

WORK-RELATED NEEDS AND
EXPERIENCES OF PEOPLE
RECOVERING FROM MENTAL HEALTH
PROBLEMS

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Abstract

This research adopts a critical realist methodology to gain explanatory insight into the job retention challenges faced by employees recovering from mental health problems. Methods involved a literature review of qualitative job retention research, a comparative case study approach, and service user collaboration. Occupational, resilience and mental health recovery perspectives were the major orientating concepts.

One case study comprised seven employed people who were using acute mental health services. The second comparative case study comprised fourteen users of a community-based job retention project for employed people with mental health problems. All twenty-one participants took part in individual interviews following a semi-structured format. The data were analysed within a critical realist paradigm using a combination of inductive and deductive thematic and constant comparative analysis.

Work mattered to people during recovery because of feelings of guilt about not working, and because some feared that work had, or could, exacerbate their mental health problems. Such fears co-existed with a strong sense that work was an important part of people's lives in terms of finance, social capital, occupational capital (a concept newly proposed in this thesis) and personal capital. These assets were under threat, but they also had the potential to be deployed to support recovery.

Participants were on complex and uncertain return-to-work journeys, facing a combination of internal and external obstacles. Barriers arose from the direct impacts of mental health problems, external and internalised stigma, job demands and the workplace environment – particularly relationships with colleagues and, above all, managers. The concept of iatrogenesis here is newly applied to being on sick leave, conceived of as an otherwise necessary therapeutic measure which brings with it additional challenges, risking delay to recovery and return to work. Findings suggest that return-to-work trajectories are likely to be more successful and sustainable when such challenges are addressed.

The implications for practice and policy drawn out in this research are related to keeping in touch with work; mitigating the iatrogenic effects of sick leave; maintaining work orientation and identity; return-to-work planning; and harnessing 'natural', specialist and peer supports. Broader implications were that occupational and resilience perspectives can be integrated to help understand the challenges people with mental health problems encounter when seeking to retain employment. This, in turn, lent support to a social critique which called for work to be organised in a way that is centred on people's needs and well-being, and not just economic efficiency.

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Author's declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

Dated

Part 1: From practice-based disturbance to research design

Chapter 1: Introduction

People who experience mental health problems can find their employment jeopardised. I will argue that this matters because work is a source of material resources, social identity, and can enable the expression of productive creativity that is part of what makes us human. The situation is made more complex because work seems to be an occupation which – through its outcomes and in its performance – can contribute to as well as undermine mental well-being. Thus my thesis is concerned with understanding and learning from the challenges that employed people with mental health problems face when trying to retain their jobs.

This introductory chapter explains how I began this research by integrating personal experiences with broader professional, policy and research contexts. Following this, I outline the structure of the thesis, setting out how I gathered and analysed the experiences of employees with mental health problems who were using either acute mental health services or a community-based mental health job-retention project.

My interest in this topic was triggered by an issue which arose while employed as an occupational therapist in an acute mental health unit for adults – what Eraut (1994) has termed a practice based disturbance. Occupational therapy has had a historical, theoretical and practice-based concern with work, often classifying it within the major occupational category of productivity (others being self-maintenance and leisure) (Reed and Sanderson 1999, Christiansen and Townsend 2004, Wilcock 2006, Kielhofner 2008). Yet I was concerned that the needs of service users who had jobs immediately prior to their admission were being inadequately addressed; this was exemplified by the story of one of my clients (pseudonym - Clive). He was working in a busy office in a job with a range of varied administrative tasks before his first admission. He had attempted suicide, and had been diagnosed with severe depression alongside anxiety-related features. Clive was discharged and, after a few weeks, a return-to-work plan was set in motion by his employer – apparently eager to make this successful. They arranged for him to return to a quieter office, doing less challenging and more routine tasks. Clive agreed; he pushed some fleeting doubts to one side, assuming that his employers probably knew best and feeling relieved they were actively trying to help. Neither his General Practitioner (GP) nor anyone from the specialist mental health services were involved in designing the plan.

After a few weeks Clive attempted suicide again and was readmitted to the acute unit where I worked and first met him. He reported that he found being in the quieter office did not help: he felt more isolated, particularly when alone. Nor did he find being given only routine work helpful: he missed the challenge of more complex tasks. The

combination of isolation and lack of absorbing challenge created a space and context for bleak thoughts and moods to grow. I believed that mental health services could have made more of a contribution to addressing his work-related needs.

Some years earlier, Mind had issued its call for acute mental health units to become ‘stepping stones to recovery’ (Mind 1999). ‘Recovery’ was a deliberate reference to the emergence of a recovery paradigm (‘approach’, ‘perspective’ or ‘model’) (Repper and Perkins 2003). This had emerged from the USA influenced by personal narratives of recovery from mental health problems (Anthony 1993, Deegan 2001, Ridgway 2001). It suggests that the degree of recovery should be judged by the quality of life lived (Gray 2006) even where symptoms persist. The importance of hope was stressed (Jacobson and Greenley 2001) and mental health services were criticised for lowering service users’ aspirations (Cohen 2005). Work was seen as one source of hope and fulfilment (Provencher et al 2002, Secker et al 2002, Morisey 2003, Woodside et al 2006, Munro and Edward 2008) – although, as we shall see in Chapter 2, this does not invalidate evidence for the potential toxicity of work with respect to mental well-being (Bonde 2008, Hausser et al 2010, Griffin and Clarke 2011, Stansfeld et al 2011).

Recovery conceptualisations were said by Drake (1998) to have had a major influence on revisions of traditional approaches to addressing the work-related needs of people with severe and enduring mental health problems. Services sought inspiration from ideas of recovery to meet service users’ aspirations and promote recovery through mainstream work. Huffine and Clausen (1979) challenged assumptions about the potential of people with severe and enduring mental health problems to work. They found much higher than expected numbers of former seriously ill patients were working, despite receiving very limited support. Lack of support from mental health services may have actually been a protective factor, given that some mental health professions have limited judgements of service users’ vocational potential (Thomas and Secker 2005b). Such recovery-based perspectives are substantiated by research that diagnosis is an inadequate indicator of a person’s ability to work – employment history and motivation are better indicators (Huffine and Clausen 1979, Waghorn and Chant 2002, Asmundsdottir 2004, Grove and Membrey 2005, Marwaha et al 2009), but of course these in turn may be influenced by many other factors.

Supported employment approaches were developed to help unemployed people with severe mental health problems to find mainstream work, but an acknowledgement of an on-going risk of job loss (Butterworth 2001, Dorio and Marine 2004) led to an emphasis on

the need for continuing support once in work (Becker et al 2008, Evans and Bond 2008, Sainsbury Centre for Mental Health 2009a). Such support has relevance for employed people, like Clive, who already have jobs, but are at risk of losing them for reasons related to their mental health problems.

Evidence suggests that exclusion from work is not desired by 70%-90% of people with mental health problems (if adequately supported and given benefit protection) (Grove 1999, Sainsbury Centre for Mental Health 2009a). Mental health policy developments may have influenced the UK National Health Service (NHS) to consider the work-related needs of all of its working-age users (Black 2008, Darzi 2008). The policy is certainly consistent with an international shifting understanding of health to encapsulate well-being and participation, moving away from narrow definitions based on the absence of disease (World Health Organisation 2001).

Occupational therapists have often needed to explain that their eponymous use of ‘occupation’ does not *just* mean work. Yet prominent commentators in the field have responded to renewed vocational research and policy attention by pointing out, not least to their own colleagues, that work *is* an occupation and that occupational therapists have a theoretical and knowledge base, as well as a skill set, that could assist people with work-related issues (Barnes et al 2007, Holmes 2007b, Ross 2008, Arbesman and Logsdon 2011). More concretely, the profession in the UK has participated in a range of initiatives to support vocational practice development, often in collaboration with other stakeholders (College of Occupational Therapists and National Social Inclusion Programme 2007, College of Occupational Therapists 2008, Sainsbury Centre for Mental Health and College of Occupational Therapists 2008, McFeely 2012). Such engagement has increased the potential for confusion about the term ‘occupation’. To prevent this in my thesis, I use the terms ‘occupation’ or ‘occupational’ in a manner consistent with the broader meanings associated with the profession of occupational therapy and the discipline of occupational science (Clark et al 1991, Zemke and Clark 1996, Wilcock 2006), referring to the full range of consciously performed human activity. Within this I include work, but I have consistently avoided using the usage of ‘occupation’ and ‘occupational’ as narrower synonyms for work and relating to work.

I was aware of these emerging practice and policy developments and some of the underpinning research and theory, as well as being an active contributor to vocational developments in my organisation, when I met Clive. I used one professional tool – the Work Environment Impact Scale (Moore-Corner et al 1998) – to structure our discussion

and identify the challenges and supports which he perceived in his workplace. The encounter crystallised my decision to select the issue of job retention as a research topic. Since then it has become all the more pertinent, in part because of debates about benefit entitlement and the participation of people with disabilities in work (Department for Work and Pensions 2011d, Campbell et al 2012), and secondly because the current economic climate is such that retaining employment may be all the more important given the reduced availability of jobs and high unemployment.

The research sought to understand and explain employees with mental health problems' experiences of and perspectives on the challenges of job retention, including of the support they received or would have liked to have received. From this, the study identified a range of implications to inform the development of specific interventions and supports to assist people who find that their work is jeopardised for reasons related to their mental health. Finally, I propose a synthesis of occupational perspectives and conceptualisations of resilience can make a significant contribution to these aims as well as to developing a critical consideration of how work can have potent positive and negative impacts on people's mental health.

Thesis structure

The thesis chapters are presented in three parts:

Part 1 sets out the context of the research, and its development from the practice-based disturbance to the focused research methods presented in Chapter 6. The literature review (Chapters 2, 3 and 4) was developed from a meta-study of qualitative research into job retention experiences of workers with mental health problems, which I carried out using Paterson et al's (2001) approach. As well as setting out that approach, Chapter 2 introduces the concept of work and explains why I have chosen to focus on paid employment. It then presents the themes from the literature relating to interactions between work and well-being. Chapter 3 focuses more specifically on literature related to what helps people with mental health problems retain work. I complete the review in Chapter 4 by discussing key conceptual frameworks identified as particularly relevant, namely: a biopsychosocial framework, a recovery paradigm, occupational perspectives, and resilience. That chapter concludes with the research questions.

In Chapter 5 I introduce and justify my selection of critical realism as the research methodology. I explain how it relates to some of the themes and questions raised by my literature review. Finally, in considering its suitability for my topic, I consider the role of

theory in the research process, in particular the critical realist rationale for my use of first-person experiences and for the study's comparative and collaborative design. The methods chapter (Chapter 6) describes the main case study context of acute mental health services, and the comparative community-based job-retention project. It includes discussion of the primary ethical challenges I encountered, recruitment, service user collaboration, data collection, data analysis, rigour and dissemination.

Part 2 contains the findings from the acute mental health service case study and the comparative community-based job-retention project. Chapter 7 provides contextual insight into how people viewed their work and its interactions with their health. Chapters 8 and 9 focus on participants' experiences and the challenges faced during their acute recovery and while on sick leave, including the role played by other people (from work, health services and their home life). Mechanisms found to either support or restrict participants' vocational recovery are considered in Chapter 10, which provides an analysis of the evolving return-to-work trajectories. These trajectories form the main focus of the comparative case study – the Retain community-based job-retention project – presented in Chapter 11. The emphasis is on the interventions provided to support job retention – enabling a qualified comparison of the two case studies that considers the difference that a strategy involving co-ordination and collaboration may make to the return-to-work trajectories of people with mental health problems.

Part 3 comprises the discussion, implications and concluding chapters. In Chapter 12 I discuss why work seemed so important to people during their recovery – even from acute mental health problems. I set out the range of personal, occupational and environmental assets which were both threatened and deployed as people attempted to retain their employment. These include established concepts of finance, social capital, and personal capital, as well as my newly proposed formulation of occupational capital. Being on sick leave added to the challenges people faced when trying to navigate their way back to work. I propose that the concept of 'iatrogenesis' highlights that these effects do not dispute the need for sick leave – but do suggest that its adverse effects need to be mitigated during recovery. Issues of rigour, quality and limitations then highlight the contribution to knowledge which this thesis has made.

The main implications for addressing the various challenges and harnessing strengths to promote a sustainable vocational recovery are presented in Chapter 13. These implications aim to be relevant to employees recovering from mental health problems and those supporting them, either directly through provision of some form of support or indirectly through shaping policy. Potential avenues for further research suggested by these implications are also presented in this chapter.

The final chapter (Chapter 14) presents three broader implications – related to the value of resilience and occupational perspectives and the humanisation of work – which contribute to concluding some of the key issues raised by my thesis. It then closes with a summary of the thesis as a whole.

Chapter 2: Literature review introduction: work and health interactions

Introduction

In this first of three literature review chapters I introduce the concept of ‘work’, delineating its scope as used in my thesis with reference to wider literature. I explain the strategy used to produce the literature review. The rest of the chapter presents the first three of four overarching themes that emerged from this review, namely: the potential toxicity of work; the impact of mental health problems on working lives; and how work can support recovery.

That work permeates both our experience and understanding of everyday life is acknowledged in the fields of anthropology, philosophy, sociology and history. The anthropological understanding of human evolution, while suspicious of tendencies to apply modern constructs to early and pre-historical periods, views tool use as a defining human characteristic which was both an active agent in human evolution as well as one of its products, alongside social intelligence and language (Leakey 1995). There is a broad consensus in the occupational, social psychological, and sociological literature that in developed Western societies work roles are central to a person’s definition of their identity (Terkel 1977, Jahoda 1982, Bradley et al 2000, Weber 2003 [1930], Christiansen 2004, Grint 2005) – although some writers have resented this influence of work, and critiqued it accordingly (Russell 1935, Illich 1978, Negri 2009, Lafargue 2011 [1883]). Christiansen and Townsend (2004) maintain that work has been an ever-present topic within the history of Western thought, citing Greek, Roman, Hebrew, Medieval and Renaissance philosophers to this end.

It appears this concern with work increased from the 19th century onwards. Within Marxist theory, work is seen as central in creating wealth and structuring society (Marx 1968 [1898]), but also as integral to human nature. This is most clearly revealed in Engels’s (1968 [1895]) consideration of the process of human evolution, in which he proposed that “labour created man himself” (p354). Arendt (1958) agreed with the centrality of occupation to humanity, but distinguished between *labour* as a process of physical or mental exertion, and *work* which involved purpose and the creation of artefacts. For Freud (2004 [1930]), while work was not used as part of his therapeutic method, it was acknowledged as an important outcome of therapy and recognised as a core feature of society. Weber (1948) drew attention to the centrality of work to the economy, social relations and status, while, according to Foucault (2001 [1961]), changes in the social

context of labour impacted on how societies have both defined and been able to accommodate ‘madness’. As we progress into the 21st century there are both hopes and concerns about the environmental, cultural and social impacts of the globalized world of work (Potter 2000, European Union 2003).

In sociological and occupational therapy literature, work tends to be defined in broader terms than paid employment – that characterises my focus in this thesis. For example, Watson (2003) defines work as “The carrying out of tasks which enable people to make a living within the social and economic context in which they are located” (p1). Similarly, Creek (2008) states: “Work is any productive activity, whether paid or unpaid, that contributes to the maintenance or advancement of society as well as to the individual’s own survival or development” (p40). Such definitions can include domestic work, caring for children or older relatives, and voluntary work. As Bambra (2011) and Bailey and Livingstone (2011) have pointed out, the status afforded to paid work can lead to a neglect of the value of other forms of work to individuals and wider society. My focus was on paid employment because of a pragmatic concern with what appears to be a related set of needs belonging to employees who experience mental health problems. As Jahoda (1982) argued, to consider other definitions of work alongside contractual employment would be mistaken, even within the context of her much larger scale research, because they encompass “activities under vastly differing conditions eliciting vastly differing satisfactions and frustrations” (p10).

Paid employment shares some important characteristics with other forms of work. Through working, people act upon their environment and shape the world around them. Such ‘shaping’ can be expressed in physical terms, such as through work in the construction, extractive or production industries; but work also shapes social networks and structures – for instance, through communication technology, or through the power relationships which influence people’s experiences of class, gender and other identities, as well as the concomitant inequalities. Simultaneously, work enables people to deploy, and potentially build, physical, intellectual, emotional and social skills. People often develop a wide range of relationships through work, which alongside the *doing* or *occupational* dimension of work may contribute to well-being and fulfilment (Jahoda 1982, Sias and Cahill 1998, Christiansen and Townsend 2004, Pettinger 2005). Possibly this is because of the centrality of productive activity to human existence. However, herein may also lie a reason for the negative impacts of work – if this critical occupation fails to meet expectations, it may thereby place excessive demands on people. Both of these seemingly

paradoxical themes will be considered later in this chapter, along with the influences of mental health problems on working lives; first, however, I set out the approach I used to construct this literature review.

Literature review strategy

There is a very wide range of literature that has some degree of relevance to the topic of work and mental health. There is much less that is specifically focused on the topic of the job retention experiences of people with mental health problems. Thus, a challenge was to develop a transparent and rigorous strategy to navigate and analyse this material, as well as to make use of the diverse body of wider literature and the narrower subset of studies with most direct relevance. Particularly pertinent to my research is the claim that more traditional narrative forms of literature are vulnerable to authors simply selecting what is most immediately available or known to them, or what they most agree with (Aveyard 2007). A more systematic approach to the literature review was needed. I experimented with a method based on Paterson et al's (2001) meta-study approach, first developed in relation to research on patients' experiences of chronic disease. Drawing on social science approaches to research synthesis, this aims to analyse the findings, methodologies, methods and theory of an identified body of qualitative research. Paterson et al (2001) were concerned that alternative forms of qualitative synthesis did not sufficiently consider methodological, theoretical and social-contextual influences on research findings. Their meta-study approach also allows for synthesis of different research methodologies.

The approach usually requires a team of researchers, but I considered it suitable because I wanted to synthesise findings from studies which used varying methodologies; and because the approach emphasised the identification and analysis of the relevant theory underpinning the research. Paterson et al (2001) described the meta-study approach as appropriate for an overarching constructivist paradigm. The rationale of synthesising different methodologies is also justifiable from the perspective of my critical realist approach (see Chapter 5). This holds that the different research approaches are investigating the same external reality – even if this is disclaimed by some of the authors' methodologies.

The research question guiding the meta-study was: What are the experiences and perspectives of employees with mental health problems regarding their work-related needs and support? The meta-study approach requires researchers to make explicit the broad

theoretical framework that informs their approach to the literature, both as a measure of trustworthiness, and in order to subsequently judge its utility. My framework was a person–occupation–environment perspective that can be seen as underpinning much occupational therapy and science theory (Law 1996, Reed and Sanderson 1999, Christiansen and Townsend 2004, Wilcock 2006, Kielhofner 2008).

The meta-study approach does not specify search, selection and appraisal criteria and tools, but calls for these to be systematic and transparent. Search terms and relevant synonyms were constructed and applied to a range of online databases (see Appendix A for further details of the search strategy and a table of selected papers). After an initial screening of abstracts, the first section of the Critical Appraisal Skills Programme (CASP) (2006) appraisal tool for qualitative research was used, alongside inclusion and exclusion criteria derived from the research question. This resulted in the selection of a set of fifteen papers dating from 1996 to 2009. The selected papers were individually appraised using a combination of the complete CASP (2006) and Greenhalgh and Taylor’s (1997) appraisal tools. To code individual papers and appraisals to identify emergent themes I followed the first two stages of Danermark et al’s (2002) stages of explanatory research (see Chapters 5 and 6), which are consistent with Paterson et al’s broadly inductive approach. I did this as an individual researcher, though I did make use of research supervision discussions to scrutinise and develop my findings.

The overarching themes that emerged from this analysis of the selected papers were: work can be toxic; mental health problems can disrupt working lives; work can support recovery; and supports for job retention (the first three being presented in this chapter, the fourth in the next). In order to provide a broader contextualisation and orientation to my thesis I then adapted Paterson et al’s approach by using these themes from the meta-study to guide the selection and appraisal of wider theory, research and policy literature. This literature (including quantitative and mixed methodology research) is integrated with the original qualitative fifteen papers in my discussion of the overarching themes. The use of a meta-study approach to identify, analyse and evaluate the theory that is relevant to the body of literature in question has particularly helped produce the final literature review chapter which includes an appraisal of key paradigms and theoretical frameworks which emerged from the review.

Work can be toxic

There are two predominant categories of explanations for how work can in some circumstances undermine well-being. The first is more political and emphasises alienation as a key mechanism. Work is experienced as disconnected from an expression of human creativity, undermining or diminishing a person's identity. Such perspectives can be found in political theory (Arendt 1958, Marx 1977 [1932]), journalistic writings (Terkel 1977, Toynbee 2003), social psychology (Jahoda 1982) and public health theory (Wilcock 2006, Bambra 2011).

The second focuses on an imbalance between job demands and individuals' capacities, exacerbated by low levels of control over work processes. Notably, Karasek's (1979) influential job-demand-control model proposes that the excessive demands of work tasks are one of the main sources of dissatisfaction and strain at work, particularly when associated with low levels of job control. Notwithstanding some caution about establishing causal links, a comprehensive meta-analysis of international studies (Hausser et al 2010) and a systematic review of epidemiological evidence for psychosocial risk factors at work and depression (Bonde 2008) have provided moderately strong support for the view that excessive job demands combined with low scope for decisions have a negative impact on psychological well-being. An international cohort study of over 10,000 people attending general medical practices (Bottomley et al 2010) identified distress at work in the absence of personal respect, and difficulties at work in the absence of adequate support, as significant risk factors affecting both the onset of depression and delay in recovery – though the authors make it clear that their methodology did not identify causes. Excessive job demands have also been established as associated with taking sick leave (Borritz et al 2006, D'Souza et al 2006). Further support is provided by the seminal Whitehall research projects into the health of large cohorts of British civil servants, although the emphasis here has tended to be on links between stress and cardio-vascular disease (Brunner et al 1991, Bosma et al 1997, Steptoe et al 2003, Chandola et al 2006).

The two sets of explanations may not be mutually exclusive. It is possible to see the job-demand-control explanations as providing more insight into the mechanism by which alienation is created. Both emphasize the importance of control, with low levels of control undermining well-being. The issue of reduced meaning of work is not as explicitly apparent in the job-demand-control explanations as it is in alienation. However, reduced meaning is a plausible outcome of an imbalance between the demands of the job with individual capacity and a lack of control.

Both sets of explanations are supported in some measure by qualitative research into the experiences of people with mental health problems attempting to retain work, and some studies, moreover, point towards the potential validity of combining the two explanatory mechanisms. People with mental health problems who have participated in research have considered work a source of significant stress (Kirsh 1996, Strickler et al 2009) which could exacerbate their mental health problems (Honey 2003, Auerbach and Richardson 2005). In their interpretive interview-based study into the role of work in the recovery of employed and unemployed people with mental health problems, Provencher et al (2002) suggested that similar views may have reflected participants' current degree of recovery. Participants' experiences suggested that the demands of the job can be excessive in physical, emotional or mental terms, but also that insufficient demands can leave people feeling bored and dissatisfied (Provencher et al 2002, Auerbach and Richardson 2005, Strickler et al 2009). Krupa's (2004) research was informed by a concern the unskilled jobs with low levels of responsibility offered by vocational programs could often be the most stressful type of work, and hence harder to sustain for people with mental health problems. Killeen and O'Day (2004) concluded that such work could be appropriate for people at an early stage of recovery, but that in the longer term it risked becoming limiting, and could erode attachment to work. Such conclusions indicate that low satisfaction and stress can arise from either insufficient or excessive job demands, and thus produce feelings of alienation and undermine well-being.

Some studies (Provencher et al 2002, Auerbach and Richardson 2005) draw a distinction between the extent to which lack of fulfilment at work arises from intrinsic or extrinsic factors. Wider research and theory has suggested that both the subjective perceptions of occupations (Eklund and Leufstadius 2007) and objective characteristics of work (Roelen et al 2008, Batinic et al 2010) have a role to play in job satisfaction and may be usefully considered in terms of a person–occupation fit (Law 1996).

A further factor that may arise from imbalances between job demands and tensions related to control is interpersonal conflict. A broad range of research reveals this to be a common and often damaging part of the landscape of work (Sias et al 2004, Chartered Institute of Personnel and Development and Simply Health 2011, Eriksson et al 2011, Lim and Lee 2011). Krupa (2004) draws attention to how such conflict could have particularly problematic interactive effects for people with even mild features of psychosis. Millward et al (2005) make a similar point with respect to workplace bullying and its negative effect

upon people who had diagnoses of depression. This may be a further mechanism by which alienation may arise from factors related to job demands and control.

Mental health problems can disrupt working lives

As well as work potentially undermining well-being and possibly causing, triggering or exacerbating mental health problems, mental health problems can also disrupt people's working lives irrespective of their origin. An estimated 1 in 6 workers in the UK experience mental health conditions at any point in time, taking 70 million days off sick per year, costing employers £8.5 billion and with an estimated total annual cost to the UK economy of £26 billion (Sainsbury Centre for Mental Health 2007) Yet the impact on individual workers and their prospects for retaining employment is in my view best understood from research into first-person experiences. Such studies suggest that there are direct impacts which arise from symptoms, symptom management and feeling overwhelmed by mental illness, and indirect impacts which result from receiving a diagnosis, erosion of worker identity, reduced confidence and self-esteem, stigma and precarious employment.

Direct impacts of mental health problems

There appears to be a broad consensus that the symptoms of mental health problems have a wide range of effects on working lives with potentially negative consequences for job retention. A large-scale qualitative study by Michalak et al (2007) found that major, variable and complex challenges arose at work from symptoms experienced by people with bipolar disorder. Smaller-scale studies provide more detailed insight into some of these for people with a range of mental health conditions.

Some research has stressed the general destructive effects of so-called positive symptoms (such as visual and auditory hallucinations, delusions and dissociative states) of psychosis on working lives (Krupa 2004, Strickler et al 2009). Gioia (2006) reported that such symptoms had profound impacts, yet concluded that her findings were consistent with other research in suggesting it was negative symptoms (such as anhedonia, flatness of affect and avolition) which most contribute to people being unable to work. Other studies identified both low and elevated moods (Honey 2003, Millward et al 2005, Strickler et al 2009) as having problematic consequences for sustaining work.

Provencher et al's (2002) and Honey's (2003) participants experienced physical symptoms, alongside psychological ones, which disrupted their work. Problems were reported with aspects of work requiring cognitive skills, such as concentration, decision

making and memory (Provencher et al 2002, Honey 2003, van Niekerk 2009). Symptoms also affected people's ability to relate to colleagues (Honey 2003, Krupa 2004 & Gioia 2006). The reports of negative impacts on job retention of a broad array of symptoms are consistent with research using quantitative methodologies – including longitudinal studies (Adler et al 2006, Russinova et al 2007), regression analysis of national survey data (Kessler et al 2006) and systematic reviews (Blank et al 2008, Lerner and Henke 2008).

Honey (2003) explored a range of Australian mental health service users' perspectives on the impact of mental illness on their experiences of work. While not using the term 'symptom', she considered that a lack of confidence could arise internally as a limitation associated with having a mental health problem, and not just as a factor internalised from external responses and attitudes. Similarly, although with less explication, Provencher et al (2002) identified lack of confidence as an internal barrier to work. Experiences of anxiety, stress and fear were also presented in a manner suggesting these could be at least partially understood as arising internally from a mental health condition (Provencher et al 2002, Honey 2003, Strickler et al 2009, van Niekerk 2009).

It was not just the type of symptoms, but also their variability of severity over time, which complicated workers' experiences. This engendered uncertainty (Honey 2003) and undermined their self-identity as workers (van Niekerk 2009). For some workers on sick leave with depression, fluctuating symptom severity was a justification for why they could not make future plans about work (Millward et al 2005). Krupa (2004) found that protracted recuperation, as workers waited for more severe symptoms to subside, delayed the return to work for people with a diagnosis of schizophrenia. Killeen and O'Day (2004) considered the tendency of participants to experience recovery over a considerable time to be problematic, due to the risk of a relapse occurring once they had disengaged from employment support services. Such relapses were disruptive, destabilising, and threatened job loss (Van Niekerk 2009).

Some findings suggested that it is important to acknowledge the negative impacts of symptoms even where quality of work performance was unaffected. Stress and anxiety could undermine job satisfaction (Honey 2003) and sense of worker identity, increasing fears of job loss (Strickler et al 2009, van Niekerk 2009).

Challenges of managing symptoms, by medication and other means, were revealed in some studies to be an issue distinct from a consideration of the symptoms themselves. Strickler et al (2009) examined first-person accounts of the working lives of 120 people with substance misuse and mental health problems over an extended sixteen-year period in

New Hampshire, USA. The authors found that for participants who worked least regularly, the demands of managing illness were perceived to be a barrier to sustaining work as well as a source of stress. The worker in Hatchard's (2008) return-to-work case study experienced mood management and other ongoing challenges. Honey (2003) found illness management required "increased effort and personal sacrifice" (p271) which could undermine the quality of work experience even when performance was unaffected. Provencher et al (2002) detailed how workers who experienced most difficulty returning to work found particular challenges managing symptoms – however, their study leaves unclear the extent to which this was due to severity of symptoms, use of less successful management strategies, or other factors.

Medication played a role in the management of symptoms for some study participants, where it is seen to have a range of positive and negative impacts. People experienced side-effects of nausea, fatigue, slowed movement and thinking, and concentration problems. These disrupted work performance and interactions with colleagues in a manner that was similar to (and in some cases indistinguishable from) symptoms (Honey 2003, Auerbach and Richardson 2005, Gioia 2006). Kirsh (1996) found a variety of attitudes to and experiences of medication, ranging between negative, ambivalent, and positive. Strickler et al (2009) reported that difficulties with medication were greatest amongst those who worked the least; though it was unclear what factors influenced these difficulties.

Studies have highlighted the challenges of feeling overwhelmed by mental health problems – though there are varying interpretations as to the genesis of this. Krupa's (2004) research in Canada used an explanatory multiple case study design which developed theories regarding the processes involved in the restoration of work participation for people diagnosed with schizophrenia; she found that a key challenge facing participants was to overcome feeling overwhelmed by their illness. Similarly, Provencher et al (2002) identified that participants with least vocational success also felt overwhelmed by their symptoms. It was, however, unclear whether this was because they experienced more severe symptoms, or because of the way in which they interpreted and responded to their symptoms. Millward et al (2005) argued that the degree to which people felt overwhelmed was related to their ability to disassociate themselves from symptoms, rather than to symptom severity per se. In support of this claim, they stated that scores on the Beck Depression Inventory did not differ between the group which was able to disassociate itself from symptoms and the group which could not. It was not clear what,

if any, statistical claims for generalisation were being made regarding the interpretation of the scores of these two groups, which were drawn from nineteen participants.

Despite the uncertainties related to the origins of the feeling of being overwhelmed in these studies, all agreed that it significantly inhibited the resumption of working lives. These findings, alongside those about the impact of symptoms, suggest that there can be times when people are so overwhelmed by their symptoms and the challenges of managing them that work is not possible.

Indirect impacts of mental health problems

General mental health research has reported that receiving a diagnosis of a mental illness has contradictory consequences on everyday life (Hayne 2003, Pitt et al 2009, Rose and Thornicroft 2010). This is also born out in work-related research. On the one hand, negative consequences arose either because of associations made by others (Honey 2003) or by the workers themselves (Millward et al 2005). On the other hand, a reinterpretation of symptoms led to a new diagnosis for the worker in Hatchard's (2008) single case study research into the return-to-work experiences of a woman with bipolar disorder. This was experienced as an important first step in helping her to see her problems as related to illness rather than as personal weakness, which led in turn to more effective medical and non-medical management strategies. The period immediately after receiving a new diagnosis of schizophrenia was a particular focus of Gioia's (2006) study. Whilst the post-diagnosis period was described by the author as an opportunity to nurture hope and plan for the future, some of the factors presented as causing work delay could be interpreted as partial consequences of receiving a diagnosis (notably: reduced sense of self-efficacy, family and professional attitudes, stigma and discrimination).

Lack of agreement between studies as to whether receiving a diagnosis had a positive or negative impact may be explained by whether it was used to inform and legitimise return-to-work plans (as in Hatchard 2008), or to validate an unhelpful illness identity (as in Millward et al 2005). In the study by Millward et al (2005), an emphasis on exploring the impact on identity of being on sick leave may have meant that the potential utility of receiving a diagnosis was not considered. In Gioia's (2006) study, the possible negative impacts of receiving a diagnosis may be explained by the time taken to arrive at giving a diagnosis of schizophrenia in the first place, and the individual (and those around them) internalising the stigma associated with schizophrenia.

The impact of labelling on identities has been considered in a broader sense than diagnosis alone. A number of studies have reported how individuals adopted identities centred on their status as someone with a mental health problem, with negative consequences for job retention and other work-related outcomes. This was a central finding of Millward et al's (2005) UK study which conducted a qualitative investigation of attitudes to work among people diagnosed with uni-polar clinical depression and notably "the role played by illness in attitudes to recovery" (p565). The study described many participants as having taken on a sick role, with some declaring attachments to an 'off' work identity and the time this afforded them. The authors concluded that where the sick role was accepted as part of a person's core identity, recovery was severely restricted. Millward et al (2003) related this to 'sick role' theory, whereby the status of being a mental health patient may add to a sense of powerlessness due to powerful social sick role discourses and in some cases paternalistic services.

Other studies in different contexts (geographic and diagnostic) had similar findings. Provencher et al (2002) described their participants as having been "engulfed", not just by symptoms, but by the "role of being a psychiatric patient" (p142). Gioia (2006) found that a change of role identity from young adult to patient could contribute to delay in commencing or resuming work. Killeen and O'Day (2004) discerned "patienthood" (p160) as being a potentially negative identity which the more vocationally successful participants were able to resist. Similarly, Cunningham et al (2000) found that their participants reported more success in securing and retaining work when an illness identity was not all-encompassing.

Low levels of confidence and diminished self-esteem have been identified as factors arising from and contributing to the work-related challenges which workers with mental health problems face. Addressing low confidence was highlighted as a key need in Johnson et al's (2009) large interview-based research into UK Individual Placement and Support (IPS) service users' perspectives on effective support. Likewise, in a quantitative study conducted in Sweden using survey data from over 2,000 people on sick leave, diminished self-esteem was identified as part of a process contributing to 'burnout'.

Honey (2003) reported that lack of self-confidence in ability to work was common amongst her participants. She considered this a more accurate term for describing the barrier to working which other researchers interpreted as evidence of lack of work identity. Provencher et al (2002) did not consider confidence to be an alternative explanatory concept to work identity, but their participants also described lack of confidence, self-

efficacy doubts, fear of failure and low self-esteem as internal barriers to work. In Millward et al (2005), reduced confidence, feelings of vulnerability and a sense of being different from others persisted even when participants considered they were recovering. Low self-esteem and confidence fuelled feelings of self-blame and guilt (Provencher et al 2002, Hatchard 2008) and could give rise to a sense of otherness, increasing isolation from people inside and outside of work (Auerbach and Richardson 2005, van Niekerk 2009). Krupa (2004), although – as we shall see – generally supportive of the role of work in recovery, cautioned that there was a risk that work may instil a degree of over-confidence and “lull the individual into a false, but hopeful sense that all is well” (p13).

Stigma has been described as involving ignorance, prejudice and discrimination (Thornicroft et al 2007). There is strong evidence of limited knowledge regarding mental health amongst UK employers (Trajectory 2010). Prejudice may exert its influence both through media and in the immediate environment of the workplace (Jansson and Bjorklund 2007). Discriminatory behaviour may account for the low employment rates of people with severe mental health problems (Marwaha and Johnson 2004). It is thus not surprising that stigma was found to be the most commonly cited perceived barrier to work in a systematic review of mental health service user’s perspectives of work (Blank et al 2011).

Stigmatising attitudes and related discriminatory behaviour from employers and colleagues have been stressed by research participants as barriers to retaining work (Provencher et al 2002, Honey 2003, Gioia 2006, van Niekerk 2009). Krupa (2004) also drew attention to negative consequences of people internalising stigma as a result of their experiences at work. Honey (2003) considered that fear of stigma had an external origin, resulting from adopting stereotypes from social networks. Such internalised stigma and fear of stigma appears to equate to the concept of ‘self-stigma’ which has been increasingly considered in a range of studies (Brohan et al 2010, Corrigan et al 2010, Yanos et al 2010a, Michalak et al 2011). Thus self-stigma and fears of stigma and discrimination undermined participants’ confidence, particularly in relation to whether they would be accepted by co-workers (Provencher et al 2002, Hatchard 2008, van Niekerk 2009).

One consequence of discrimination may be the less favourable conditions of employment of workers with mental health problems. The World Health Organisation’s World Mental Health Surveys (Levinson et al 2010) have found that people with severe mental ill-health earn on average one third less than the median income across 10 high and 9 low-to-middle income countries, with no significant differences in this ratio between countries. Auerbach and Richardson (2005) found that such comparably low pay was a

factor which led to some of their participants leaving work (Auerbach and Richardson 2005). Honey (2003) found that having mental health problems meant that people had less choice in types of work and career than their colleagues. Krupa (2004), concurring, suggested that this comparatively limited career development reinforced a sense of separation from others, undermining the quality of work experiences and reducing attachment to work.

Standing (2011) has suggested that people with mental health problems are particularly at risk of becoming part of what he has dubbed ‘the precariat’ – people in society moving between unemployment and unfulfilling, low-paid, stressful and insecure jobs.

Participants in a number of studies considered the future of their work to be associated with uncertainty (Provencher et al 2002, Gewurtz and Kirsh 2007, Strickler et al 2009), giving it a more negative and disempowering meaning. Certainly, survey research has demonstrated the very real risk of job loss for people with mental health problems in the United States (Salkever et al 2003) and the UK (Solomon et al 2007). A systematic review of international literature (Blank et al 2008) reported that only 50% of people with mental health problems, on sick leave for longer than 6 months, ever returned to work. In the UK just 14.2% of people with mental health problems were in employment, compared with 76.2% of the overall population – and even for the less severe problem of depression and anxiety the proportion employed was just 27.2% (Office for National Statistics 2011). In their international epidemiological review, Sanderson and Andrews (2006) found evidence for poor mental health being associated with less secure employment – though the direction of causation is unclear. The negative general health links with precarious employment have also been demonstrated by Laszlo et al (2010), who analysed data for 23,245 workers from three cross-sectional studies across sixteen European countries. They found job insecurity to be significantly associated with ill health in nine of the sixteen countries, with only the findings from Sweden and Belgium showing no effect.

The impact of financial strain on the psychological well-being of unemployed people has been well documented and debated (Jahoda 1982, Fryer 1986, Warr 1987, Creed and Klisch 2005, Waddell and Burton 2006, Andersen 2009, Paul and Moser 2009). Mental health policy and research has similarly focused on the negative impact of poverty and debt on the psychological well-being and exclusion of people with mental health problems (Fryer 1998, Social Exclusion Unit 2004, Mind 2008, Sainsbury et al 2008, Royal College of Psychiatrists et al 2009). Even before the current recession, Fitch et al (2007) drew attention to the vulnerability to debt faced by people with mental health problems.

However, the impact of financial strain upon employed people with mental health problems who are working or on sick leave has not received the same level of attention, either in research or in policy.

The direct and indirect consequences of having a mental health problem thus have the potential to severely disrupt people's working lives and increase the challenge of retaining employment. The research presented in this chapter further suggests that there are times when some people are so overwhelmed by these consequences that they are not able to work. This is an important qualification to the often-cited general conclusion of Waddell and Burton's (2006) impressively comprehensive systematic review, namely that work is better for a person's health and well-being than not working. Yet the research reviewed which suggests this qualification also implies that this state of being unable to work need not be a permanent state of affairs. Indeed, it goes further and presents evidence, in line with Waddell and Burton's (2006) review, suggesting that working need not only be an outcome of recovery (for an example of this see Cougnard et al 2009), but can actually contribute to recovery itself. The literature relating to this will now be considered.

Work can support mental health recovery

In the wider literature the case for work being able to promote recovery from mental health problems is strong (Grove and Membrey 2005, Waddell and Burton 2006, Bond et al 2008, Shepherd et al 2008, Perkins et al 2009), though is not uncontested (Connell et al 2011, Essen 2012). Drake (2008) – an influential figure in the development of supported employment – has described work as the most effective of all therapeutic interventions (including medication) for people with severe mental health problems. Qualitative research and related literature suggests a number of plausible explanations for this, namely that work can be a powerful distraction from illness; provides flow experiences; demands illness management; supports connections with others; and brings meaning and purpose, increasing self-esteem and hope, and reinforcing a positive sense of identity.

Dunn et al (2008) proposed that one of the mechanisms by which work promoted mental health was by the occupation providing a “distraction” (p61) from symptoms. I consider that this formulation could plausibly be reversed, such that occupation is seen as resistant to the distraction of symptoms – thus promoting wellbeing. Either interpretation could be applied to the illustrative quote provided by Dunn et al (2008): “You know what helps me ... when I'm working? ... I don't think about my illness. I think ... [about] just gettin' my job done and going home” (p61).

Wright et al (2007) did identify ‘positive distraction’ as one of four types of flow experiences experienced by some of their participants. Yet, unlike Dunn et al (2008), this was used to describe optimal experiences gained from participation in occupations which placed limited or no skill demands on people, lacked clear goals and had limited meaning. Pleasure was experienced, but there were little or no enduring effects reported. The quotation from Dunn et al (2008) above appears more in keeping with some aspects of Wright et al’s (2007) challenge-skills optimal experience, involving no thought apart from that which concerns the occupation itself.

A limitation of distraction-based explanations for the therapeutic potential of work (or indeed any other occupation) may be that they devalue the significance of occupations and make them subordinate to illness and symptoms. Arguably, labelling an occupation which is significant to people’s lives as a ‘distraction’ devalues that occupation by diminishing the significance it holds for people in and of itself. It may also increase the risk that insufficient attention is paid to enabling people to sustain the occupations that they want or need to have in their lives.

A further risk of typifying occupations as distractions is that it may mean that more inherent restorative therapeutic mechanisms of occupation are overlooked. One such concept which is used to explain the power of occupation to increase well-being is that of *flow*. Csikszentmihalyi’s (1992) flow theory describes certain optimal experiences – which have benefits for health and well-being – as being associated with immersion in tasks demanding a high but not excessive level of skilled responses. Occupational therapists have been interested in this as a possible explanatory mechanism for the positive effects of occupations, which are meaningful to individuals and provide a ‘just right’ level of challenge (Emerson 1998, Rebeiro and Polgar 1999, Wright et al 2006). In a US study which tracked the experiences of 78 adults for a week, Csikszentmihalyi and LeFevre (1989) found that flow experiences were experienced far more frequently at work than in leisure. Jacobs (1994) implied that a lower than anticipated occurrence of flow experiences in the working lives of occupational therapists may explain evidence of increasing job dissatisfaction. However, subsequently occupational therapy research has neglected flow in the working lives of either practitioners or their clients, focusing instead on flow experiences in leisure and therapeutic creative activity sessions (Persson 1996, Scheerer et al 2004, Reynolds and Prior 2006, Griffiths 2008, Timmons and MacDonald 2008). There was no explicit evidence of a ‘flow’ mechanism operating to support job retention in much of the qualitative research considered in this chapter. This, however, may be because

research showed limited exploration of participants' experiences of actually *doing* work – rather, discussion was focused on the barriers to working and outcomes of working.

