) treading carefully at first; 3) discovering my new self; and, 4) using my experience and extending relationships. These themes further support a tentative theoretical framework that considers supported volunteering to enhance recovery because it fosters positive risk taking and gives individuals a valued identity that integrates their mental health experience. In phase two, this framework will be tested with service users in more diverse volunteer positions. The findings of my study suggest that mental health services are in a unique position to build partnerships with service users to support their recovery and journeys toward employment by providing opportunities for volunteering.