A further explanation for at least some of the therapeutic potential of work for people with mental health problems, is that working reinforces both the need for, and the effectiveness of, illness management – thereby reducing negative impacts of symptoms. Dunn et al (2008) and van Niekerk (2009) noted many participants reported working even when feeling unwell and heavily medicated. The apparent explanation was that the routine occupation of work was perceived as stabilising and helped symptom management (Borg and Kristiansen 2008, Dunn et al 2008). This accords with occupational therapy/science research, both theoretical and empirical, which has since its inception maintained that structured routines are generally good for people's health (Trombly 1995, Ludwig 1997, Gallimore and Lopez 2002, Wilcock 2006, Clark et al 2007b, Kielhofner 2008).

Similar to Dunn et al (2008), Strickler et al (2009) found that the “business and structure of work tended to diminish the salience of symptoms” (p264), but they emphasized how employment required, as well as supported, illness management. A comparable cumulative dynamic process was also presented by van Niekerk (2009), according to which on-going participation in work promoted success and reduced feelings of social isolation, and vice versa. For Krupa (2004), the wider societal attitudes were important in helping people to sustain efforts to work, hypothesizing that “the high value placed on work may encourage individuals to find new ways to understand and live with expressions of illness” (p13).

A commonly shared theme across various studies was that work could be valued as a means of belonging and connecting to others, notably in a way that felt normalising, and which helped prevent illness from enveloping their identity (Millward et al 2005, Strickler et al 2009). Thus, people were concerned to preserve (Hatchard 2008) and extend (Provencher et al 2002) their social relationships. Strickler et al's (2009) study found the more vocationally successful participants were often those who reported feeling able to use relationships to sustain and develop opportunities at work. By contrast, Kirsh (1996) judged that there was little evidence of people seeing work as an opportunity to overcome social isolation. This finding was not shared in other studies and may be explained by a form of selection bias, as Kirsh's participants were recruited through user groups – suggesting that they already had alternative social networks and roles outside work. Consistent with the supported employment literature (Bond et al 2008), studies suggest that

such benefits appear to be dependent on work being neither explicitly (van Niekerk 2009) nor implicitly (Krupa 2004) segregated.

For some, working meant more than simply connecting with others. Provencher et al (2002) found that those with most vocational success saw their networks in a reciprocal manner, through which it was important to both receive and provide support. All ten of Gewurtz and Kirsh's (2007) Canadian mental health service user participants expressed a desire to feel they were making a contribution to society. This may explain why a number of studies found that work in caring, advocacy and peer-support roles was particularly valued (Provencher et al 2002, Killeen and O'Day 2004, Dunn et al 2008).

This last point is also an indication of how positive meanings attached to working may be beneficial to the recovery of people with mental health problems. Strickler et al (2009) concluded that those who reported working most consistently over a long period of time were also expressed most satisfaction with their work – though the authors did not commit themselves to an interpretation of whether consistent working and job satisfaction had an associative or causal link. Provencher et al (2002) explored the role of work in recovery, suggesting that to enjoy work there needed to be a fit between personal preferences and job characteristics. They found that participants could be categorised into three profiles of recovery that they tentatively suggested as stages of recovery. They proposed that those who saw work as an arena for self-actualisation might fit a more advanced profile – in which they see 'recovery as a challenge'. Similarly, some of Krupa's (2004) participants interpreted some stresses of work as "evidence of meaning and responsibility" (p11).

For many participants in the selected studies, working promoted self-esteem, increased the attachment to work, and was also a source of hope – a key positive factor in the literature concerning recovery (Anthony 1993, Deegan 2001, Jacobson and Greenley 2001, Repper and Perkins 2003, Cohen 2005, Gray 2006, Piat et al 2008) and resilience (Cyrulnik 2009, Edward et al 2009, Masten and Wright 2010). While Gewurtz and Kirsh (2007) and Provencher et al (2002) emphasised the development of hope and pride through working, Gioia (2006) added the qualification that this could not happen "when people find themselves in a job vocationally devoid of all the things that provide passion and hope in a vocational future" (p186). By contrast, Dunn et al (2008) found that work could be an arena where people felt valued to a degree that was not experienced elsewhere in their lives. This, alongside evidence of increasing efficacy gained from working, could boost confidence (Krupa 2004), and was used to challenge negative self-perceptions (van

Niekerk 2009). Thus, for some people work could be a source of empowerment which was motivating and restorative (Kirsh 1996, Provencher et al 2002, Strickler et al 2009).

Auerbach and Richardson (2005) interpreted a desire to feel “normal” and not to be “leading lives as ‘patients’” (p268) as evidence of work constructively contributing to participants’ sense of identity. Cunningham et al (2000) argued that when participants were not overwhelmed by illness there was space for work identities to develop. Some divergence exists as to whether work identities develop through working (Provencher et al 2002, van Niekerk 2009) or from cultural and social norms (Dunn et al 2008). Studies presented evidence that working was self-reinforcing (with the converse effect for not working) (Strickler et al 2009, van Niekerk 2009). Thus working could strengthen peoples’ vocational futures because it became embedded in their identities, was rewarded, and supported problem solving (Auerbach and Richardson 2005, Iannelli and Wilding 2007). Millward et al (2005) and Gewurtz and Kirsh (2007) emphasised that such positive outcomes were achieved because working provided an alternative identity to that of a person with a mental health problem. Not all research has counterpoised worker and sickness identities. Krupa (2004) emphasised the crucial importance of workers developing an integrated identity of being “a regular employee with an illness” (p12), in contrast to feeling overwhelmed by illness or denying they had a mental health problem. She emphasised the importance of the appraisal of skills, interests and goals gained through *doing* work, enabling arrival at this unified self-identity.

Gewurtz and Kirsh (2007) also discerned that self-knowledge might be gained through doing work, enabling people to gain “insight into their skills, competencies, challenges and limitations as workers” (p201). Provencher et al (2002) and Krupa (2004) suggested the enhanced self-knowledge gained through working could be transformed into a process of self-reconstruction. This is consistent with occupational therapy and science perspectives which have considered meaningful engagement in occupations as central to identity formation and maintenance (Creek 1998, Dickie 2003, Braveman et al 2006).

By contrast, Eklund and Leufstadius (2007) have presented evidence from a cross-sectional correlational study of people with severe mental health problems, arguing that the well-being resulting from occupation lies more in the meaning attached to activities than in the doing of them. These findings could be criticised, in that at least one of the variables – ‘occupational value’ – appears to be very similar to the factor of ‘satisfaction with daily occupations’, such that one would expect there to be a greater correlation between the two than between ‘activity levels’ and ‘satisfaction with daily occupations’. Moreover, the

claimed challenge to occupational therapy orthodoxy seems to be misplaced, as contemporary occupational theories see ‘meaning’ as an essential part of therapeutic occupational participation, not as an alternative to it (Trombly 1995, Creek 1998, Rebeiro and Polgar 1999). This coheres with findings that the meaning of work, a robust worker identity and the desire to do work during recovery were all positively interrelated (Provencher et al 2002, Hvalsøe and Josephsson 2003, Dunn et al 2008).

Finally, the meaning of work is influenced by the material resources it provides for people. Provencher et al (2002) reported work was seen as a means to obtain more money by people in the second of their three profiles – ‘recovery as a self-empowering process’. The location of this perspective in the middle profile (and not in the third, who saw work as a source of self-actualisation) seems to imply that they consider the significance of the financial dimension reduces as people recover. However, in a broader study, comprising more participants but with less depth, Strickler et al (2009) found that people who were most able to sustain work were also more likely to associate material benefits with working. Participants in Dunn’s (2008) research – who were purposively selected for having some form of psychosis and considering that their life had had a positive trajectory for at least two years – were said to experience the financial reward of work as promoting recovery. This was explained by reference to the material benefits, and because income reduced dependence, thus becoming a source of pride. This mechanism may be less significant for individuals or in cultures which place a lower premium on independence.

There is a possibility that the emphasis on some of the positive outcomes of working may reflect a bias inherent in the vocational rehabilitative paradigm within which most of the reviewed studies were situated. Alternatively, it could be that for many people the greater threat to their identity and associated social status (and material resources) came from the risk of job loss. This possibility certainly coheres with Jahoda’s (1982) formulation of the latent benefits of work, in which even alienating experiences of work are considered more beneficial in terms of material resources and psychological well-being than unemployment. Furthermore, Jakobsen (2004) is one occupational scientist who has pointed out that occupational alienation is a phenomenon which can arise from unemployment as well as employment.

Conclusion

This chapter has introduced the topic of work in broad terms related to my own profession of occupational therapy and with respect to a range of social science

perspectives. While acknowledging that there is a range of definitions of work, I went on to explain the essentially pragmatic reason why my thesis adopted a more limited focus on paid employment. This was in order to explore the related set of needs and experiences of employed people whose working lives are disrupted for reasons related to their mental health problems. Following this I set out how I have adapted Paterson et al's (2001) meta-study approach in order to construct this and the following two literature review chapters based on the emergent themes and analysis of relevant theory.

Three of the themes were discussed in this chapter, beginning with the potential for work to be toxic to individual health and well-being. Two broad explanations for this appear to predominate: explanations citing the alienating experiences of work; and explanations pointing to imbalances between individual capacities and demands of work, exacerbated by low levels of control. I suggested that a synthesis of the two is possible according to which the job-demand-control explanation provides insight into the mechanism by which alienation is created. This possibility found some support in a range of research findings.

Next, the review considered how mental health problems can disrupt people's working lives. This involved, first, considering direct impacts arising from symptoms, challenges of managing them, and feelings of being overwhelmed by mental health problems. Second, I presented the indirect impacts of mental health problems arising from receiving a diagnosis, the effect on identity, low self-esteem, stigma and precarious employment.

The final part of this chapter discussed the evidence for how work can potentially support mental health recovery. This was structured around four broad explanations for why this may be the case. I questioned the reasoning behind the explanation that work is therapeutic because it provides a distraction. The other explanations – that work demands illness management, provides flow experiences, connections with others, and meaning and purpose – all appeared more plausible given the evidence, although the evidence specifically in favour of flow experiences was limited.

There is a paradox at play here, in that work can both be toxic to well-being as well as a potential source of recovery; this may suggest that the therapeutic potential of occupations (at least in the workplace) depends on their 'dosage'. It is also clear that mental health problems may restrict and jeopardise a person's working life. This points to a need to consider how best to help people retain work in a manner that is sustainable in terms of its interactions with their mental health. The next chapter will consider the literature pertaining to this issue.

Chapter 3: What helps people with mental health problems retain work?

Introduction

The previous chapter used existing research and other literature to illustrate how mental health problems can disrupt, and in some cases jeopardise, a person's working life; and that work, although potentially toxic, can also support mental health recovery. Thus, employed people who experience mental health problems may benefit from help provided in order to retain their work as long as their experience of working supports, rather than undermines, their recovery. This chapter reviews what is known regarding what can help people achieve this. It begins by looking at the UK policy context, and then turns to a consideration of the practice developments that have arisen from this. Subsequently, the chapter reviews the research on job retention interventions and approaches. Because of the limited quantity of research that has been carried out on specific interventions, there is a greater emphasis on approaches and on discerning the positive factors which support job retention. These begin with factors related to the individual worker, then the people around them, and finally their job. As with the previous chapter, the review is underpinned and structured by the findings from a meta-study of selected qualitative research into first-person experiences of job retention.

The policy context

From the late 1990s, the concept of social inclusion has informed UK mental health policy, emphasising the benefits to people with mental health problems of participation in all areas of life including employment (Social Exclusion Unit 2004, Cross-government strategy: Mental Health Division 2009, HM Government 2011). This was an implicit criticism of the 'virtual' segregation (Foucault 2001) of 1980s community care provision, whereby mental health services were provided outside institutions, but to individuals who were still excluded from large areas of community life (Repper and Perkins 2003, Simpson 2004).

In the UK, the Disability Discrimination Acts (DDA 1995 and 2005) have provided legal protection for people with disabilities (including an initially limited and then broader range of mental health conditions) against discrimination when applying for work, or once in post. These included rights to 'reasonable' accommodations or adjustments, whether to work environments or to job roles, to enable people to work despite on-going health problems. Bambra and Pope (2007) used a large data set from the UK General Household Survey to compare employment rates of disabled and non-disabled people over a fourteen-

year period before and after the introduction of the DDA 1995 and concluded that anti-discrimination legislation is not an effective approach to reducing employment inequalities. Their conclusion appears somewhat bold given the possibility that other variables could have mitigated the impact of the new laws. Such variables might range from economic changes in the labour market to whether individuals feel supported, empowered and entitled to make use of legislation. Subsequently, Bamba has (2011) adapted her position, stating the legislation is helpful because it involves the state acknowledging that disabled people do face wider discrimination at work – although she also questions whether this further marginalised people defined as sick but not disabled.

Away from employment legislation, UK vocational rehabilitation practice developments initially focused on the needs of people with severe and enduring mental health problems to find employment. The Perkins review into the vocational needs of adults using specialist mental health services argued that such service users may already be employed and need support to retain their work (Perkins et al 2009). Attention to the work-related needs of people with mild to moderate mental health conditions was given impetus by a presentation to the Cabinet Office Strategy Unit by the economist Richard Layard (Layard 2005b). Layard expressed concern at the economic costs of lost productivity resulting from these conditions, which result from sick leave, underperformance ('presenteeism') or job loss. In 2011, 13.1 million days were lost due to sickness absence for stress, anxiety and depression, the third highest figure after the 34.4 million for musculoskeletal problems and 27.5 million for colds and flu (Office for National Statistics 2012). Layard's call for action was allied with tenets of positive psychology (Seligman 2003, Layard 2005a) and based on a belief that people's well-being could be improved by policy focused on mental health needs and not just budgetary measures. His solution was to provide walk-in clinics offering cognitive behaviour therapy (CBT).

The Government responded with the Improving Access to Psychological Therapy (IAPT) initiative (CSIP Choice and Access Team 2007). Clinicians were trained and funded to deliver talking treatments in IAPT services throughout England. However, the case for expecting CBT to successfully address the job retention needs of people with mental health problems does not appear as strong as Layard had initially suggested. Clark et al's (2009) evaluation of two IAPT pilots – co-authored by Layard – described employment outcomes as 'encouraging'. However, the results – a 5% increase in numbers employed without claiming sick pay – could be seen as limited. There were no control

groups – whether ‘treatment-as-usual’ or ‘no-treatment’ – which could have helped indicate whether the improvement derived from intervention, chance or the passage of time.

Layard’s (2005b) paper had cited National Institute of Clinical and Health Excellence (NICE) guidelines and research as supporting the efficacy of CBT. A review commissioned by the Department for Work and Pensions (Campbell et al 2007) concluded there was strong evidence for the efficacy of CBT for people with mental health problems in primary care settings. The specific evidence for job retention needs was based on a systematic review by Seymour and Grove (2005). However, this was a review of workplace-based interventions, not walk-in clinics. Seymour and Grove concluded that interventions needed to be delivered in a bio-psychosocial context; furthermore, they acknowledged significant limitations due to the “paucity of published studies” (p32), and that most were conducted outside the UK with professional groups with high degrees of control over their work.

McPherson et al (2009) also challenged the use of NICE guidelines for Depression to justify the IAPT’s predominantly CBT approach, drawing attention to its use of evidence comprising mainly symptom-based rather than recovery-orientated outcome measures. In this, they draw attention to an assumption that may well be flawed – namely, that reducing the symptoms of mental health problems will consequently reduce sick leave duration and increase the rates of return to work. The same concern was identified by economists who were otherwise generally supportive of Layard’s initiative and the IAPT’s inception (Oxford Economics 2007). McPherson et al (2009) concluded by calling for more research focused on recovery processes and outcomes rather than symptoms. The subsequent (albeit still incomplete) proposal to link vocational specialists to all IAPT teams (Department for Work and Pensions and Department of Health 2009) appears to acknowledge that CBT intervention alone may be insufficient to produce positive work outcomes.

Vocational specialists, allied to IAPT or primary care mental health teams, will have encountered service users who need support to retain existing jobs. This may have accelerated the emergence of a category of vocational interventions termed ‘job retention’. This includes ‘Fit for Work’ pilot projects established as a separate initiative from the vocational specialists in IAPT teams (Department for Work and Pensions and Department of Health 2009). Seven of the original eleven pilots have received continued funding up to 2013 (Department for Work and Pensions 2012) – though there is as yet no wide scale

development of these services or any indication of what will happen after 2013. This suggests that the conclusion of the Sainsbury Centre for Mental Health updated systematic literature review (Seymour 2010) into common mental health problems at work remains pertinent: “delivering psychological therapies without some form of employment-focused case management will not produce positive work outcomes for working age adults with mental health problems” (p13).

The recession and subsequent economic problems (on-going at the time of writing this chapter) have hit the UK economy particularly hard. It is likely that this is presenting particular challenges for supported employment interventions in attempts to help people with mental health problems find and retain work (Royal College of Psychiatrists et al 2009, Rinaldi et al 2010). The evidence base of supported employment draws from research carried out during the comparatively stable economic condition of the USA and Europe in the late 1990s and early 21st century (Crowther et al 2001, Burns and Catty 2008). The European study found that the supported employment intervention of Individual Placement and Support (IPS) was most successful in the more buoyant economies. This does not tell us what will happen in a recession, but clearly the intervention requires real job opportunities to be available. People with mental health conditions may be particularly vulnerable to losing jobs in current circumstances and have greater difficulty in finding new jobs (Social Exclusion Unit 2004, Royal College of Psychiatrists et al 2009, Sainsbury Centre for Mental Health 2009b). Reduced job opportunities increase the importance of helping those in employment to retain their jobs.

Bond and Drake (2008) have criticised the lack of research into broader socio-economic and cultural factors related to the employment of people with a diagnosis of schizophrenia. Kirsh (1996) argued that a person’s environment should not just be seen in immediate terms, but also in relation to “political, economic, institutional and societal elements” (p34). However, there is often limited consideration of such factors across the qualitative research studies that investigate job retention experiences. One area that did receive a moderate degree of attention, however, was the role of social security payments in supporting or undermining job retention.

A major area of debate in media, research and policy literature concerns whether there exists an actual or perceived ‘benefits trap’. The idea that some people are, or may consider themselves to be, better off on benefits than working, has been used as part of the justification for welfare reform by both the current and previous UK Governments (Department for Work and Pensions 2007, Freud 2007, Department for Work and Pensions

2011d). Mental health service user organisations and advocates for promoting mental health service users' access to work have raised concerns that too much compulsion may undermine the policy's effectiveness (Perkins 2008, Mind 2009, Sainsbury Centre for Mental Health 2009b). This critique has heightened in response to the current UK administration's latest welfare proposals (Campbell et al 2012). Some academic studies (with varying degrees of evidence and confidence) have posited the existence of an actual, or perceived, benefits trap effect, deterring those already unemployed from seeking work, both in the UK (Burns and Catty 2008) and internationally (Lakatos 2006, OECD Economic Surveys 2008, Gournellis et al 2010). The evidence for this affecting people with severe mental health problems in the UK has been challenged by Rice et al (2009).

None of the aforementioned studies suggested that there are financial motives for employed people who have mental health problems to go on sick leave in the first instance. However, in her US-based study, Gioia (2006) reported that benefit entitlement was a disincentive to return to work, adding that mental health professionals encouraged what Gioia termed – with some implicit criticism – 'early benefits applications'. Yet she did not discuss the possibility that the disincentive to return to work may derive more from the low aspirations of the mental health professionals for the working potentials of their clients (perhaps suggested by the encouragement to apply early for benefits), than from the entitlement to benefits per se. By contrast, Auerbach and Richardson (2005), also in a US study, found entitlement was valued as an important safety net that supported attempts to sustain work. Killeen and O'Day (2004) reported mixed findings, with some participants appreciating the way in which benefits made part-time employment financially viable and allowed them to work at a level they felt sustainable, whereas others felt trapped in low-level part-time jobs and worried about the prospect of having to reapply for benefits if their circumstances changed (Provencher et al 2002, Killeen and O'Day 2004, Auerbach and Richardson 2005). This situation was said to be exacerbated by people having a limited understanding of the benefits system (Killeen and O'Day 2004). No authors or participants advocated the removal or reduction of benefits, though some called for review and redesign.

Job-retention-focused interventions

Research into interventions which are specifically focused on job retention research, particularly in a UK context, is limited (Sainsbury Centre for Mental Health 2009d). The British Occupational Health Research Foundation has published a review of the evidence

for effective intervention for job retention for people with common mental health problems, and a comparison between its original report (Seymour and Grove 2005) and its 2010 update (Seymour 2010) reveals a shift from support for CBT-informed approaches to the value of workplace-focused (but not necessarily based) independent case management in line with some of the UK policy developments discussed above. A review of occupational therapy interventions supporting employment and education of adults with severe mental illness (Arbesman and Logsdon 2011) did not consider job retention interventions. This may reflect a questionable assumption in the literature that people with severe mental health problems do not work except when supported by services to do so.

The evidence base (some from outside the UK) includes projects which help employees with mental health problems retain employment through a range of support and advice, solution identification, and by supporting communication between employees and employers (Gates 2000, Butterworth 2001, Secker and Membrey 2003, Nieuwenhuijsen et al 2004, Thomas et al 2005, Krupa 2007, Pittam et al 2010). As with IPS, these elements call for a 'hands-on' coaching (Shepherd et al 2008) or case-management style of intervention, whereby those supporting people with mental health problems at work are willing to accompany them into the workplace (Sainsbury Centre for Mental Health 2009c). This applied approach is clearly different from more clinically based CBT and is also supported by findings from the Sainsbury Centre for Mental Health (2009c) into skills needed for job retention. Although based on expert opinion rather than direct practice evaluation, this Delphi study comprised a broad base of mental health service users, vocational practitioners working in the field and researchers with an interest in the topic.

One of the first mental health job-retention projects in the UK was the Avon pilot (Butterworth 2001); the evaluations of this project – comprising a book chapter (Thomas and Secker 2005a) and a brief peer-reviewed paper (Thomas et al 2005) – provide some evidence for its efficacy. The Avon pilot combined educative, problem-solving, counselling and vocational interventions, for both workers and employers. Those interventions which were focused on the employee involved advocating for them, providing vocational and mental health counselling, and giving advice on benefits and on financial and legal issues. Employer-focused principles involved training the employers regarding healthy workplaces and mental health. Interventions with a shared or wider focus comprised facilitating dialogue between employee and employer and providing on-going support for both; facilitating natural supports; ensuring the service could provide early intervention and easy access; and providing training to mental health workers and

General Practitioners (GPs). The emphasis on maintaining or restoring the relationship between the worker and their line manager is a factor suggested elsewhere as central to job retention (Thomas and Secker 2005b, Lysaght and Larmour-Trode 2008).

Many of these elements appeared to be included in Schene et al's (2007) randomized control trial (RCT) for adjuvant occupational therapy for work-related major depression. This was just one of six studies judged to be of sufficient relevance and quality for inclusion in Seymour's (2010) aforementioned updated review of job retention interventions for common mental health problems. This small-scale RCT, based in the Netherlands, notably found that the participants who received occupational therapy in addition to treatment as usual (outpatient psychiatric appointments), returned to work a mean of 92 days earlier than those who received treatment as usual alone. The occupational therapy intervention involved both group and individual sessions discussing past work and health interactions, identifying problems and potential solutions, and liaison with participants' workplace to plan return to work and provide follow-up support. Whilst the effect size is impressive, the problem with an individual RCT for a complex intervention is that it is unclear what the relative contributions of the different components might be. The authors also acknowledged an ethical dilemma relating to their finding that the intervention was cost-effective for those who earned more than \$10 per hour but not for those who earned less. This indicates a consideration whereby cost-effectiveness may not be as consistent with social inclusion and equity as some of the policy discussed above has suggested.

While indicating a degree of support for these types of approaches to job retention, the evidence is nowhere near equivalent to that provided by the more clearly defined IPS intervention (Bond et al 2008, Catty et al 2008, Drake and Bond 2008). Since IPS includes provision of ongoing assistance once someone has been helped to secure employment, one can look to the 'support' elements of IPS to find evidence that has relevance for job retention. This indicated that successful vocational interventions need to consider broader issues such as stigma, attitudes of colleagues, disclosure and the demands of jobs (Dalgin and Gilbride 2003, Thara 2003, Corrigan 2004, Henry and Lucca 2004, Boyce et al 2008, Terluin and de Vet 2009).

Details about specific interventions tended to be lacking in many of the studies that considered first-person experiences of job retention. Gewurtz and Kirsh (2007) reported in general terms that the presence or absence of interventions was considered by their participants to influence whether they managed to sustain work. Killeen & O'Day (2004)

noted that some people found and sustained work using help from specific programmes, while others did so independently. By contrast, Strickler (2009) found that those who were most successful at maintaining work tended to make most extensive use of support networks – including mental health services – to pursue work-related goals. Auerbach and Richardson (2005) reported participants found interventions such as problem solving to be helpful, whereas psychodynamic therapies were not considered helpful to further work-related goals.

Rather than directly evaluating interventions, Provencher et al (2002) analysed participants' needs at different points in recovery, From this they recommended psychiatric interventions to manage disabilities and develop social skills for those feeling most overwhelmed by illness, as well as vocational interventions to promote self-belief and develop skills and motivation. They suggested that those who felt more able to engage with work could benefit from supported employment, with psychiatric interventions addressing advanced social skills (notably validation and resolving conflicts), and vocational interventions addressing job accommodation, coping with job barriers and career development counselling.

Hatchard (2008) and Gates (2000) provided a high degree of detail regarding the interventions deployed as part of their research. These aimed both to facilitate return to work and promote acceptance. In Hatchard's (2008) case study there was an emphasis on supporting the participant to reach and implement decisions about disclosure and negotiating accommodations. Gates's (2000) programme had similar aims, but the research findings put a greater emphasis on mental health and vocational services as being providers of information (such as legislation), interpreters of policies, negotiators and trainers; whereas in Hatchard (2008) the clients were enabled to undertake the latter two roles themselves.

Thus, workplace-focused interventions (such as problem solving, accommodations, and disclosure support) were more commonly cited as helping job retention than general mental health interventions (e.g. medication and psychotherapy). This is consistent with the National Institute for Health and Clinical Excellence's (NICE) (2009) guidance on long-term sickness and incapacity – though, as Gabbay et al (2011) have pointed out, most of the studies reviewed in its supporting evidence base related to people with musculoskeletal conditions.

Elsewhere, quantitative research has been undertaken to attempt to identify factors which predict successful return to work of people on sick leave due to mental health

problems (MacDonald-Wilson et al 2003, Shiels et al 2004, Post et al 2005, Pluta and Accordino 2006, Landstad et al 2009). The variable and indeed often contradictory findings highlighted by systematic reviews of such studies (Blank et al 2008, Cornelius et al 2011) could be explained by a questionable expectation to identify factors which are common across varied contexts.

Qualitative studies have identified challenges and supports to job retention for individuals with shared geographic, service use or diagnostic characteristics. A limitation of these studies is that they tend not to differentiate between those seeking new work and those returning to an existing job (Kirsh 1999, Secker and Membrey 2003, Secker et al 2003, Krupa 2004, Auerbach and Richardson 2005, Millward et al 2005, Strickler et al 2009). Nevertheless, this research does enable us to identify a range of factors which have the potential to support job retention and could inform the development of more specific and targeted interventions. These will now be considered, starting with predominantly worker-related factors, then factors related to the people around them, and finally job-related factors.

Worker-related supports to job retention

Research suggests that strategies for living with mental health problems, problem-solving skills, and communication skills all help people sustain work. These contribute to increased motivation, self-awareness, belief in self-efficacy, empowerment and hope – all of which may act both as outcomes and as further mechanisms supporting job retention.

Strategies to live with mental health problems

Evidence in the previous chapter suggested that one of the ways in which work is able to promote recovery is by supporting illness management. Much of that research suggests that this is a dialectical process, whereby some forms of illness management can also support job retention. Some studies saw this as beginning with acknowledgement of illness. Kirsh (1996) and Cunningham et al (2000) emphasised the value of personal insight into the nature and impact of mental health problems. In a recent and rare example of a study focused on return to work experiences following acute mental illness from Canada, Hatchard et al (2012) found this awareness to involve a challenging process of self-acceptance. Such insight was found by Krupa (2004) and Hatchard (2008) to help workers identify and attribute problems to the illness, and not in a potentially destructive or self-blaming way to themselves. Krupa (2004) identified evidence of a beneficial process of synthesis of health and illness at work. Once achieved, this synthesis allowed workers

to recognise the need to manage symptoms, be vigilant to signs of relapse and stop feeling overwhelmed by illness (Krupa 2004, Millward et al 2005).

Having acknowledged and gained insight into the impact of mental health problems, people may then benefit from finding ways to manage their illness. Effective strategies for symptom management and monitoring were found to reduce the risk of relapse and helped workers notice signs of recovery – in some cases augmented by collaboration in mental health care, use of crisis plans and medication (Provencher et al 2003; Krupa 2004; Millward et al 2005).

Provencher et al's (2002) participants expressed mixed attitudes to medication, but, like Strickler et al (2009), found those with most vocational success reported more positive medication effects. With less caution about cause and effect, Krupa (2004) concluded that the experiences of participants suggested a need to accept medication in order to achieve a stabilisation of symptoms. By contrast, Millward et al (2005) considered that taking medication may “act as a marker for illness and inability to perform valued social roles (rather than enabling the individual to live as normal a life as possible)” (p570). However, the use of medication was not referred to at all in their findings – making it difficult to decide whether this point is justified. The lack of consensus within and between studies concerning the impact of medication on prospects for job retention appears likely to reflect a real external variance in its efficacy. As Marwaha and Johnson (2005) and Secker and Membury (2003) found in their UK qualitative studies, the use of medication presented challenges in itself which might need to be taken into consideration, even when found to be on balance constructive.

Cunningham et al (2000) found management strategies to be helpful as long as they were not used to “cover up the illness or to push it aside” (p491). Yet their emphasis showed limited resonance with a medical model – concluding that strategies were most effective when they were focused not on illness management in general terms, but on “how one manages one's life having an illness” (Cunningham et al p492). This coheres with Shepherd et al's (2012) call for management of symptoms and support for functional participation not to be counterpoised, nor seen as needing to occur at different points of recovery. Strategies identified as helpful in Kirsh (1996) and Hatchard (2008) were also of a more holistic nature, including mindfulness in daily living, pacing and stress management, nurturing relationships and valuing mind–body links involving attention to physical health.

Problem-solving and coping skills

Problem-solving and coping skills helped participants gain and retain work (Kirsh 1996, Auerbach and Richardson 2005). Echoing the arguments for strategies to manage one's life with an illness rather than manage the illness itself, Krupa (2004) found problem solving was more efficacious when problems experienced at work were normalised and interpreted as common occurrences within working life. This was similar to van Niekerk's (2009) finding that return to work was more successful for people who displayed personal flexibility in response to change. Other studies have emphasised the value of problem-solving and coping skills as being part of a wider set of skills and strategy (Provencher et al 2002, Hatchard 2008). Killeen and O'Day (2004) argued that the key factor in making this strategy effective was the extent to which the participants actually believed it could work.

Communication skills

The centrality of communication skills as an essential life skill has been stressed both in relation to preventing psychological problems arising from work (Corbiere et al 2009) and in relation to supporting the participation of people with mental health problems at work (Kirsh 1996). Even where stigma was not involved, communication skills were needed to inform supervisors and colleagues about helpful and unhelpful stances (Gates 2000), to accept criticism (Auerbach and Richardson 2005), and to manage workplace conflict (Provencher et al 2002, Krupa 2004, Hatchard 2008).

These elements would appear to be part of the 'task' which Krupa (2004) concluded faced workers with mental health problems, which concerned "presenting a public image that is both consistent with the image of a regular employee and the need to negotiate work-related disabilities" (p14). As with other skill-development issues, Hatchard (2008) concentrated on how communication skills, such as assertion, grew through the process of negotiating and experiencing a supported return to work. By contrast, Provencher et al (2002) proposed that communication skills development at all levels was a suitable psychiatric (as opposed to a workplace-based vocational) intervention.

Motivation

Levels of motivation, and use of goal-setting as a motivational strategy, were reported in a number of studies as factors which either influenced, or were associated with, different degrees of vocational success. Provencher et al (2002) concluded that those most overwhelmed by illness could benefit from vocational support to motivate them to carry

out tasks. Fluctuations in levels of motivation to work were reported in the same study as a challenge experienced even by participants who viewed work as a support for recovery and empowerment.

Findings from Strickler et al (2009) differentiated between motivation to work and motivation to access support to work, suggesting that both were important. They found that the less consistent workers were those who exhibited less initiative to access vocational support. Those who worked the most had most motivation to work *and* seek work-related support. For such consistent workers, motivation was interpreted as a factor which additionally increased their own personal capacity to cope with difficulties: “[they] were not deterred by temporary setbacks ... they demonstrated persistence and resilience” (Strickler et al p 266).

Dunn et al (2008) concluded that positive motivation to work during recovery was related to work having strong meaning for participants. Successful experiences at work may in turn result in work feeling more meaningful. Kirsh (1996) discerned evidence of work reintegration being supported by a similar dynamic combination of motivation and sense of empowerment aided by the development of goals. Goal-setting as a supportive strategy was found to be helpful by Provencher et al (2002) in relation to the management of emotional problems, whereas Krupa (2004) focused more on the use and development of goals through, and in relation to, work itself. Such evidence lends weight to Lloyd et al’s (2008a) call for research into the potential for motivational interviewing to be used to support the vocational needs of people with mental health problems.

Spirituality (mainly presented as religious belief in the meta-study papers) was found to be helpful for some people in the form of either belief systems (Provencher et al 2002, Krupa 2004, Auerbach and Richardson 2005), or support from religious organisations (Kirsh 1996, Provencher et al 2002). Some participants in a study by Auerbach and Richardson (2005) reported spiritual organisations as having a negative impact on their working lives. These studies were all conducted in North America and one might not expect a similar level of influence in more secular societies. The form and development of human productive activity in a given society has been argued – most famously by Weber (2003 [1930]) – to be influenced by religious belief systems. A non-conformist parallel in the use of productive activity to treat mental illness can be found in Tuke’s (1813) ‘moral treatment’. No contemporary vocational research literature was identified which focused on similar influences.

Self-awareness and self-efficacy

In their general review of research into experiences of recovery from severe mental illness, Andresen et al (2003) identified awareness as a key stage in people's recovery journey. Here they were not simply referring to awareness of the impacts of their mental health problems discussed earlier, but to knowledge of their own needs, strengths and aspirations. The value of this is also discussed in some of the more specific vocational research.

Self-awareness was found to be an influential psychological factor contributing to job retention in Kirsh's (1996) Canadian study. This research aimed to "illuminate psychological, social, and environmental factors" (p25) involved in supporting success in gaining and retaining employment. Self-awareness and the ability to identify personal strengths and emotional, psychological and physical needs were important influences on successful experiences in employment. These findings led Kirsh to recommend psychological strategies to promote insight and awareness of needs, alongside support and education to recognise strengths, as part of the preparation for work.

A different emphasis was given by Provencher et al (2002), who presented enhanced self-knowledge as an outcome, rather than precondition, of empowerment, that could be developed through working. The difference may lie in a distinction between self-awareness and self-knowledge, where self-awareness involves a varying degree of awareness of a range of personal capacities, skills and attributes which are not necessarily fully integrated into a unified whole. Integration of awareness appears constitutive of Provencher's concept of self-knowledge (2002). Seemingly adopting an intermediate position, Krupa (2004) considered that the capacity to appraise skills was achieved through working, as part of the phase of achieving an integration of health and illness at work. Millward et al (2005) similarly found that self-awareness of the two sides of this integration – in their terms, 'reduced capabilities' and 'coping' – was helpful to participants seeking to return to work. To help achieve this integration they proposed a form of narrative therapy to explore the relationship between the self and the illness, for those who had been off work for a long period.

Belief in self-efficacy is another factor which appears to both contribute to and develop from successful vocational recovery. A strong belief in self-efficacy is more apparent in studies involving participants who are seemingly more advanced in their recovery (Provencher et al 2002 and Krupa 2004) than with those at an earlier point (Millward et al 2005). Hatchard's (2008) interpretation of the return to work journey of

her single participant emphasised how confidence both contributed to and increased during the process of planning, negotiating and actually returning to her work. This is also suggested by Killeen and O'Day (2004), particularly in relation to confidence to resist negative messages from others. To address low levels of confidence, Millward et al (2005) advocated "cognitive reframing involving the positive future of selves as competent and able" (p571).

Provencher et al (2002) and Hatchard (2008) considered overcoming feelings of guilt to be part of developing such self-belief in a successful future. Provencher et al's (2002) more psychologically orientated study presented a range of cognitive strategies which participants found helpful to achieve this. These included: reframing problems as challenges; reappraising skills and capacities in a positive light; and self-discovery. In some cases this was supported by psychotherapy, in others they were self-help approaches (Provencher et al 2002). Similar processes were reported in Hatchard's (2008) more occupationally informed study, but guilt was also overcome through learning that they were not the only one to experience a range of problems related to mental health and work. Additionally, she suggested that guilt was reduced through the actual experience of returning to work, as well as the positive responses of others once back at work. The importance of overcoming feelings of guilt is also present in Svensson et al's (2006) theoretical model, which emphasises the significance of a pride–shame dimension in understanding the return-to-work challenges of workers on sick leave. It is also consistent with van Vliet's (2008) grounded theory study which considered that overcoming shame was a major task for people recovering from depression and other severe mental health problems.

Hope and view of recovery

Overcoming self-blame and guilt may then be important in enabling people to feel hope for the future. The value of hope is suggested by findings that lack of hope for recovery can become a self-fulfilling prophecy (Provencher et al 2002; Killeen & O'Day 2004; Van Niekerk 2009). Killeen and O'Day (2004) reported that reduced hope was apparent despite all of their participants reporting significant mental health improvements. Millward et al (2005) found that those exhibiting most hope were more able to view such improvements to be steps on a path of recovery. Instilling hope was proposed by Kirsh (1996) as a key element of preparing people for finding or returning to work. Participants in Krupa (2004) reported recovering with a developing belief that it was possible to lead a

life that was not dominated by illness. These findings thus cohere with the broader ‘recovery’ literature which has stressed how hope can help people with mental health problems to rebuild their lives (Jacobson and Greenley 2001, Repper and Perkins 2003, Deegan et al 2005, Brown et al 2008). Van Niekerk et al (2009) also discerned rediscovery and reconstruction of the self but found assumptions of a return to their former self were often unhelpful.

Empowerment and fears

As with hope and belief in self-efficacy, empowerment has been reported to be a contributor to job retention and an outcome of the recovery of working roles. In Hatchard’s (2008) single-case study, empowerment was classed as an outcome of being heard. Provencher et al (2002) identified empowerment to be one of six primary themes framing the experiences of their fourteen employed and unemployed participants, who they found could be subdivided into three groups reflecting various degrees of recovery. Lack of empowerment characterised a subset most overwhelmed by illness and least likely to engage in working roles. The middle group were considered to be increasing their empowerment through working or attempting to find or resume work. The third group – characterised as experiencing recovery as a challenge – displayed a high degree of empowerment, involving knowledge of themselves and their environment, and an internal locus of control. This was very similar to Auerbach and Richardson’s (2005) finding that participants defined successful work experiences as those in which they “felt responsible and empowered” (p271).

The variation in the ways in which the reviewed studies portrayed empowerment as a process and as an outcome echoes patterns discerned in Svensson et al’s (2006) more general writings on empowerment and in Hillborg et al’s (2010) qualitative study into eight Swedish persons’ experiences of vocational rehabilitation. These studies suggest that it is most useful to see empowerment as *both* a process and as an outcome, operating at individual or community levels, and it appears particularly useful to understanding the return-to-work challenges of people on sick leave. Similarly, Kirsh (1996) interpreted empowerment in a dynamic way, seeing it as an outcome of fulfilling work-related goals, but also saw evidence of it as enhancing motivation and confidence to work. In this way it appears possible that empowerment may have reduced the range of fears reported as barriers to retaining work.

The role of other people

There is strong evidence of how the understanding, support and acceptance of people in a workplace towards colleagues with mental health problems can help them retain their work (Kirsh 1996, Gates 2000, Provencher et al 2002, Krupa 2004, Auerbach and Richardson 2005, Hatchard 2008, van Niekerk 2009). Gates (2000) highlighted the centrality of supervisors' roles, especially in ensuring that any accommodations are successful, arguing it was therefore important to understand managers' perspectives and position. Gates (2000), like Hatchard (2008), also considered it important to educate co-workers about mental health generally and how best to support specific individuals. Kirsh (1996) drew attention to the importance of the general culture in a workplace – with more respectful, open and caring workplaces being most able to provide constructive support and understanding. Conflicts in workplace relationships were among the greatest barriers to a successful return to work (Gates 2000, Auerbach and Richardson 2005).

In order to make acceptance and support possible, a central issue which people need to consider is disclosure of their mental health problems to others at work. With sound reasoning and evidence, Thornicroft et al (2009) and Corrigan et al (2010) have proposed that different interventions may be needed for addressing fear of stigma and stigmatising or discriminatory behaviour. However, the process of disclosing mental health problems in the workplace appears to involve addressing both.

Disclosure

Concerns about disclosure of mental health problems were apparent across a number of studies. It was the main focus of Hatchard's (2008) single-case study, as the participant saw disclosure as a central task in returning to work with the necessary supports. This was achieved in three steps. Firstly, she discussed the need for disclosure with her occupational therapist. Secondly, she decided to disclose her diagnosis and implications to fully to her employer, and partially to colleagues (to reduce stress about their possible misconceptions of her). Thirdly, she had direct discussions with her manager, which led to her manager and human resources officer holding a mental health educational meeting with colleagues (at which the client chose not to be present). The meeting closed with a partial disclosure of her mental health challenges and related needs at work.

This approach shared some similarities with that described by Gates (2000). One key difference was that Gates ran a programme which was applied to all who opted into the study, rather than constructing an individualised disclosure strategy. In Gates' (2000)

targeted intervention, colleagues and managers were educated about mental health problems in advance of a specific employee's return. The premise that broad disclosure was needed in order to make effective accommodations is questionable – certainly in respect of disclosure to colleagues. Whilst success was claimed in relation to the twelve people who were recruited, a majority of eligible participants declined to participate – despite incentives of guaranteed job protection for one year and payment for medication in this US-based study.

For Gates (2000) and Hatchard (2008), disclosure was important because they saw it as a prerequisite to negotiating necessary supports. Both also considered the value of disclosing to colleagues, seeing this usually as a desirable option, but also as one that the individuals should decide upon themselves. As well as varying in the degree of formality and structure involved in the process, the studies also differed in that Hatchard drew attention to the potential for considering what to disclose. Thus, the client in the case study disclosed her diagnosis to her manager, but chose only to disclose her mental health needs in general terms to colleagues, and focus on functional implications. In Gates's study (2000), whilst there was consideration of disclosure to different people, the issue of the extent and content of disclose was not considered in an otherwise comprehensive strategy. Shepherd et al (2012) have argued that a more flexible, normalising and considered approach to disclosure may be supported by redefining the term as one of 'management of personal information', which all people need to consider at work.

Findings from other studies have suggested, both explicitly or implicitly, that disclosure could usefully involve promoting awareness of the additional demand that strategies to manage mental health problems can place on individuals, as compared to co-workers without mental health problems (Provencher et al 2002, Honey 2003, Hatchard 2008). Kirsh (1996) reported participants felt that disclosure relieved the related pressure of concealment. Van Niekerk (2009) found that feelings of isolation associated with having a mental health problem were greatly reduced when people experienced acceptance after disclosure at work.

Elsewhere, more negative experiences were reported, with some participants fearing or experiencing stigma following disclosure (Krupa 2004, Auerbach and Richardson 2005). Provencher et al (2002) suggested that fear of disclosure was driven by a desire for protection from stigma and discrimination. However, this came at the cost of restricting their engagement with the world around them – something also found in van Niekerk (2009) – with consequent limitations to self-development. Concealment could lead to

acceptance of social prejudice and undermined the acknowledgement of the illness's impact, something which could otherwise be helpful at work (Cunningham 2000, Krupa 2004).

Family and friends

There was limited detail about the influence of family and friends on job retention across the studies reviewed – in some papers these findings were aggregated with support from professional and other support networks (Provencher et al 2002, Gioia 2006, Gewurtz and Kirsh 2007). Nevertheless, a range of positive, mixed, and negative influences were apparent.

As with Svensson et al's (2010) findings from research into experiences of people with musculoskeletal problems, families and friends of workers with mental health problems were seen as offering positive support when they provided a combination of encouragement and concern, provided that the concern was not presented in a manner that precluded the possibility of returning to work (Kirsh 1996, Provencher et al 2002, Auerbach and Richardson 2005). Killeen and O'Day (2004) emphasised that it helped most when such attention was focused on a person's talents and interests and how to lead one's life with a mental health problem – rather than a narrower focus on monitoring and controlling symptoms. Rinaldi et al's (2010) review suggests that, in England, this medical perspective may trigger fear on the part of families and form an obstacle to implementation of IPS for people with severe and enduring mental health problems.

Thus not all interactions with family and friends were seen as helpful to people's working lives. Families of participants in Gioia's study (2006) tended to encourage a delayed return to work – except where there were financial pressures and unspecified cultural influences. This may have helped some, but not others. This finding may be specific to the sample of participants, all of whom had experienced a first episode of psychosis and a new diagnosis of schizophrenia. Gewurtz and Kirsh (2007) found that family support could have negative as well as positive influences upon people's attitude to work and future vocational plans. Relationship problems (Auerbach and Richardson 2005) and lack of family role models (Millward et al 2005) were cited by some as obstacles to job retention. There was evidence of negative messages from some families about the recovering worker's current ability and future working potential (Killeen and O'Day 2004, Millward et al 2005). Honey (2003) considered that this could contribute to a process by

which participants adopted stereotypes from people around them, thereby undermining their confidence.

Wider research about the influence of family and friends upon job retention is limited. Lysaght and Larmour-Trode (2008) found that family support was important in the return-to-work process of their participants who had some form of injury or disability, but their analysis and discussion chose to focus on workplace-based support. A brief general reference is also made to the value of family support in Thomas and Secker's (2005) evaluation of a UK job retention pilot for people with mental health problems, but detail is lacking. A US-based study interviewed family members of people with severe mental health problems, and found that their priority was to help their relative achieve a normal life, securing a job being specifically highlighted as a factor which increased their optimism (Forchuk 2003).

There is some evidence that could be interpreted as pointing to the benefit of access to close family support. A Finnish cohort study found that those who were cohabiting with a partner at the onset of schizophrenia had better vocational outcomes than those who were single (Miettunen et al 2007) – though, of course, it may be that those who were single at onset had actually experienced some problems related to an undiagnosed pathological process beforehand, which had disrupted their capacity to form and sustain relationships. Similarly, an Australian study (Evert et al 2003) found that those with stronger family and social networks were more likely to be in paid employment than those who were isolated – again, there is a possibility that the cause may lie in the fact that being out of work may undermine participation in social and family networks. Thus there appears to be a particular need for further research to consider the role of family and carer support in job retention.

Mental health professionals

Research has drawn attention to the elements of mental health professionals' roles beyond application of clinical and technical knowledge about mental illness or accommodations. General mental health (Kai and Crosland 2001, Brown et al 2009) and supported employment research (Johnson et al 2009) has found the relational style or perspective of the professional to be important to fostering recovery. In more job-retention-focused research, the personal qualities of therapists were valued (e.g. trustworthiness, consistency, ability to listen and provide emotional support) (Kirsh 1996, Auerbach and Richardson 2005). This supports Sennett's (2012) thesis that in many areas

of society – including public services – such skills which contribute to co-operation may be undervalued in comparison to technical and scientific practices, and to an assumption that quality can best be achieved by competition.

In keeping with recovery-orientated approaches (Repper and Perkins 2003, Shepherd et al 2008), as well as some of the more practice-focused resilience literature (Ungar 2005b, Hart et al 2007), Killeen and O'Day's (2004) participants commonly saw having a collaborative relationship with a mental health professional as particularly helpful to job retention. Hatchard (2008) concluded that the occupational therapists' use of a specific model (the Occupational Competence Model) was a key method to promote such collaboration. Provencher et al (2002) presented collaboration as interacting with levels of empowerment – with those feeling least empowered having more of a dependent relationship with services, and those who felt most empowered exhibiting a more collaborative relationship. The implication is that mental health services should pay close attention to how they support or undermine empowerment. Thus, Honey (2003) and Provencher et al (2002) found that over-reliance on others to deliver illness management was detrimental to fostering empowerment, whereas Auerbach and Richardson (2005) found that a more enabling form of external support for problem solving could be useful.

Again in keeping with the literature on wider mental health recovery (Marwaha and Johnson 2004, Lauber et al 2006) and resilience (Ungar and Teram 2000, Friesen 2007, Hart et al 2007), mental health professionals' and service providers' expectations of their clients' potential was identified as having a significant impact on participants. Krupa (2004) found that people had received contradictory messages from professionals, which increased the challenge of retaining work. High expectations on the part of professionals about the possibility of retaining work was experienced as encouraging, whereas the converse was demotivating (Gewurtz and Kirsh 2007, Strickler et al 2009).

Clinicians in the UK have been found to have low expectations of the employment prospects of service users with a diagnosis of psychosis (O'Brien et al 2003, Marwaha et al 2009, Rinaldi et al 2010) and for mental health service users generally (Rinaldi and Hill 2001) – a conclusion corroborated by research into service users' experiences of mental health services in the UK (Marwaha and Johnson 2005, Secker and Tebbs 2008). In the US, Killeen and O'Day (2004) found such low expectations to be embedded in the state programmes which their participants accessed, whilst O'Connell (2011) found that case managers' expectations varied but were the most reliable predictor of employment status among the other professional or client characteristics which they considered.

Honey (2003) suggested that practitioners should help clients identify and resist the risk of adopting stereotypes of themselves as incapable from their social networks. Unfortunately, in their UK-based study, Millward et al (2005) found that professionals themselves may have contributed to this process by making explicit statements about clients not being able to work. They maintained that this implicit reinforcement of an illness identity was made especially by day services, and that it undermined participants' aspirations and belief in the possibility of a return to work. It should be noted, however, that most participants were recruited from one day service, so it is less clear how representative this may be of other day services either at the time of their study or today. The authors also noted that participants valued the mental health services and used them to help normalise their lives (Millward et al 2005). It may then be mistaken to assume that removing the mental health service support would have helped set them on a trajectory back to work – indeed, they may have experienced a greater degree of isolation which further limited their recovery, as suggested by Bryant et al (2010) and Kelly et al (2010).

It seems that wider conceptualisations of recovery by professionals can support or undermine people's expectations of retaining work. Van Niekerk (2009) concluded that it was not helpful for either professionals or clients to view recovery as a return to their previous "feelings, ideals and decisions" (p463) about work. This is consistent with Krupa's (2004) argument that people should be supported to integrate and accommodate their mental health challenges at work rather than expect them to disappear.

Peers

Whilst not a main focus of any of the studies identified for the meta-study, findings across a number of the studies suggested that peer support from other people with mental health problems helped people sustain employment. Indeed it may be testament to the potential power of peer support that it emerged without being explicitly present in any of the studies' research questions. In Gioia's (2006) study it appears that the opportunities and benefits of peer support arose inadvertently from study participants being brought together as part of the research process. Peer support has been provided formally through self-help or peer support groups, and informally through people's own social networks (Killeen and O'Day 2004, Auerbach and Richardson 2005). Killeen and O'Day (2004) found that all participants who had success in sustaining work reported relying on peer support at some point. Similarly, Kirsh (1996) stated that her participants discussed the value of peer support "frequently and extensively" (p31). There was limited reporting or

discussion of mechanisms which may explain the benefits of peer support – though Hatchard (2008) stated that her participant benefitted from realising she was not the only person facing similar challenges in trying to return to work. Participants in Provencher et al's study (2002) stated that peer support increased empowerment, with those who had most vocational success expressing a desire to provide support as role models for others.

Whilst peer support in general terms is well established in mental health literature (Ernst and Goodison 1981, Solomon 2004, Stastny et al 2007, Lawn et al 2008), there is very little research into its role in mental health vocational services. There is, however, evidence of services making use of peer-support interventions. Harding (2005) and Moll (2009) describe peer involvement in the form of vocational mentoring and employing service users as vocational workers – but these do not necessarily entail the use of peer support groups. Davis et al (2008) used a support group as a control for their investigation of how people with schizophrenia evaluated Cognitive Behaviour Therapy (CBT) as an adjunct to work therapy. Participants reported greater satisfaction with CBT than the support group alone, particularly with regard to quality of service and help with problem-solving, but both control and CBT groups reported high levels of satisfaction (Davis et al 2008). Indeed, it could be argued that one would have expected CBT to have been most highly rated given that this intervention comprised both individual and group interventions, and has a high status attached to it – which may have influenced participant ratings irrespective of its relative efficacy. In Schene et al's (2007) RCT (see above) the authors report that the occupational therapy intervention involved 24 weekly group sessions involving discussion of progress and specific themes. Whilst the authors discuss whether the therapeutic elements can be understood in behavioural terms, unfortunately they do not consider whether peer support processes had any role in contributing to the positive job retention outcomes.

Job-related factors

In terms of job-related factors, the previous chapter has already made the case for how working has the potential to support recovery, suggesting that this in turn can support job retention. If work has the potential to promote recovery, then it follows that job retention may be helped by the person feeling able to sustain and return to work from a period of sickness absence. In considering some of the skills and personal attributes which may support retention, I have already indicated a degree of debate about the extent to which such skills may be developed through working, or in preparation for work resumption. To

this debate one can add that the more extensive evidence base regarding supported employment suggests that, for unemployed people with mental health problems, greater vocational success is achieved through developing skills in paid employment than through pre-vocational training (Bond et al 2008, Burns and Catty 2008). Similarly, most occupational therapy/science theory proposes that occupational performance in naturalistic (as opposed to clinical) contexts can be part of a therapeutic process (Clark and Larson 1993, Law et al 1997, Haertl and Minato 2006, Wilcock 2006, Kielhofner 2008, Leufstadius et al 2009, Kelly et al 2010).

Past working experiences

Past work history is one of the few consistent factors reported as a predictor of employment status for people with a range of mental health problems in a variety of contexts (Wewiorski and Fabian 2004, Nordt et al 2007, Catty et al 2008, Campbell et al 2010). Its emergence in some first-person studies as a factor which could influence job retention – but not always positively – is indicative of the contribution that qualitative research can make to qualify less nuanced quantitative findings.

Limited past experience of working made sustaining work more difficult because it made it harder to consider future possibilities (Gewurtz and Kirsh 2007) and undermined worker identity (van Niekerk 2009). Kirsh (1996) emphasised the value of past positive experiences of work, while Millward et al (2005) found that negative past experiences were presented as reasons for people not to return to work and could override positive experiences. Gewurtz and Kirsh (2007) placed a similar, but more explicit emphasis, on how people interpreted such negative experiences, decisive as to whether they disengaged from work. Gioia (2006) noted that some of her findings were not consistent with previous research, which she acknowledged had suggested that past work experience was the best indicator for future vocational success. Whereas Gioia (2008) found that the fact that some people had working histories led them to feel worried about “exposing themselves with their illnesses at work” (p186). This finding may reflect a specific concern of her participants, who had received a diagnosis of schizophrenia for the first time, and thus may not be applicable to people with established diagnoses of other mental health problems. It also may underscore the importance of individuals achieving some acceptance of, and strategies to live with, ongoing mental health problems, in order to fully deploy previous vocational strengths.

The possibility that past working history may be beneficial because it bolsters a sense of worker identity has been challenged by Honey (2003), who disputed the significance and value of the concept of ‘work identity’. She maintained that all her participants – including those with limited past experience and those who struggled to find or retain work – had work identities, a formulation which she criticized for being “a professional concept not applied by these participants to themselves” (p273). Kirsh (1996) raised related doubts, reporting that her study did not find evidence of a work ethic contributing to the reintegration of people with mental health problems into work (though she did not report any contrary evidence either).

Even if most people – other than certain professionals – do not use the *linguistic term* ‘worker identity’, the *concept* is arguably relevant to understanding people’s needs and experiences, and nurturing that identity may help to promote vocational and general recovery. So while Honey (2003) proposed lack of confidence as a factor which had a more significant negative impact on employment than presence or absence of a worker identity, it may be that the two are related. Nurturing worker identity, in the face of competing identities, may serve to boost self-confidence and increase the possibilities for positive work trajectories. This may particularly be the case if mental health services do not consistently recognise the extent to which work forms part of the lives of some of their service users, or if they reinforce more passive sick role identities.

Accommodations

Claims in the previous chapter that work could be both toxic and supportive to recovery point to how the form or nature of a job can influence job retention. Of particular importance appears to be how the demands of work interact with a person’s mental health problem. Krupa (2004) described how people developed vigilance to early signs of relapse, and identified those aspects of work that triggered symptoms and others that promoted well-being. Jobs that supported flexible and part-time working were considered helpful to some people’s efforts to retain employment (Kirsh 1996, Krupa 2004, Gewurtz and Kirsh 2007). Strickler et al (2009) summarised the aim of a successful job match as to “maximise the positive and minimize the negative aspects of working” (p267).

This importance of the nature, or form, of a job indicates how retention can be supported by accommodations (changes to a job role, setting or task). There is a limited evidence base for the value of specific job accommodations for people with mental health problems, though they commonly include changes to working hours; time off to attend

therapy; and, adjusting, temporarily or permanently, tasks within a job role (Schultz et al 2011). Adjustments that help may be less tangible than some physical environment changes and also may not be as closely aligned with diagnosis as they would be with some physical conditions. This may partially explain the lack of detail relating to specific accommodations in many reviewed studies; instead, these tended to advance in more general terms the benefits of formally agreed accommodations to the nature and structure of work to support retention.

Provencher et al (2002) concluded that accommodations were an effective vocational intervention, particularly for people whom they identified as being in the second of their three profiles of recovery. These were people who did not feel completely overwhelmed by their mental health problem, and saw work as a potential source of self-empowerment, despite facing internal and external barriers to participation. It may have been the absence of accommodations that appeared to leave people in van Niekerk's (2009) South African study feeling that they were having to start afresh every time they resumed work after a relapse. By contrast, the US-based participants in Auerbach and Richardson (2005) did receive and benefit from adjustments. Their experience was not uniformly positive, with some considering that they had received insufficient training to do their job (Auerbach and Richardson 2005). This finding was echoed in Killeen and O'Day's study (2004), where the participants encountered barriers accessing development opportunities – implying that insufficient accommodations had been made in this area. Strickler et al (2009) found that people who had the greatest difficulty sustaining consistent work also had the greatest difficulty coping at work and accessing support to overcome challenges. This suggests that putting the onus on individual workers to initiate accommodation requests may be problematic.

Accommodations to working schedules were specifically highlighted in Auerbach and Richardson (2005) as helpful, and implied as useful by people interviewed by Gewurtz and Kirsh (2007). Krupa (2004) viewed the challenge of accommodations in a more dynamic way; accordingly, people had to find a way to negotiate “tasks demanded by the work environment in the presence of ongoing features of the illness” (p10). Similarly, Gates (2000) found the interactive process of accommodation to be important, but placed an emphasis on the social prerequisites for this to be effective – criticising a traditional view of accommodations focused on job tasks and routines in a physical environment, on the grounds that it ignores the people involved. Other research (notably in North America) has also stressed the importance of the process of identifying and agreeing workplace

accommodations (Shamberg 2005, Williams et al 2006, Schreuer et al 2009). Fleten and Johnsen (2006) considered that the raising of awareness of the possibility of accommodations may be one explanation for why they found that a postal questionnaire and information resulted in an earlier return to work for sick-listed Norwegians with mental health problems.

Co-ordination between the worker, health professional, workplace colleagues and managers was identified as a particular area to develop in Gates's (2000) psycho-education programme. This was typified as a form of relationship accommodation in the way it aimed to help colleagues and managers develop an understanding of mental health problems. The less formal approach to promoting acceptance, described in Hatchard's (2008) single-case study, involved developing a plan for managing workplace challenges in collaboration with an occupational therapist. This, combined with a new clarity about diagnosis, helped the participant feel confident to request accommodations and thus feel more assured in colleague interactions (Hatchard 2008).

Occupations beyond work

In circumstances where people found their work particularly unfulfilling, with or without accommodations, some looked to develop a positive vocational future beyond their main employment by volunteering, adult education, and advocacy work (Provencher et al 2002, Killeen and O'Day 2004). This, of course, depends on the availability of opportunities. Others used occupations outside their main employment to sustain both their recovery and working lives. Although there are some who dispute the value of the concept of work-life balance (Primeau 1996, Runté and Mills 2004, Fincham 2008), Hatchard (2008) found it helpful, suggesting that in her single-case study mindfulness and an education class contributed to stress management. Similarly, Provencher et al (2002) referred to a range of active and restful non-work occupations which people used to reduce feelings of stress. General benefits of hobbies, sports and community involvement were identified as supportive of vocational recovery because they promoted the capacity to be active (Kirsh 1996, Auerbach and Richardson 2005). Some occupational roles outside work were identified as helpful alternative identities to a sick role (Millward et al 2005), and helped bolster a more robust and active self-definition congruent with working roles.

Chapter conclusion

This chapter has reviewed knowledge and practice relating to supporting people with mental health problems to retain work. The extent to which policy has addressed this issue

– in the UK in particular – was considered. This suggested that, after an initial focus on helping unemployed people with severe and enduring mental health problems to find and sustain work, there has been an increasing concern with helping people with more common mental health problems, largely in the form of CBT interventions through the IAPT program. I agree with some of those who have questioned an apparent assumption that CBT's efficacy in reducing symptoms will of necessity resolve challenges that people with mental health problems face at work. My policy discussion also pointed out that debates about welfare benefit entitlement have largely obscured the financial situation of employed people who find themselves having to take sick leave from work.

There has been some development of specific job retention interventions for people with mental health problems which have a stronger workplace focus than CBT, but evidence for specific programmes remains very limited – particularly in the UK. Drawing heavily on findings from my meta-study, I then discussed evidence for a range of strategies and influences on job retention. Those focused on individual workers included ways to help people manage or live with their mental health problems, the value of problem solving, coping and communication skills, and the role of motivation. Self awareness, belief in self-efficacy, hope and empowerment were commonly identified as factors associated with sustaining work. There were varying views about the extent to which these skills and attributes were contributors to or outcomes of vocational success. Similarly, while there was greater support for such skills and attributes to be developed through working, some studies emphasised their development away from the workplace.

Research suggests that other people can play an important role in either supporting or reducing people's prospects of retaining work. Acceptance and understanding from colleagues and particularly line managers has been found helpful. Conversely, conflict and stigma form major barriers. In light of these points, some studies have shown a particular concern with how best to approach the question of disclosure of mental health problems at work. Whilst there was consensus that this was usually desirable, approaches varied. Those which normalised disclosure as a form of management of personal information may hold most promise here. There was limited detailed consideration regarding the role of family and friends. Encouragement and concern was often found helpful, except when attention was focused on symptoms alone or if it was assumed that people always needed to be protected from work. The influence of family – either positive or less constructive – arose frequently enough to suggest that further research is warranted. Some of these themes were shared with regards to support from mental health professionals. Low

aspirations on the part of professionals may risk becoming self-fulfilling prophecies. Research into first-person experiences has often emphasised the importance of there being a collaborative, empathetic and supportive relationship between professional and mental health service user. Much of this research has arisen with regard to people with severe and enduring mental health problems. The extent to which it applies to those with less severe or more short-term acute problems is not known. None of the meta-study papers focused on peer support, yet it emerged as a commonly cited – albeit only partially explored – source of vocational support by people with mental health problems.

The previous chapter discussed how the doing of work may contribute to recovery – this forms one of the job-related factors which evidence suggests helps people retain work. Past experience of having worked was confirmed as a generally (but not universally) supportive factor – possibly because it bolsters a sense of worker identity. Despite being less tangible and often focused on relationships at work, accommodation to job tasks and roles were also found to be helpful. However, these were not always developed or implemented. Finally, some research reported how people used occupations outside of their main work role, either to develop alternative careers options or to find occupations which provided a source of meaning and balance.

The following chapter will complete the literature review by considering some key perspectives which have emerged as relevant to the topic.

Chapter 4: Frames of interpretation and literature review conclusion

Introduction

One of the aims of the meta-study approach to the literature review is to identify, consider and appraise the theoretical underpinnings of a body of research (Paterson et al 2001). This involves revealing the assumptions underpinning the theories in question, and exploring paradoxes and the compatibility of alternative frames of interpretation; and it may also involve proposing alternative frames of interpretation.

Through both preceding chapters, a number of paradigms and theoretical frameworks have emerged as explicitly or implicitly relevant to understanding the challenges confronting people with mental health problems who are seeking to retain their work. The most significant appear to be a biopsychosocial framework, a recovery paradigm, occupational perspectives, and resilience. In this chapter I evaluate the contribution of these perspectives to understanding the job retention needs of people with mental health problems, while also using them to summarise the literature review findings, indicating areas where further research appears most needed. Following this, I conclude the literature review with some general appraisal of methods and methodological characteristics of the reviewed literature, and by outlining a rationale for my subsequent methodology chapter.

Biopsychosocial frame of interpretation

The label *biopsychosocial* has been used to describe perspectives and therapies which integrate biological, psychological and social factors (Pilgrim 2002). It has been argued to be particularly relevant – and indeed to be superior to narrower medical models – to understanding the return-to-work needs of people on sick leave with a range of conditions (Peters et al 2003). The importance of, and interrelationships between, the biological, psychological and social emerged powerfully from the literature review.

Mental health symptoms and the demands of managing them were major challenges to sustaining employment. Of particular importance was whether people felt able to move beyond feeling engulfed by their mental health problem. Thus symptoms and their impact should not be ignored, but – as Shepherd (2012) has argued – nor should they form sole criteria for judging the success of job retention strategies or wider recovery. This appears to be a limitation of some policy expectations for cognitive behaviour therapy (CBT) based interventions to be able to help people with mild to moderate mental health problems return to work. Nonetheless, wider psychological perspectives help understand how a person's capacity to deploy strategies for living with their mental health problems could

influence prospects of retaining employment. Self-awareness, problem-solving, communication skills, motivation and belief in self-efficacy were amongst those skills and capacities that were particularly highlighted by the literature review.

The social environment of work provided a potential arena to overcome the social isolation associated with the experience of mental health problems. However, this ceased being a positive influence on retention when people experienced conflict, stigma or discrimination at work. There was some support for the value of distinguishing between anticipated and experienced stigma. Disclosure of mental health problems at work was a consistent concern and generally considered desirable – as long as there was sufficient acceptance in the workplace – but need not involve disclosing full details about one’s mental health problems, to everybody, and to an equal extent. Outside work, families had the capacity to provide effective support when this was experienced as helping people lead their lives, rather than focusing predominantly on illness management and monitoring. Mental health services and professionals could undermine job retention by having low expectations of their clients’ working potential. They could support job retention through interventions with a workplace focus and a collaborative relationship. Peer support emerged as a consistently positive factor, though with limited direct exploration of its role. UK policy has emphasised how enabling participation in work supports social inclusion. However, it remains the case – despite the Improving Access to Psychological Therapies (IAPT) development – that most vocational policy attention has been focused on the very real needs of people with severe and enduring mental health problems who are out of work. It may be that economic factors have limited the consideration of the needs of people already in work.

A review of factors which influence the implementation of individual placement and support (IPS) has found four key barriers (Rinaldi et al 2010), all of which can be seen to reside mainly in the social environment: firstly, the fears of professionals, individuals and their families of the impact that work might have on people; secondly, a culture of low expectations – particularly in mental health services; thirdly, a failure to provide the support that evidence suggests works; and fourthly, the global recession. All but the third resonate with the literature findings. For the third, there is insufficient clarity and consensus about what job retention approaches work to be able to say there is a failure to implement specific support. But the evidence I have reviewed does suggest that support from others can be helpful, and gives some indications of how. Further exploration of the

contribution that various types of support can make for people seeking to retain employment and identifying suitable frameworks to analysis is therefore recommended.

Recovery paradigm

More recently, some have sought to locate the biopsychosocial perspective within the recovery paradigm introduced in the first chapter (Noiseux and Ricard 2008). However, tensions arguably remain between the emphasis on symptom reduction implied by biological (and some psychological) approaches, and the quality of life lived, as stressed in recovery perspectives (Bonney and Stickley 2008). This tension was an apparent and not fully resolved theme in the literature review. For instance, there were varying emphases on the benefits of a focus on illness management versus management of life with illness.

Recovery ideas (Anthony 1993, Deegan 2001, Repper and Perkins 2003, Bonney and Stickley 2008, Brown et al 2008) – emphasising hope, empowerment and the quality of life lived, rather than the presence or absence of symptoms – were very apparent and often explicitly referred to in the literature reviewed. Hope and empowerment was portrayed as both an outcome of recovery and a contributor to it. Thus retention of employment was often promoted when people had a sense of hope and a view of recovery that was functionally, as opposed to medically, defined. Such a functional definition of recovery precludes narrow medical perspectives which may maintain that one has to have recovered first before resuming life roles such as work. This is because the extent to which a person is able to lead the life that they choose is central to understandings of recovery (Social Perspectives Network 2007). There appeared to be a degree of consensus about how people seeking to sustain employment might benefit when they find ways to transcend, but not ignore, their mental health problems. This process of transcendence, present in wider recovery literature (Deegan 2001, Repper and Perkins 2003), appeared to be best supported when it did not necessarily involve a return to a former self, but supported a reconstruction of the self, developing and inspired by self-belief, hope and empowerment.

The notion of a process also relates to the value of understanding peoples' recovery journeys. Use of first-person experiences would appear vital to recovery-orientated research because of the argument that the people best placed to judge their quality of life – and therefore their recovery – are recovering individuals themselves (Deegan 2001, Cohen 2005, Gray 2006) Most of the reviewed qualitative studies did this by asking people to reflect back on their journeys, often from the perspective of variable points along the way.

There is an argument for also understanding how people prospectively encounter the challenges they face as they seek to navigate their way back to work.

Occupational perspectives

Empirical research and theoretical arguments have proposed that ‘recovery’ and concepts from occupational therapy and occupational science are highly compatible (Gruhl 2005, Lloyd et al 2008b, Kelly et al 2010). They point to shared concerns with people harnessing their strengths and defining their own recovery in relation to what they are able to do in their lives (as opposed to presence or absence of symptoms). Lal (2010), though, is one occupational therapist who offers a more critical consideration of the concept of recovery, arguing that people commonly combine clinical understandings of recovery with more functional and socially based understandings. This point found support in some of the reviewed literature, which suggested that symptoms did matter to people and their working lives. It is also the case that wider occupational therapy practice models (Law et al 1997, Reed and Sanderson 1999, Kielhofner 2008) and occupational science theory (Clark et al 1991, Wilcock 2006, Matuska and Christiansen 2008, Clark and Lawson 2009) acknowledge that biological factors can be an important influence on occupational participation. Nonetheless, there was a strong sense that resuming the occupation of work formed part of what many participants understood by recovery.

Achieving a successful return to work appeared partially related to a range of influences that can be described in terms of the form, function and meaning of the occupation of work. Occupational scientists have considered study of the form, function and meaning of occupations as central endeavours of occupational science (Clark et al 1991, Larson 2004, Russell 2008, Dickie 2009, Hocking 2009). An aggregation of their definitions is used in the following paragraphs, giving some credence to their claims that analysing occupations in this way can help deepen knowledge of human occupation.

The form of an occupation comprises its discernible physical, temporal, social, cultural and historical aspects. My literature review has drawn attention to how these aspects of people’s work could either promote or reduce prospects for job retention. These included factors related to alienation, control, a level of demand that exceeded or failed to meet people’s capacities, conflict, discrimination and precarious employment. Conversely, characteristics of occupations which may support retention included: flexibility (from the employee’s perspective); routine and daily structure; positive social contact and support; material reward; a degree of physical, emotional and cognitive challenge that individuals

found matched their capacities; accommodations to jobs (though detail was often lacking); and anti-discriminatory legislation.

The function of an occupation is the outcome – intended or otherwise – it produces for those who participate in it. My literature review suggests that in broad terms work occupations could function in ways which could be either toxic or beneficial to health and well-being. These related to how various occupations provided social contact, material resources, opportunities for productive or creative participation (or a denial of these) and a source of social and self-identity. These factors in turn could either increase or reduce self-confidence, motivation and hope.

Meanings which people ascribe to occupations include symbolic, aesthetic, economic and other evaluations; and the purposes and goals which they consider occupations enable them to pursue. As with the forms and functions, different occupations at work, for different people, had meanings which could increase or reduce their attachment to – and thus participation in – work. A work occupation could mean a person felt they were an independent successful citizen, who was well and was fulfilling expectations of immediate friends and family and wider society. One problem some found with these meanings was that when they could not work, feelings of guilt and inadequacy were generated. At other times, work occupations could also be perceived as a source of stress, a threat to recovery, or an unfulfilled obligation.

Arguably there is a risk that an emphasis on the form, function and meaning of occupation can lead to insufficient attention to the *doing* of occupation – i.e. experiences and impacts of working – which also emerged as an important factor influencing job retention. Nelson (1988) maintained that doing may be ignored if occupation is defined by its form alone (the same could be said of function and meaning). He also stresses the importance of the occupational performance which is elicited by an occupation's form and to which people could respond by adaptation. The literature contains suggestions on how occupational form shaped experiences of work occupations – but also how some people were able to adapt to work despite illness, making use of a range of strategies including problem solving, communication skills and lifestyle management. Others benefitted from more compensatory strategies, where either the workplace environment (often social) or job tasks and roles were adapted – though detail was often limited.

The literature supported claims made concerning theoretical (Wilcock 2006) and research (Creek and Hughes 2008) justifications for a link between occupation and health – but also bore out the limitation, noted by Creek and Hughes (2008), that there is

insufficient knowledge of the mechanisms by which occupation may influence health. This supports the case for conducting more research that seeks to understand the mechanisms involved in how working may have supported or undermined mental health recovery.

On balance the literature review also supported Wilcock's (2006) thesis that through doing people shape who they are – they *become*. The doing of work both developed, and was developed by, a person's identity, in ways that could either diminish or enrich identity and occupation – depending on the quality of experiences and the interpretations placed upon them. Some contrasted illness-related identities to a more positive worker identity. This formulation was rejected by one author for being a professional construct, though I argued that the concept could still be relevant and is consistent with wider occupational science and therapy theory – even if not routinely used by people to describe themselves. A proposed integrated identity of the self as a worker with a mental health problem was also advanced. This appears to transcend the binary opposition of sick and worker identities in a way that is consistent with the other findings, which also pointed to the value of acknowledging the impacts of mental health problems without allowing them to restrict vocational aspirations.

An alternative account, according to which meaning was a greater source of identity than occupation, found more limited support. That account appears consistent with Reed et al's (2011) apparent attempt to reify meaning, as well as their criticisms of other authors for discussing meaning “as *merely* a characteristic of occupations that is subjectively experienced, dynamic, and motivates participation” (p305 – my italics). However, applying the word ‘merely’ to subjective experience, dynamism, and volition in occupation appears highly problematic. In relation to the job-retention challenges facing people with mental health problems, these aspects are often of central importance influencing the unfolding return-to-work trajectories.

Wilcock (2006) also added *belonging* to her formulation of *doing*, *being* and *becoming*. In this she is in line with others (Jakobsen 2004, Braveman et al 2006) who have suggested the importance of considering social context not just as a background factor, but in terms of its centrality to occupational participation at work. The mental health literature in this review certainly emphasized the role of people at work, and also family, friends and mental health professionals in influencing prospects for job retention; however, more knowledge of these roles in different contexts as people try to return to work may be useful.

An orientation towards occupational performance necessitates attention, not just to occupations, but to the person doing those occupations and their environmental context. This explains why many occupational therapy professional practice models are consistent with a person-occupation-environment framework (Law et al 1997, Reed and Sanderson 1999, Iwama 2006, Brown 2008a, Kielhofner 2008). This framework has been applied to the work context (Jansson and Bjorklund 2007, Hatchard 2008, Kirsh et al 2009) and contrasts with individual psychological perspectives (such as McGurk and Mueser 2006), by drawing attention to the job a person does and also to their workplace. It also contrasts with psychosocial approaches which consider the individual and his/her social environment (eg Thomas and Secker 2005b, Krupa 2007), but, arguably, insufficiently consider the occupation of work by conflating job-related issues with either the individual or their workplace. Occupational therapy literature considers the environment to be an area that can be adapted just as much as the person - or occupation - related components can. This includes work-related contexts (Davis and Rinaldi 2004, Shamberg 2005, Braveman et al 2006, Barnes et al 2007, Ross 2008, Arbesman and Logsdon 2011) as well as in general contexts and theory (Law 1996, Reed and Sanderson 1999, Whiteford 2000, Creek 2003, Finlay 2004, Kielhofner 2004, Iwama 2006, Hocking and Wright-St. Clair 2011).

Hocking (2009) and Dickie (2006) have raised concerns that there is a lack of integration of the elements of person-occupation-environment frameworks which underpins occupational therapy practice models and related theory. Nonetheless, the literature review suggests that this framework is sufficiently complex to capture many of the multi-factorial processes and themes suggested by the reviewed research. As such, the framework may usefully contribute to context-specific research which seeks to identify mechanisms which may be transferable, or to some degree relevant, to similar contexts.

Resilience

The relevance of the concept of resilience emerged less explicitly from the literature than the other perspectives – as such it can be seen as an alternative frame of interpretation suggested by the meta-study (Paterson et al 2001). Influenced by one of my supervisors, Professor Angie Hart, over the course of my research journey I developed an interest in, and understanding of, resilience theory and practices. Masten (2001) has defined resilience as “a class of phenomena characterised by good outcomes in spite of serious threats to adaptation or development” (p228). As we shall see, other definitions exist, placing

varying emphases on the nature of the phenomena involved and the extent to which resilience is a process or an outcome.

At first, my interest in resilience was of a parallel nature, perhaps because much resilience-related literature has focused on children and families, or the legacy of childhood experiences in later life (Masten 2001, Ungar 2001, Hart et al 2007). Then, with support of experts in resilience (including expertise derived from personal recovery experiences), I found that the concept resonated with issues in my research and the field of adult mental health generally. I initially considered whether resilience was synonymous with the concept of recovery in adult mental health. For me, this possibility was increased on reading the *Handbook of Adult Resilience* (Reich et al 2010) which neither discussed nor acknowledged the body of recovery literature in its otherwise scholarly and thorough chapters. Similarities are certainly apparent.

The notion of bouncing back (or up) following some kind of adversity is present in recovery (Cohen 2005, Deegan et al 2005, Gray 2006, Noiseux and Ricard 2008) and resilience (Schissel 1993, Netuveli et al 2008, Aumann and Hart 2009, Masten and Wright 2010) literature. However, resisting or overcoming adversity appears a more consistent theme in resilience literature. Thus, the value of developing resilience, rather than expecting that adversity can always be avoided, is particularly present (Masten 2001, Luthar and Brown 2007, Cyrulnik 2009). Research on resilience has suggested that past experiences of successful recovery from adversity, or even a more limited survival, can contribute to future resilience (Polk 1997, Werner and Smith 2001, Cyrulnik 2009). In my literature review the challenges of isolation, conflict, stigma, symptoms, and in some cases material hardship were all part of a landscape of adversity confronting people with mental health problems as they attempted to retain work.

Both resilience and recovery perspectives are positively orientated in that they look for strengths people display and seek to learn from those, rather than focusing on 'deficits' alone. In the recovery literature there is an emphasis on nurturing strengths (Anthony 1993, Deegan 2001, Lloyd et al 2008b) and some qualitative studies' concern with learning from the strengths displayed by workers with mental health problems (Cunningham et al 2000, Killeen and O'Day 2004, Cohen 2005, Woodside et al 2006, Dunn et al 2008) signalled the potential relevance of resilience to my research topic. In their exposition of how the concept of resilience can help understanding of recovery and sustenance of well-being, Zautra et al (2010) argue that strengths and vulnerability are best understood as separate constructs, rather than bipolar opposites of a single phenomenon. This

formulation could possibly explain some of the paradox of how work can act as both a potential stressor, as well as a resource which can provide strength in recovery.

Furthermore, if strength and vulnerability are not part of a shared continuum then this may explain the suggestion that strategies informed by a stress avoidance agenda – possibly encouraged by influential stress-vulnerability models of mental illness (Powell 2000) – may not be helpful in vocational terms (Provencher et al 2002, Honey 2003). By contrast, my literature review findings suggest that a degree of acceptance of mental health problems, coupled with flexible illness - or lifestyle-management strategies, was found to be helpful. Van Niekerk's (2009) conclusion regarding a worker's ability to respond to mental health problems with flexibility, tolerance of mild symptoms and to "roll with the punches" (p463), was particularly redolent of resilience formulations.

Other individual attributes in the literature review and recovery writings also cohere with resilience conceptualizations. There is an emphasis on individual traits or attributes in some of the broadly psychological resilience research (Crowley et al 2003, Tugade and Fredrickson 2004, Grote et al 2007). Notably, having a positive identity has been identified as a key internal resource that promotes resilience (Skodol 2010). Similarly, hope and a capacity to live with challenges has also been a central feature of resilience literature (Edwards 2005, Ong et al 2006, Dowrick et al 2008). Some recovery accounts have explicitly referred to the resilience displayed by individuals (Cohen 2005, Deegan 2005, Dowrick et al 2008, Edward et al 2009). A central aim of such accounts is often to challenge negative and passive views of people with mental health problems as victims, dependent on mental health systems to rescue them. An understandable consequence of this aim is that sources of resilience more related to the individual come to be emphasised. This is potentially problematic if this emphasis is detached from the implicit critique of paternalistic service provision – and thus may explain criticism by some service users that they feel recovery perspectives are being used to justify what they see as services withdrawing support and so undermining the sustainability of their recovery (Social Perspectives Network 2007).

Yet, rather than counterpoising individual resilience to service provision, Ungar (2005b) has gone so far as to define resilience as "Adequate provision of health resources necessary to achieve good outcomes in spite of serious threats to adaptation or development" (p429) – here writing in the context of the predominantly child-focused resilience literature. Rutter (1999) maintains that "resilience does not constitute an individual trait or characteristic" (p135). An investigation of educational success amongst

African Americans born into poverty led Abelev (2009) to conclude that resilience need not entail leaving individuals to resist adversity on their own. In a similar manner, this time in a quantitative study of outcomes of childhood adversity in adulthood, Roisman et al (2002) argued that resilience is best understood as “an emergent property of a hierarchically organized set of protective systems that cumulatively buffer the effects of adversity and can therefore rarely, if ever, be regarded as an intrinsic property of individuals” (p1216).

There is a strong body of resilience research and theory which follows this ecological perspective of resilience and is not restricted to looking for evidence of resilience in individual attributes and capacities (Egeland et al 1993, Werner and Smith 2001, Jones et al 2006, Hart et al 2007, Ungar et al 2007, Drury et al 2009, Kent and Davis 2010). Here resilience is seen as a process, or outcome, residing in both individuals and their context and collectivities. It follows that resilience-building can aim to build individual and environmental assets – or challenge restrictions to both. Much of this resilience literature, however, relates to children, families and young people; though a World Health Organisation report for the European region (Friedli 2009) has made the case for both individual and wider societal public health solutions to increase resilience and improve mental health and well-being.

While concepts and theories of resilience are increasingly being discussed in relation to adults with mental health problems (Cohen 2005, Deegan 2005, Ong et al 2006, Edward et al 2009, Reich et al 2010) there is very limited explicit application of them in relation to the topic of work and mental health. As well as referring to recovery approaches, the *Working our way to better mental health* policy document (Department for Work and Pensions and Department of Health 2009) proposed that people with mental health problems may experience more success at work if they are resilient, where this was defined in predominantly individualistic terms, as having the capacity to endure adverse circumstances and maintain emotional stability and well-being. Furthermore, claims for the relevance of resilience in this document were largely reliant on research and practice interventions focused on developing resilience through childhood and adolescence.

The concept of resilience can be found in the more general world of work-related literature. However, here a more sophisticated understanding of the concept is often absent. Thus, some resilience-at-work tools, interventions and resources focus on how individuals can be made more resilient to cope with pressures of work (Northup 2005, Lioassis et al 2009, Robertson and Cooper 2011) and display limited consideration of how

these pressures could be reduced. Exceptions to this include the research report produced for the Chartered Institute of Personnel and Development, which presented the relevance of resilience to the workplace with a thorough grounding in resilience theory (Lewis et al 2011), though cites limited research directly related to the world of work. A similar environmental perspective of resilience is apparent in the blogs and guide produced by *The Resilience Space* (2012) which also criticizes elements of positive psychology for an expectation on individuals to change their thinking to cope with adversity. Environmental dimensions of resilience are partially considered in the Emotional Resilience Toolkit (Emotional Resilience Steering Group 2009), which was developed by a collaboration of a number of UK governmental, voluntary sector and business organisations – however, there remains an emphasis on the emotional resilience of the individual, rather than of the organisation.

While *occupation* does not feature in the resilience literature to the same degree as factors related to the individual and their environments, the concept does not appear to preclude it. Zautra et al (2010) write about resilience in a way which implicitly acknowledges the significance of the occupational nature of people: “sustainability calls attention to outcomes relevant to preserving valuable engagements in life’s tasks at work, in play, and in social relations” (p6). Aumann and Hart (2009) provide examples of how a range of play, leisure and learning occupations may not just be outcomes of resilient practices, but can contribute to helping children with complex needs recover from adversity.

There has been limited explicit consideration of resilience in the occupational therapy literature. Fine (1991) explored the concept of resilience in presenting findings from her research into the narratives of how people have survived or overcome a broad range of adversities; Price et al (2012) used a case study of one man’s recovery from stroke to attempt a similar discussion; while Lopez (2011) discussed the concept of resilience in relation to the challenges faced by people with a diagnosis of post-traumatic stress disorder. All these papers shared a concern with the threat to identity posed by adversity. They agreed that coping strategies, problem solving, re-appraisal or reflection, as well as hope and motivation, all helped produce resilient responses. The performance of occupations was seen as helping people to find meaning and purpose in their lives and thus maintain an occupational identity that fostered resilience.

All stressed the importance of support from others as an environmental factor that contributed to resilience. However, in contrast to Ungar’s (2005b) unequivocal definition

of resilience as involving the adequate *provision* of supportive resources, these occupational therapy papers emphasise the capacity of individuals to access that support, rather than the extent to which it is provided. In Fine's (1991) study, a concern with "recruitment of social support" and "how persons manage to harness the necessary resources" (both p496) may have been motivated in part by a key aim of her paper to encourage occupational therapists to pay greater attention to their clients' "inner lives ... [to] add perspective to our professional assumptions and enhance our understanding of human performance capacity" (p501). By contrast, interpretations of the role of social support in the other papers appeared to be more allied to a narrower understanding of resilience as an individual attribute or characteristic. Thus Price et al (2012) adopted Connor and Davidson's (2003) characteristics of resilience including an evaluation of the extent to which individuals "engaged the support of others" (Price et al 2012, p113) and not the amount or nature of available support. Similarly, Lopez (2011) defines resilience as "a stress-resistant personal quality that allows the individual to perform occupation in the face of adversity" (p34), one aspect of which is whether people "look to support" (p35). Beyond social support, other environmental factors find only limited consideration, particularly in Price et al (2012) and Lopez (2011). There was not the same emphasis on the role of poverty and constellations of disadvantage as found in some other resilience literature (Werner 1993, Hart et al 2007, Abelev 2009, Canvin et al 2009). Indeed, Price's study could be criticised for failing to acknowledge that the personal wealth of their single subject, which enabled them to charter a yacht and captain to sail around the San Juan Islands, was an asset which helped them overcome their adversity and is not available to many.

Understanding resilience as emerging from complex processes involving interactions between individuals and their environments (Fonagy et al 1994, Rutter 1999, Masten 2001) has enabled researchers and practitioners to see resilience as something that can be developed and nurtured (Ungar 2001, Hart et al 2007, Luthar and Brown 2007). This literature review suggests that there is evidence of this development occurring as some people with mental health problems seek to retain their work. It can be found at the individual level as they construct and deploy their own strategies or are helped by others to do so. It can also be seen in attempts to create more supportive environments, either at the immediate level of the workplace or at the level of policy and service developments. Consideration of resilience seems to bring with it an emphasis on the sustainability of recovery that adds to the other perspectives. More ecological conceptualisations of

resilience, which are more widespread in relation to children and families, may help in understanding the adversities that workers with mental health problems face, and may also call attention not just to whether they manage to return to work, but the sustainability of the return.

Conclusion

This chapter has discussed four frames of interpretation that the literature review, based on Paterson et al's (2001) meta-study approach, has suggested can make useful contributions to understanding the job-retention challenges of people with mental health problems. A biopsychosocial perspective draws attention to the importance of the impact of biological symptoms, but does not give this primacy over psychological factors or environmental factors which may also support or restrict the prospects for a people with mental health problems to retain employment. Recovery perspectives further emphasise the quality of life lived, rather than the presence or absence of symptoms, and understand that return to work may be part of an individual recovery journey in which hope and empowerment play a significant role. Occupational perspectives can consider the form, function and meaning of different work occupations, suggesting mechanisms which can influence return-to-work trajectories. Occupational science stresses the importance of the 'doing' dimension of occupations and thus the powerful impacts that working potentially has on well-being, identity and sense of belonging. Person-environment-occupation frameworks signal how workers may develop new or lapsed skills, how occupations at work may be modified and how workplaces may be adjusted to support job retention. Notwithstanding their limited application in the area of work and mental health, more ecological conceptualisations of resilience appear relevant to understanding the strengths of, and adversities faced by, people seeking to retain employment. These strengths and adversities may be located in themselves, others and their environments; they may respectively help or hinder attempts not only to return to work but to make that return sustainable.

This literature review has thus provided some justification for biopsychosocial, recovery, occupational and resilience perspectives to be used as orientating concepts in mental health job retention research. It may also be the case that, in the process, further insights may be gained into how these perspectives may themselves be applied and developed. In suggesting their relevance I do not preclude other theory from emerging as relevant (as the next chapter will explain). That other bodies of theory – and indeed other

findings – may emerge is perhaps not unexpected given some of the limitations associated with the body of literature that I have reviewed.

The methods used in much of the qualitative research were often more clearly reported than their underpinning methodologies and predominantly described interview designs at various stages of recovery. While there were some longitudinal studies, many were retrospective studies in which participants reflected back on their experiences. This often enabled the research to make fruitful use of people's reflexive appraisals of the significance of their experiences in trying to sustain work; however, it also meant that no study focused on how people understood the challenges of returning to work whilst they were currently off work, or only recently returned. This may be important, since – whatever people may think in retrospect – it remains unclear the extent to which people feel motivated and able to address work-related issues when experiencing a mental health problem of a degree that involves them being on prolonged sick leave (and perhaps receiving acute mental health service support).

Throughout the literature review I have referred to research related to IPS. In part this is because some of this has clear relevance – since once someone has been helped to find work, IPS then seeks to help them retain it by providing ongoing support. However, it is also the case that there is simply more IPS literature than literature focused on the job retention needs of people with mental health problems. Thus the review has used research which often included a mix of participants who were both employed and unemployed, asking them about their experiences of work in more general terms. The studies specifically concentrated on people with mental health problems who have jobs which they are seeking to retain were much more limited. As well as drawing on IPS literature, much of the wider research relates to the musculoskeletal literature, or that on general disability and work. This reflects the comparatively limited amount of research that has been conducted into job retention for people with mental health problems. Within this, the lack of UK-based evidence is also notable, leading a Sainsbury Centre for Mental report to conclude that “The need remains for research conducted in the United Kingdom that evaluates interventions that deliver early effective return to work for people who have experienced a period of mental ill health ...” (Seymour 2010 p3).

Some quantitative research may suggest that explanations have been identified when in fact all that has been established is an association (Goldacre 2009). Some qualitative research more or less explicitly abandons the quest for explanation, preferring to provide rich and thick descriptions. The reviewed studies varied in the extent to which they

claimed they were providing description, presenting perspectives, or revealing factors or mechanisms involved in job retention. Sometimes this was clearly related to their methodologies – most commonly described as interpretative, phenomenological or grounded theory – but there was often limited explication of this.

The challenge for those seeking to develop strategies for supporting themselves or others arguably involves a need to explain phenomena. Explanation of phenomena may help to identify and harness mechanisms most likely to promote success, and minimise countervailing mechanisms that restrict it. Assessing existing knowledge and identifying theoretical perspectives that can help with explanation is an important step toward that aim. Too often, in my view, research leaves that explanation to individuals in the ‘real’ world of practice to make on their own. Practice-based judgement clearly is vital, since, as situations vary, so should research make its contexts explicit. At the same time research should offer some assistance, with some suggestions for explanation and mechanisms that may have wider relevance.

It is from this perspective, and in view of my understanding of the existing research, theory and policy relating to my chosen topic, that my thesis aims to answer the following questions:

How do employed people who are recovering from mental health problems experience and perceive their work-related needs?

What are the experiences and perspectives of employed people recovering from mental health problems of the support they have received, or would like to have received, to address their work-related needs?

What mechanisms can be identified which might help explain people’s experiences and inform development of job-retention interventions?

There may, or may not, be the potential to develop an approach for job retention that is as geographically transferable, and that has as unified a set of principles underpinning it, as has been achieved by IPS. However, this literature review has indicated that understanding first-person experiences of job retention in a range of contexts is a valid endeavour of which we only have limited knowledge – especially in a UK context. Gaining insight into the challenges people face, and the strategies they use, can, hopefully, suggest approaches that can be helpful at least in some circumstances, and that may have relevance for others. Analysis within a critical realist framework holds that because first-person experiences have a relationship with a shared external reality, it is possible to draw on these experiences and related perspectives so as to develop such explanatory insights into

challenges faced and potentially effective supports for job retention. The next chapter will explain and justify this methodological approach; the subsequent chapter will explain the related methods and contexts used in the comparative case studies presented in this thesis.

Chapter 5: Methodology

Introduction

Two particular features of my research questions signal central elements of my research methodology. Firstly, my motivation to explain phenomena – so that the findings may be of use to people facing job retention challenges – points to my realist methodological orientation. Secondly, I argue that first-person experiences are a rich source of data which could help achieve that aim – and my design took that a step further, harnessing such ‘expertise by experience’ in other parts of the research process. These aspects evolved during the course of the research.

I consider that it is intrinsic to my identity as an occupational therapist that I accept that the people who make use of my services have faced real issues arising from specific internal or external circumstances. That occupational therapists draw on a range of professional practices, theories, concepts or models to help address these issues logically implies an ontological commitment to the presence of a shared external reality. I acknowledge the risks of naive realism in assuming that all people with a shared circumstance will interpret and respond to this reality in the same way (something which is perhaps a particular fault with the practice history of mental health treatment). The positions I have not adopted – for instance, postmodernism – can make valuable contributions in exposing such assumptions (Creek 1997, Weinblatt and Avrech-Bar 2001, Ungar 2004) and considering their implications for research methods (Cheek 1999, Fontana and Frey 2003, Power 2004). That said, the research in this thesis has held from the outset that the experiences and views which were gathered from the participants have a common grounding in a shared external reality – albeit one which is variously and differentially experienced and interpreted.

As my own understanding of research methodologies and the associated epistemological and ontological issues grew (enabling me to design Figure 1), I decided that critical realism was a more accurate description of my orientation than an initial depiction of interpretive phenomenology. In this chapter I justify my choice of critical realism as a research methodology, beginning with an introduction to its key elements and philosophical underpinnings. I explain the three domains involved in its view of external reality and how this makes a search for explanation possible in critical realist terms. From this I discuss the similarities and differences between inquiries into the natural and social worlds as seen from a critical realist perspective, and the implications thereof. Subsequently, I argue that the critical realist view of a stratified reality is highly

compatible with an occupational science perspective, drawing on some themes that emerged from my literature review in support of this. Then critical realism is discussed as a research methodology that is relevant to my topic, including consideration of the role of theory in the research process, and the critical realist rationale, both for my use of first-person experiences, and for my comparative and collaborative case study design.

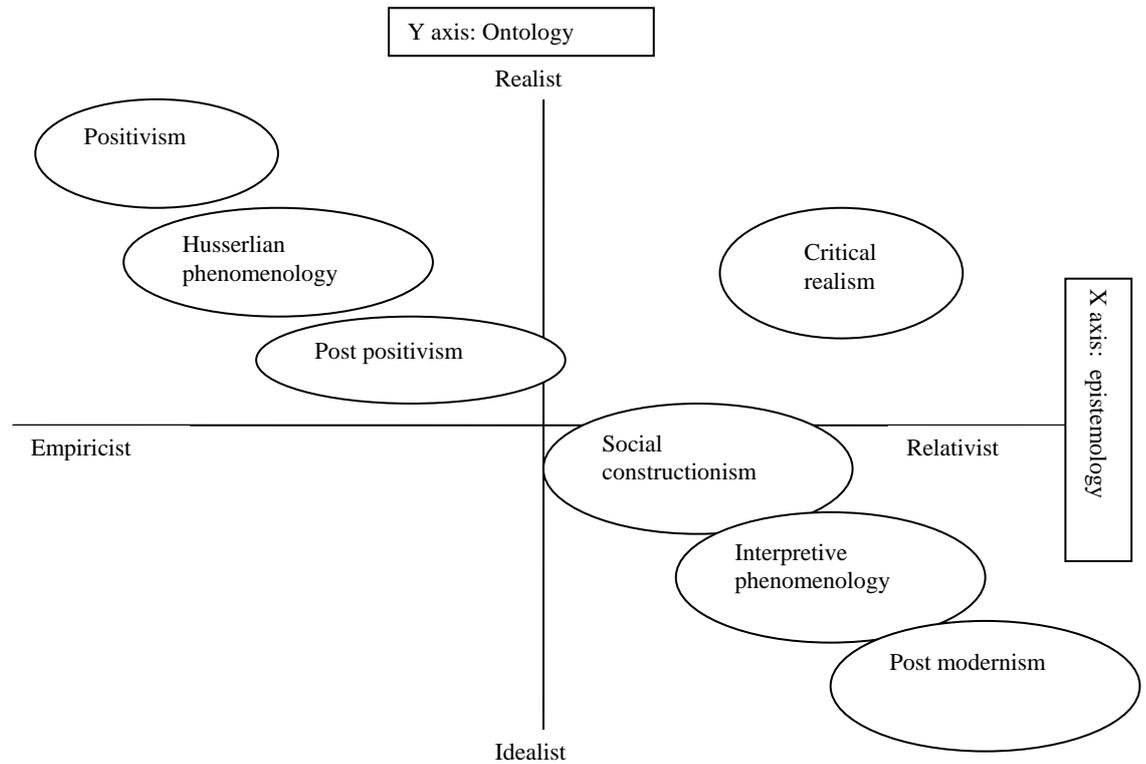


Figure 1. Critical realism and other methodological positions plotted on epistemological and ontological axes

Introduction to critical realism

The term *critical realism* was introduced by Roy Bhaskar, initially with respect to natural science, in *A realist philosophy of science* (Bhaskar 1978), and was extended to a consideration of the social sciences in *The possibility of naturalism* (Bhaskar 1979). Bhaskar developed the philosophical position drawing on work of previous philosophers of science – notably Rom Harré (Harré 1972, Sayer 2000). In the sense that it is a label for a certain epistemological and ontological orientation, critical realism can be seen as being consistent (to varying degrees) with positions held by a number of theorists, some of whom pre-date and/or never used the term: Pierre Bourdieu, Anthony Giddens, Jürgen Habermas and Karl Marx have all been claimed, to varying degrees, by the tradition (Sayer 2000, Danermark et al 2002). There is a growing body of literature by those who align

themselves with critical realism (Outhwaite 1987, Collier 1994, Archer 1995, New 1996, Lawson 1997, Sayer 2000, Norris 2002), much of which has a general philosophical orientation towards exploring critical realist perspectives on ontology and epistemology. For the more applied aspects of my research design I have drawn on the work of Danermark et al (2002), which contains a more direct consideration of the methodological implications of critical realism in social science research. Before considering these aspects, I will set out the central elements of critical realism (drawing on positions set out by some of the authors above) that have greatest relevance for my thesis.

The critical realist view of reality: the domains of the empirical, actual and real

Critical realism holds that a real world does exist independently of any one individual's perceptions of it. In this, there is a clear difference from those postmodern views which posit that there are multiple realities, each created in the eye of the perceiver. But critical realism also breaks with pure empiricism, in that it maintains that our ability to know that independent world is imperfect, since it is mediated through our means of perceiving and our interpretations of it. The essence of the critical realist position is that reality is divided into three domains: the empirical, the actual and the real (Bhaskar 1979, Danermark et al 2002).

The *empirical* is the domain of events which occur and are observed or experienced; this is the domain which both positivism and Husserlian phenomenology can be criticised for restricting themselves to. The *actual* is the domain in which all events occur whether they are observed or not. Critical realism holds that these events have an independent existence, even if not experienced – this is in contrast to some postmodern and constructivist positions.

The third and most significant domain for critical realists is that of the *real*. This is the domain in which reside the structures and mechanisms which have the potential to produce the events occurring in the *actual* domain, of which a proportion is experienced in the empirical domain. Within the domain of the *real* it is important to note that structures and mechanisms are considered to be real even if they do not produce events. This may be because they are not activated by other events or contexts; or because, although they are activated, they do not produce events in the *actual* domain – this being due to other counteracting mechanisms or structures which have an opposing or mitigating effect.

Structures, mechanisms and events within a stratified external reality

Critical realism maintains that this external world is stratified, with physical, chemical, biological, psychological and social layers (Danermark et al 2002). Each stratum has a degree of relative autonomy within which structures and mechanisms have the capacity to produce ‘events’, ‘outcomes’ or ‘phenomena’. People perceive ‘events’ or ‘outcomes’; however, these events are the outcome of underlying potentiality – they could not happen unless conditions in the world made it possible for them to happen. An apple would not fall to the ground from a tree unless reality was constructed in such a way that large agglomerations of matter (such as planet earth) exerted a pull force on smaller objects (such as an apple). This then is one of the underlying *conditions* of reality, which causes the *event* of the apple falling off the tree. However, other conditions will influence the occurrence of this event, for example conditions which make the growth of apples possible. These conditions generate interacting *mechanisms*, which influence when and whether the potential event will occur. Mechanisms involved in the apple falling off the tree include the exertion of the force of gravity, the growth of the apple and the ageing process weakening the stem linking the apple to the twig.

How the critical realist view of reality makes the search for explanation possible

The example of the falling apple is chosen deliberately, due to its role as a famous example of the importance of empirical observation for science. Bhaskar (1978) holds that this is an example of the importance not simply of the observation of the event, but of the theorising that the scientist does to try and explain the event by asking what mechanism may explain it, as well as what the nature of the world must be (i.e. what conditions must exist) to generate those mechanisms. Critical realism has termed this operation of thought ‘retroduction’, and claimed that the development and application of this analytic method is critical realism’s unique contribution to scientific enquiry (Danermark et al 2002). Bhaskar does not claim that critical realism has properly *invented* theorising and the seeking of explanation, of course, but rather that its importance has been overlooked in methodological theory, particularly in the natural sciences (Danermark et al 2002).

Critical realist inquiry in the natural and social worlds

It is this emphasis on the role of theorising and the search for explanation which Bhaskar (1979) sees as a unifying approach to natural and social sciences. Critical realism rejects the idea that a completely different type of science is needed for the natural and social worlds. However, two crucial distinctions are acknowledged. The first is the

manner and extent to which perception and interpretation becomes part of social reality. The second, which is a partial consequence of the first, is that systems in the social world tend to be more open and complex than those studied in the natural world. I will now address these points in turn.

Perception and interpretation as part of social reality

Events in the natural world, such as apples falling off trees, and the conditions and mechanisms which give rise to them, occur irrespective of whether they are observed. How we perceive is important, in that perceptions, and particularly interpretations, may be fallible, but do not change the nature of the natural world. This is not true of the social world, in which case how an individual, group or society perceives and interprets a phenomenon becomes part of the social world itself. This is not an idealist statement, but rather an acknowledgement that becoming part of the social world means having real-world consequences.

This can be illustrated with an example relevant to my study – the phenomenon of stigma. If one worker with mental health problems experiences behaviour from a colleague at work which s/he interprets as stigmatising, this is likely to affect the worker's behaviour and confidence. Therefore his/her interpretation of experience has real-world consequences and becomes 'real'. A set of ideas and interpretations which have a 'real' effect on the world could legitimately be described as a discourse; thus, my research may identify discourses which are revealed as having impacts on the experiences and attitudes of the participants in the study. The distinction between this and postmodern concepts of discourses lies in the fact that critical realism sees them as part of the social world, not as evidence of multiple competing realities.

The logic of this remains tenable even where another individual in similar circumstances would not consider their colleague's behaviour stigmatising. In this sense, the term 'fallibility', as used by Danermark et al (2002), is itself perhaps imperfect, as these writers acknowledge that the way in which people experience a phenomenon itself becomes part of the social world, and so becomes 'real'. Consequently, I prefer, and tend to use, the term 'variable', rather than 'fallible'.

The tendency for social world systems to be open and complex

The second central distinction between inquiry into the natural and social worlds is that the systems involved in the social world (those mainly in the psychological and social stratum) are more likely to be complex and open, in contrast to the natural world where

more closed systems are present (Sayer 2000). This can render certain forms of experimental design less useful for social world inquiry (Pawson and Tilley 1997). Experimental designs work best where variables can be minimised or controlled for, and are also most useful when a regular pattern can be established – something which, in the social world, is highly unlikely to occur outside the experimental context. Arguably, the considerable research and practice development regarding Individual Placement and Support (IPS) interventions referred to in my literature review provide an example of where randomised controlled trials (RCTs) have been able to produce broadly consistent results (Bond et al 2008, Burns and Catty 2008) – although IPS research could still be criticised for gaining this understanding ‘back to front’, beginning by investigating an established complex intervention and only then asking which elements are most effective, and thus not considering what additional elements may also be effective. In any case, and as my literature review has also made clear, there is no evidence-based consensus on a set of job-retention interventions that is equivalent to that of IPS. This suggests that the complexity of the social world systems involved and our current limited knowledge of it reduce the possibility of reliable prediction, and indeed even of designing appropriate job-retention experiments (for instance, deciding what job retention interventions should be included in a complex intervention to be used in an RCT).

Critical realism’s view of the stratified nature of reality, and compatibility with an occupational science and therapy practice perspective

Blair and Robertson (2005), in their exploration of the nature of inquiry underpinning current occupational therapy practice, concluded that “Occupational therapy lies on a medical/social fault line and, as such, is theoretically eclectic and epistemologically pluralistic” (p275). They express concern that, despite this, it is the practice-based epistemology of positivistic evidence-based practice, as opposed to reflective or reflexive practice, that dominates the literature. They see this as arising from a traditional professional link with biomedicine, now sustained by social policy which sees evidence-based practice as the guarantor of best practice, as well as less challenging to current power structures. There is a call for increased attention to interpretivism and critical social theory, which they associate with reflection and reflexivity respectively. Notwithstanding the force of their argument concerning the need to redress the balance, it would appear that methodologies are needed which are able to accommodate both sides of the ‘medical/social fault line’ in a way that biopsychosocial perspectives, discussed in the previous chapter, have attempted to.

The critical realist concept of a stratified reality appears able to traverse that fault line. I was struck by the similarities between it and Clark and Larson's (1993 p51) model of the human as an occupational being, as presented in one of the early writings introducing occupational science as a distinct academic discipline (see Table 1). This was important to me, because I was endeavouring to adopt a methodological approach which was compatible with core concepts relevant to my discipline and able to bridge the medical/social fault line. My reasons for this were, firstly, because I accepted that I would not be able to remove the influence of my professional perspective; and, secondly because I judged that these concepts had valuable potential for the understanding of the occupational issues faced by people with mental health problems seeking to retain their jobs.

One clear difference from my approach, which should be acknowledged, was that in 1993 (though not in the first presentation [Clark et al., 1991]) Clarke and Larson presented their model as heuristic – as an aid to think about people as occupational beings, and not necessarily as a model of reality itself. However, I considered that the concrete (as opposed to metaphorical) nature of their model meant that there was no reason why it could not be applied in a realist rather than interpretivist manner. Their proposal to use the model to generate theory about the occupational nature of human beings, as well as about their occupations, is also consistent with realism. The next section will present the stratified levels of the model and explain how I applied it in a critical realist manner to help orientate and alert me to some potentially significant issues for data collection and analysis.

The human subsystems in the model of the human as an occupational being

Clark and Larson's (1993) model presented a hierarchy of human subsystems (physical, biologic, information processing, sociocultural, symbolic evaluative, and transcendental). Crucially, like the critical realist conceptualisation of the stratified nature of reality, these subsystems are seen as being related to each other – such that aspects of one level can be seen as being foundational for the next level – but not to determine the phenomena that each level might give rise to. Thus, neither Clark and Larson, nor the critical realists, would claim that a comprehensive explanation and understanding of a sociocultural phenomenon such as stigma can be found in physiochemical processes, even though the agents who experience stigma, or who carry out stigmatising behaviours, can be described in physiochemical terms. On this basis, both critical realists and the authors of

the model of occupational behaviour would claim that they are not reductionist. I shall next present the subsystems, employing examples informed by my literature review concerning the relevance that each might have for my research study.

Model of the human as an occupational being (Clarke and Larson 1993)	Critical realist strata (Danermark et al 2002)
Transcendental	Psychological and Social
Symbolic evaluative	
Sociocultural	
Information Processing	
Biologic	Biological
Physical	Chemical
	Physical

Table 1. Comparison of the model of the human as an occupational being with critical realist strata

Physical subsystem

This “encompasses phenomena that can be appropriately described by physiochemical processes ...” which occupational science addresses “in relation to the role they play in the enactment of occupations” (Clark and Larson 1993 p51). The potential relevance to my research topic can be seen in understanding the impact of physiochemical processes, with their genesis in either a mental health illness or medication, on a worker’s ability to perform work tasks, and on their ability and motivation to plan their return to work – all consistent with factors identified earlier. For example, low mood caused by reduced serotonin can affect motivation, and neurotransmitter disturbance can affect the ability to process information needed for work tasks or planning to return to work. That this appears to be equivalent to the two strata, physical and chemical (see Table 1 above), of the critical realist model, reflects the latter’s greater concern to offer a philosophy of science that is relevant to natural and social sciences, in comparison with occupational science’s focus on social science.

Biologic subsystem

I consider this subsystem to be equivalent to part of the biological strata of critical realism. It comprises “Living systems involved in biologic adaptation” (Clark and Larson p51) – examples include a biologic urge for competence; the role of sensory integration in execution of occupations; and possible biologic (as distinct from social) influences on occupational behaviour and human evolution. It could be argued that the biological processes enabling bi-pedalism, the opposable thumb, and language can be partially understood in these terms. Alongside environmental demands, such processes would then have contributed to humans evolving into social beings that seek to shape and act upon their world in a way that, for some anthropologists, is what defines us as a distinct species (Engels 1968, Leakey 1995). If this could be established to be part of a biologic urge to ‘work’, then this further legitimises the rights and opportunities for all people to engage in productive activities irrespective of what impairments they may have. Another, more grounded, example of how the biologic subsystem may relate to my study, is consideration of how the system that supports sensory integration may be impaired as a result of symptoms (such as hallucinations) or medications (such as anti-psychotics). As with the example in the case of the physical system, this mechanism could disrupt work performance or attempts to resume work.

Information-processing subsystem

This system is defined as “the cognitive processes that are employed by human beings to successfully enact occupations ... [eg] perceptual and conceptual functions, learning memory and planning” (Clark and Larson p52). The more biological processes here appear to equate to aspects of the critical realist biologic stratum, while more complex psychological processes find equivalences in the psychological and social strata. Like the previous two subsystems, disruptions to this – for instance, ones affecting concentration and attention – could occur as a result of impacts of mental health symptoms or medication effects (the latter could also mitigate the negative impacts of symptoms on thought processes).

Sociocultural system

The sociocultural system, along with the systems that follow, is equivalent to the highest of the critical realist strata – the psychological and social. Clark and Larson (1993) describe this subsystem as “focussing on perceived social and cultural expectations” (p52). For example, within this they consider how issues of gender, ethnicity, and nationality

impact on occupational choice and behaviour. Thus sociocultural structures and mechanisms may affect the expectations that workers, or those around them such as family and health professionals, may have about the possibility of returning to work, if on sick leave due to a mental health problem. Other implications are the possibility of structural gender or ethnic biases of services providing support to workers with mental health problems. Of course, research exists within a sociocultural context and reflexive acknowledgement of that may act as a counterbalancing measure that can enhance the trustworthiness of the findings.

Symbolic evaluative subsystem

The symbolic evaluative subsystem is concerned “with the symbolic systems that are used to appraise the individual’s valuing of occupations” (Clark and Larson p53). Economic, aesthetic, moral and emotional value systems are cited as examples. There may be significance for vocational outcomes when establishing whether a worker with a mental health problem has for instance a predominately economic, as opposed to moral, or emotional, conceptualisation of the value of work to them. As with the sociocultural subsystem, my literature review findings support the possibility that the impact of this apparent subsystem may well be exercised through family, friends, colleagues, employers, professionals and researchers.

It is notable that in this subsystem the authors emphasize the importance of the emotions people attach to and experience in occupations, and not just to the cognitive or rational interpretations a person may hold: “choices of occupation seem to be emotionally laden, but reciprocally, occupation can modify emotional state” (Clark and Larson p53). This lends support to endeavours aimed at trying to understand individual experiences in these terms, such as their emotional experiences at work or when on sick leave.

Csikszentmihalyi, a ‘Flow’ theorist, is cited by Clark and Larson (1993) with reference to how people appear to experience well-being when they feel physically and mentally challenged, but not to the point of feeling stressed. This draws attention to the value of understanding the demands that jobs and workplaces may place on people recovering from mental health problems. It also reminds me of ‘Clive’, introduced at the start of the thesis, who initially returned to work with what he considered was insufficient mental challenge. As I suggested in Chapter 2, actual or anticipated ‘flow’ experiences at work may contribute to mechanisms which promote and sustain recovery.

Transcendental subsystem

At the top of Clark and Larson's (1993) hierarchy of subsystems is the transcendental subsystem. This is "concerned with the sense of meaning the person ascribes to his or her everyday experience over the course of a lifetime" (p53). Arguably, this might have been included in the symbolic evaluative subsystem, and many of the points raised in that section seem pertinent here as well. Presenting it as a distinct system, however, signals the potential relevance of the concept of 'career' (including the danger that those of us with 'careers' interpret all people's experiences of work in those terms). Whilst 'career' may be more specific to middle-class employment, the notion of a stage of adult life – which many people associate with working (or expectations of working) – appears more universal. We saw in Chapter 3 how some people sought to develop alternative careers when their current work seemed to offer them little fulfilment or satisfaction.

In a research project which encounters people at just one point in their life, this subsystem attunes us to the journeys people have travelled and directions they may go in future. There may be mechanisms from the past that still exert their influences (for example, past positive experiences of understanding colleagues). There may also be mechanisms acting in the present that may not produce outcomes until later (such as attempts to increase the vocational training provided to Improving Access to Psychological Therapy therapists). This implies a need for my research to try and discern such processes where possible and acknowledge limitations where not.

Here it is relevant to consider critical realism's concern with issues of structure and agency (Archer 2007). Albeit using more metaphorical language, the transcendental subsystem appears to be compatible with a critical realist understanding of the potential for individual agency to operate within the constraints of existing structures. Agency, in turn, is able to impact and change those same structures – in some cases making new journeys possible. Perhaps the agency of individuals who have used their experiences of recovery to challenge and produce some change to the structures of mental health services, provides an example of this – such as, for example, in the case of Deegan (2003) who has used her own experiences of mental health recovery to develop 'recovery' perspectives and influence service development.

The compatibility of Clark and Larson's (1993) model with critical realist strata to understand issues pertinent to my topic thus provided justification for the use of both. It also provided a framework which I was able to use to contribute to higher level analysis of

research findings in a manner that is consistent with my critical realist methodology (See Appendix Q).

Critical realism as a research methodology

The fact that there is a comparatively greater body of critical realist literature that could be classified as philosophy of science rather than research (Kemp 2005, McEvoy and Richards 2006) has led to a criticism that critical realism is “a philosophy in search of a method” (Yeung 1997 p51). This criticism may be misplaced, since arguably it fails to acknowledge the extent to which critical realism distinguishes between method and methodology (Bhaskar 1979, Danermark et al 2002) – in a manner that is similar to Habermas’s (1978) distinction between the need for different approaches according to the purpose of enquiry and what is being investigated. Particularly useful here is Danermark et al’s (2002) methodological framework for selecting methods suitable to the research topics and purposes of social science, along with the work of other authors within the critical realist tradition who have also explicitly considered social science research methodology (Pawson and Tilley 1997, Sayer 2000, Archer 2007). Their work demonstrates an openness to using a range of research methods with regard to both data collection and analysis. However, this eclecticism is not of a pragmatist philosophical nature (Rorty 1980, Rorty 1991) which can justify methods according to the purpose of research (Doyle et al 2009, Shaw et al 2010a, Glogowska 2011), but relates to the critical realist view of a stratified reality and complex social world (Mearns 2011). This has resulted in recognition of the value of using, often in combination, data which other traditions would term both quantitative and qualitative (McEvoy and Richards 2006). In lieu of those terms, critical realists have preferred to use the terms ‘extensive’ and ‘intensive’ methods, respectively (Sayer 2000, Danermark et al 2002).

Consistent with its emphasis placed on theorising, critical realist research assigns an important role to the identification, application and development of theory. Central to this is the process of *abduction*, which involves interpreting findings through frames of reference which may either be established or newly applied in a particular field. One reason for selecting the meta-study approach in my literature review was because it offered a rigorous and transparent method with which to identify such frames of references, perspectives which may in turn directly support interpretation of research findings, or act as orientating concepts (Layder 1994, Sayer 2000) This step appears underdeveloped in Danermark et al’s (2002) stages of critical realist analysis which in other respects I found

very helpful (see Chapter 6). A critical realist methodology necessitates openness to the possibility of alternative perspectives emerging as relevant in the process of analysis as well.

Alongside abduction, Danermark's et al's (2002) framework proposes the use of *inductive* and *deductive* methods of thematic analysis as also being consistent with a realist ontology and more relativist epistemology. Abduction, induction and deduction then provide a basis for the process of *retroduction* – revealing the explanations (in the form of emergent mechanisms and their contexts) of observed phenomena by asking what the world must be like in order for those phenomena to be possible.

Mearns (2011) has argued that critical realism is well suited to work-related research because it acknowledges the variable roles, perceptions and knowledge of the individuals who interact at work. MacEachen et al (2010) used a critical realist methodology in their research which, by using data derived from interviews, identified explanations for why some injured workers failed to return to work; they maintained that the methodology helped them consider the role of conflict and power relationships in return-to-work systems and processes. Further support for its relevance to my thesis is found in Vassilev et al's (2011) literature review of chronic illness self-management and in Pittam et al's (2010) evaluation of employment advice in primary care.

In the sections that follow, I will explain how critical realism has informed my study design with respect to: the use of first-person accounts as intensive data; the comparative case study design and meta-study; and research collaboration with service users.

The critical realist rationale for use of intensive data in the form of first-person accounts

Even before adopting critical realism as a methodology, my concern with people's experiences reflected a view that, to understand a person's work-related needs and the challenges they faced, their story had to be heard. In my view, statistics describing shared characteristics and events, and giving numerical outcomes (for example, proportion returning to work), do have some importance (hence my frustration at the limited data of this kind). However, they do not say what the quality of the person's experience was – they may even mask it. Even where someone manages to return to work after experiencing a mental health problem, is working an experience which promotes their recovery, or is it a living hell which they feel they have no choice but to endure? My decision to gather such experiences as research data also reflected an epistemological and ontological

position that such experiences could yield insights which have the potential to be relevant to other people facing similar challenges.

Quantitative or extensive data (for example as gathered by surveys) support descriptions of broad contexts that can help inform the extent to which findings from qualitative data may be relevant to broader society. Experimental designs – for instance, in comparing specific interventions – may also be helpful in indicating potential areas of inquiry for qualitative research to search for mechanisms which may explain certain phenomena (McEvoy and Richards 2006). Although I did not plan to collect extensive data, extensive data from other studies is used both in my literature review and in the discussion chapters.

Qualitative or ‘intensive’ data is seen within critical realism as offering the potential to reveal the structures and emergent mechanisms in the domain of the real. First-person accounts regarding both experiences and interpretations of experience can be helpful for this in two ways. Firstly, as has been set out, critical realism considers that people’s beliefs about and interpretations of the world around them form part of the real social world. Thus, if a worker on sick leave with a mental health problem believes they will inevitably experience a problem (such as stigma or difficulty with work tasks) when they return, then this belief, whether ‘correct’ or not, is likely to have a real impact on how they approach the prospect of returning to work. Secondly, analysing reported experiences can help increase understanding of the real domain because critical realism considers that these experiences, albeit variously interpreted, are still anchored in a shared reality (Sims-Schouten et al 2007).

This can be further illustrated with reference to the sub-systems of the model of the human as an occupational being (see above, Clark and Larson 1993). First-person accounts can be expected to reveal data that will relate to the physiochemical, biologic, and information-processing systems. Interpretation may produce insights about those systems and the structures and mechanisms that operate them, for example by uncovering how symptoms may affect work performance.

With regard to the socio-cultural, symbolic evaluative and transcendental systems, first-person accounts can also be expected to provide data which can be interpreted to gain greater insight into the structures and mechanisms potentially operating within these systems. First-person accounts will also include direct expressions of these higher psychological and social world systems (the real world object itself). For instance, there may be direct expressions of the meaning a person attaches to their work in the symbolic

evaluative system, though this is not the same as saying they are direct expressions of the mechanisms that produce that meaning.

Finally, first-person accounts also offer the potential to advance understanding of issues of agency and the constraints on agency. For example, data may help explain in what circumstances (*structure*) and to whom a worker feels able to disclose (*agency*) information about their mental health problem which may be prerequisite to negotiating needed accommodations (*amended structure*).

Rationale for the choice of a comparative case study design and meta-study.

Given the greater complexity and presence of open systems in the social world as outlined previously, it follows that social world research should not expect to reveal mechanisms which produce events with a predictable degree of law-like regularity. Rather, they can attempt to identify mechanisms and structures which produce events and explain how and in what contexts they operate. This, in turn, suggests the value of research being specific to a real-world context; hence the compatibility of a case-study approach with critical realism (Pawson and Tilley 1997, Picard 2006, Clark et al 2007a).

Mechanisms and structures present in one context may well be present in others, particularly if there are some similarities. Comparing contexts that have similarities and differences consequently has the potential to reveal mechanisms, as well as countervailing mechanisms that may suppress them in some contexts. This supports the validity of using a *comparative* case study design. The opportunity for me to include what was initially a separate study of job retention in a community setting, alongside my study of experiences of users of acute mental health services, was thus not just a pragmatic means of broadening the range of data in my study, but was a step which could potentially increase the explanatory power of the research. This provided me with sets of data from two case study contexts: seven individual interviews with employed users of a NHS Trust acute mental health service, and 14 individual interviews with users of a community-based job-retention project.

In Chapter 2 I explained that I went through a similar evolutionary process with regard to my literature review, which had begun as a traditional narrative literature review in order to set the research context and justify the research rationale. Ultimately I constructed the review based on a meta-study approach (Paterson et al 2001) which reviewed the research into the first-person job-retention experiences of people with mental health problems. As with critical realism, the meta-study approach emphasises the importance of

analysing theory and methodology, as well as findings, before attempting an overall synthesis. In addition to setting the context and suggesting frames of interpretation, it can also be seen as providing comparative findings from relevant data from a range of contexts other than my own.

How the critical realist social world research methodologically implies the need for a collaborative design

The third element of my research design – collaboration with research participants – was, in the initial stages, the most tentative of the three presented here. I had had discussions about my potential topic at the patients’ forum meeting of the acute unit where I was based, and these discussions supported the validity of the topic and alerted me to some potential challenges in recruitment. However, I was unclear how to carry collaboration forward – both in practice and also how I would fit it with my developing methodological position.

I have subsequently reflected that part of my hesitation was related to feelings of novice anxiety at doctoral-level research (and arguably a clash of academic and collaborative paradigms). This involved two elements: a fear of relinquishing control of an academic process for which I was required to produce an original thesis; and a fear that I did not yet know enough about how I would carry out the research to enable me to collaborate. In relation to the first anxiety, I found Zuber-Skerritt and Perry (2002) helpful in distinguishing between the collaborative elements of a research project and the individual task of thesis production. In relation to the second, I am indebted to my supervisor Professor Angie Hart for challenging me to transform theoretical commitments to collaboration into practice (by establishing a panel of service user advisors) and, in the process, alleviate anxieties by actually experiencing how much I could learn from collaboration (and realising I did not need to present myself as an expert in all areas beforehand).

As my critical realist methodology developed, I have increased my clarity regarding the role that collaboration can play in terms of research rigour, by providing a challenge to my undoubtedly professionally influenced perspective and an alternative point of interpretation for the research data. In this my methodology and supervision has helped me overcome the ‘epistemological dissonance’ (involving researchers’ difficulties, possibly related to their own professional insecurities, in embracing and/or valuing knowledge derived from sources outside of their professional or academic worlds) which Ward et al (2010) identified as a factor which explained why there appears to be a gap

between some researchers' expressed knowledge of potential benefits of collaboration in health and social care and their more limited actual practice.

A consequence of critical realism's distinction between social world and natural world enquiry is not only that people's perceptions become part of the social world, but that people are therefore not equivalent to the passive objects of natural science. By contrast, they have a potential interest in the scientific enquiry (Danermark et al 2002). By 'interest', what is meant is not simply an interest in the sense of having an interest in what the results may be, but rather a *positional* interest which may have an impact on whether the inquiry has meaning (validity), and thus carries the potential to inform the design and selection of methods of inquiry (reliability).

This interest, then, can contribute to the rigour of data analysis, notably by presenting a challenge to the researcher's interpretations. It can then also recruit the human reflexive processes (Archer 2007) of collaborators to give insight into the possible internal conversations that research participants may have been having regarding the research topic; this may help address Speer's (2007) complaint that critical realism is insufficiently reflexive because it fails to analyse "the interview as an interview, and as an occasion for interaction in its own right" (p125). Finally, as real-world research aiming at having some impact on a community of practice which includes the participants, these interested parties are likely to aid the effectiveness of dissemination of the findings.

The forms that the collaboration took in the two case studies varied. These will be set out in the method chapter (6).

Conclusion

I have presented the rationale for my critical realist research methodology. This involved introducing its view of a stratified reality and the domains of the empirical (observed events), the actual (events that occur whether observed or not) and the real (structures and mechanisms which have potential to produce events). Critical realism considers it is possible to gain explanatory insight into these structures and mechanisms. There are important distinctions between natural and social world inquiry: firstly with regard to how people's perceptions of the world become part of that social world, and secondly with regard to the tendency for the social world to involve more open and complex interactions between structures and mechanisms.

The chapter increasingly considered the relevance of critical realism to my discipline and research topic. To justify its compatibility with my occupational perspective I set out

the compatibility of the critical realist view of a stratified reality with Clark and Larson's (1993) model of the human as an occupational being, and in the process related my discussion to some themes which emerged in my literature review. Consideration of the use of critical realism as a research methodology initially focused on how theory can both be developed by and used in a critical realist project. Then I presented my rationale for using first-person experiences as a source of *intensive* data which could help gain some explanatory insight into the job challenges faced by people with mental health problems. Similarly, the comparative case study design was justified and related to my use of an adapted meta-study to underpin the literature review. A critical realist perspective in social world research logically implies that other people's 'expertise by experience', should be harnessed in the research process because of the increased insights it has the potential to bring (rather than for tokenistic reasons). In the next chapter details of the specific methods that were used within this overall methodology are presented.

Chapter 6: Contexts and methods

Introduction

In this chapter I describe and discuss the methods, beginning with the two case study contexts, as well as issues pertaining to ethical approval, inclusion and exclusion criteria, and the demographic characteristics of the participants. I next include a discussion of important issues related to service user collaboration. Following this, I consider data collection, analysis, measures of rigour, and dissemination, before concluding with a link to the following chapters.

Case study contexts

The research took place in two settings: acute mental health services and a community-based job retention project for people with mental health problems.

Acute mental health

The participants were recruited from two acute mental health services in one mental health trust in the South of England. Six of the participants were using inpatient mental health services across two sites, and one using a Crisis Resolution and Home Treatment team based at one of the sites.

This setting was chosen in order to make it possible to investigate people's job-related needs and was driven by practice-based concerns when working in an acute mental health service. Health policy in England and Wales has, in recent years, aimed to shift the balance of mental health service provision from acute to community-based services, seeking justification in terms of economic efficiency (Department of Health 2011a) and recovery-based philosophy (Cross-government strategy: Mental Health Division 2009, HM Government 2011). Whilst there have been calls (Mind 2011) for humanising and broadening the range of acute mental health care, these perspectives still envision inpatient mental health treatment as an important part of service provision – albeit supplemented with the use of Crisis Resolution and Home Treatment Teams developed in order to provide community-based acute care (McGlynn 2006).

The vocational needs of acute mental health service users appear to have been relatively neglected in UK policy and research. For instance, the Mental Health Bulletin – which reports annual statistics from the NHS – includes data about age, ethnicity, and gender of inpatient service users, but not employment status (NHS Information Centre - Mental Health and Community 2011). The Care Quality Commission (CQC) mental health inpatient survey (2009) found that 20% of the 7128 respondents who had recently

used inpatient services in England described themselves as in paid work (including those on sick leave), while a further 7% stated that they worked on a casual or voluntary basis. While it is not clear how representative the sample is of the total population, it is a greater proportion than in the equivalent CQC (2011) survey of community mental health service users, where 15% described themselves as being in paid employment (and 8% as casual or voluntary workers). Despite this comparatively high proportion of people using acute mental health services in paid employment, the CQC (2009) inpatient survey also suggested that there is insufficient practice concern with the working lives of mental health inpatients:

Respondents were also asked whether they needed any help from hospital staff with organising their home situation (e.g. paying bills, taking care of relatives, looking after pets, keeping in touch with work). Those who said yes (22%) were asked whether they received any help. Forty three per cent said that they had received all the help they needed, 34% said they received some of the help they needed, and 23% said that they did not receive any help. (p7)

Thus, findings suggest that 57% of inpatients with needs in this broad category would have liked more help. Since work needs are subsumed into the broad category of 'home situation' (perhaps telling in itself) we do not know whether a greater proportion of those employed inpatients would have liked more help, as they are not presented as a sub-group.

Community job-retention project

The other setting was a community-based job retention project for people with mental health problems. The focus of the research was initially bounded by my original practice context and so was restricted to investigating the experiences and needs of employed users of acute mental health services. My developing knowledge and experience of researching this issue resulted in me and another university researcher (Dr Carl Walker) being approached by the Richmond Fellowship Retain project in Brighton. This was a voluntary sector community-based mental health job-retention project, which had asked the Community University Partnership Programme's (2012) Helpdesk for advice and possible support to research and evaluate their project. It increasingly became clear that insights and questions which emerged from the acute study were relevant to the community-based study and vice versa. As I voiced this in research supervision, my supervisors suggested I consider including the data from the community project too, and it certainly seemed likely that using two comparative case studies (each comprising of a number of interviews with people who found their mental health problems had significantly disrupted their working lives) would be consistent with my critical realist design. I also thought that the addition

of a second context would increase the potential to identify which explanatory mechanisms may have broader relevance. I subsequently sought and obtained the necessary agreements for this to become possible; my study then became a comparative case study design, investigating job retention issues faced by participants in the two contexts.

The emergence of job retention interventions has been detailed in Chapter 3. The participants were users of the ‘Retain’ project run by the Richmond Fellowship mental health charity. Referrals were from General Practitioners (the main source), other health workers, employers, or by clients themselves. This project was based in the South of England and was funded by Big Lottery. Using a vocational guidance model, clients were provided with an opportunity to explore their situation. Project workers listened, clarified, gave information, referred people on to other services, and collaborated to draw up client action plans. A range of interventions were being used. Prominent amongst these were supportive counselling, confidence building, problem solving, education on employment law, negotiating return-to-work redeployment, and adjustments. Client ownership of the process was held to be a central feature of the process. The project workers’ role was not to direct clients, but they were directly involved in discussions with employers (Edmonds and Neumann 2007). Project workers provided most interventions by working with individual clients and employers. There was also a monthly evening support group facilitated by a project worker. This combined peer support and topic discussion.

Ethical issues and approvals

Ethical approval for the acute mental health study was obtained from the University of Brighton (Appendix B) and a National Health Service Local Research Ethics Committee (LREC) (Appendix C). Ethical approval for the community job-retention study was gained from the University of Brighton (Appendix D). The main issues that needed to be addressed related to avoiding coercion whilst supporting participation, minimising risk of distress, ensuring confidentiality and payment of service user collaborators.

Coercion and participation

A key issue was that participants should not feel coerced to participate. With both studies there was some concern about the proposal that potential participants would be passed information by a member of staff, as opposed to being invited to opt in using a poster or flyer. Additionally, for the acute study, I proposed that there should be a follow-up approach to all who had accepted information, in order to find out if they had reached a decision.

I defended the direct personal approaches on two grounds. Firstly, in the acute setting only those judged well enough to participate and meeting other criteria (see below) were to be approached. Secondly, experience of working in acute mental health settings (seemingly not shared by any of the NHS LREC members who reviewed the study) suggests that an opt-in design requiring responses to a poster was not likely to be successful in the busy environment of an acute psychiatric ward where, understandably, people had other concerns. For the community study, we argued that for a project worker to pass initial information about the study meant that they were receiving information from a person with whom they had an established relationship involving trust and to whom they could direct questions. We maintained that this was preferable to receiving details impersonally through the post (the alternative).

I acknowledged the NHS LREC's concern that a prompting approach by a member of the person's care team could be interpreted by the client as coercive. This was consistent with aspects of the Royal College of Psychiatrists' research guidance extant during the research period (Royal College of Psychiatrists 2001). However, I also referred to a concern in the same guidance, echoed by INVOLVE (Steel 2007), that vulnerable groups should still have the opportunity to participate in research and have their needs investigated. Being deemed vulnerable should not result in people being inappropriately excluded from participation in research. Levine et al (2004) point out that, despite its powerful presence in research guidance and policy, vulnerability is one of the least researched ethical concepts. They consider that "so many groups are now considered to be vulnerable ... that the concept has lost force" (p44). They suggest that focusing on the characteristics and environment of research protocols may be more reliable guarantors of proper ethical conduct. I have discussed these issues further in Cameron and Hart (2007), where it is suggested that a further source of meaningful protection from coercion and other research exploitation may be obtained by greater service user involvement in both ethics committees and in research projects

Having put my case and clarified the characteristics of the studies and environmental contexts, both university and NHS ethics committees ultimately agreed to the passing of information to be done in person. In the acute study it was agreed for there to be one follow up prompt by a member of staff not involved in their immediate care team. This prompt was not to support decision making but, as is often routine in acute mental health settings, a prompt to remind someone about a decision that they have been invited to make (see Appendix E: information letter for health and social care professionals – acute study).

Minimising risk of distress

A less contentious, but nonetheless important, concern was to minimise the distress to participants arising from participation. The participant information sheets (Appendices F and G) cautioned that it was possible that people might find themselves upset at talking about difficult experiences they may have had. This was balanced with an evidence-based view (Hart et al 2005, Jorm et al 2007) that talking about such experiences can also be helpful. It was made clear that participants could stop participation at any point and that the interviewer would also stop the interview if a person became distressed. In both studies a member of staff was available should anyone feel a need to speak to someone immediately due to distress. Information about sources of support related to work and mental health generally were also provided. For participants in the acute study it was agreed that there was a possibility that in the process of participation someone might realise that they had work-related needs that required addressing. It was arranged that should this occur that the interviewer would liaise with the care team for this to happen.

Confidentiality

A number of measures were taken to protect confidentiality and anonymity. In the acute study it was explained that identifiable details would only be passed to a person's care team if what was said suggested immediate or significant risk to self or others. Transcripts were anonymised such that information which might identify specific individuals or employing organisations was removed. Accordingly pseudonyms were used and data stored securely according to university and NHS guidelines.

Similar measures were taken in the community job-retention study, though it was agreed with both the Retain project and the service user group that the project name would not be anonymised. The Retain service user group (RSUG) was, however, concerned that individual confidentiality should be preserved by not using focus groups (preferring instead individual interviews). Furthermore, whilst the RSUG was keen to participate in analysis, they did not want to review individual transcripts or excerpts from transcripts in case this enabled them to identify a peer. Thus it was agreed that they would only review emergent themes, though it is acknowledged that this was a limitation in comparison with the acute study, where the acute service user panel (ASUP) did review some transcripts (there being minimal risk of them identifying a participant).

Payment and reimbursement

Participants were reimbursed for travel and caring costs sustained from participation. Funding secured from University of Brighton Clinical Research Centre was used to pay acute service user members of the ASUP for their travel and also for their time at the rates set by the university for their role. The members of the RSUG were not paid for their time input as they agreed with the Richmond Fellowship that this was an established group and that they were willing to participate in reviewing the research as part of their regular meetings. Individual members of both the ASUP and the RSUG were paid for their time and expenses for contributions to dissemination activities.

Participants

Participants were recruited and interviewed from autumn 2007 until summer 2008. As well as considering issues of risk and consent, a key aim for both studies was to recruit people who were able to talk about their experiences and perspectives during the process of recovery rather than retrospectively. This has meant that in terms of stage of recovery, participants were more homogenous than in much of the related research (see literature review), where often people recalled their job-retention challenges from a later point in time. Thus data was collected about what Griffiths et al (2010) has termed people's 'emergent presents' and their unfolding recovery (adapting Griffiths et al.) 'trajectories'. Griffiths et al's (2010) rationale for using the formulations in clinical practice to inform selection of interventions, whilst taking into account the complex situations in which different people find themselves, appears also to be valid for this research. We need to know about what people think and experience during their recovery, as this may be just as, or even more, relevant to developing helpful strategies than what they think at a later date.

Next I will present the inclusion and exclusion criteria for each study, and then describe participant characteristics in a way that preserves anonymity.

*Acute mental health participants***Inclusion criteria:**

- *People who were at the time of recruitment to the research receiving a service from the working age adult acute mental health services.* In one sense this could be seen as a limitation, as having an acute mental health problem is thereby defined by service use, whereas it could be argued that either subjective self definitions, or attempts at objective criteria, might be preferable.

However, acute mental health service use can be seen as a reasonable proxy for

some form of objective, and in some cases subjective, mental health judgements. It also means that the findings have a clear relevance to a specific context – and, as will emerge, there are some specific challenges that arise from service use and not just from other external and internal factors associated with having a mental health problem. Finally, this criterion was considered the most pragmatic option for implementation of the research.

- *People who had a paid working role prior to their current episode of care from the acute mental health services.*

Exclusion criteria:

- *People who were at time of recruitment and/or interview subject to a compulsory detention section of the Mental Health Act (e.g. section 2 or 3).* This was justified firstly because these people might feel coerced to participate as they may consider that it might affect decisions about the continued application of their mental health section. Secondly, people subject to the Mental Health Act may not be able to give informed consent due to the severity of the symptoms.
- *People whose anxiety levels, in their opinion, or the opinion of their care team, would have been exacerbated by taking part.* Whilst, in light of my comments about vulnerability above, one could construct an argument that this judgement should only be made by potential recruits, it is unlikely that this would have gained ethical approval (the same applies in the subsequent two criteria). To my knowledge, no conflict between care team and individual judgements did arise.
- *People who were not able to remain sufficiently focused to meaningfully participate in the proposed interview in either their opinion or the opinion of a professionally qualified member of their care team.*
- *People who posed a current significant risk to self or others, either in their opinion or the opinion of a member of their care team.*

Seven people were recruited from acute mental health services. Two described themselves as having bipolar disorder, and three others as having severe depression. The other two did not use specific diagnoses, but one stated that they had been admitted following auditory and visual hallucinations, and the other that they had experienced suicidal and intrusive thoughts. Four were male and three female. All described their ethnicity as white British and none as having a disability. They were aged between 21 and

45 (all but one were in their 30s or 40s). Job types were: two factory workers (one of whom had a voluntary job too), a supermarket worker, a delivery worker, a craft tutor, a bank clerical worker and a care worker. Three lived alone and four with a partner or other family member. Four lived with children under 18.

Community mental health participants

For the community study, people were eligible to be included if they were currently using the Retain project's services and considered they were able to participate in an interview of approximately one hour.

Fourteen project users were individually interviewed. Participants reported a range of mental health diagnoses, including depression, bipolar disorder, and schizo-affective disorder. Most were being supported by primary health care services, whilst some received input from specialist mental health services. There were ten women and four men aged between 29 and 54 (average 42.5). Twelve were single, one married and one had a non-cohabiting partner. All were white British. Three were health or social care professionals, three worked as administrative staff in various industries, two were care workers, two had non-teaching roles in higher education, and there was a legal executive, a courier, a kitchen assistant and a retail manager.

Service user collaboration

I have explained in the previous chapter the broad methodological reasons for collaboration in the studies and will explain below how this contributed to data analysis and rigour. I aimed to collaborate in an ethical manner. As others involved in collaborative research have suggested (Smith et al 2008, McLaughlin 2010), a range of practical and broader matters needed to be considered to ensure the effectiveness of collaboration. As well as issues of support and payment outlined above, it was important to manage the processes of beginnings, endings and pauses; to hold meetings at suitable times and venues; and to conduct discussions in a manner that did not assume specific research training (Tetley and Hanson 2000, Hewlett et al 2006, Abma et al 2009). I also sought to ensure that collaborators felt their contribution was valued, whilst not feeling responsible for any shortcomings in my PhD study. Addressing the latter point helped manage my related concern (raised in the previous chapter) of a potential clash between academic paradigms that seemingly privilege and demand individual original contributions and collaborative approaches that emphasise co-operation and collectivity. I have endeavoured to reflect this approach by referring to collectively produced findings and

interpretations in the first-person plural and to my individual interpretations and analysis in the first-person singular.

Service user collaboration: the acute service user panel (ASUP)

I approached two people who had already participated in training or service user networks and a third person who had expressed an interest in doing so. All had had experiences of using acute mental health services whilst also having a working role in the past. Neither I, nor they, would claim that they are representative of all employed people who use mental health services, but they did agree that they had relevant expertise by personal experience (McLaughlin 2010). It was agreed that their roles were to:

- Bring a service-user perspective to how the research was conducted.
- Bring a balance/challenge to my professional perspective.
- Participate in analysis of interviews by discussing anonymised transcripts.
- Optionally participate in dissemination activities.

Just as I had supervisory and other support that I could access if I became distressed for reasons arising from the research, it was agreed that each advisor needed similar support (how this was provided varied for each individual). Establishing that they had this support was considered to be particularly important since they would be discussing situations that may have had some similarities to their own experiences.

Meetings were generally scheduled for evenings at a university venue with food provided. A total of 10 meetings were held from 2007 to 2008 and one of the panel also participated in some dissemination activities beyond those dates that involved further discussion of findings and comparisons to the other study (See Appendix H for sample meeting notes).

Service user collaboration: the Retain service user group (RSUG)

In the community study there were similar aims to seek service-user involvement in the research implementation and analysis of findings. A group of Retain service users collaborated in the design and analysis of the findings over the course of seven meetings held from 2008 to 2009. Participation in these meetings was by open invitation to Retain service users, with between four to eight service users attending each meeting. Some individuals also contributed to dissemination activities. The first two meetings discussed the project design, including deciding on individual as opposed to group interviews and proposing topics and questions which would support the aims of an evaluation of the range of Retain interventions. The next three meetings discussed the findings. Since the group

did not want to review individual transcripts, the approach to this involved myself and Dr Carl Walker, the co-researcher for this study, presenting emergent themes and then the group discussing them. This was a limitation as it relied on us as university-based researchers to make initial interpretations. However, discussions were detailed and one example of a challenge to our assumptions led to a theme we had labelled ‘advocacy’ being revised to ‘support for self-advocacy’ (see Chapter 11). The final two meetings discussed the presentation of results analysis and final evaluation report (see Appendix I for community study sample meeting notes).

Data collection

I conducted a pilot interview with an acquaintance who had experienced job retention challenges in the past (Appendix J). This helped me to develop research interview skills, and, using the work of Wengraf (2001), reflexive awareness of my own impact on the research interview as dialogue. Data were collected for both studies using semi-structured interviews (Fielding and Thomas 2001), which are consistent with the critical realist combined inductive and deductive approaches and were designed to capture the depth and breadth of job-retention experiences (see Appendices K and L). Interviews were all individual and in the case of the acute study were carried out by myself; for the community study half were carried out by myself and half by Carl Walker. Interviews lasted for 45 to 90 minutes. Acute study interviews took place on NHS premises and the community study interviews at the Retain project base. With consent, interviews were audio recorded for all participants and subsequently transcribed.

Data analysis

My approach to analysis was derived from Danermark et al’s (2002) six stages of explanatory research, based on critical realism (p109-110). These stages are: description; analytic resolution; abduction; retroduction; comparison between different theories and abstractions; and, concretisation and contextualisation. These were generally sequential, but at times there was overlap, as well as occasions when revisions involved returning to an earlier stage to address certain elements of the analysis more closely.

The first stage involved describing the concrete data and context. For this thesis, that meant the interpretations and experiences of participants in the two studies and meta-study, and information about the case study contexts and meta-study criteria. This involved the first stage of coding data. I have also augmented this stage of Danermark et al’s (2002) approach by adding information about myself as a researcher, included in the introduction

and elsewhere in the thesis – since Danermark et al's work has, in my view, somewhat neglected the importance of reflexivity.

At this stage, I coded the data (initially in a descriptive manner) using Wengraf's (2001) format which distinguishes between objective referent coding and subjectivity. I considered this appropriate for my critical realist orientation because the objective referent element applied to those elements of the data which referred to events occurring in an external objective reality. The subjective referent element referred to a person's interpretations, thoughts and feelings suggested by the data (which, as I explained in the previous chapter, are also considered part of social reality even if internal and variable from one individual to another). Thus, when participants referred to attempts to communicate with their employer, this was coded as objective referent material. Fears about receiving a negative response were coded as subjective referent data (though any past experiences of being bullied were objective referent data). This measure was also applied to the interviewer's words on the transcripts as a measure of rigour and to reveal instances when the questioning may have influenced the response of the participant in a way that might have limited responses (see Appendices J and M).

At this stage, the coding was primarily inductive, though the critical realist methodology holds that interpretation cannot take place without the influence of existing concepts and experiences explicitly and implicitly brought to the study by the researcher. I used the NVivo version 8 software to support the process of storing and coding data. In NVivo terminology this led to the production of 'free nodes' – that is, grouped units of coded data that are not arranged in any form of hierarchy or relationship with other free nodes (see Appendix N).

The second stage of Danermark et al's (2002) approach is analytic resolution, involving separating or dissolving "the composite and the complex by distinguishing the various components, aspects or dimensions" (p109). Here, I used Hillborg et al's (2010) analytic method of producing condensed meaning units and associated interpretations (see Appendix O). To support the interpretations, both inductive and explicitly deductive approaches were used, alongside constant comparative analysis whereby transcripts were coded individually and then revised in light of subsequent coding. I acknowledge that the deductive element involved selecting certain components and not others – influenced by pre-existing and developing orientations derived from my own and my collaborators' experiences, as well as related theory and research literature.

At this stage, I sought to evolve the descriptive codes into analytic codes – creating a coding frame and categorical hierarchies where this was justifiable. The ASUP contributed to this process by discussion of specific transcripts (see Appendix P). I took notes on these discussions and then sought to integrate points in a manner that was coherent with the coding. I was prepared for the possibility that their interpretations and mine might diverge in a manner that could not be synthesised – in which case I would have reported the divergence. In the community study I coded all the data, while my co-researcher Dr Carl Walker coded a subset of the transcripts before we met to compare and achieve a consensus on the themes identified in the coded data. These provisional themes were then discussed with the RSUG as explained above. I discussed this stage of analysis of both studies with my research supervisors and, in more general terms, during research presentations to audiences of researchers, practitioners and service users (Appendix Q).

The results of these first two stages can be found in Part 2 – the findings chapters of this thesis – and were also used in the meta-study. The findings from the acute studies are presented in a number of chapters and are reported in more detail. This is because, first, they began at an earlier stage, and second, because the Retain findings were used to produce an evaluation report by a specific schedule. Nonetheless, I consider that they served well to provide a comparative case study that has increased the potential of the research to achieve its explanatory aims.

The search for explanation in critical realism involves viewing findings through various theoretical perspectives and seeking to identify mechanisms and underlying structures that can coherently and logically account for the findings of the first two stages. This is achieved through Danermark et al's (2002) remaining stages – the results of which are to be found in the literature review, discussion, implications and concluding chapters.

Abduction, the third stage, involves viewing the analytic elements identified in the previous stage in the contexts of different theoretical perspectives, interpretations and explanations. The principal elements, supported by my literature review and used in my thesis from an early stage, were a biopsychosocial perspective, an occupational science perspective, the recovery paradigm and the resilience framework. The process of analysis suggested additional perspectives: notably, established concepts of iatrogenesis, social capital, and newly proposed concepts of occupational capital and an integrated biopsychosocial occupational perspective. These aimed to help provide an explanation of structures and relations underpinning the analysed phenomena.

The fourth stage is retroduction, which comprises the critical realist process of identifying generative mechanisms and their contexts. This is achieved by working back from research findings, and asking what mechanisms and contexts can possibly account for the phenomena and their structures and relationships, as proposed in the third stage. For instance, this might involve asking what mechanisms can account for the variable experiences and interpretations of stigma associated with return to work after experiencing a mental health problem.

In stage five, the relative explanatory power of different mechanisms and their associated structural contexts are evaluated. This may involve rejecting previously identified mechanisms, qualifying in what contexts they seem to operate, or suggesting what different mechanisms may reinforce or counteract each other's impacts. For instance, it may be that mechanisms which contribute to gaining a supportive reception from work colleagues are negatively impacted upon by other mechanisms related to public discourses about mental illness. This stage and the preceding stages of abduction and retroduction were particularly influential in the literature review and discussion chapter.

The final stage of concretisation and contextualisation is the critical realist attempt to generalise from theory to the concrete. This involves looking at the specific circumstances in which identified mechanisms may act and interact. I intended that the use of the comparative case study design and literature review would support this process. Commonalties and differences between the community-based context and the acute mental health context were particularly important. The aims were to enhance the explanatory power of the research, to identify what mechanisms appear to be operating in each context and to suggest whether there are any overarching mechanisms operating in both contexts. Concretisation and contextualisation also aims to be able to explain why certain specific events occurred. Thus, it acted as a measure to support the validity of any theory that is built. This stage, whilst apparent in discussion and meta-study chapters, was central to being able to propose the implications set out in chapter 13.

Rigour

Understanding of the best way to demonstrate research rigour and quality varies greatly within research paradigms, particularly those of a qualitative nature (Guba and Lincoln 1994). Consequently, Madill et al (2000) have emphasized the importance of published qualitative research making explicit the study's interpretation of these concepts and demonstrating their consistency with the declared methodology. Concerned that

realist research did not have any explicit criteria for judging its quality, Healy and Perry (2000) developed six such criteria. These are ontological appropriateness; contingent validity; use and acknowledgement of multiple perceptions of participants and peer researchers; methodological trustworthiness; analytic generalisation; and construct validity. In my concluding chapter I will demonstrate the rigour and quality of this research, and acknowledge limitations, with reference to these criteria.

Dissemination

Throughout my research journey, I have disseminated issues and findings that have arisen on the way. This was also a particular concern of the RSUG who were keen for evaluative lessons to be shared as soon as possible. As discussed above, I also consider that the dissemination activities have helped to enhance the rigour of the research by making it subject to wider scrutiny and challenge. A list of dissemination activities (including presentations, workshops, informing a successful post graduate MSc vocational interventions module, and publications) to date is included in Appendix Q.

Conclusion

This chapter has presented the two case study contexts of acute mental health services and a community-based job retention project. Ethical issues related to participation and coercion, minimising risk of participant distress, confidentiality and payment were then discussed. Following this, the inclusion and exclusion criteria and participant characteristics were set out. Whilst also embedded throughout, I then detailed key elements of the role of service user collaboration in the research design. Processes of data collection, analysis and measures of rigour were then explained and justified. Finally, I noted that significant dissemination has already occurred, which I consider has in itself helped to strengthen the thesis. The findings generated by these methods are now set out in the following Part 2 of this thesis.

Part 2: Findings

Part 2 of my thesis reports the findings from the interviews with the seven participants who were using acute mental health services in the acute case study, and the fourteen participants using the job retention project in the comparative community case study (see Table 2 below). These findings are the outcomes of the descriptive and analytic resolution stages of Danermark et al's (2002) explanatory research framework as described in the previous chapter. The findings from the acute study participants are considered in the greatest depth and are presented first.

Chapter 7 presents the themes relating to participants' *attitudes and experiences of work and work and health interactions*. These themes are primarily concerned with contextual elements, providing insight into how people viewed their work and its interactions with their health – and as such they include some retrospective and general reflections on their experiences.

By contrast, the focus of the subsequent three chapters is on the emerging present (Griffiths et al 2010) – although this does include some discussion of (mainly recent) past events that appeared to be influencing their unfolding recovery trajectories. Thus Chapter 8 reports *sick leave experiences and challenges*, and Chapter 9 reports participants' *experiences of others*. In these chapters I indicate the contextual elements and the relevant mechanisms which have been found to either support or restrict participants' *return-to-work trajectories*. Further reflections on these evolving return-to-work trajectories are presented as a higher level of analysis in Chapter 10.

Return-to-work trajectories are also the main focus of the comparative case study – the community-based job retention project Retain – which is presented in Chapter 11. The conclusion of this chapter will highlight the differences between the two case studies (in particular, the extent to which a co-ordinated, collaborative job-retention strategy was present) and the similarities (in terms of many of the participants' needs). These differences and similarities will support the analysis, discussion and conclusions in the final part of my thesis.

Pseudonym	Job type	Case study group
Ben	Delivery worker	Acute
Daniel	Factory worker	Acute
Gavin	Factory worker	Acute
Hilary	Craft tutor	Acute
Mark	Supermarket worker	Acute
Penny	Care worker	Acute
Yvonne	Bank clerical worker	Acute
Alice	Health/social care professional	Community
Anna	Health/social care professional	Community
Charles	Care worker	Community
Harry	Courier	Community
John	Administration worker	Community
Laura	Administration worker	Community
Linda	Kitchen assistant	Community
Mary	Higher education staff (non-teaching)	Community
Naomi	Legal executive	Community
Rebecca	Health/social care professional	Community
Ruth	Administration worker	Community
Sonia	Retail manager	Community
Steve	Care worker	Community
Zoe	Higher education staff (non-teaching)	Community

NB limited details are presented to protect anonymity. Broader non-tabulated characteristics of acute and community participants are presented on pages 102-103.

Table 2. Participant pseudonyms and job types

Chapter 7: Work and well-being (acute study)

This chapter presents the first two overarching themes identified by my analysis: *attitudes and experiences of work* and *work and well-being interactions*. They comprise predominately contextual factors which had, in the main, been present and developing in the participants' lives for some time prior to the interview. These appear to have contributed to certain mechanisms which directly influenced participants' return-to-work trajectories, as well as others which did so more indirectly, by impacting on the third and fourth overarching themes: *sick leave experiences and challenges*, and *experiences of others' support and attitudes* (presented in Chapters 8 and 9 respectively).

Attitudes and experiences of work

Participants displayed varying attitudes to, and experiences of, their working lives. These diverse attitudes and experiences related to a wide variety of aspects pertaining to work, including performing work tasks; the routine of work; social and physical workplace environments; other life commitments; finance; the perceived value of their work; and actual, or possible, alternative career paths. These appeared to exert important potential influences on participants' futures, primarily because of how they could increase or undermine their attachment to work.

The experience of performing work tasks

The extent to which people felt their work required using their skills at a level that enabled them to feel competence had a major influence on how satisfied they felt with their jobs. Gavin, Hilary and Penny reported enjoying often challenging work tasks requiring expertise, concentration and manual skill:

[...] that's my favourite part of the job, I love soldering and that's what I was brought in to do [...], because it's making sure joints are done properly. It's good, it's really good. (Gavin)

I've been able to use it [skill gained in previous training] in this job [...] I've been doing a bit of hand massage using essential oils, so hopefully I will be able to [...] continue it, because it is something that I really like doing. (Penny)

[...] the physical thing of hands on metal. I'm very good at a technique called piercing, [...] where you saw very detailed, piercings [...] that is deeply satisfying to do. (Hilary)

In his voluntary work Daniel described the use of skills in similar terms, but also gained satisfaction from the stimulation and sense of helping others that the rescue work involved:

The thing I enjoy is the buzz out of the job. [...] a Sunday afternoon and the wind had got up and they'd broken down and mum, dad and three kids are on there, shouting and screaming and scared and you get them [...] and calm them down. (Daniel)

By contrast, it was the lack of opportunity to use his skills in his main line of work that led Daniel to feel negatively about it: "And that's probably what does me in as well. I'm not using my brain to [do] what I know I can do". This was similar to Yvonne's diminished satisfaction with her job when she lost some tasks which had demanded more of her existing skills:

When I worked full time it was different. [...] this particular job I've only ever done part time [...] I don't enjoy that as much as what I used to do [...] I used to run the [...] centre and train the new recruits [...] I had the technical knowledge for that, whereas what we're doing today I've had to learn as you go along [...], so you're not a necessarily a subject matter expert. (Yvonne)

The routine of work

The routine and structure provided by work was particularly valued by some:

I just felt like I needed some structure to the day of a paid job, [...] I was finding it really difficult to fill my time [...]. (Penny)
I like the routine of having work – occupies my day. It gives me something to do. (Mark)

Ben stated "I've always had a job since I was sixteen. It just keeps my mind occupied really. [...] Stops me getting bored." He also appreciated the sense of relative freedom from the degree of control and flexibility about how he carried out his work and the element of lone working:

Yeah, it's a good job actually. You're kind of your own boss because once you're out there you've got no-one overlooking you, so if you want to run round like a maniac [...] and go home early you can. If you feel a bit tired you can just potter round and get it done. (Ben)

We will see in the next chapter how the suspension of such routine and structure impacted on people during their sickness absence.

Social environment of work

It will also be shown that the loss of positive social contacts at work was a challenge people would subsequently face on sick leave. Mark, Ben, Penny, and Hilary recalled positive experiences and attachments to colleagues and clients at their work:

I enjoy working with the general public. [...] You get a bit of camaraderie with the other people you work with so it's nice. (Mark)

[My colleagues are] actually really nice. It makes the job [...] We have a good laugh and you go in there and the time flies [...] I see them out of work as well. (Ben)

I got a really nice feel for the place and I liked the residents, they were really friendly, so I just thought [...] this is my ideal job. [Colleagues] were really friendly, really supportive, really positive people. (Penny)

I [...] exhibited work] several times and you get an amazing response from everybody [...] it really lifts your ego [...] that's very pleasing to have people that do appreciate handmade objects [...] meeting likeminded people and it was a nice community spirit. But that's one of the good times. (Hilary)

Hilary's closing remarks signal that her work did not always entail positive experiences of others. In part this was because some of the time she worked from home alone: "it's been my downfall being completely on my own". Even when teaching others at college she felt "shy" and "uncomfortable"; and since her hours had been reduced she had very limited contact with colleagues, increasing her sense of being "very isolated". This disconnection was shared with Yvonne who, like Hilary and Daniel, expressed a critical view of some of the people at their work. A sense emerges from their accounts that some of their criticism of others may be influenced by frustration at their own position. Yet it remains the case that an important aspect of their workplace context was a lack of strong attachment to others – which might have otherwise have helped support a successful return to work:

You get several people that have absolutely no talent whatsoever, no empathy with metal, don't know how to handle tools and have no design skills whatsoever and they can be a bit frustrating, [...] and these are just housewives, just want to make set stones, and it's all very dull. (Hilary)

I get along with them from the professional point of view and we go out for lunch for someone's birthday, but they're not what I'd call, close friends [...] office politics [...], bitching behind everyone's back – I can't be done with all that [...], but again my own memory seems stuck with the last year, rather than before. (Yvonne)

The blokes are very small-minded, they moan about any little thing [...] [They] don't help themselves because they're not like where I used to work, the cabinet makers all had a bit of brain. (Daniel)

Physical workplace environments

Daniel and Hilary also expressed a dislike of aspects of their physical work environments. Daniel characterised his workplace as "an absolute mess" with machines "like antiques". Hilary did not like the size of her workspace in her house, but more of an

issue was that it was located within *her own home* – something that was particularly difficult to face when she felt unwell:

[...] the environment became more and more important. I loathed so much the environment, I mean, this little tiny room at home [...] it just became this really negative horrendous place to work in, and then that sort of seeped out in the rest of the house. (Hilary)

Others did not directly raise the physical environment of work – though there is an implication that part of the sense of freedom Ben appreciated came when he was outside on deliveries. There is always a strong potential for environments to be taken for granted and to recede into the ‘background’ (which in a sense they are). Thus it may be that the others would have had more to say about their working environments in response to more explicit questions – something which may not have been necessary for Daniel or Hilary because of its strong negative connotations for them. The physical environment of their workplaces also represented a negative context which may have undermined the effects of some positive mechanisms supportive of a successful return to work.

Work and other life commitments

Work was not viewed in isolation from other life roles. Hilary, Penny and Yvonne all worked part time and related this to their parenting commitments. Penny had moved from not working to part-time work, and saw this as opening up a new area of her life, having found it really “difficult to fill time when the children were at school”. For Hilary and Yvonne, the part-time work, as well as accommodating their parenting roles, had more negative impacts. Hilary’s college job felt vulnerable, since over the last two years “the hours have dropped because they’ve changed the system”. She felt frustrated at having to combine two part-time jobs while her friends were “all in careers that they’ve been building”. Yvonne stated that the importance of having a career had diminished: “before I had children I was more interested in going up the ladder then, whereas now there isn’t any more they can offer me”. Whilst appreciating the flexibility, she still experienced a sense of frustration, describing her job as “a necessary evil” which she could not leave because it paid well compared to alternatives. Ben also valued the way his job accommodated his parenting role: “I can pick my daughter up after school and not have to rush around, so that’s quite nice really”. He and Daniel considered their main jobs as enabling them to pursue interests in photography and volunteering work respectively.

Thus, for some, attitudes to work were shaped by the extent to which it supported participation in roles linked to family, interests and other commitments – as well as in

some cases generating tensions with these other roles. This draws our attention to the complexity involved in balancing positive aspects of flexibility with some of the costs – particularly for two of the female participants in part-time work. Attempts to orchestrate a return to work had to be made in the midst of this complexity.

Finance

Income was another key contextual factor shaping attitudes to work. As suggested above, Yvonne considered that since she had had children “if money was no object then I don’t think I would work”. Daniel was more certain that income was the main reason for remaining in his current employment: “I can’t stand the job [...] but it pays the mortgage”. Receiving an income brought Ben and Penny benefits additional to direct economic factors:

I like the feeling to go out and you come back after a day’s work and you go I’ve just earned blah blah quid and you feel like you’ve achieved something for the day.
(Ben)

I actually felt my morale would feel better if I was actually earning some money and doing a paid job. (Penny)

Value and status attached to work

The status people attached to work was a further important influence upon their appraisals of it. Hilary’s thoughts about status and income in some ways mirrored the previous comments of Ben and Penny:

It is a lot of the problem of why I’m here [in hospital] really, [...] I have a lot of anxieties around work and income and how that gives you status. I don’t feel I’m contributing really... (Hilary)

She questioned the social value of her work (though acknowledged this may have been partially influenced by her depression):

I got to feel, who am I to make these things and just fill the world up with more stuff. It just felt like a sort of self indulgent thing to be doing. (Hilary)

Similarly, Yvonne questioned how worthwhile her work was to society:

Always said I’d never work in a bank, I always wanted to do much more... you know, people job, and helping others. (Yvonne)

Conversely, for Mark and Daniel (in his voluntary work) the value of their work to others constituted reasons to be satisfied with their jobs:

If you provide good service to the customers and they’re quite satisfied that’s a good aspect of it. (Mark)

And it’s achieving, [...] I just get enjoyment out of helping people. (Daniel)

Ben did not question the social importance of his work, but was almost apologetic in describing it as lacking complexity, possible because of its perceived low social status:

I just go around delivering [...] normally in a van, but sometimes I walk round. So, there's not much to it really. (Ben)

Penny's words suggested she may have considered that having a social identity as a worker gave her a status not afforded to non-employed parents:

When I'm out of work I know that I've got children and that bringing them up is work, but to me, I just felt I needed like some paid employment as well. (Penny)

It is possible that some participants' remarks about the perceived social value of work may have been influenced by the context of interview – namely, in a healthcare setting with a researcher from a health profession background. Still, the content appears sufficiently developed that it seems likely the ideas were at least to some degree already present in their minds before the interview, and were thus having some bearing on their emerging presents.

Alternative careers

As some of the quotes above indicate, with the exception of Gavin, attitudes to work were shaped by the possibility of alternative career paths in the participants' past, present or future. Mark had aspired to something he considered more intellectually challenging. Yvonne had originally trained as a student nurse, but had to stop this due to a physical health condition. Penny had similarly qualified as a health professional, but stopped this work when she had children; she saw her new employment as the first tentative step back towards this. Daniel was pursuing a parallel, and for him much more satisfying, career in his voluntary work. Ben's interest in photography was developing into a possible alternative future employment. Hilary was expressing an as-yet-unformulated and qualified desire to explore some kind of alternative career in the future.

Summary of attitudes to and experiences of work

The disruptions to participants' working lives and their attempts to recover, as detailed in later chapters, operated in the context of these varied attitudes to and experiences of employment. Performing work tasks had positive connotations when participants felt that they were using their skills to a degree that was sufficiently challenging. Negative experiences were reported when they felt their skills were under-deployed. The routine of work was generally seen as making a positive contribution to people's daily lives. Social contacts at work were appreciated by all, for at least some of the time; however, some were

critical of people they encountered – a perspective which those involved acknowledged, albeit to varying degrees, may have been influenced by the impacts of their mental health problems. Physical work environments may have been taken as a given by most, but the two who were most dissatisfied expressed strong negative feelings about it. Work did not happen in a vacuum – participants had other commitments and interests in their lives; but the extent to which work also allowed them to manage competing demands influenced their attitude to it. All considered they had to work for financial reasons. This could be a source of resentment for those generally dissatisfied with work, but for others earning a wage brought satisfaction additional to the income gained. This sense of satisfaction was closely related to the perceived value and status that participants believed their work conferred. Some felt their job lacked social purpose or recognition, while others saw it as having a socially valued purpose. This influenced how participants thought about alternative working pathways in their past, present or future. Here there was evidence of regret and hope, both within and between different individuals.

These factors influenced how attached participants felt to their work. Positive attachments to work seemed to support recovery trajectories which contained more clearly envisioned possibilities of return to work (especially in the cases of Gavin, and to some extent with Mark and Penny). Yvonne, Hilary and Ben experienced more mixed attachments to their jobs, while Daniel's positive attachment to his voluntary job contrasted starkly with his extremely negative experience of his paid employment.

Work and well-being interactions

It was not just past experiences of work which were influencing participants' thinking, but also their experiences of and perspectives on how work affected their well-being and *vice versa*. Findings within this category comprise the themes of *past job loss and disruption*, and issues of *stress and work*. Following this, I present findings concerning the *impacts of symptoms on work*, then the reverse directionality of *impacts of work on symptoms*. The final theme reports the implications of seeing *work as a public and health as a private matter*.

Past job loss and disruption

Participants varied in the extent to which mental health problems in the past had affected their working lives. Gavin and Hilary, both with long-term histories of bipolar disorder, reported extensive past disruptions:

Before, I've just said 'No! I can't cope, 'bye, see you later, I don't want my job anymore.' [...] I've actually signed a resignation before on the day that I've said that, [...] that of course made me feel worse because I'd chucked my job in and it was sort of like taking three steps forward, four steps back. (Gavin)

I was not being productive in any way. I was just spending money [...] sort of adrenalin driven. (Hilary)

Whilst Gavin reported actual job loss, Hilary considered that the impact was more related to disruption of work and restricting her career development. Similarly, Penny's account suggests that her gradually developing depression delayed her in looking for a job: "I wanted to be back in the world of work and be normal again, [...] and function again, which I didn't feel like I had been doing". It also seemed Mark's intermittent past experiences of depression may have contributed to his episodic work history: "I did some other work – I was ill for a while first with depression. Then when I was feeling better I did a few other jobs". He also reported a more recent, though less severe, episode which resulted in him taking sick leave. This experience resembled Yvonne's and Daniel's, though they had not described previous episodes further back in time:

I was off for about two and a half months and then things improved and I went back to work until July. When I was off before it was slightly different [...] it was anxiety really, but characterised by headaches. (Yvonne)

Last time I was off that was two years ago, that was in the same job. It was shortly after my father died. [...] Problems in my home life as well. I was unable to cope so I was off for about five or six weeks. (Mark)

I did have a bad time just before last Christmas. [...] I ended up with a month off [...] it was at a time when my wife had just left. (Daniel)

The framing of such recent absences with reference to either a physical health problem or grief reaction will be considered further under the discussion of disclosure and stigma (Chapter 9). Most participants had firm reasons – grounded in past experience – for being concerned about how their current mental health problem might disrupt their working lives. In a way Ben was an exception to this, having had no previous history of mental health problems – though we shall see how his lack of any past experience through which to frame his current situation may have itself engendered feelings of uncertainty and frustration, which in turn increased the challenges he faced.

Stress and work

Participants described differing experiences of stress at work – referring to demands being made that exceeded their coping capacity. For some it was apparent that such

experiences had the potential to make their return to work more difficult; for others this was not the case.

Pressures at Gavin's and Mark's workplaces could be challenging at times, but they expressed a general acceptance of them – perhaps because they were not excessive:

[...] if things are late, things get a bit het up, because we have to keep to shipment dates, [...] I'll get used to that pressure again of working to times. (Gavin)

Sometimes if we're short staffed [...] you end up doing two people's job rather than just your own normal job and that can be a bit stressful [...] But most of the time it's not too stressful. (Mark)

Ben did not describe his work as stressful before he became unwell, but he was concerned that he might not be able to manage the various demands when he returned: “much as I love work, and I'd rather be at work than at home, I'm not going to put myself into a position where I might be out for longer, because I have to do a lot of overtime”.

Hilary and Yvonne considered feelings of stress at work could be engendered by an interaction between work demands and aspects of their own character:

I'd like to stop teaching, I'm not a very confident person – even though this is my seventh year of doing it. (Hilary)

I'm a bit of a perfectionist and I like everything just so. [...] I think it will be important for me to recognise if there is something that I can't do and say. (Yvonne)

Two participants explicitly implicated work stress as contributing to their current mental health problems:

It just took a lot out of me, going back into that type of work again, and having to be the initiator and the leader and the motivator. [...] I put too much pressure on myself maybe to try and get back into that work so quickly. (Penny)

I was also doing private work as well as the [voluntary] work, [...] apart from my other job, I just ended up doing too much [...] that's how it more or less started. (Daniel)

Impacts of symptoms on work

Participants reported a broad range of symptoms and gave clear accounts of how they directly impacted on their ability to perform their jobs – suggesting on-going concerns influencing how they thought about returning to work and what that might actually be like.

Most revealed how their ability to concentrate on work tasks was affected by some very varied symptoms:

I nearly crashed one of the work vans because I heard voices. I physically can't concentrate on anything when I hear the voices. [...] I was like halfway in a bush and I had to pull myself out. (Ben)

I have this physical thing where my vision is distorted, [...] in my depression, it detaches me so I feel like I'm in some sort of trance [...] and although I can hear my voice talking, it's like it's detached, it's out of me – so I just find focusing very difficult. (Hilary)

Concentration for me is still an issue [...] the things like [...] the paying of the invoices. (Yvonne)

My memory was going. Where I was on the ball and they always used to say 'oh you're always one step ahead'. [...] I just started losing it totally. (Daniel)

Enduring physical demands of work was affected by a more uniform experience of fatigue:

[...] physically [...] I feel weak, I feel like I can't do it [...] you've got obviously the heavy [...] bags and stuff like that, and although I know I probably could do it, it would absolutely, probably kill me trying. (Ben)

[...] the sort of lethargy and exhaustion you feel with depression just overwhelms me and because I was working at home more often than not I would just retreat to bed. (Hilary)

I was just driving over there in the forklift and I was driving round the back and just having like half an hour's sleep on the forklift just to help myself get through the day. [...] I knew I wasn't well and at work I tried not to show it. (Daniel)

I just came home and I had to go to bed, I just felt so drained [...]. I don't think I had the energy really for it. (Penny)

Participants considered that taking responsibility and managing the organisation of work were particularly restricted by some symptoms:

We pay thousands of pounds worth of exams at a time. I wouldn't want to rush into doing that. I don't think I'd want to mark tests either [...] but I think [I could manage] just tasks with not so much responsibility. (Yvonne)

[I would like] confidence to achieve things [...] just to be how I was before I was ill and sort of going to work every day and not worrying about work or worrying about people. (Mark)

I suffer from bipolar, so in the summer I was the extreme of what I am now [...]. Whereas now I want to sleep all the time, then I would sleep for four hours a night and then be up and rushing about. And everything was superb and my perception [was that] everything was lovely and I was interested in everything and much more creative, but in fact it was a different sort of stress. I was not being productive. (Hilary)

I was [on a rescue mission in voluntary work] and my mate come up and he said 'you alright?' I said 'no'. I said 'I feel ill'. I said 'I haven't got any energy to do this'.

And we were on a shout and usually you're buzzing [...] and it had disappeared for me [...] I said 'I can't do it, I've got to come off'. (Daniel)

Four participants emphasised the significant degree to which interactions with others at work were affected by themselves being aggressive, overbearing and/or lacking confidence:

I know that I can't go out because I get such a short fuse and if one of my customers was rude or something I don't know how I'd react. (Ben)

I was just [...] being loud and overbearing and over-excited. (Hilary – reporting on interactions when elevated in mood)

The thought of being with people all day and having to keep talking [...], I just don't have the stamina for that. [...] I tend to go and sit in my car and eat, just to be away from people. (Hilary – describing when low in mood)

And my self-esteem's a bit low so I find it quite hard sometimes talking to people, relating to people. (Mark)

If I've got someone demanding or somebody stressy on the other end of the phone I don't know how I'd react. Well I could just see myself bursting into tears and walking out the room. (Yvonne)

Hilary's and Gavin's symptoms seemed to have affected their commitment to work. In Gavin's case this had led to his impulsive walking out of previous jobs; in Hilary's case there was a profound questioning of the value and purpose of her work, undermining her capacity to be creative – an essential element of her craft work:

[...] with the depression that I was suffering and deteriorating with I got to feel that my work was completely irrelevant and unnecessary. [...] I just couldn't find anything that would alleviate this awful feeling of total despair [...] it just sapped all my creativity really. (Hilary)

It was notable that different symptoms could result in similar occupational problems. The graphic accounts of how varied symptoms affected their work suggested strongly that they were an important contextual barrier to returning to work that needed to be overcome in some way.

Impacts of working on symptoms

Just as symptoms could impact on work, some participants spoke of how they considered working had, or might, impact on their symptoms. Gavin was the only one who had began a phased return to work when interviewed. He described how carrying out skilled absorbing tasks helped reduce some of his symptoms:

[...] the soldering [...] it's got to be spot on, the time just flies by because you're really concentrating [...]. The [feelings of anxiety and depression] drop. They drop

because I'm concentrating more and [have] less time to think of what I'm actually feeling. (Gavin)

Gavin found it most helpful to be performing such challenging, absorbing and rewarding tasks – using some of his greatest skills – than the more routine tasks he had done on his first day back. Here there appeared to be a good fit between task demand and his performance. He felt challenged but competent. Perhaps the feelings of total engagement and experience of himself as a competent worker combined to reduce feelings of anxiety and vulnerability on return to work. That he also referred to “enjoy[ing]” and “lov[ing]” soldering suggests that the therapeutic benefit may relate to this satisfaction, and not just to distraction due to concentration. Though Hilary did not describe a reduction of symptoms in such explicit terms, we have seen above that she felt deep satisfaction when performing a comparable skilled manual task, and also found her mood lifted when she felt her work was valued by others at exhibitions. It appeared that Penny was hoping for a similar outcome, since a prime motivation for resuming work just before her relapse had been to help reduce her depression: “I was on my own and I was spending a lot of time ruminating and brooding and getting quite depressed, when I thought if I was out in the world of work it would be healthier for me.”

Ben feared that working now might exacerbate his symptoms: “I think working your way into work would be better than just jumping straight in, because you don't know how it's going to react.” In other themes – whilst not necessarily referring to symptoms – it is also apparent that others feared that work also had the potential to undermine their mental health.

Work is public, health is private

Despite identifying some linkages between work and well-being, two participants made explicit references to seeing work and their mental ill-health as belonging to separate realms:

[...] work's different from your private life. Depression and the illness you're going through is private and work is a different sort of topic – it's hard to bridge the two. (Mark)

I suppose I really do know that it's my responsibility to sort this out, because it's... I'm... I am an adult. (Hilary)

This formulation appears to have reduced their expectations of receiving work-related help from mental health services, or mental-health-related help from their workplace.

Summary of work and well-being interactions

Participants' attitudes towards interactions between work and well-being, as well as their past experiences of it, constituted an important contextual influence on their thinking about recovery and the prospect of returning to work. Past experiences of job loss and disruption, attributable to mental health problems, had served as salutary lessons motivating Gavin's determination to minimise the risk of job loss. For most of the others, their past problems mainly increased anxiety as they contemplated a return to work. An exception was Ben, whose lack of past experience meant that he found his symptoms all the more disturbing and his working future concomitantly more uncertain. All participants reported that there were times when there could be increased pressure at work, which made them feel stressed. For some this was viewed as normal, not as excessive, and therefore manageable. Two considered that their own personal characteristics made stress harder for them to cope with; while another two considered that their work had in some way contributed to exacerbating or triggering their mental health problem.

All described ways in which symptoms arising from their mental health problems affected them at work, notably in relation to concentration, physical fatigue and interactions with others. Hilary and Gavin acknowledged that their symptoms had affected their general commitment to their jobs. Analysis also suggested that elements of their work could affect their symptoms positively (though Ben feared that certain tasks might trigger some of his symptoms). Some described times when they felt particularly challenged and engaged in work tasks in ways which led to accomplishments that lifted their mood. Whilst all were able to reflect on interactions between work and their well-being, Mark and Hilary in particular saw issues related to health and those related to work as belonging to separate private and public realms of their life. This formulation appeared linked to reduced expectations that health services would consider work and that their workplaces to consider their health.

This chapter has reported findings pertaining to the overarching themes of *attitudes to, and experiences of work*, and *work and well-being interactions*. These findings formed part of the context which participants found themselves in while attempting to recover from their acute mental health problems, and considering future return to work. The next chapter reports the challenges and experiences of being on sick leave that were affected by this context, and which more directly influenced their unfolding return-to-work trajectories.

Chapter 8: Sick leave experiences and challenges (acute study)

The previous chapter reported on the influences that participants' past experiences and attitudes had on their work and well-being. This one presents findings related to the experiences and challenges encountered while they were on sick leave. These provide a basis for explanatory insight into their immediate context of recovery, as well as providing preliminary indications of the types of mechanisms that may influence return-to-work trajectories. The findings suggest that participants were on an uncertain sick leave journey and confronted a range of challenges; yet, at the same time, work remained a pressing issue, and there was clear evidence of attempts to manage these challenges.

The uncertain sick leave journey

Participants' experiences of sick leave were analogous to a journey with a route and destination, in which both were uncertain. The beginning of the journey was often sudden and unplanned, even where participants had been experiencing increasing mental health problems beforehand:

[...] it took me four months from the start of it to admit that I weren't getting well and to get some help, so as soon as I went to the doctor he told me [...] not to be around too many people. So he'd signed me off from then. (Ben)

Well literally the Tuesday I worked, the Wednesday wasn't good – I think it was the Friday, she [her manager] texted me and wished me happy birthday and that's when I was signed off [...] and that's when I texted her [...] I just said I'm sorry I've been signed off [...]. (Yvonne)

The exception was Gavin, who approached his employer when he judged he was becoming unwell and would need some time off:

I said one day [...] that I was feeling particularly unwell. I said I have to go home because [...] I'm going through an acute phase and I need help and support, so that's what I did. I left work and came home. (Gavin)

Similarly, the expected duration was unknown; participants had been on sick leave from two weeks up to six months at the time of interview:

When I gave in my sick certificate I was hoping I'd only be off for a week. (Ben)
I certainly wouldn't want to be given a sick note for a long period of time again. I think, we need to keep looking at [a return date] but again, until I can speak to work I don't know. (Yvonne)

Things didn't improve. I started to feel worse and I went back to the doctors and he signed me off for three weeks, and then it went into another three weeks, and then it was a month. (Daniel)

On the journey, the process of obtaining approval to be on sick leave had to be navigated. This involved repeated interactions with employers and health professionals. Participants' knowledge of this process varied, as did their capacity to effectively engage in these interactions, with Penny and Hilary being most uncertain:

[Ward staff] said they can always sign me a sick note [...] but I don't really know how it works, that's the thing. I don't know whether [...] I'm getting sick pay.
(Penny)

I suppose when I see the doctor I could ask him [for a sick note], but I don't have any idea how to do that. (Hilary)

The perceived purpose of the sick leave was often not explicitly expressed. For some, like Mark, it was simply a consequence of having an acute mental health problem – they were unable to work: “I didn't feel that I was ready to go back to work [...] 'cos of being anxious in crowds – things like that.” Ben considered he needed to be on sick leave partly because of the risk he judged he posed to others – so sick leave was something to be endured. For others it was understood like an intervention, a time to recover. This is clearest in the case of Daniel, who expressed the view to me that he needed more time: “I'll be honest with you, I've got no intention and I don't feel well enough to go back on Monday.”

Challenges of sick leave

Participants experienced major challenges while on sick leave, related to acknowledgement of illness, finance, social isolation, losses and disruptions to routine, and other feelings engendered by these. These arose from direct illness-related factors, other people's attitudes, and the consequences of being on sick leave itself.

Acknowledgement of illness

People grappled with making sense of and acknowledging the impact of their illness. This involved understanding and recognising symptoms. The point can be illustrated by comparing Ben's and Gavin's contrasting experiences: Ben had no previous mental health problems and was understandably shocked by his apparently psychotic symptoms – so much so that it took time for him to acknowledge this before seeking help: “I started becoming unwell four months before I actually admitted to anyone that I weren't well [...], because it shows [...] like a weakness.” By contrast, Gavin had experienced his symptoms before, so recognised what was happening and took action (see above).

At the same time as acknowledging the impacts and consequences of illness, participants were challenged to try and resist feeling overwhelmed by them:

I would just retreat to my bed because I couldn't cope, I felt overwhelmed and although I'm not doing the sleeping here [psychiatric inpatient unit], I think when I get home I'm just going to do the same [...]. (Hilary)

Achieving this balance of acknowledgement, and not feeling totally engulfed by their mental health problems, was related to the complex task of how they thought about illness. This was complex because it involved not just thinking about how their illness affected their life, but also how it affected the way they *thought* about how it affected their life:

I'd always be full of self-doubt and I'd be berating myself for doing things badly and not functioning as well as I could [...] but always the outcome at the end of the year is very good and the feedback from the students is fine [...] I can see that really, that I have a skewed perception. (Hilary)

Acknowledgement of illness was just one challenge. As significant were the direct and indirect consequences of illness on their lives, shown in Ben's frustration at psychiatrists not asking him about this: "They ask me loads and loads every day about my symptoms, but they never ask anything really personal."

Financial challenges

One set of sick leave consequences were financial challenges. Circumstances varied considerably, due to employers' policies; what other financial support, commitments and debts they had; and how long they had been off work. Five participants were worried about loss of income. Even though still on full pay, Ben was losing £60–70 a week on lost overtime. Some feared what might happen when their pay reduced to the Statutory Sick Pay (SSP) rate:

I'd lose a bit of money because I'm on a tight budget I'm worried about that happening (Mark)

I'm going to run out of money shortly [...]. Obviously I'll get further in debt. I mean I already owe them [his parents] thirty grand for keeping the house. (Daniel)

Penny was not immediately worried about loss of income, having only just started her part-time job. Gavin would have been worried, but for his confidence he would be returning to full-time work soon. He had been able to control and monitor how much leave he had already taken:

I can take up to eight weeks sick a year. [...] this time I was careful that I wasn't going to [...] go over the mark with that because otherwise I wouldn't get full pay. So it was good that I've still maintained full pay while having a crisis, which has

taken a lot of anxiety away, because the last thing you want with a crisis is financial problems as well [...]. (Gavin)

Money worries increased when participants were uncertain about how long they would be paid and at what rate:

I don't know exactly how much statutory sick pay I'm entitled to. Full sick pay: from when I was ill last time I think it ran out after two or three weeks. So I'm not exactly sure. (Mark)

No. I haven't even looked into that [how long his SSP will last]. (Daniel)

Money worries affected participants' thinking and planning about return to work. On the one hand it was experienced as a pressure to go back, on the other there was fear that if they went back too early both their health and financial situation would suffer:

The sooner I go back to work the better because obviously it's Christmas and I'm on half pay. (Yvonne)

I don't want to start borrowing loads of money off them again and go backwards again. I want to get back. (Daniel)

I'm not going to put myself into a position where I might be out for longer, because I mean I have to do a lot of overtime so I'm losing quite a bit of money every week. (Ben)

For Mark it also seemed to preclude an option of returning to work part time: "I'd like to [return part time initially] but the financial aspect might make it a bit tricky".

Social isolation

Other than Gavin and Penny, participants reported more limited social contacts since they were on sick leave:

[...] just through text messages – I've spoken to one of my friends at work and just sort of let her know sort of how I was doing [...]. (Mark)

I didn't see any of my friends. I didn't. My own parents didn't come and visit me [...]. (Yvonne)

For some, isolation arose from a direct consequence of how illness made them feel about seeing others:

And my self-esteem's a bit low so I find it quite hard sometimes talking to people, relating to people. (Mark)

I mean I haven't got the confidence to go to the chemist on my own [...]. (Yvonne)

I have this thing that I can't answer the front door, [...] and if the phone rings I never answer [...] I mean it's crazy because if I went out with my friends that would alleviate the loneliness, but I don't seem to be able to do that. (Hilary)

For others, isolation seemed to be a consequence of losing social contacts at work:

[...] for hours in the day I might not see anybody, whereas normally I'm talking to my customers, or having a laugh with workmates so it's quite a bit depressing. (Ben)

Faced with this, Ben tried to sustain work social contacts through a football club and pool tournament, but found the pressure of concealing his mental health diagnosis difficult.

Similarly, Daniel maintained some infrequent links with people at his voluntary work:

I still go down, or try to go down and see [...], the mechanic, during the week now and again, [...]. I'm hoping to see the [team] this Sunday. I've only seen them probably once as a whole [team] in the last three or four months (Daniel)

However, his attempts at social links were curtailed by concerns that this might be used as evidence that he wasn't really unwell:

Because I know if I do anything in [town], anything, you get found out, because a lot of the blokes in that company, as I say, are so small-minded, most of them live in [town]. You've only got to go somewhere and it's back to work. (Daniel)

Losses and disruptions to routine

Being on sick leave caused an unsettling disruption to regular routines. For Hilary, her stay in hospital was a measure which removed her from her routine and helped her feel safe – but did not prepare her for when she had to return:

It's nice to be in the hospital because you're protected and you feel safe here, but you do know that your responsibilities have been taken away [...] but we've got to go back to all of that, so my concern is although I feel better being here, it's like your whole life's just been put on hold [...]. (Hilary)

People found they had extra time to manage and cope with – without structure and activity to organise and fill it:

[...] having too much time on my hands can be a problem. (Mark)

[...] the last five weeks have seemed like five months, [...] it just seems to drag on when you're ill – It just seems to, to just go on, and go on, and go on. (Ben)

Some found the loss of purposeful activity particularly hard to cope with:

I just feel like I haven't achieved anything for the last month. (Ben)

But I, you know, I realise I should be doing something productive. (Hilary)

Work [his voluntary job] [...] I've missed [...] I did miss it the other Sunday [...] and I thought I bet they're having a good old time out there. (Daniel)

Feelings of vulnerability and doubts about self-efficacy

These challenges of sick leave gave rise to distressing feelings and emotions which became additional challenges in themselves. Isolation, symptoms and losses of roles

seemed to have contributed to generating a sense of vulnerability and doubts about self-efficacy:

I just worry that I won't be able to do that job, that I've lost my confidence. (Penny)
I see other people managing their lives ok while I seem not to be able to cope. I feel weak that I can't manage. (Mark)

You know you're supposed to know yourself the best and at the moment I don't think I know myself at all [...]. (Ben)

It's been a long time and I'm anxious, you're anxious about going back and will I cope with doing it? (Yvonne)

This in turn fuelled uncertainty and anxiety, particularly in relation to what it would be like to return to work. Especially in the case of Penny and Yvonne, this added to their other concerns:

[...] there's a lot of anxiety for me around that, around not knowing whether or not I've got the job. (Penny)

[I've] sort of been a bit nervous about whether I'll be able to manage. (Mark)

You're just anxious, since I haven't been at work they've taken on new staff and they've moved to a new part of the building and there's so many things that are new, [...] and then you think, 'am I going to go and not be able to cope and make myself unwell again?' and they all just sort of in your head: go round and round. (Yvonne)

People felt guilty about not meeting their own expectations and letting down others at work:

I feel like I'm letting my employers down a bit by not sort of being able to cope and be reliable so that worries me. (Mark)

[...] it's a vicious circle because you then feel terribly guilty. (Hilary)

Work remained a pressing issue

Such feelings of guilt and anxiety indicated that work remained on participants' minds. Gavin, remembering past job losses, turned such anxieties into positive actions: "Well it was on my mind that I didn't want to lose my job, so I kept in regular contact with work, explained what was going on, sent my sick notes off [...] so they knew exactly where they stood". Past experience meant the issue of work was current for Mark: "I've been thinking a lot about my work – mainly because I was in a similar situation a couple of years ago, where I had to take time off for being ill with depression".

Hilary's material concerns about money coexisted with the more symbolic worry that not being able to work equated to letting her son down. These combined to keep work prominent in her thinking and intertwined with other parts of her life:

I worry a great deal that I'm failing miserably in my own work. Where I am in the working world and like how am I ever going to support him [her son...] when I was really low a couple of weeks ago, that was part of the reason for wanting to kill myself. I thought I can't help him, I'm going to fail him all the way. (Hilary)

Ben felt the symbolic value of earning a wage was lost, despite receiving some sick pay. This was because of the centrality that work had for his life and identity. Thus, it was the gap left in his life, and the challenge to his identity by its absence, which kept work on his mind:

I hate not working [...] it's like an extra bit of me has been taken away, like my freedom and I don't like being at home in the evening and knowing I haven't gone out and made some money. (Ben)

When asked about whether she had been thinking much about work, Penny's reply seemed very different from Ben's. She said she had been thinking about things she could do in her new job – yet like Ben it might have reflected a sense that she was missing her new job – it suggests that she had not forgotten the hope of purpose and direction which she considered her work provided for her:

I've just been getting ideas from the OT [occupational therapist] here and from the games and activities that we've had on the ward, I've just been sort of mulling them over and thinking 'Oh that's maybe something that I could do'. (Penny)

Hilary's thoughts about alternative jobs contributed to keeping work on her agenda: "I did start to make a list [...] I headed the thing 'Work' and what I could possibly do". Yvonne expressed a greater confidence in her enduring expectation that she would at some point return to work: "It's always been in the background [...] I've never thought that I wouldn't go back to work". A lack of such certainty and feelings of boredom at missing work were evident in Ben's unsuccessful attempts to try and block out thoughts of work: "Much as I want to be back there and everything, I'm trying to leave it out of my head but I just can't, because I'm getting so bored and I keep thinking well if I was at work I wouldn't be bored".

Daniel appeared to have more success in suppressing thoughts about work. He stated that work was not in his active thoughts; but this seemed to be because he found it too painful to think about, particularly since he thought work had contributed to his mental health problems: "But I haven't even given that [returning to work arrangements] a lot of thought, because I've still been trying to get through... I just can't think of work". That he was suppressing difficult feelings about work is supported by his emphatic closing statement: "I've let a bit off my chest today I tell you", suggesting if work was not on his mind, it was nevertheless making its presence felt elsewhere within him. Like Daniel,

Hilary considered that her work had in some way contributed to her mental health problems and felt its presence remained with her; though in her case this was identified more as a lurking threat in her home, rather than embodied within her: “It’s all still there, like held in, the rooms will still be chaotic and my work is still all on my bench sort of waiting” (Hilary).

Self-management of challenges

Faced, on their uncertain journey, with the challenges of sick leave and the ever-present issue of work, participants described a range of self-management strategies and approaches. These are presented within the sub-themes of reflection and reappraisal, and use of occupations.

Reflection and reappraisal

There was evidence that most participants put thinking about work to constructive use in trying to manage the challenges they faced. In Gavin’s case it was apparent that he tried to normalise feelings of anxiety experienced when he returned to work: “I did feel anxious, I mean I think that was normal to be anxious, because it’s a month off work and things change”. He made time to reflect on his experiences of returning to work in order to challenge his feelings of vulnerability: “I’m still feeling quite vulnerable [...] thankfully I’m having a few days off this week in between work, so that’s helping me re-evaluate and relook at it and say ‘Oh that did actually go quite well’”. His thinking here shows parallels with some cognitive behavioural approaches. Penny had sought out a cognitive behavioural therapy self-help book, “about challenging negative ideas and turning them around”, to try and boost her confidence. Others reappraised their views about work and themselves, suggesting an acknowledgement of alternative ways of understanding their situation:

[...] my recent memories of it [work] aren’t fond [...] But certainly it, it wasn’t all bad. I do recall it being OK. (Yvonne)

I suppose the best way is just to change myself. Change how I see myself and how I see my depression. Not to see it as a weakness but as just something that happens for whatever reason and it’s not necessarily a bad thing. That it’s just something that I’ve got to deal with and accept and try and cope with. (Mark)

However, the fragility of some attempts at reappraisal was also apparent; for instance, in the words of Yvonne – who questioned her own reasoning – and in those of Hilary – for whom the weight of her depression could be seen as preventing her from completing the word ‘purpose’:

I think maybe I should just think well [...] I do do something that is fairly huge, I mean there are galleries all over the country [...] that] have work, like mine, so there must be some pur- [pose] I don't know, I seem to have just lost the pur-[pose].
(Hilary)

I'm sure – the sensible part of me – I'm sure it'll be fine, but equally it's a long time to be off, but I have done it before because I've been on maternity leave for a period of time and gone back and you do cope, so I suppose this is just a bit different in that when you're on maternity leave you're not ill are you, whereas – ? (Yvonne)

Use of occupations

Participants deployed a range of occupations to varying degrees of success to try and manage the challenges encountered on sick leave. In many instances occupations were used palliatively, attempting to mitigate or limit some of the problems they faced. Thus, Penny spoke of trying to “keep busy” to distract herself from suicidal ideas. Mark reported a visit to the swimming pool, an activity he chose because “I find it quite relaxing and it's a good bit of exercise”. Ben tried to manage boredom and lack of stimulation by doing “sudokus and everything like that to try and keep my mind active, but no it's still – . You still go a bit brain-dead”. He was not alone in finding some self-initiated occupations only partially effective: Hilary considered: “Reading I find keeps my sanity really. Going out for a walk, just enjoying being with people a little bit during the day [...] but I realise I should be doing something productive”. From this it seems her sick leave occupations did not replace the role that work had played for her.

Ben tried to participate in football (for the first two weeks of being on sick leave) and later pool with work colleagues in an attempt to find a social activity that filled the void left by work: “Wednesday was the first week I've gone for probably a month, just because I was getting really bored”. He found a new occupation which provided some satisfying physical exertion which he missed:

I found the new hobby as in the weights [...] that's the only thing that makes me feel like I've done something in the day, is if I have a workout and I wake up the next day and I feel achy, I think ‘Oh that's good it's worked’. (Ben)

Here there was also a sense, shared by others, that it was important to try and maintain or reintroduce some form of routine:

Even though you're ill you've still got to keep abreast of your normal life as much as possible. (Gavin)

I've actually been trying to get myself more involved in the house [...] I've been doing a lot in the garden, thoroughly cleaned the car. (Daniel)

There were occupations which some participants saw as indicators or contributors to recovery:

This week has been a really good week. I've done something every day this week, [...] so hopefully (you can't give a timeframe can you?), but I would hope that in a few weeks time I can go back. (Yvonne)

I [...] did some creativity at home, like doing word searches, puzzles, some creative art, and [...] it's given me a quicker recovery rate than if I'd been in hospital. (Gavin)

[...] we have a pampering evening [on the inpatient ward], so I'll actually do reflexology on people, I'll do aromatherapy, I'll do hand massage [...] it's quite empowering, it feels like I'm doing something positive and not just being a passive sort of like recipient of health care, really. (Penny)

Most of the occupations which participants used were of a solitary nature, the main exceptions being Ben's sports with work colleagues and Hilary and Penny's hospital-based activities. Mark's attempt to go swimming – a solitary activity in a social context – was one he felt he had to curtail because “the swimming pool was crowded – [...]. So I found that a bit hard to deal with. I only swam for a short period.” Mark had been encouraged to try swimming by day service staff. The occupations described by Gavin and Penny above were also prompted by mental health staff and so not fully self-initiated. There were other ways in which mental health professionals and other people influenced the experiences of the participants. These are discussed further in the next chapter.

Summary of sick leave experiences and challenges

Participants' experiences of their sick leave were analogous to a journey rooted in uncertainty, with yet further uncertainty with regard to its duration and to how it might end. Only Gavin expressed some tentative sense of control over this. On this journey the main challenges faced were acknowledgement of illness, financial, social isolation, and losses of and disruptions to routine; in turn these engendered feelings of vulnerability, anxiety and guilt. A partial consequence of this was that, despite experiencing acute mental health problems, work remained a central concern for all participants – even when they did not feel able to think about it on their own. Participants adopted two broad self-management approaches to the challenges they faced: reflection and reappraisal, and use of occupations. Approaches involving support from others are considered in the next chapter.

Chapter 9: Experiences of others' support and attitudes (acute study)

The findings suggest that other people – family and close friends, colleagues and managers at work, and health professionals – exerted considerable influence on participants' developing return-to-work trajectories. These influences acted both as mechanisms in themselves, and as part of the context – generating, suppressing or modifying the nature of other influences on job retention. While there were some common features across the different categories of people involved in the research, there was sufficient specificity in each case to warrant presenting the findings of the categories separately.

Family and friends

Significant involvement and contacts with family or close friends during acute recovery were reported by all participants apart from Mark. The nature of this involvement and participants' evaluations of it varied. Gavin and Daniel gave the most explicit praise for the support from their families, with Gavin emphasising emotional aspects and Daniel the financial help and protection from perceived risks of a premature return to work:

My partner, he was excellent [...] he came home straight away from work, [...] what's stopped me from self-harming was him and the support of him and my mother-in-law, she was fantastic. (Gavin)

You could talk to my parents about me going back to work and they'll both say no, they would rather me build up money I owe them [...] But they support me [...]. I'm lucky they can. (Daniel)

A similar protective motivation may have also influenced the apparent lack of encouragement to return to work which Penny and Hilary reported from their friends and families:

People have said 'well if it works out, it works out. If it doesn't, it doesn't, there's always other jobs', [...]. (Penny)

Nobody has any sensible advice really. I mean my mother's reaction is 'oh well something will come up' [...]. (Hilary)

In Yvonne's situation a combination of protective concern with a 'recover first' outlook may explain her reportedly limited discussions of returning to work within her personal network:

I think everyone wants to see me get back [...] they've been very supportive of the fact that I haven't been at work. And obviously they'd like me to go back to work because that means you're better, but it isn't something that we've really talked [about]. (Yvonne)

Ben described significant contacts and discussions with members of his family during his acute recovery, although he did not find them as understanding as he would have liked, and felt that he could not always be open with them:

Even with the people that I've told, like my mum and my dad they change in the way they talk to you. (Ben)

I said to my mum, 'I nearly feel the same', that's when I didn't, but I just said to her 'I nearly feel the same', and then, she was talking to me normal. (Ben)

This sense of not being understood and people responding to his illness rather than himself, increased when he discovered that his father had chosen to conceal Ben's uncle's diagnosis of schizophrenia and, for related reasons, that his mother had not let his father know when Ben himself had been admitted to hospital:

I only found out a little while ago that my uncle was schizophrenic, and he doesn't ever go out in public to family functions and I never even knew, and I just said to my dad [...] 'Why ain't uncle [...] never come out? Why ain't he?' And he just goes 'Oh he's a bit of a loner' and then I found out that he was schizophrenic [...] I rung my dad up and I went absolutely ape at him. And he didn't know that I was in hospital either [...] I didn't know why my mum didn't want me to tell my dad and then she said 'Well your uncle's schizophrenic and look how he treats him' and I couldn't believe that he [Ben's father] said 'Well he's not all there is he?' [...]. When he said 'I don't know why you're being so – about it' and I told him [about Ben being in hospital] and he went 'Oh that's different' and I went 'Why?' and he went 'Well you're not schizo'. (Ben)

The exception in Ben's family was one brother, who he felt treated him normally:

My other brother, he's a complete joker and he doesn't care who he upsets, so he'll just say anything about anyone and I love that because even when I told him, five minutes later he'd make jokes about it, but they were jokes [...] not spiteful jokes. (Ben)

This was consistent with a sense that he could gain support from social contacts without necessarily sharing his problems:

If you can: always try and keep your sense of humour, because at the same time, when people come round, I can still have a laugh and a joke. (Ben)
If I've ever got a problem I'll keep it to myself and I'll always work it out [...] if I have to – I'll talk to me mum and me dad and my wife, but that's at an absolute push. (Ben)

This preference, combined with the attitude of some of his family members, may have produced a situation whereby – despite their presence – Ben did not experience his family

as providing the same level of support as many other participants did. He did, however, consider that his mother might be a useful person to bring to a return-to-work planning meeting, stating "I'll have to take my mum; she's a bit of a bulldog".

For Penny, Hilary, Yvonne and Daniel, close family members had already been involved in liaising directly with work, either alongside them or on their behalf. A more senior manager's criticism of such indirect contact had led Yvonne's line manager to contact her directly. Although Yvonne had mixed feelings about the direct contact, it cannot be ruled out that in some cases such an approach might be beneficial, as indicated by Penny's reflection that:

At the moment I'm just using my husband as like a go-between. He's just ringing up and sort of giving a progress report and I think part of me is just burying my head in the sand really, because I don't really want to have the conversation with her that I need to have. (Penny)

The presence of Daniel's parents 'around the table' was both real (in one instance) and metaphorical in others. For Daniel, his parents were an important source of trust in a context where he had lost trust in his employers. They were also a point of reference to balance judgements from doctors (who lacked the familial allegiance to Daniel) about when he might be able to return to work:

I've got a doctor on each day [...], so I'm going to try and get a general opinion about what people think, to see whether I actually go back, [...] to work on that Monday. But me – if you were to talk to me parents, they'd say no way. (Daniel)
And what do you say? (Interviewer)
I don't think I can. (Daniel)

Family, and to a lesser extent friends, were important and potentially influential figures in shaping most participants' return-to-work trajectories; notably with regard to their roles as go-betweens, protectors, and providers of empathy and understanding to participants.

The workplace

Experiences of interactions with people at work – as well as the anticipation of such experiences – had profound impacts on participants' thoughts and plans about returning to work. This category of 'people at work' can be divided into two discrete groups: those with some degree of formal managerial responsibility for the employee, and other colleagues. The different power relation in each case appears to be clearly expressed in the findings, and this warrants presenting each sub-group separately.

Colleagues

Experiences of interacting with colleagues, as well as the anticipation of such interactions, were shaped by factors of acceptance, support, stigma and disclosure.

Acceptance and support

Both Gavin and Yvonne (on a previous return to work) had experienced a greater-than-expected degree of positive support from colleagues:

I went back to work yesterday and that sympathetic attitude was still there, so it wasn't just a front, it was actually genuine concern, so my work have been brilliant really. (Gavin)

[...] actually it was better than I expected, everyone was supportive. (Yvonne)

Despite finding his return "enlivening", Gavin was aware that colleagues were hesitant, and seemed to understand why this might be. He wished the tension could be broken with a joke (in a way similar to Ben's appreciation of his brother's humour): "I felt fine, but thought 'Oh I wish someone would crack a good joke'." Hesitancy was also apparent in Mark's limited contact with colleagues – which took the form of text messages to one friend, but he anticipate that it would "be nice to see some of my colleagues and friends."

Positive experiences of colleagues led Ben to try and sustain social contact with them by playing football or pool during his time off work. Daniel anticipated that "a couple of my blokes will stand by me" at his main paid job, but he had a predominately negative view of the support that he would receive from colleagues "because a lot of the blokes in that company [...] are so small-minded". This contrasted with the support he received and expected from his voluntary work colleagues: "My close mates [...] I go up their houses in the evenings, when I feel like it, and their wives sometimes cook me dinner [...]". This difference between paid and voluntary work suggests that low expectations of his colleagues at his paid job cannot be simply explained by internal factors of low mood or self-stigma. Similarly, Yvonne's expectation of a less positive response when she returned this time was grounded in external factors, specifically the length of sick leave, changes at work, and more people knowing about why she was off work:

This time [compared to the previous return to work] I just think it's longer. I think more of the office know why I've been off. They have moved to a new office. They have taken on new staff [...]. So much has happened since I've been away that adds to my anxious fears of going back really. (Yvonne)

Disclosure to colleagues

Yvonne's words as just quoted reveal concern about what was known about her mental health problems and by whom. Daniel also expressed this. They feared that details may have been disclosed without their consent:

I don't know [how much colleagues know about why she has been on sick leave] ... when I talk to her [Yvonne's manager], I need to ask. [...] I would like to know before I go in and I'm confronted with them. [...] I'm assuming some discretion has been used. (Yvonne)

I would imagine everyone will know because there was another chap down there [...] got depression, was on antidepressants and he was then put on counselling, and the manager used to say [...] 'Oh C's at the nuthouse again today', so like everyone knew. (Daniel)

Disclosure to colleagues concerned most participants. Least concerned was Penny, who expressed a confident and clear view of what colleagues should know and how she would respond: "I think I'd just leave it sort of open-ended really, just kind of say I've just had a few problems and I've been in hospital. [...] I don't feel I have to tell everybody about it really." Yvonne also saw no need "to be going into it with every person I meet on the stairs", but she seemed less comfortable with needing to deflect the "dreaded question: 'How are you?'" with the "auto-response of 'I'm fine'". Possibly she felt this denied her suffering, increasing her feelings of isolation. Previously she had met two of her best friends at work, but now felt: "there isn't anyone at work I would confide in". She did wish she had been able "to be more open at the beginning if there was somebody at work you could confide in". Similarly, Mark stated that he thought "sharing things is good wherever possible". Prior to his current episode of mental health problems, Gavin had told colleagues about his depression (though did not use the term bi-polar), with a clear intention to promote their understanding, resulting in increased support:

Amongst my peers I've sort of explained that I do suffer from depression. [...] they were very supportive [...] there was no judgement, which was nice. Because, usually if you're off sick for a month or so, you usually get some kind of comment, or such conversations, which aren't very nice. But this workplace have been fantastic. (Gavin)

Stigma

That Mark, Daniel and Ben had not disclosed any details to colleagues seemed to be influenced by their view of the power of societal stigma towards people with mental health problems:

If you tell someone you've got a mental illness or something, you're labelled then, aren't you? As a bit of a nutter and I don't really want that, you know. (Ben)

I feel there's a stigma with mental illness which makes it a bit awkward telling people and also I feel awkward embarrassed myself, cos I feel that having depression is a bit different to other people. Maybe I'm not as good or not able to cope as other people. (Mark)

The younger [colleagues at voluntary work] don't know exactly what I'm going through and I don't really want them to see me like I am [...] I don't want to lose the respect I've built with them when they see that I might be a gibbering wreck or something. (Daniel)

The self-denigration in all of these comments may indicate some internalisation of societal stigma. Ben sought to avoid such stigma, yet maintain contact with colleagues, by telling them that he was off work because of a wrist injury – though it was clear he felt uncomfortable with the deception:

And they all were saying 'Oh you still not back', and I said 'No', and they were like 'Oh your wrist looks fine to me' and I was saying 'Oh yeah I don't know what's really going on with it at the moment', [...] that made me feel quite annoyed really because they know something's not right, but I don't want to tell them because it's personal and you've got to go and work with them for god knows how long anyway. (Ben)

Yvonne had not felt so much pressure to either disclose or conceal her mental health problem on her previous return to work, because it had actually been labelled as a physical condition, but this time she felt she didn't have that protection:

When I was off before it was slightly different in that it was anxiety really, but it's characterised by headaches. [...] So when I went back I didn't actually mention stress/anxiety/depression to anybody [...] whereas this time all my sick notes have said stress/anxiety/depression. (Yvonne)

Mark had found it easier to disclose to colleagues on his previous sick leave because he felt they could understand how his depression had been triggered by bereavement: "I told them a bit, [...] They was quite understanding because they knew that my father had died recently so they knew that it was related to that." His reluctance to disclose to more than one close colleague on this occasion may be because he did not consider he had a legitimising explanation that would protect him from stigma.

Both Ben and Daniel had direct experience of the stigmatising and discriminatory behaviour of colleagues that for them justified their caution in disclosure:

One of the guys [...], about a decade ago, he had [...] a nervous breakdown and everyone now still goes, if he gets in a bit of a slanging match with someone, 'Ooh calm down, don't have a breakdown!' [...] it's always there and getting brought up and I don't really want that. (Ben)

There's a couple of blokes – if a knife's in your back they'll twist it. So I tried not to show anyone that I wasn't feeling well. I ended up sitting in my office more than I should have done, just to keep away from everyone. (Daniel)

Again, Daniel had a contrasting experience with some colleagues at his voluntary work, where he had felt able to be “quite open” with four of them.

Interactions of acceptance, disclosure and stigma

Some degree of disclosure to colleagues was ideally seen as desirable to most participants. Whether they disclosed or planned to disclose depended on how they thought colleagues would actually react. This perception appeared to be influenced by their own past experience of how colleagues had behaved with respect to them or others with mental health problems. It was also influenced by how powerful they considered general societal stigma to be, and, in a related manner, how much this may have been internalised in the form of self-stigma. Fears about how colleagues might react were increased when participants considered they may have lost control over to whom they would disclose, when and to what extent. The presence of acceptance and understanding from colleagues can be seen as a mechanism which supported return to work by reducing people's anxiety and feelings of isolation. It appeared that for this mechanism to be able to exert influence on the participants before their actual return to work, they needed to perceive that colleagues might be supportive. This perception was itself influenced by contextual factors of past experience, interpretations of societal stigma, degree of self-stigma and self-confidence.

Managers and employers

Compared with colleagues, experiences and expectations of managers' and employers' support and understanding, as related to issues of disclosure and communication, appeared even more important in influencing participants' return-to-work trajectories. Additional factors involved sickness-monitoring procedures and union involvement, recovery expectations and uncertainty.

Support and understanding

A broad spectrum of degrees of support and understanding from participants' employers and managers was reported. This ranged from descriptions of “very supportive” (Gavin) and “very sympathetic” (Hilary) to making “a joke” of Ben's mental health problem and “bullying and unreasonable behaviour” (Daniel). Ben and Daniel's

experiences also demonstrate that there could be varying behaviours by different levels of managers:

One of them, my assistant manager, when he was on his own, took it quite serious. Then when he was in front of our boss, the main manager, he was a bit more, 'Oh well we don't want you coming in and starting on everybody'. (Ben)

My top boss is quite understandable with what we've been going through [...]. My immediate boss [...] he's also a bit of a two-faced person. [...] I'm not really looking forward to going back and seeing him because I know when I go back to work that I will get hammered for being off work for so long. (Daniel)

Despite this understanding from his 'top boss', Daniel was angered when this man arranged a private meeting in a pub – where his production manager happened "to be the only other customer in the pub". The 'top boss' also asked Daniel (on another occasion) to formally complain about this production manager's behaviour rather than address it himself. This was something Daniel felt he lacked the energy to do whilst recovering:

I said I can't do it. I've got too much going on, I'm trying to get myself better, I'm still trying to get me divorce sorted out. I've now got money problems because they're not paying me. And I can't take him on as well. It would be an ideal time, because I'm not there, but I couldn't do it. (Daniel)

That Daniel had a very different response from his voluntary work, who had paid for him to have private counselling, reinforced his sense of injustice at the treatment he received from his main work:

And my mobile went, and it was my production manager. He said, 'Oh I've got a message for you. [...] Just to let you know if you decide to shit anywhere in [town] in the next three weeks I will know about it'. I said 'Is that it?' He said 'yeah, that's all I wanted to say', and he put the phone down. That was harassment. [...] I had a few messages like that to start with. (Daniel)

Disclosure

Penny's, Hilary's and particularly Gavin's managers had been helped to understand their situation by past disclosure of their mental health problems:

I just went into my manager and I said 'look I feel suicidal and I feel really bad, I feel really depressed'. I said 'It's come on me over the last week or so' and he said 'Well you'd better go home'. So there was more communication between the manager and I; and I felt more comfortable about that; and it was him that said 'You'd better go home', instead of me saying 'I'm going home', so I let him make the decision rather than me, because he could see I was unwell. (Gavin)

For Daniel, however, a similar approach did not meet with the same positive response:

I went and saw my production manager at work, told him I wasn't feeling well, [and that] unless he starts working with me rather than against me and stirring all the shit at work then I will end up going to the doctors and I will be off work. I then saw my big boss, [...] told him what I told the production manager. He said 'Fair enough',

he said 'I'll keep an eye on it', because he does know things are not right with the production manager and I went back to work, I carried on for about a month [before then going off on sick leave]. (Daniel)

Penny's earlier disclosure of her mental health problems on a pre-employment health-check form was not discussed at the time, but she did consider that it was important and that it would help her:

[...] to tell her [manager] about the fact that I've been in hospital and why I've been in hospital, but not go into too much great detail about exactly why, but just say that I am prone to depression and maybe even say to her 'look I might need time off in the future'. (Penny)

By contrast, Yvonne said her employers were unaware of her mental health problem and she thought the news "would have come as a shock" to which they would have to adjust.

Hilary and Penny found it easier to disclose because of their managers' personal style, and the presence of a human dimension to their relationship:

[...] she's somebody that encourages you to be open and she tells me [...] about her personal life. So I guess it was [...] out of the college situation and I said I was low. (Hilary)

She was very sympathetic and because she's got someone else on her team who has got mental health problems and I think it sounds like she's very kind of protective towards her own staff [...] just wanted me to get better basically. (Penny)

Daniel, by contrast, was concerned that even boundaries of a contractual relationship could be breached by his managers: "There's not one thing that he doesn't tell everybody. So everyone will know when I go back what I've been going through."

Hilary and Penny expressed a strong belief that people should be able to feel they could disclose to their employers and receive a positive response. In this they were aware that their own positive experience might not be the same for others. Hilary wondered whether it would have been different had she not been working only very limited hours, qualifying her positive comments about her employer's response: "if it was a full time post I think it might be more problematic".

Broader contextual factors of work situations appear to be significant in influencing how participants felt about disclosing details about their mental health problems to their employers and the responses that they received. This includes the possibility of the greater culture of acceptance (both formally and informally) in Hilary's professional public-sector workplace than in Daniel's, Ben's and Mark's workplaces. Social class and gender may also be influential. These factors may have combined in Daniel's and Ben's male-dominated and more traditional working-class industries; however, Gavin had a markedly

different experience of acceptance after he disclosed to both managers and colleagues in his engineering factory. Explanations of the specific nature of these experiences are likely to lie in an intersection of such macro-structural factors and the individual characteristics of workplaces, employees, managers and relationships between them.

Communication between employee and employer

These issues of support, understanding and disclosure affected the processes of communication between employees and employers during their sick leave journey. Apart from Gavin and Daniel, notification of sick leave was made in an indirect manner – in many cases by people other than the participants:

It's been indirectly, so my husband's been ringing them [...] (Penny).

[...] I just couldn't have made the phone call [to her manager] and then I spoke to her then I don't think I spoke to her for a couple of weeks, she'd had another sick note [...] she'd sometimes text and I'd perhaps text back – and that was the main contact. (Yvonne)

My ex-husband phoned them last week to say when I'd arrived here [inpatient ward], [...] then he spoke to them again yesterday [...] and then, funnily enough, she [her manager] phoned my mother when she was here, so I was able to speak to my line manager. (Hilary)

In some cases, at certain points the indirect nature of the contacts were due to the severity of the participants' acute mental health problems, but in others they were shaped in part by limitations of trust in the relationship between employee and their manager. Thus, despite Penny's earlier confidence in being able to disclose to her manager, she expressed some uncertainty: "The last thing I heard was that she might be getting in someone like a locum to just cover whilst I'm ill [...] rather than, – you know, because my fear is that she'll just – I'll lose the job."

A breakdown of trust underpinned Daniel's direct notification to his manager that he was going on sick leave, because he felt he had had no response to his request for support: "In the end I went to the doctors. I told the management I was going, obviously, because health and safety, leaving the building, came back and I had a certificate for three weeks."

There were some attempts to establish more direct communication – most notably by Yvonne's manager, who came and visited her on the ward – though Yvonne implied that this could have been better at a later stage:

I remember seeing her and nothing untoward happened, but I don't really remember what we talked about or how she seemed. She seemed pleasant enough, but I don't remember a great deal of it [...]. But I didn't see anybody, so how I managed to see

her? I didn't see any of my friends. My own parents didn't come and visit me. So certainly how I saw my boss I'm not entirely sure, but I did. (Yvonne)

Sickness monitoring, formal procedures and union involvement

Formal sickness absence procedures were, for a number of participants, associated with tensions which did little to improve the relationship with their employer. This was most noticeable in Ben's case:

At the moment they're [...] quite pushy and I've had a couple of letters saying 'We're going to stop your pay', because I was in hospital and I hadn't contacted them in the week, because in my contract you've got to contact them. (Ben)

Now I'm on long-term sick leave [...] I've got to see their own doctor, [...] and I said to them 'Well I'm not allowed to drive at the moment' so they'll have to make arrangements for me to see him either at my house [...] or arrange for some sort of transport [...] and they said 'No you'll have to get a taxi down here' and I said 'Well no, I ain't doing it, I won't turn up, because I can't afford to spend thirty-fourty quid on taxis'. (Ben)

Improving the limited, tenuous and, in some cases, formalised communication, or repairing damaged relationships, seemed an important precondition of establishing return-to-work discussions.

There is some evidence of a helpful formal process in the form of the report that Yvonne's personnel department had asked her psychiatrist to write. While it was notable that Yvonne had conceived of the report as something that was done when a person had been off for a certain length of time, she considered it to contain some detailed return-to-work recommendations which were in accord with her own understanding of what could help:

[The psychiatrist's report] says that I've always planned to go back to work and he would recommend a planned strategy for return to work and to reduce potential anxiety and allow me to gain in confidence. ... This is where he says about reduced hours, light duties, reduced amount of interaction with clients. He recommends that I'm well supported and have a sympathetic supervisory figure. Estimated duration, it just says that 'I'm of the opinion that such a timescale needs to be discussed directly' with me, as he thinks it's dependent on what support they can offer. (Yvonne)

The process followed by the employer, which had been initiated by their occupational health department, seemed to have been a constructive step, opening up the possibility of specific return-to-work negotiations. Without this process, and had the plan simply relied on the manager's judgement who "never mentioned coming back on reduced hours", the range of available options may have been much more limited. The occupational health nurse from Daniel's company similarly became involved following a formal "medical". Daniel considered her to be one of the few positive contacts he cited with his main

workplace because of her understanding manner. He judged he could trust her, and through her keep in touch with his employers: "I've kept in touch with her, because she's been the kindest one out of everyone there. So she tells my big boss what is going on".

Ben and Yvonne were the only two who stated that they were in a union. Ben had not thought of approaching his union for support, only thinking of the possibility of asking "the union guy" to accompany him to a return-to-work meeting when asked during the interview whether he thought of bringing anyone with him. Yvonne had contacted her union to clarify her sick pay entitlement. Just as for Ben, it was only a question posed during the research interview which prompted her to think of the possibility of asking for a union representative to come to a return-to-work planning meeting:

You said you were in the union. Would you consider asking them to come?
(Interviewer)

Yes, that's an idea actually. I hadn't thought of that. Yeah, I expect they probably do do that don't they? I've been paying my union membership for ten years [...] so I might as well get something! Yeah, I wonder if they – hmmm? When I know when it is I might ring them and see. (Yvonne)

'Recover first' expectations

Gavin had just started a graded return to work. He had been able to arrange this with his employer without difficulty – possibly helped by the dialogue he had sustained from the onset of his acute relapse. For others, possibilities of graded return to work, or other adjustments, appeared to have been limited by an employers' view that the employee had to recover fully and then return to usual duties. For Mark, Hilary and, to some extent, Daniel, this was framed in a positive supportive way:

[The department manager] was just explaining that their position was okay and that I was to get myself well first and not to hurry back, so he was sort of being sympathetic and understanding. (Mark)

I was able to speak to my line manager and she said not to worry, that they'd pretty much thought that I wouldn't be back until after Christmas, so if I put in a sick note from the doctor, then that should be OK, so that to not worry about it. (Hilary)

[The occupational health nurse] told me 'don't even think about work, don't worry about going back, you stay away as long as you need', keep in touch with her and 'work with the people that you've got helping you' [...] Even my big boss said 'I don't want you coming back and then being off again'. He said 'Get yourself sorted and come back'. (Daniel)

Ben experienced a similar 'recover first' message as more of a threat:

I've spoke to work. I went in this morning and they were just: 'Well, when are you coming back?' And I said: 'Well I think I'll do maybe a couple of days first' and

they went: 'No, you've got to come back straight away or you don't come back' [...] They just said 'You either come back, or you're sick, you can't do both'. (Ben)

Whether positively or negatively framed, such 'recover first' messages seemed to put the responsibility to recover on the individual worker. This risked causing delays in addressing those factors in the workplace that might be an obstacle to recovery. Thus, Ben's proposal to do indoor as opposed to delivery work was rejected: "I thought [...] I could maybe do [...] some indoor work like some sorting or... and that would be a good idea, and then they didn't really go for that at all".

The 'recover first' message also risked neglecting aspects of working that might for some actually help recovery (see Chapter 7). The same message may also account for why Penny felt she would have to wait until she returned before explaining what had happened to her: "I think the first day back's going to be really difficult and I think I'll need to spend some time talking to my manager about just what's been happening to me really".

Uncertainty

The 'recover first' message could also partly explain the degree of troubling uncertainty that participants felt regarding what would happen to their jobs on their return:

I genuinely don't know what I'm going to be doing. The impression when I saw my boss [...] was everybody's doing a bit of my job and it all seems to be ticking along. I got the impression I wouldn't be given it back. (Yvonne)

I'm not sure whether or not my job is safe. I've had sort of conflicting messages about it. Initially my manager was saying, 'Oh yeah, we want to keep [Penny], she's great' [...] but now she's kind of saying, 'Oh Christmas is coming and the residents need their activities, blah, blah, blah'. (Penny)

Daniel and Ben were suspicious that any accommodations would inevitably fail, with managers ignoring Ben's apparently sound appraisal of risk, and not even being willing to consider what might be feasible in Daniel's case:

I said to them I could do some indoors sorting [...] but they go, 'Oh yeah, because you could then drive the vans' [...] And I went, 'Yeah but if I crashed a van and killed somebody, I'd never forgive myself'. [...] And they were like, 'Yeah, but you could, couldn't you?' and I went, 'Right, yes, I could. I could physically get in there and drive, but I'm not going to'. 'But you could do it for a few hours couldn't you?' [...] And it's – they're always pushing, and, you know, I know what I'm like. I'd probably go, 'Alright I'll do it'. (Ben)

Knowing the manager, he would – and he's tried to get me to do this – work a machine and also run the place [...]. And you can't do it. You cannot do it. [...] They'll probably have an idea that will be totally different to mine anyway. (Daniel)

The employer-employee relationship during sick leave

Participants' relationships with employers while on sick leave were thus dominated by the degree of acceptance and understanding which they considered they had received. Three categories of factors shaped this. Firstly, of particular significance were perceptions of individual managers' attitude, management style, and mental health knowledge. This included managers' motivation to sustain dialogue and the extent to which there were other views and voices – additional to the line manager's – being expressed from the employer's camp (such as occupational health and other senior managers). Secondly, employees' confidence to disclose and discuss work-related mental health issues could affect the degree of acceptance and understanding they experienced. This confidence was in part influenced by internal factors, such as the impact of mental health symptoms on self-esteem and energy. There were also very important external factors; notably, the trust they had in their managers based on past experiences of management style and managers' responses to their own or others' mental health issues. It is therefore apparent that willingness of participants to disclose and engage in dialogue was only effective in promoting acceptance when they were sufficiently confident of receiving an accepting response from employers. The third category of factors influencing participants' experiences of employer acceptance and understanding was the nature of communication between them. This was to a great extent a product of the intersection of the first two factors, which could reinforce, either positively or negatively, the nature and content of the dialogue. This was notably apparent in the tendency for indirect communication arising from employer reticence and the employee's low confidence or ill health. Such indirect contacts, whilst appropriate at times, did not appear to be a very effective bridge to the resumption of dialogue needed for return-to-work planning. There were also independent aspects which shaped the communication, notably the presence or absence of formal sick leave monitoring, or return-to-work procedures, and how they were applied.

Whilst research findings focused on the micro-level of individual relationships and experiences, there was some indication of broader contextual influences upon employee, employer and their communication during sick leave. These included: workplace culture, class, gender, and societal discourses about mental health. The three categories (manager's attitude, approach and mental health knowledge; employee's confidence to disclose and discuss mental health issues; and the nature of communication between employee and employer) appeared to be areas where key mechanisms could emerge and exert either

positive or negative influences on participants' return-to-work trajectories (see figure 2 below).

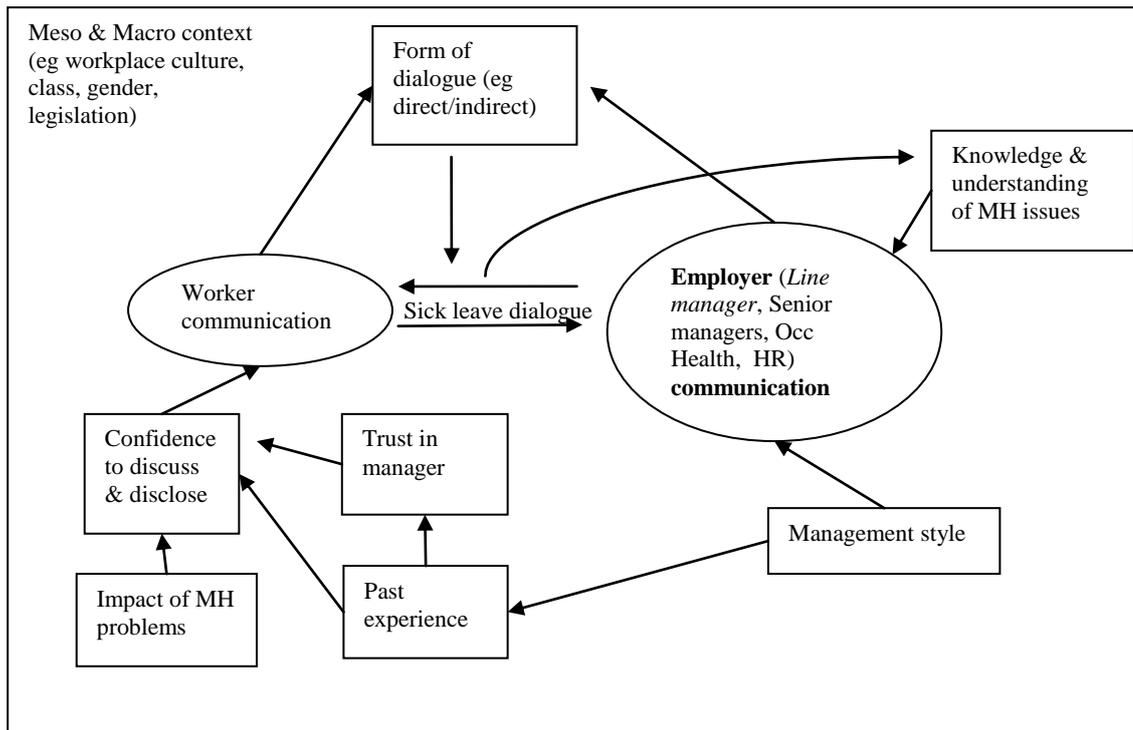


Figure 2. Influences on worker/employer dialogue during sick leave

Health service support

Participants' discussions of experiences of health and other formal support agencies during their recovery focused largely on experiences of mental health services and to a lesser extent on experiences of General Practitioners (GPs).

General Practitioners

Input from GPs varied considerably once participants had started using acute mental health services. Some were relieved when psychiatrists took over the responsibility for medication after dissatisfaction with what their GP had prescribed. For many, the GP retained the role of issuing sick notes. This was despite limited evidence of discussions about their mental health and readiness to work. Exceptions to this were Daniel and Mark, whose GPs did advise about return-to-work arrangements – though how this was co-ordinated with mental health service input was unclear:

I was thinking about going back last week. [...] But he [GP] suggested that I leave it two weeks to make sure that I'm better and got over my depression and was feeling ready to go back to work [...] I did speak briefly [about work]. Just said that I didn't feel that I was ready to go back to work right about, 'cos of being anxious in crowds – things like that. I also told him that I'd like to go back as soon as I'm feeling better. (Mark)

My GP has said, 'When you go back to work, you won't be going back full time'. He said, 'We're going to break you in slowly'. He's been in contact with HR [human resources], my counsellor and they've both agreed that I might only be doing two half days a week to start with for two weeks. (Daniel)

Yvonne intended to have a discussion with her GP about readiness to return to work – though again there was a lack of clarity about co-ordination with mental health service support:

I will be seeking his [GP] advice, because like I said today to [... the psychiatrist], I don't know how I know when I'm ready. [...] You've sort of reached a point that I'm comfortable and I'm frightened of taking any more risks because I'm frightened of it all going pear-shaped. [...] I know I'll need a little bit of a push, but equally, like the doctor said today, it's important not to push too far, because that could be detrimental in the long run so. [...] I certainly wouldn't want to be given a sick note for a long period of time again. I think we need to keep looking at... but again, until I can speak to work, I don't know. (Yvonne)

Mental health services

Analysis of participants' experiences of mental health services produced findings relating to the degree of concern participants felt was directed towards their working lives; types of therapeutic intervention which could impact on return to work; and specific liaison with workplaces.

Degree of attention to worker identity and work-related needs.

A number of participants reported that acute mental health services had shown only limited interest in their working lives:

I've only spoken to the doctor and that's usually about the medication. No I haven't talked about it [work]. (Hilary)

[...] the questions sort of went, 'Work?' And I'd go, 'Yeah I work for [employer]'. 'How do you like it?' 'Yeah I think it's alright'. 'Oh right. And what about your family?' And that was it. [...] they skimmed straight over it really. (Ben)

[In the ward round] we weren't really talking that much about work. It was more about my state of mind and my mental health. I think that the jobs and vocation and that sort of thing was seen as like further ahead. (Penny)

Yvonne explicitly agreed with the view, referred to by Penny above, that this lack of concern about work, certainly at the beginning of her acute care, was appropriate. At the time of her interview she reported discussions were just beginning:

Work's only a recent thing, but [the occupational therapist] and I have talked about it, but all very loosely, because I think while you're with the crisis team is you're not immediately looking at going to work, so it isn't something that really factors [...]

because I think it's just something else you're going to worry about when it's weeks away. [...] to date I think I've talked about it as much as I would want to. (Yvonne)

On the other hand she also admitted that anxiety about work was a significant issue for her (see Chapter 8) which could possibly have been helped by discussion at an earlier stage.

There was little evidence of consistent and structured identification of work issues. Hilary acknowledged that there must have been some awareness that she was a worker, as she had been approached with an invitation to participate in the study – but she laughed and added “I wouldn't have mentioned anything to her [the staff member] about work, [...] maybe I looked like somebody who would have a job!” Even if that was not the case, that she had this impression was consistent with other participants' experiences. If there was a protocol or care pathway involving identification of work-related issues, it was not one that demanded active conscious collaboration with participants.

Mark provided some justification for the limited attention to work issues based on a view that mental health services related to a private world, whereas work lay in a social realm (see Chapter 7). Daniel was surprised that sessions with a counsellor (paid for by his voluntary work) did not involve exploring his working life:

We haven't really spoke about work yet. [...] I thought she would get the background of what's happened the last, say, couple of years [...] and then she'll start picking all through it, but she hasn't. She just looks at each week what I've been doing this week, how I've felt. (Daniel)

While he could not recall being told about the approach being used, it appears that it was to some degree consistent with a cognitive behavioural approach. This might in part explain the limited discussion of past issues, but not why there were no explorations of how he was feeling about work at present, which he stated made him feel considerably “angry”.

Symptoms versus managing life focus

Ben was frustrated by the mental health staff's emphasis on his symptoms. He considered that this did nothing to reveal a “catalyst that's started everything”. Ben provided a direct critique of the lack of attention to work:

They could talk about your friends at work, just socialising, ‘Do you go out with them?’, ‘What do you do?’ [...] maybe even talk about people that you don't like at work and why [...] because they're more likely to be the ones that are causing the problems [...] maybe asking about the bits that you don't like about work, because they're the bits that are going to upset you. [...] It's like it's a forgotten part of your life [...] let's face it – most people spend more time at work than they do at home. (Ben)

Ben related this lack of attention to a view that the senior echelons of the health service had a narrow outcomes-related focus:

I get the impression that they want to sort of get you out ASAP and just give you the drugs and push you out and say to the NHS, 'Oh we've solved a hundred people with mental health problems' [...], but don't get me wrong I think the nurses and like the crisis team and stuff, I think they're very good, but it's the main doctors, like the higher up people that don't really give a toss. (Ben)

Participants described a range of ways in which mental health interventions services affected their recovery. For Ben, interventions to help him reduce the impact of his symptoms on his ability to work were of central importance. He described limited satisfaction with medication, which he considered felt, "like I'm taking an air tablet, so, it doesn't really help at all" and additionally left him "feeling a bit groggy". If he had been told that his symptoms may have been more acute without the medication, then he did not seem to have registered any such message. His frustration with the emphasis on medication was accompanied by a desire to be helped to find alternative ways to manage the impact of symptoms: "They've never really said, 'Oh try this, this and this and that'll help you keep your mind off it' or anything like that, they've just more tried to focus on tablets". This sense of frustration was compounded by him having found himself a new hobby that helped, and by not receiving acute day service attendance despite being initially offered it. He lacked confidence to ask why this never transpired:

They mentioned me coming in every day, with the bored factor, [...] doing like their group sessions [...]. They mentioned coming to get me because I can't drive [...] and I said, 'Yeah, that'd be a great idea. Yeah, I'll do that', and then they never done it. They never mentioned it, so I thought well I don't really want to seem pushy about it [...]. (Ben)

He acknowledged finding a sense of relief from talking with professionals about feelings and symptoms:

But when I started telling professionals, [...] it helps you get it off your chest, even if it was only for the half hour or twenty minutes, I felt free, yeah, and then it drags you back down, but at least you feel free for that tiny bit of the day. (Ben)

As well as qualifying the duration of the benefit of this sense of relief, he was also dissatisfied with the way he considered some professionals put pressure on him to only give positive feedback about recovery:

And even the doctor, when I said, 'I don't feel any different', it was kind of like quite short and brief, his answers were like yes's, no's and when I started to say I was feeling better, it was, 'Yeah', and then he would explain the yes's and explain the no's. [...] I asked [Dr A] a question and he said, 'No', and [...] was silent [...]. You would have thought doctors [...] should be able to talk to people whether they're in cuckoo land or England [...] it just made me quite angry. (Ben)

Mark and Gavin were able attend the day service and gain some of the benefits which Ben had hoped for:

I came into the day services here and did structured groups like pottery, creative art, gardening, things that would distract you from maybe suicidal thoughts or self-harm. (Gavin)

That's why I like coming down to the Day Unit and doing some of the group therapy. It occupies my time. (Mark)

Penny was given the opportunity to lead a pampering activity group on the ward herself and thereby affirm and connect with skills she used in her work (see Chapter 8). Gavin considered that such therapeutic activity helped speed his recovery by maintaining normal daily routines, something he thought the non-inpatient emphasis of the crisis resolution and home treatment team also contributed to:

Even though you're ill you've still got to keep abreast of your normal life as much as possible, and the day services helped me to do that because I went home in the evening, knew what was going on in the world outside, did some creativity at home, like doing word searches, puzzles, some creative art, and really it's given me a quicker recovery rate than if I'd been in hospital. (Gavin)

Service- or person-centred 'moving on' focus

Participants valued being helped by mental health professionals to prepare to move on from acute services. To some extent this was focused on service provision and the transfer from acute to community services. It was apparent that for Gavin, despite some reluctance to criticise services, there could have been some improvement:

[...] it would be good for a bit more communication between day services and the Community Mental Health Team. I think that could be better, but that's not their fault, it's just the way it's run, but overall I've been really, I've been quite satisfied with the results that I've got. I don't think there's much more you can do to improve it. I feel that it was quite adequate. OK, you have staffing level problems, but [...] I mean everywhere's got staffing problems and sickness or whatever. (Gavin)

There were also instances when moving on looked beyond service provision and considered support to prepare and plan for return to work. For Yvonne this included the detailed psychiatrist's report on how she could be supported back to work that had been initiated by her employer. No such report had been requested by Penny's employer, which may have contributed to her feeling that plans for return to work were "up in the air".

Planning mental health service provision and return to work need not be mutually exclusive. Yet this was not always apparent. Post-discharge day service was discussed as an *alternative* to resuming work for Penny:

[...] ward rounds [have discussed] what I'm going to do from here and my future and if I am going to go back to that [work] or whether I'll just make a clean break and go over to the day hospital or something like that. (Penny)

Return to work also seemed to preclude use of day services for Gavin who would have liked to have combined the two: "I think it would have been good if there was a bit more support for longer while I'm at work, [...] just a bit, maybe a week or so longer, to come in for day services while at work".

Explicit and non-explicit vocational aims

Participants gained the impression that the role of acute mental health services in relation to their working lives was to support their general mental health recovery; advise on when they might be ready to return to work; and, in some cases, consider what adjustments might help that process. Only in Yvonne's case had this been considered in any detail. There was potential for such detail to emerge for Daniel, as the occupational therapist had just suggested to him that they complete a work-related assessment:

A back-to-work role assessment; I think that's what we've got to do next week. It's just to see your needs, work needs, back to work needs. Because I've suggested, and I don't know if we're going to do it yet, but somebody like [the occupational therapist] or one of the team can come with me and have a meeting with my big boss before I go back to work to try and explain what we need to do. (Daniel)

Gavin had also initially asked for the acute mental health day services to liaise with his employer. They had declined and encouraged him to do it himself:

I wanted the day staff to contact my employer on my behalf, but they said, 'No you must do it', so really [...] that's the idea of the day services is to empower you, not to take responsibility away from you and take that empowerment away from you. [...] Even though you might be having a crisis, they've still given you the tools to do it [...] gradually as you get better and come out of your crisis, you find then that they've not take any responsibility away from you and that's good. (Gavin)

This appears to have been well-judged, as Gavin had managed to negotiate arrangements for a gradual return-to-work plan. For others, despite a view that it could be useful, the possibility of mental health services getting involved in such direct contacts was not something that some of them had even considered. It did not appear to have been suggested by mental health services at all:

I didn't think about that to be honest. I didn't think that they would sort of come along [to a meeting with his employers]. (Ben)

In a way it would be quite nice having someone there that understands from the health point of view where you've been and what you can probably cope with [...]. Rather than – I know what I'm like. I'm likely to sit there and agree to undertake more than I can probably do. (Yvonne)

Explication and summary of participant mental health relationship

Most participants experienced limited acknowledgement of and attention to their identities as workers and their work-related needs from acute mental health services. Interventions which had the potential to influence their vocational recovery can be located on three related continua: firstly, a symptom management–managing life axis; secondly, whether ‘moving on’ had a service focus or person focus; thirdly, the degree to which any vocational aims of mental health support were explicit or non-explicit.

There was limited satisfaction when interventions were perceived to have restricted themselves to symptom management; in contrast, participants valued those interventions which helped them to manage the impact of symptoms on their lives. It is possible that this was related to the extent to which interventions were delivered in ways which were centred on helping people move on *from acute services*, or move on *with their lives*. Participants did not describe a clear structured approach to identifying their vocational aims. Explicit work-related aims did emerge as the prospect of a return-to-work date approached, but were not prepared for in advance. The most detailed return-to-work planning report and liaison with work occurred when Yvonne’s workplace sent the psychiatrist a form to complete. While they may not have been allied to explicit vocational aims, participants considered that interventions (notably acute day services) which provided structure, purposeful occupation and supported restoration of routine, helped them take steps towards resuming their working roles.

This chapter has reported findings showing how other people at home, work and in the health service were important influences on participants’ developing return-to-work trajectories. The next chapter shifts the focus to an analysis of these trajectories and seeks to identify some key mechanisms suggested by the acute study findings.

Chapter 10: Return-to-work trajectories (acute findings)

This chapter draws together the findings from the previous acute study chapters, so as to gain insight into participants' developing return-to-work trajectories. In Chapter 7 it was proposed that participants found themselves in a micro-level context shaped by their experiences and attitudes to work, and interactions between their work and sense of well-being. Chapter 8 presented their uncertain sick leave journeys, as they unfolded in their emergent presents. During these journeys they faced and responded to a range of challenges, and work remained a pressing issue for all. They experienced varying degrees and types of support from the three main realms in which they were situated, corresponding to their personal world, their workplace, and the health services; and this was the focus of Chapter 9.

The foregoing analysis has identified a number of mechanisms which are operative during the sick-leave journey, and which either support or obstruct the potential for a successful vocational recovery. For most participants this recovery had only partially been fulfilled at the time of interview. To a degree, this is a consequence of the study design, which gathered participants' reflections on their experiences from a particular point in time during their journey, and not from a standpoint which could be said to be at the end of a recovery journey.

The experience of one participant – Gavin – stands out in drawing attention to three key mechanisms which appear underdeveloped in the others' return-to-work trajectories. These are mechanisms related to co-ordination, collaboration and strategy. This chapter closes the acute study findings by considering these mechanisms in more detail. This provides a link to the following comparative case study chapter, wherein these mechanisms are found to be more developed, largely because of the nature of the support the participants received.

Co-ordination

Excepting the case of Gavin, there was no clear sense that any person or organisation was taking the lead in co-ordinating how best to prepare and plan for a return to work. In Gavin's case, he himself took the lead in co-ordinating plans, with some encouragement from acute mental health service staff, a high degree of support from his partner and family, and understanding from his workplace. That this was not simply because he was further on in his recovery journey is supported by strong evidence that he had taken a significant degree of control over the process from the beginning of becoming unwell. He

had openly shared with his employer the question of what his needs might be when he became unwell.

This does not mean that others could have easily done the same. Gavin appeared to have learnt, often from bitter experience, how to manage the impact of mental health problems on his working life. Ben, Daniel, Mark and Yvonne had not had the same history of years of experiencing mental health problems. Ben in particular was feeling overwhelmed and shocked by the impact of some of his symptoms. Penny had experienced her mental health problems for a number of years, but had not worked for most of this period. Thus, she had not been able to gain experience of managing work while simultaneously experiencing mental health problems. Hilary was perhaps most like Gavin in having some idea of what she might do to begin to resume work. Actively engaging in this was difficult for her, however, because she was currently questioning whether she wanted to return to her jobs. While there were examples of a number of participants receiving support from their home life, health services or work, this was not taking place in a consistently sustained manner. Gavin was able to co-ordinate return-to-work planning himself (with important support in the background). The other participants might have benefitted from someone else consistently working alongside them to co-ordinate identification of work-related issues with a plan to support recovery in these areas.

Collaboration

Effective support was reduced by limited collaboration, and enhanced when collaboration was evident. Potential collaborators can be divided into three groups: the employee and their personal world; the workplace; and health services. Within and between each of these there were examples of both effective and ineffective collaboration. Thus, Gavin found his partner and family to be actively supportive of his recovery and plans for returning to work, while Ben did not feel understood by many of his family members. Within the workplaces, Yvonne's occupational health services were seen as effectively collaborating with managers, but Daniel and Ben considered that the advice from occupational health was not always being heeded. Collaboration between crisis resolution and acute day services worked well for Mark and Gavin, but a number of them questioned the communication between acute and community teams as they neared discharge.

Collaboration between – as opposed to within – each of these realms (of the participant and their personal world, their workplace, and health services) appeared to have been more

of a challenge. Again, the exception was Gavin's situation, where his co-ordinating leadership of the process overcame this. In some cases, constructive co-operation between the person and their workplace was undermined by lack of trust (often with a basis in participants' experiences of their own or others' mistreatment). In other instances, co-operation was supported when communication could be open and direct. Collaboration between health services and the participants' personal worlds was often restricted to the approval of sick notes, underpinned by a 'recover first' discourse. More effective collaboration may have subsequently emerged for Daniel, who had been offered a detailed assessment of work-related needs. Collaboration between the workplace and health services was most limited. It occurred for Yvonne when her employer's occupational health service asked for a psychiatrist's report to assist with return-to-work planning. There was also evidence that it might occur with the involvement of the occupational therapist in a return-to-work planning meeting in Daniel's case. Analysis suggests that at times the respective realms of health and work were considered by participants to be distinct, representing private and public spheres of life which they felt very cautious about breaching. Unfortunately, this seemed to further undermine the potential for collaboration. These supports and constraints to collaboration are summarised in Figure 3 below.

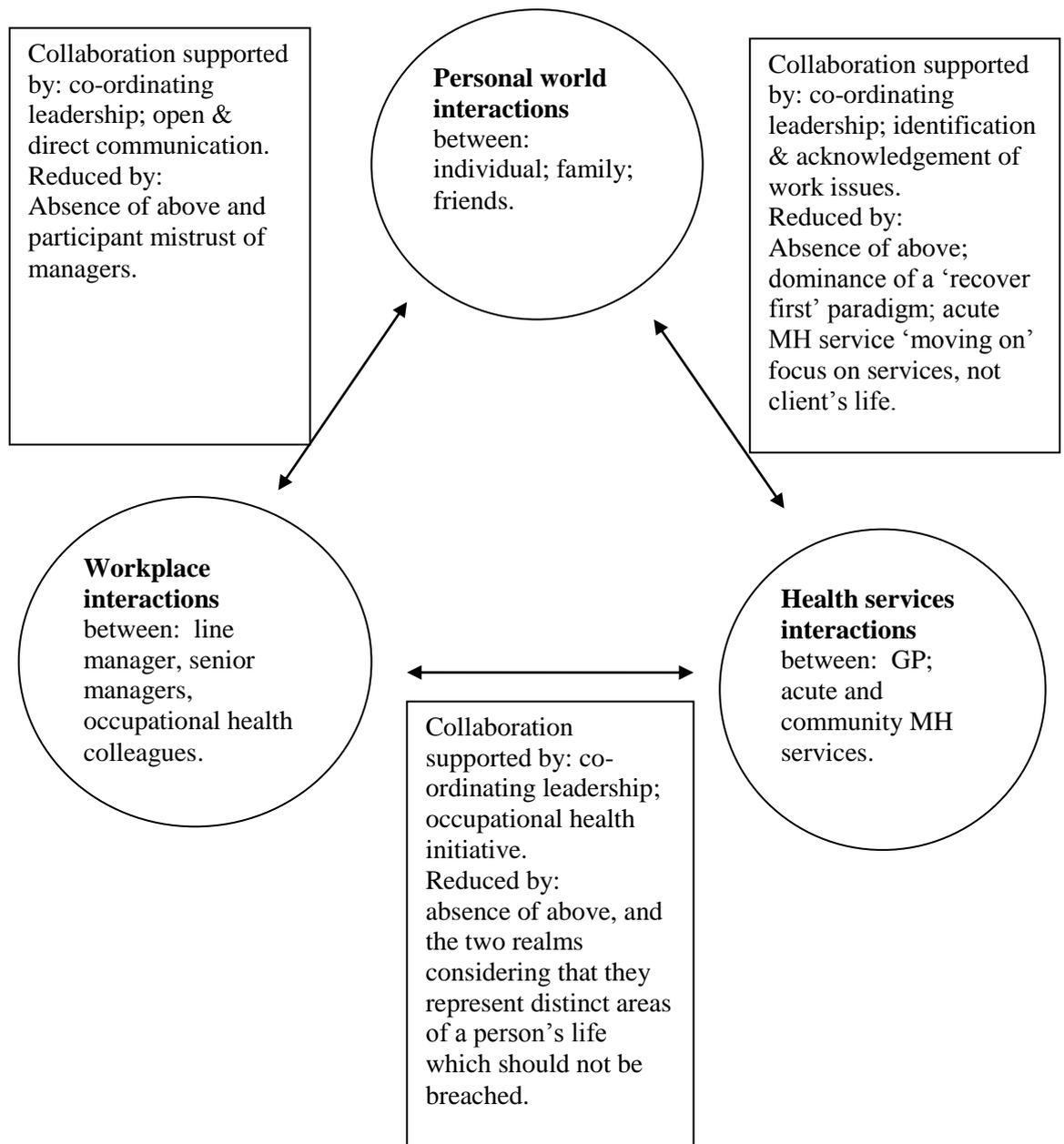


Figure 3. Supports and constraints to collaboration in return-to-work planning

Strategy

The potential for explicit vocational strategies to emerge and be efficacious appeared to be influenced by the presence and effectiveness of co-ordination and collaboration. Thus, Gavin took the initiative and put in place a strategy from the onset of his episode of illness. He collaborated with his workplace and health services to aim to return to work when ready, in a graded and supported manner. Without the same degree of leadership and collaboration, there were, in Yvonne's case, signs of potential, albeit less developed,

strategies (in the psychiatrist's report for her company's occupational health service). There were similar germs of a strategy in Ben's ideas about initially returning part time to indoor duties. This had some collaborative support from his occupational health service, yet he reported obstacles in the form of his line managers' lack of empathy and understanding about his mental health problem, and in the line manager's desire to get Ben to return to full duties and overtime, irrespective of his degree of recovery. For others, there were possibilities that could perhaps be nurtured and so eventually become full-fledged strategies. These included participants' identification of issues to address at work, and their ability to generate some ideas about what could be changed to help them return. It appeared, however, that in the absence of co-ordination and collaboration, an explicit strategy for supporting a return to work was being left until a medical signal was given that someone no longer needed to be off work. This risked leaving little time to develop specific plans, or to prepare the participant – and those around them at work – for their return.

If there was little evidence of explicit strategy for all but Gavin, there was evidence of general recovery strategies. Participants considered that these were helping them move towards a return to working life – even if that aim was not stated (and possibly not even intended). The general recovery strategies included medical and non-medical symptom management, social re-engagement, and strategies which supported participation in occupations and restoration of routine and structure. Such occupational strategies were seen as particularly useful and essential to moving towards the possibility of returning to work. Some strategies were facilitated by mental health staff, such as use of acute day services, and advice about increasing self-care and leisure routines at home. Others identified strategies themselves; notably, Ben's discovery of weight-lifting as a leisure pursuit that provided him with the same bodily sense of physical accomplishment that he missed from work, which he felt was also helping to restore his stamina. There is a strong case for suggesting that these measures could have been more effective if integrated, via co-ordination and collaboration, into a clear strategy, as Gavin did with his use of occupational interventions from day services and through his own devices. The influences of the mechanisms of strategy, collaboration and co-ordination on return to work trajectories are presented in Figure 4 below.

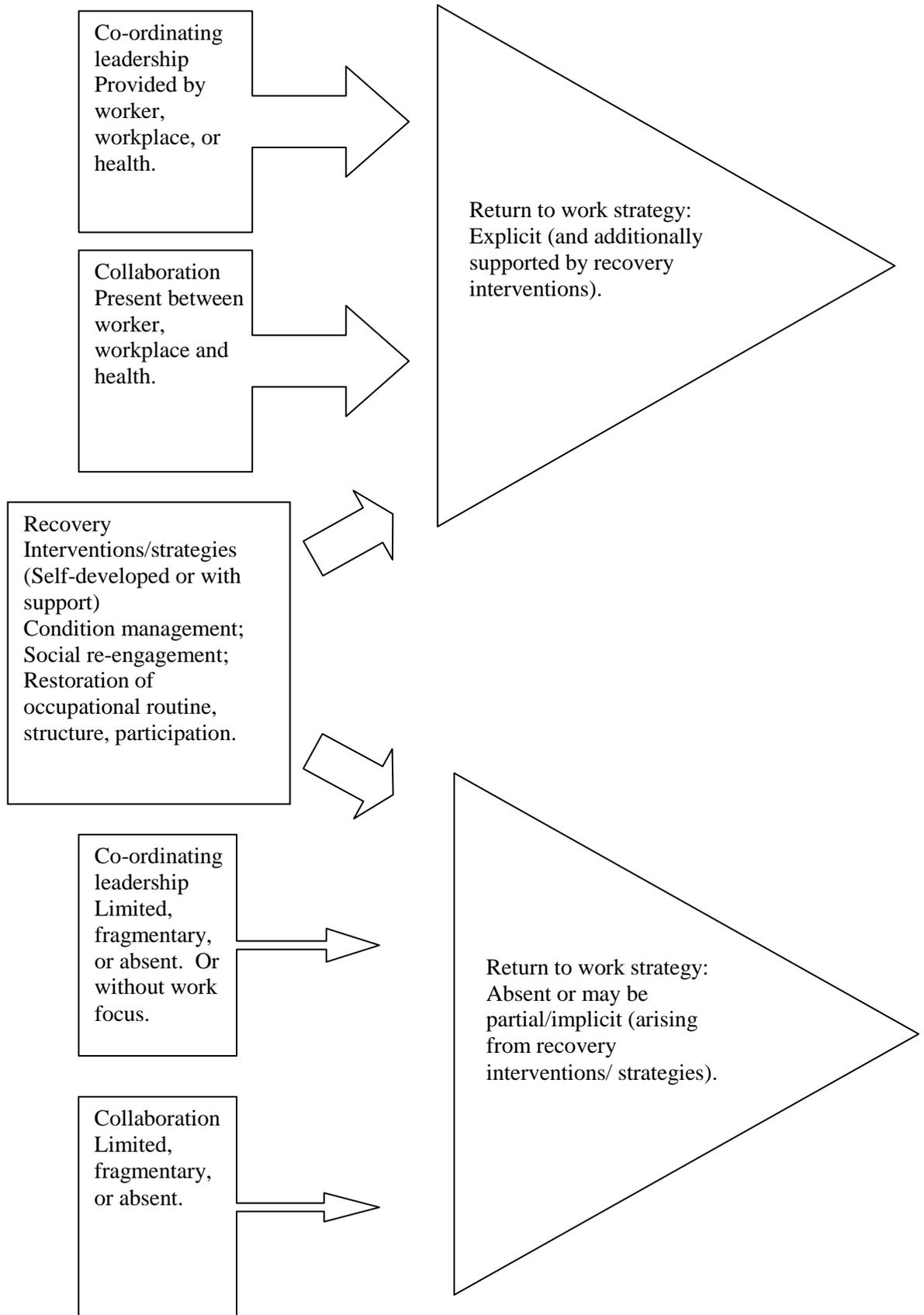


Figure 4. Influences of recovery interventions/strategies, collaboration and co-ordination on return to work

Chapter conclusion

These findings are not final outcomes, but outcomes in the sense of indicating the stability and trajectory of participants' return-to-work journeys. The value of our gaining this insight *during* their journeys is that it supports understanding of the on-going process, as revealed in the contexts and mechanisms and their developing outcome (which in turn may lead to revision of the contexts, and thus the emergent mechanisms). This process of discerning trajectories also comes closer to the situation that people seeking to orchestrate their recovery find themselves in, and which they and those seeking to provide support have to negotiate.

Thus, the findings help to reveal the most significant contextual factors and emergent mechanisms influencing the return-to-work trajectories for these participants (see Figure 5 below). The acute study findings suggest that people's past experiences and attitudes to work were an influential part of the context. Likewise, how people experienced and interpreted interactions between their work and well-being influenced how they envisioned and sought to enact return-to-work initiatives. They were on an uncertain journey: none of the participants was completely alone, but they were alone in being the only people who occupied the three realms of personal life, work and health. Gavin was able to bring some coherence and direction to his journey back to work by providing co-ordination, collaboration and strategy himself. For other people these mechanisms were fragmented or lacking.

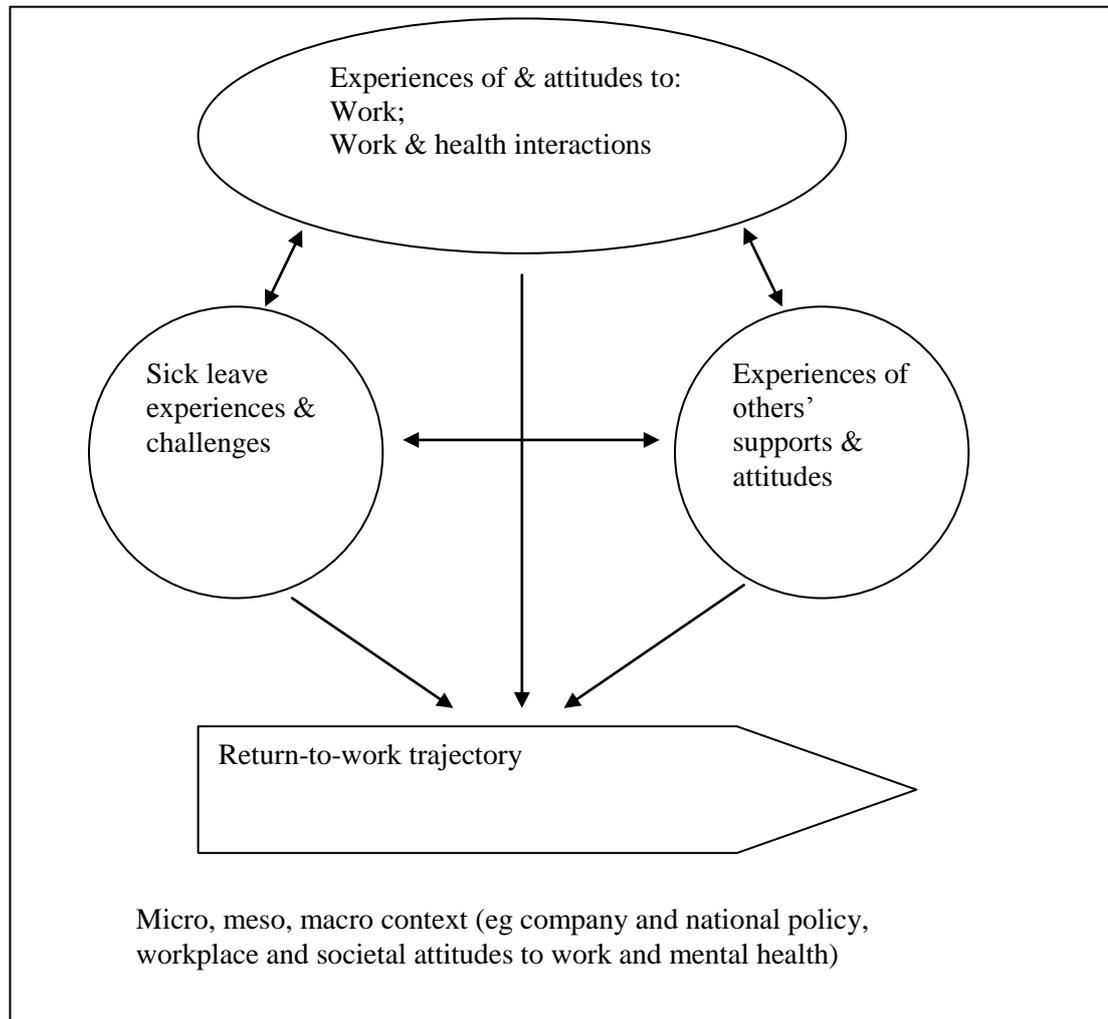


Figure 5. Influences on return-to-work trajectories

The next – and final – findings chapter will focus on research into a job retention project which harnessed the mechanisms of co-ordination, collaboration and strategy for people who were also experiencing mental health problems which were directly or indirectly threatening the continuation of their employment.

Chapter 11: Comparative findings from community case study

This final chapter of Part 3 presents the comparative case study findings from the community-based Retain job retention project for people with mental health problems. The emphasis is on themes which relate to interventions provided to support job retention. This was in part a result of the collaborative research priorities established at an early stage of this research (see Chapter 6), but this emphasis also enables an effective comparison which considers the contribution that a strategy involving co-ordination and collaboration may make to the return-to-work trajectories of people with mental health problems. Thus, in the process of presenting the findings, I hope that explanatory insight can be gained by comparing the two groups of people who all had job retention needs – but of whom only one group had received focused job-retention intervention. There are other important differences between the two groups which will be acknowledged, before concluding the chapter with a revised model of the influences of recovery interventions/strategies, collaboration and co-ordination on return-to-work trajectories.

Findings

The principal themes relate to participants' experiences of and perspectives on their job-retention needs and the support received from the Retain job-retention project. They are set out in six categories. The first comprises the difficulties participants reported facing at work. The following three categories include themes related to how the project supported people to enhance their self-confidence, communication skills and problem solving; analyse jobs and identify changes; and negotiate and collaborate with their employer. The fifth category reports participants' views and experiences of the skills and competencies of the job-retention project workers. The final category presents the outcomes and impacts of the job-retention projects on participants' lives. This includes some descriptive numerical data about employment status outcomes as well as qualitative data. It also includes themes which focus on factors associated with those who did not retain employment.

Difficulties at work

Participants described a range of issues related to the direct and indirect impact of their mental health problems at work, using terms that were very similar to the participants in the acute case study. These included symptoms of their mental health problem, side-effects of medication, and the challenges of attending health appointments in working hours. Many described either experiencing, or fearing that they might experience, stigma

from managers or colleagues at work. This was often related to concerns about disclosure of their mental health problems to employers and colleagues. Most stated that they lacked self-confidence:

I felt so dreadful, my depression was so bad, I was really in a bad place mentally and physically as well [...] I couldn't go back. I had to contact them. I felt dreadfully guilty [...] and didn't even feel that I could speak to my line manager because she was so unsupportive and uncommunicative as well. (Alice)

Some people described challenges they were facing with work tasks, roles or the organisation of their working life (e.g. hours worked, workload, start/finish times):

I was much more chaotic in my work [...] didn't feel that I'd complete all that I had to do, found it quite difficult to concentrate on particular things and my memory was [...] not as good as it used to be. I was also really tired all the time. (Rebecca)

Many of the participants blamed themselves for problems they were facing at work and felt guilty about this: "When pay day came around I felt like my colleagues were working hard for their money [...] I [...] didn't deserve maybe the full money" (Ruth).

Despite these challenges, and again as in the acute case study, it was very clear that all participants saw work as an important part of their identity and wanted to be working (though not necessarily in their current job):

I would always need that structure of work. I think it kind of normalises me really [...] I like the social aspect of it, but I also like the structure of it. (Mary)

Supporting self-confidence, communication skills and problem-solving

In contrast with the feelings of uncertainty expressed by many in the acute study, Retain participants described ways in which the project supported them to review their current situation, revealing new options, possibilities and hope. Current restricting or self-blaming understandings and interpretations were challenged. Some then considered whether the problems they faced could be explained by factors other than their mental health issue. A number of people were helped to recognise their own worth:

It was through coming to those [facilitated peer support] groups [...] that I realised that actually what was happening was not ... necessarily about my mental health condition[...] (John)

I can remind me '[...] you are an asset to your company if it's done in the right way and you're not under too much pressure'. She [Retain project worker] really made me see that and it's amazing because it turned around my view of the situation. (Alice)

Participants explained how they were helped to look at their situation differently by realising that they were not the only person to be facing such problems. This was a particular achievement of the support groups:

Sometimes you think you're alone, you're experiencing a unique experience but then you come up and meet up, you find 'ah' you all face the same problem. It sort of makes you less bothered... (Steve)

[...] you have a tendency to think [...], 'maybe it's just me? Maybe [...] I'm struggling because I've got a mental health problem? Maybe I just can't cope with it?' And that was something that Retain really helped with [...] because you come to the drop-in groups and everyone says the same! (John)

Retain [...] helped validate [...] my whole experience [...] I just thought [...] 'It's only me' and 'I don't know what happens' and 'I'm frightened' and 'What does actually all this mean?' [...] [the Retain worker explained] 'Actually [...] this is the way it works, it's a completely normal thing [...] given your set of experiences [...]' (Zoe)

All participants reported times when their self-confidence was very low, particularly when on sick leave. Expressions of confidence in them and help to identify their positive achievements and skills helped to increase their self-esteem:

[...] my perception is changing in terms of how I see that people see me. That's maybe part of coming out of depression, but [...] it's also about [...] thinking, 'Actually, people do actually respect me and I think that people want me to be successful [...]' (Zoe)

I think this service is very good at [...] helping you to see yourself as you are and with the work side of it [...] 'look at you, you are still valuable, you are still important' ... (Naomi)

There have been times when I've thought, 'Oh God I can't cope! I'm not doing this very well' and with [Retain worker] there for support its being able to say those things to someone that's not kind of judgemental. It's just made me feel like actually I can go ahead and that I have got certain skills, I'm not a complete waste of space, I'm not a gibbering wreck [...] there is a future, not just feeling completely useless. (Laura)

There was evidence of increased confidence to plan to return to work and in being able to clearly express themselves to employers – an area of frustration for some of the acute study participants:

During the meeting with [Retain worker] I realised, 'Yes I really do want to come back. Yes I actually really do have skills that I can use' and that [...] if they're a bit more flexible, and they take into account that I have this severe long term problem that is not my fault. It just is how it is, that they can accommodate me. (Alice)

How stressful it was for me [before] to even see my line manager, never mind sit in meetings [...], to the last meetings that he was in [...] to actually say to him, 'When you did this, this is how it made me feel and I understand that you're saying you didn't intend to do that, but it's how I was made to feel'. (Alice)

We were then talking about [...] finding my voice and that helped me [...] begin to have the confidence to [...] put my point of view. (Zoe)

Participants expressed a sense of hope for their future working lives in which work could be part of sustaining mental wellbeing:

So just stay on this road, that will involve promotion and that will involve moving to other jobs and what have you [...] My goal is just to continue to grow [...] (Harry)

[...] because [...] of this support with [Retain worker] – and we've been looking at actually what is ok about me with my illness and not what's wrong with it – [it] has helped me to [...] really stay above that and keep myself from getting really negative[...] I've not had to go into hospital and I've actually had a really positive outcome. (Alice)

Analysing jobs and identifying changes

Where acute case study participants had variable but usually limited assessments of their work, Retain participants described how the project helped them analyse their jobs and identify any accommodations which might help them remain at work. These included changes to patterns of working (shift start/finish times, varied hours, and changing work base):

One of the very first things that [the project worker] did [...] was [...] to try and offer suggestions of proper adjustments [...] like changing my start time slightly so that I wasn't battling rush hour traffic when I was feeling very stressed already, which would also help my childcare situation. Or the possibility of [...] transferring here [...] perhaps of a job share and making lots of suggestions [...] things that are potentially answers to the situation. (Alice)

I wasn't able to do as much as I normally would, because I was so tired at the end of the day. So that was taken into account and I just [...] did what I could to begin with and if I couldn't manage it, I would do my two and half days, but I would just be doing less and I'd do what I could manage in that time. (Anna)

I needed a reasonable adjustment in that I needed time off to go and have my appointments if I was going to be able to manage my condition, and they agreed to that. (Mary)

Accommodations considered and agreed also included changes to work tasks and roles. As with adjustments to working hours these were mainly reported to be temporary changes to facilitate return to work. For instance, Sonia reported returning on reduced hours without her managerial responsibilities. More permanent changes were found in participants' approaches to work performance. This was viewed as making work more sustainable:

I no longer have to try and push and work harder than everyone else. [...] I just do what I can do. (Alice)

[The Retain worker] helped me look at the issues of perfectionism and if I felt like too much has been asked of me at the moment ... (Anna)

Assistance with problem-solving was also reported, including consideration of the job tasks and roles and social processes around them:

I didn't quite know what my role was and [workplace name] was absolutely chaotic [...the project worker] came and supported me to settle in. (Steve)

She's [Retain worker] helped me with things like putting a proposal together, sorting out my CV, thinking about how to deal with different situations that I'm finding difficult, how to approach people. (Laura)

For a number of workers, analysis of the job involved considering whether alternative jobs with different employers might be preferable:

I came to see Retain and talked at length to [Retain worker] about were there any other adjustments, but I think I just reached the conclusion that [...] I just wasn't going to have the confidence to carry on working there [...] and my plan initially then was to have enough time to find another job. (Naomi)

Maybe find that I could move to another job. [...] I had kind of hit a point where I wasn't too happy in the office where I was anyway and I did have plans, long-term plans to do something else. (Ruth)

I spoke about it with [Retain worker] and said, 'Well you know, we need to then come up with a solution because I don't think I can sustain working there.' So, we had this meeting and we [...] arranged I think for six weeks' notice to try and get me another job. (John)

Help to collaborate and negotiate with employers

In the acute case study it was found that a consequence of the often well-intentioned 'recover first' perspectives was that there were expectations that problems would be resolved if and when the worker recovered. Thus contacts between those workers and employers were often indirect, with limited return-to-work planning. Retain helped individual workers see job retention as an issue to share with their employer. This opened up the potential for employers to engage in discussions of accommodations and other solutions. A number of interventions appeared to play a key role in supporting this. Whereas health workers in the acute case study generally had little or no direct contacts with participants' workplaces, Retain was instrumental in arranging meetings and ensuring they were constructive. Rather than advocating for or representing the worker, preparation for meetings resulted in the worker feeling confident and clear about what they wanted to say themselves:

It was more helping me with how I was going to try and explain how stress affects me [...] (Mary)

Before any meeting there's been a discussion, we've gone through what [Retain worker's] role is, what my role is, what we'd like to happen in a particular meeting [...] so we go in there very prepared. (Alice)

Even where the Retain worker did actively communicate the worker's views to the employer, this was only done when the participant felt they could not carry on doing so and when what they said had been agreed prior to the meeting:

She had a meeting here with my boss and myself in which, because at that time I was very upset, she spoke on my behalf and clearly understood everything that I'd said and that we'd spoken about the last time that I saw her. (Sonia)

We went over like a structure of like what we thought was going to happen and how she could support me. And when I burst into tears she would just fill in and carry on the conversation until I got myself back together and it kept continuity. (Anna)

We also know that I might not actually be able to say what I need to say, so it's knowing that I can have a signal that I can give to [Retain worker] if I need her to come in and say things for me. But also knowing that she's not going to go in there and talk for me and I think that has been incredibly powerful. (Alice)

Analysis suggested that a key outcome of such meetings was that employers had heard participants' voices and increased their understanding of mental health problems:

I'd written out a two page [...] document really about the experience of the anxiety and the depression and what it was like, and took that to the meeting which I think, well [Retain worker] said that they both found very moving. (Anna)

Even to be able to say that, he heard what I said, he listened and he apologised for something in that meeting and that meant the world, it was so important and I thanked him in that meeting as well and so it was very cathartic. (Alice)

Emphasis on empowering workers to express their own views and concerns may have also contributed to establishing more enduring communication between the worker and employer:

We set up another meeting, maybe even another two meetings, where we had the four of us and it was agreed that I would have regular supervision. (Anna).

[...] that helped me [...] on a continuing basis [...] to have the confidence to [communicate with her employer] [...] either verbally or by email or whatever [...] (Zoe)

There was also some suggestion that the presence of the Retain worker in the meetings may have helped ensure that due process was followed and relevant legislation observed.

When asked what she thought would have happened if she had not made contact with Retain, Rebecca replied:

I think that they would have heard the [disciplinary...] they would have made a finding against me based on what this woman had said – which wasn't even true. I wouldn't have had the strength to fight it because I was so ill [...] (Rebecca)

Alice reported her employers were now looking at providing mental health awareness training for their staff. She believed that her case may have left a legacy that would benefit other people in a similar situation. Sonia promoted Retain to a colleague: “The lady I've got at work who's been off [...], I gave her [Retain]'s number”.

Constructing plans for return to work with the employer constituted a major part of the dialogues between worker and employer, along with problem-solving workplace issues, and it is clear that they could result in accommodations and other effective supports for the workers:

I needed a lot of support from [Retain worker 1] to get back into work and for her to reassure me that it was not impossible, and also to meet with my manager and somebody from HR. We had a three-way meeting, so that I could set up [...] special arrangements, adjustments. (Anna)

At that time it was just to [...] really get a plan in place like to reintegrate me, because I was finding a full day hard [...] (Ruth)

Skills and competencies of project workers

Many participants commented on the project worker skills and competencies. A number highlighted qualities supporting communication, trust and empathy:

“a very good listener”; “very, very helpful”; “a very calming and soothing influence”. (Naomi)

I feel really at ease with [Retain worker]. [She]'s the only person I've told everything to [...] I trust her and because she actually seems to be genuinely interested. (Sonia)

[Retain worker] has been really helpful in any way she possibly can, always been very supportive, very kind [...] (Linda)

Others appreciated the skill set and knowledge base of the project workers:

I mean from my point of view, it is, it's a fantastic service 'cos you've got people like [project worker A] involved who's been a service user [... and] you've got people like [Retain worker B] who's got such amazing knowledge. (John)

It's a good mix of skills that [Retain worker] has I think because she's obviously not a counsellor but she's done occupational health [actually occupational psychology] and been involved in HR and I think that's what people need [...] (Mary)

Acute case study participants had given similar praise for mental health staff (though less consistently for some doctors), however it tended to be more general in nature and not associated with consideration of work-related issues.

For John, one of the strengths of the Retain project lay in its independence:

I think that a really, really important thing about Retain is that they're independent and you actually feel like it's someone on your side [...] it's a fantastic service. (John)

Laura and Sonia contrasted the project to other support they had received:

I think it's brilliant actually. I don't really have any other kind of support now. I've been signed off by the psychiatrist. I don't really see the GP for anything regarding mental health issues. So it's my only kind of place where [...] there's someone there that knows the score, I don't feel like they've got 3 minutes to assess the situation and write a load of rubbish down and then get turned away and never speak to them again. The interaction is real, it's not just clinical. (Laura)

All sorts of things were suggested [...] The only thing that worked was here, for me, it's the only place that I came to and went away feeling like I'd achieved something, or I felt a bit more at peace with myself. The doctors [...] I just felt that nobody actually had a clue. (Sonia)

Impacts and outcomes of job retention intervention

The employment statuses of the workers were identified in January 2009 (6–9 months post-interview). Six had retained employment (in a previous or new post) with their original employer, four had gained a new job with a new employer, and four had left their job and were unemployed. Thus employment status outcomes were positive for 10 of the 14 participants.

General comments revealed an appreciation of the project's impact on their wider lives:

It just makes me feel like a human being rather than just being a problem. (Laura).

It wasn't only getting back it was sustaining me as well. (Anna).

And my thoughts on work and mental health is that work is [...] a really good medicine [...] if you can manage to get back to work, even if it's just part time, it's really good for you.. (Harry)

Factors associated with workers who did not retain employment

Analysis of those who had not retained employment revealed some potential mitigating factors which may explain this outcome and also suggested that positive work-related outcomes can be identified for three of these four individuals. Those Retain

project participants who were not employed at follow up reported factors involving tensions, conflicts with managers or colleagues and/or stigma and workload pressures:

[my manager] was basically complaining about the fact that I'd gone off sick [...] – oh, what was it her words were – 'Oh I don't suppose you can help your sickly friend out can you and do this visit for her.' (Rebecca)

[my manager] said, 'You're not doing your work' and I said, 'Well I am doing my work, I'm doing it to the best of my ability, but you know I'm struggling.' And she was quite aggressive and just basically said to me, 'Well I think you need to find another job.' [...] And there were other things about working there [...] they'd see clients [...] with mental health problems and [...] these clients would come in and they'd go and you'd get comments like, 'I can't stand seeing that nutter' [...] I just sort of thought, 'Okay maybe I'm not in the right place here'. (John)

There was three original people [...] ganging up really, stirring up of one of the people [...] to complain about me and it was soon after that the problem started [...] then when I went back off of being off sick, they didn't speak to me for a month. (Linda)

For John and Ruth, workload pressures and insufficient workplace support and isolation combined to make job retention unsustainable:

I think within the team I just kind of isolated myself and [...] when it got to that point I felt really uncomfortable [...] and also my boss, he was under quite a strain and also I just couldn't face the work anymore. (Ruth)

I wasn't being supported and I was being overworked, yeah. (John)

Linda also considered the main issue was not her mental health problem:

Well, it's physical [...] if I didn't have the physical problem then I wouldn't have come to Retain and I wouldn't be taking anti-depressants which I think are just masking the problem anyway. (Linda).

While issues of conflict, stigma and workload were experienced by some of the other participants they were generally most severe for the four people who were unemployed at follow up. Here the findings are similar to the acute study, where very similar factors were found amongst people with the more problematic return-to-work trajectories.

Retaining working identity and aspirations during unemployment

For three of the four Retain clients who were unemployed at follow up, there is evidence that they were helped to maintain work aspirations and a work identity:

My greatest hope would be to [...] get my mental health sorted out [...] to be [...] doing something in paid employment by the end of the year. (Rebecca)

[...] certainly when I go back to work eventually, I will try to involve Retain because I think from the start I would like to disclose my mental health problem, I think that's really important [...] (John)

So my main hope is to progress with [...] [studying] [...] and get some experience in a job. (Ruth)

Conclusion

Participants in the Retain case study experienced a range of internal and external barriers to job retention, and it was apparent that there was a particular emphasis on the impact of guilt and self-blame. Interventions focused on individual workers, their jobs, and their workplaces. Individual reappraisal supported job analysis and identification of possible accommodations. This formed a basis for restoring contact with the workplace. Dialogue between self-advocating participants and their managers meant job retention could in most cases be addressed as a shared objective. Interventions were revealed to be multi-faceted. This underscored the importance of job retention project workers having a broad skill set and a high degree of interpersonal skills. Ten of the fourteen participants retained employment (four with new employers), while for three of the other participants there was evidence that they were assisted to retain a self-concept of themselves as a worker. This suggests an extension of the range of outcomes of job-retention interventions to include support to retain a worker identity and vocational aspirations.

Comparing the experiences of Retain users with the participants in the acute mental health study, it is clear there are differences between the two groups other than in the nature of job-retention interventions that each received. These may account for some of the differences in retention trajectories; they may also qualify the extent to which one can assume that needs and strengths of individuals are similar. Those receiving acute mental health service inputs had experienced problems which often had a comparatively more severe impact and more sudden onset. This could result in a greater dislocation to their lives (in part because of the internal impact of the acute problems, and in part because of others' reaction to them). Consequently, even if neither group of participants had received support from Retain, it still is likely that the acute participants were less able to initiate contacts with their work and that their work was more hesitant in sustaining contacts with them.

Other important differences arose from the study design. The Retain project users had decided to access support from the project, whereas it is not known whether all of the acute mental health service users would have made this decision, and to what degree this motivation itself might contribute to different outcomes. The Retain participants were also aware that the research would be contributing to an evaluation of the project, so there is a

risk that they may have wanted to emphasise positive aspects of their experiences – but, as one participant suggested, they had nothing to gain by presenting an inaccurate picture:

Like I say, I wouldn't normally come to something like this [the research interview]. There's no benefit to me, I'm doing it for [Retain worker] because I think what's she done, even though I can't put it into words, has been really helpful. (Sonia)

Concerns that people with more negative experiences may not have come forward are limited by the high recruitment rate, with 14 out of 16 people approached having agreed to participate in the research, thus testifying to the representativeness of the data.

Nonetheless, the comparison between Retain and acute mental health service users is valid, in that both groups found that their working lives were severely disrupted for reasons related to their mental health problems. All were on sick leave from work, and described a similar range of challenges. These included internal challenges, such as symptoms which undermined their ability to sustain work, as well as external challenges such as the experiences of stigmatising attitudes. Multiple parties were involved. All this meant that for both groups the task of navigating a return to work was considerable and complex. For the Retain participants this was also apparent in the broad range of interventions which they received; for the acute mental health service users it was often revealed in the degree to which they struggled to address those challenges with limited and uncoordinated support.

The previous chapter suggested that all but one of the acute participants lacked sufficient co-ordination, collaboration and strategy to support their job-retention needs. They did, however, benefit from some more recovery-orientated interventions that appeared to support vocational as well as general recovery. By contrast, the Retain project provided a high degree of co-ordination of return-to-work planning, either by the project workers making contacts with people's employers, or by them enabling and encouraging the participants to do so. In the process, they displayed a high degree of collaboration with both the participants and their employers. Collaboration with health services was less apparent. In part this may be because the participants were less engaged with either GP or community mental health services – but it may also be that such collaboration was more difficult because the project was neither organisationally nor physically integrated with either primary or secondary mental health services. This may have arisen because it was a charity-funded pilot and not a health-commissioned project. We do not know if it would have undermined the project's efficacy had more of the clients been engaged with mental health services.

In terms of strategy, the co-ordination and collaboration enabled a range of effective interventions to be deployed, focusing on the worker, their work and their environment. In providing the interventions, the project workers' interpersonal skills were valued as highly as more knowledge-based skills. The peer support group also contributed to developing and sustaining effective job-retention strategies. It did this by activating some of the more general recovery-promoting mechanisms (also experienced by some of the acute study participants), notably in terms of reducing feelings of isolation and by people sharing effective problem-solving strategies and knowledge.

The additional insights which the Retain study has added to the importance of coordination, collaboration and strategy enable me to present an amended version of the diagram originally presented in the previous chapter (see Figure 6 below).

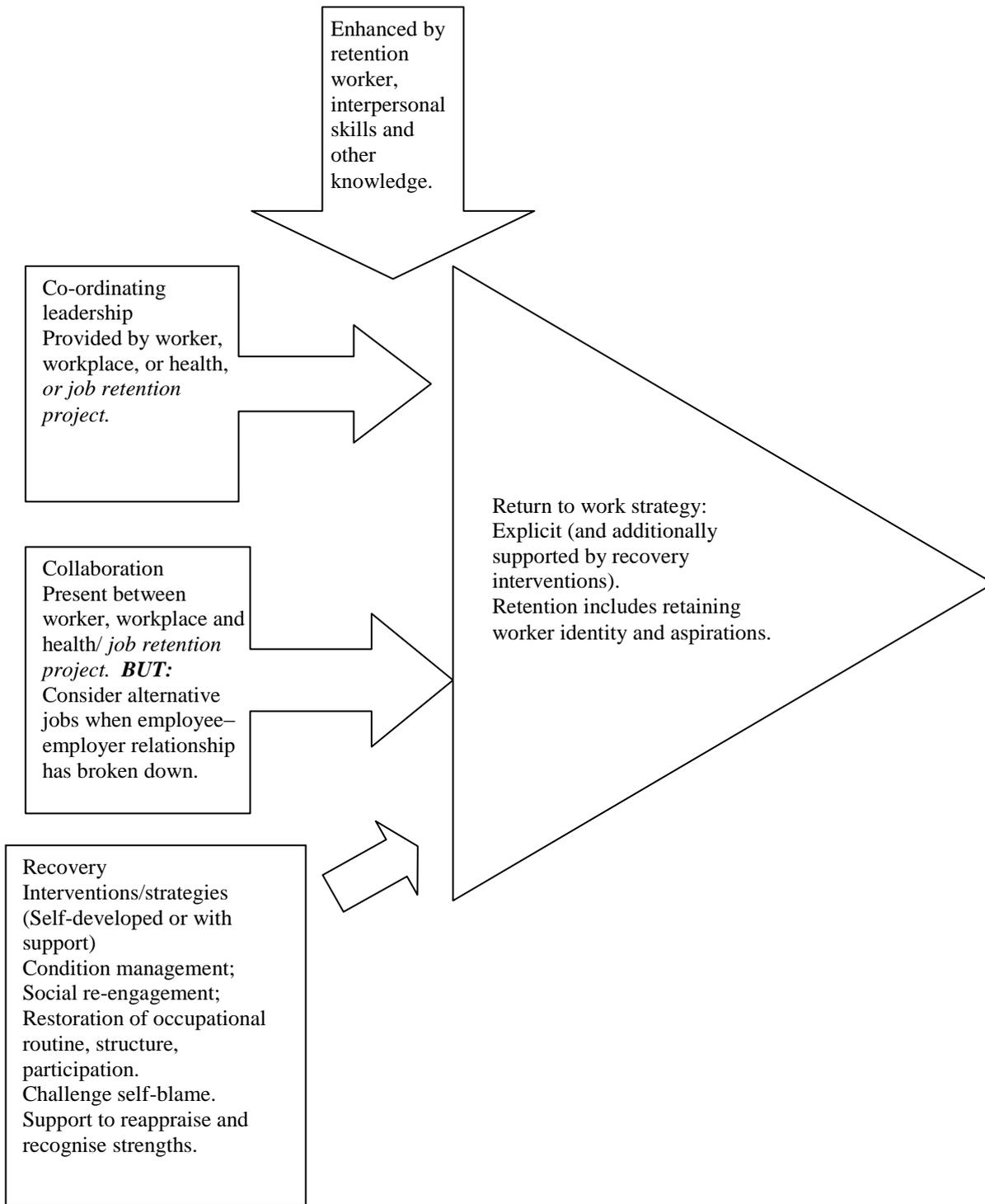


Figure 6. Revised Influences of recovery interventions/strategies, collaboration and co-ordination on return to work

In the next part of the thesis I will develop the analysis and consider the implications of these findings through discussion related to wider research, theory and policy.

Part 3: Discussion, implications and conclusion

Chapter 12 Discussion: The significance of work during mental health recovery

The findings show that work matters to employees recovering from mental health problems and not simply because it is part of a person's context – their 'history' or (suspended) identity – but because it is an active on-going concern that has the potential to support, as well as undermine, their recovery and its sustainability. Work mattered not just retrospectively but prospectively, as revealed through interviews *during* their sick leave. This research design also helped illuminate the intense feelings that people had regarding their work in the past, present and future. It seems that work can be a much more important factor in recovery during the acute stages of mental health problems than has previously been acknowledged. The potential to support return-to-work trajectories is seen to be greatest when a strategy is present that involves collaboration and co-ordination.

This chapter provides further analysis and discussion of these findings. It explores *why* work appeared important to participants and it identifies key mechanisms which influence recovery positively or negatively. To do this I draw on Danermark et al's (2002) explanatory research processes of abduction and retroduction. In terms of abduction – that is, viewing findings in the context of different perspectives, interpretations and explanations – I use related literature, and consider the evidence more broadly by adopting the occupational, biopsychosocial, recovery and resilience perspectives. I also use the perspectives that emerged from the contributions to the analysis made by the Acute Service User Panel (ASUP) and the Retain Service User Group (RSUG) (see Chapters 5 and 6 for rationale and methods). More specific concepts of personal and social capital and iatrogenesis emerged, as well as a newly proposed concept of 'occupational capital'. In terms of retroduction – the process of identifying generative mechanisms – possible mechanisms and underpinning structures are discussed.

Mechanisms were identified which influenced people's return-to-work trajectories by depleting or deploying key assets. These personal, environmental (finance and social) and occupational assets are used here to structure the discussion. Subsequently, the dislocation of and disruption to working lives that arose from threats to these assets are considered in terms of the iatrogenic effects of sick leave, a central contribution of this research. Issues of rigour, quality and limitations highlight the contribution to knowledge which this thesis has made.

Personal assets

Personal assets which were threatened or deployed involved capacities that were restricted by the impact of mental health symptoms. They also involved participants' identities – which, while challenged, were a resource drawn on to respond to adversity.

Personal impacts of symptoms

Symptoms of mental illness had a real impact on capacity to work and to plan return to work. Direct and indirect references to a broad range of symptoms included: elated and depressed moods, hallucinations, anhedonia, thought disturbances, and anxiety. At times people felt disturbed and engulfed by their symptoms to such an extent that, unless assisted, it was very difficult to consider work in a constructive fashion (though they could worry about it). Reduced energy and limited concentration, and low levels of self-esteem and social confidence were the main symptoms which diminished capacity to work and plan return to work.

Previous studies have identified the negative impact of symptoms related to depression (Adler et al 2006, Kessler et al 2006, Lerner and Henke 2008), psychoses (Krupa 2004, Gioia 2006), and a range of general mental health problems (Honey 2003, Russinova et al 2007, Blank et al 2008, van Niekerk 2009). These studies have generally focused more on social factors (such as stigma and support) than on symptom impact, although exceptions include: Gioia's (2006) study into work delay following first-onset psychosis; and Michalak et al's (2007) investigation of the impact of bipolar disorder on participants' work experiences. Seymour's (2010) review of predominantly quantitative evidence found severity of mental health symptoms to be a key variable affecting job retention. Our findings add explanatory detail suggesting that there are times when people can simply feel too overwhelmed by their symptoms to work. However, this did not mean that work was unimportant to participants, nor did it preclude the possibility of helping people to participate in discussions about returning to work, even at an early stage. These were points considered particularly important by both the ASUP and RSUG.

This supports the biopsychosocial perspective that therapies and other strategies for managing symptoms are of great importance for people seeking to retain employment. Participants needed to consider how these strategies could be integrated into their lives – for example, the timing and dosage of medication in relation to possible side-effects, and how a person might access talking therapies in the context of their daily routine. But, as Lerner and Henke (2008) found, whilst symptoms have an impact on work performance,

alleviation of symptoms only had limited effects on work-related outcomes – indicating a need to understand the multidimensional mechanisms involved in inhibiting and promoting vocational success.

Identity

One such factor, which can combine with symptoms to influence mental health recovery, was how people viewed and felt about their identity; in particular, the sense of themselves as a worker. Work mattered to participants during their recovery because it influenced how they perceived themselves, as well as how they considered others viewed them. Disruptions to worker identity were not welcomed (not even for Yvonne, who had expressed a view that in some ways she would rather have been able to dedicate herself to parenting). During recovery, even those who disliked or hated their jobs remained attached to the idea that work would play some role in their lives.

There is a widely shared view, with a strong basis in evidence and theory, that the meanings which people attach to their occupations contribute to forming and developing their identity (Bradley et al 2000, Dickie 2003, Wilhelm et al 2004, Wilcock 2006). Accordingly, disruption to engagement in working life has the potential to erode a person's sense of self, with negative impacts on confidence, mood and self-esteem. This was experienced by our participants, particularly where they did not have a range of alternative activities available to them.

Having a worker identity seemed to matter to participants, in part because it was under threat, but also because it had the potential to be a motivational mechanism, supporting a successful vocational and general mental health recovery. This is consistent with Leufstadius et al's (2009) finding, in their qualitative study of Swedish people with persistent mental health problems, that meaningful work supported a sense of identity and fostered recovery. It also challenges Honey's (2003) rejection of the utility of the concept of worker identity to understanding the vocational experiences of people with mental health problems.

The relationship of worker identity to motivation and hope coheres with two empirically based theories that consider the impact of unemployment on well-being. Firstly, Jahoda (1982) concluded that hope helped to sustain unemployed workers' continuing identification with their previous trade. Secondly, in their 'incongruence model', Paul and Moser (2006) proposed that psychological distress is experienced by unemployed people because their motivation and aspiration to work is frustrated by their

current situation. Although not actually unemployed, the situation for our participants was often similar; their desire to work could be frustrated because they were on sick leave, increasing distress and – as we also found – feelings of self-blame and guilt. Like Jahoda, we too found that hope could counteract these mechanisms by helping sustain concepts of the self as a worker and support what Masten (2001) has typified positive adaptation in adversity.

Andresen et al (2003) identified ‘finding hope’, and ‘establishing identity’, as key processes of mental health recovery. This is in line with our findings; however, Andresen et al’s proposed stages of recovery may be too rigid, particularly in presenting their later stages of rebuilding and growth as *following* one of the earlier stages of awareness. By contrast, it appeared that some of our participants developed their awareness *through* rebuilding and growth. Others struggled to rebuild because of diminished occupational and social opportunities to support the development of increased self-knowledge.

One reason why a worker identity may support recovery (*if* acknowledged and harnessed) is that it provides an alternative self-image to that of a ‘patient’, overwhelmed by their illness and passively waiting for a ‘cure’. It has been suggested that positive self-identity is a key internal resource in promoting the resilience of people facing a range of adversities (Lefebvre and Levert 2006, Ungar et al 2007). This may explain that many of our participants remained attached to their identification as workers, because they found it could help to anchor them in relation to symptoms and distress that can engulf people – especially during acute episodes (Provencher et al 2002, Millward et al 2005, Yanos et al 2010b).

Andresen et al (2003) typified resilience “as a quality of the [final] growth stage” (p592), and thus as a potential outcome to be measured. My thesis questions this analysis by identifying resilience as a resource which our participants were challenged to deploy and develop from the onset. Indeed, there was evidence of Gavin having previously increased his resilience from often negative past experiences of job loss. This occurred in a manner consistent with a view that resilience can develop, not only through a successful recovery but also through more limited survival (Polk 1997, Werner and Smith 2001, Cyrulnik 2009), or experiences of ‘innoculated resilience’ (Hart et al 2007) that bolstered their worker identities.

Sustaining worker identities helped some participants to access past evidence of themselves as competent. However, not all participants’ views of their performance at work were positive. This appeared to be a further source of the feelings of guilt and self-

blame, which emerged in greater measure here than in other studies. Such feelings were considered by members of both the ASUP and RSUG to be important and powerful findings, with one advisor describing how a participant appeared to be “damning himself”. The potential for worker identity to act as a positive asset could thus be undermined by negative self-interpretations of efficacy at work, as was also suggested by Michon et al’s (2005) systematic review, and by Busch et al (2007). A similar process was discerned by Coutu et al (2007), in their comprehensive review of the research on the coping strategies of workers with musculoskeletal disorders, leading them to conclude that workers’ self-representations were an important factor in the return-to-work process. Our findings show that this may also be the case for many people on sick leave with mental health problems.

The presence of feelings of guilt and low belief in self-efficacy at work may explain why reappraisal strategies were beneficial. The Retain study highlighted how reappraisal helped people challenge self-blame, recall past achievements at work, and construct images of themselves as efficacious workers. This was an important precondition to help our participants feel that they were entitled – and indeed deserved – to seek support and accommodations in their return to work. Put starkly, if you blame yourself for problems at work you may not feel you deserve remedial accommodations. If you consider yourself incapable of working effectively you may not think that such accommodations could help anyway. The mechanism here is consistent with Yanos et al’s (2010b) evidence-based model, according to which people with severe mental illness may need specific help to overcome the constraints of their identity as someone who is ‘ill’, if they are to be able to benefit from vocational and other interventions. Yanos et al argue that Cognitive Behaviour Therapy (CBT) and narrative enhancement (involving helping people to construct stories about their past, present and future lives which pay greater attention to their strengths, opportunities and potential agency) may be particularly helpful for this. Whilst not labelled either as CBT or narrative enhancement, the process of reappraisal, as described by participants, shares common features with both. Thus, participants were supported to question and challenge beliefs and assumptions about their capacities, in ways that resemble CBT – except with a more direct workplace focus and involvement than traditional CBT. The participants were also encouraged to review and reconstruct a narrative of their life story and its future potential in a manner akin to narrative enhancement. Further evidence for combining cognitive and narrative approaches is

provided by Roe et al (2010), this time as part of a structured group approach, which has some resonance with elements of the Retain support group.

The RSUG emphasised the importance of this reappraisal, or ‘reframing’ as some preferred to describe it. They drew attention to how it appeared not just to involve challenging negative thoughts but to support clarity of reflection or, in the words of one member, “to find a pathway through the fog”. Whilst reappraisal itself was not identified by the ASUP, issues, such as low self esteem and “black and white thinking”, which reappraisal could address were highlighted. They also noted the value of how one participant drew on past successes to help them persevere in their current adversity, in a manner consistent with narrative enhancement.

Work therefore mattered to participants’ identity during recovery, both because it was under threat and also because it was a potential source of strength. Participants’ feelings that they had to some extent been abandoned by their workplaces also contributed to undermining their identity and status as a worker. Furthermore, the same process appeared to estrange them from the sense of purpose that work could provide. By maintaining their identities as workers, participants could sustain self-images of themselves as potentially active, efficacious people. This provided a supportive challenge to the passive patient identity that their situation was conferring upon them.

The concept of *personal capital* (Phillips 2010, Scambler and Newton 2011) appears helpful to understand the ways in which people used identity and related personal factors as resources. Phillips (2010) presents personal capital as a collection of inner resources which, alongside social capital, can enhance self-esteem and identity, particularly when challenged by adversity. Her use of the term is similar to Scambler and Newton’s (2011), which, in a study of parents of children with Batten’s disease, they identify as developing partly in resistance to exclusion from other types of capital. They view personal capital as key to their participants’ ability to deploy other forms of capital. Although our research context is different, the same could be said to apply. This may particularly be the case in relation to the use of identity as a resource described by the ASUP as a process involving the extent to which people “owned” positive thoughts for recovery. Other personal resources which the advisors discerned were participants’ ability to handle stress, think and talk about issues that cause them “grief”. Thus on the one hand, our participants’ personal capital risked being diminished by the impacts of their mental health problem and by being on sick leave; on the other hand, they deployed their personal capital in order to access social and occupational capital. The latter enabled people to initiate what Rutter (1999)

has described as a positive chain reaction in an adverse context. In their study of return to work experiences of Canadian workers after acute mental illness, Hatchard et al (2012) describe this process, finding that “Accessing personal strength was integral to managing RTW [return to work]” (p47).

Environmental assets

Two major environmental assets emerged as having significant roles in participants’ return-to-work trajectories: these were financial and social resources that, as with other assets, were both under threat but which also had the potential to support recovery.

Financial assets

Participants experienced short-term financial problems due to reduced sick pay and loss of overtime. They feared the consequences of this continuing if they were not able to return to work, or if they had to return to work on reduced hours. None felt financially better off. For some, as recently reported in a Canadian qualitative study (Hatchard et al 2012), financial concerns were an additional pressure to return to work before they felt ready. Irvine’s (2011) qualitative research into the influence of sick pay on sickness absence for people with mental health problems in the UK suggests that this may fuel unproductive ‘presenteesim’. Our research has highlighted an additional – and arguably more concerning – danger, that a premature return to some work roles (e.g. driving) could prove dangerous both to the worker and to others. We also found that money worries could form a barrier to contemplating a staged return to work. This in turn fuelled an anxiety that their return might be unsuccessful, with further financial, and broader, consequences.

I have already noted that the financial position of people temporarily off work has been overlooked in the public debate about disability benefits. However, our findings of unevenness in the amount and duration of sick pay are consistent with the Workplace Employment Relations Survey (Kersley et al 2005). This is also confirmed by a recent independent review of the UK sickness absence system commissioned by the Department of Work and Pensions (Black and Frost 2011), which acknowledges that employees can often unfairly bear the burden of the financial cost of sickness absence. This report proposed that costs be shared more equally between employee, employer and state; the Government’s response was scheduled to be published in November 2012 but was still pending in December 2012.

We found evidence that financial strain may be an important mechanism which undermines people's resilience in coping with other problems they face. Other studies from different settings have reached related conclusions, emphasising that poverty is an environmental challenge to which individuals, families and communities may respond with varying degrees of fortitude (Netuveli et al 2008, Sanders et al 2008, Abelev 2009, Griffiths et al 2009). However, Canvin et al (2009) have argued that locating poverty as part of the context of adversity leads to a risk that it is accepted as an invariable factor which cannot be challenged. Accordingly, better outcomes may be achieved by helping to improve the financial position of people on sick leave, rather than by trying to help them cope with financial challenges on top of their other issues.

Social assets

Bradley et al (2000) maintain it is important to understand "the ways that work can provide people with resources other than the purely financial" (p186). We found this as well, and notably with regard to the assets comprised by people's social relationships at work. It was not just workplace relationships that were important to people's working lives, but also relationships with family and friends, health and vocational professionals, and peers. Alongside this, however, we found that some aspects of these relationships could also form barriers to positive return-to-work trajectories. This was either because such relationships were limited, or because some relationships could in themselves be problematic.

Understanding relationships as potential assets, which people had variable access to and experiences of, suggested that the concept of *social capital* could be helpful in exploring the mechanisms at work here. Vassilev et al's (2011) literature review concluded that insufficient attention has been paid to the role of social networks and social capital in the self-management of chronic illness, and our findings may go some way to help address this. Portes (1998) discerned consensus supporting a definition of social capital as standing "for the ability of actors to secure benefits by virtue of membership in social networks or other social structures" (p6). Whilst not focused on people on sick leave with mental health problems, a range of studies have found links between levels of social capital and mental health (De Silva et al 2005, McKenzie and Harpham 2006, Irwin et al 2008). Identification of robust evidence that explains the role of social capital as a mechanism that enhances mental health appears to be limited by the complexity and varying understandings of the construct. However, the derivative concepts of *bonding* and

bridging social capital are, according to Almedom (2005), particularly relevant to mental health issues. *Bonding social capital* is defined as an intra-group relation, and is present where a group is “inward-focused and characterized by homogeneity, strong norms, loyalty and exclusivity”. This contrasts with *bridging social capital* which “is outward-focused and links different groups in society” (Mckenzie 2008 p367). Both concepts appear useful for the purposes of understanding the shifts in access to work-related social capital experienced by our participants.

Bonding social capital and stigma on sick leave

There is a risk that the term ‘bonding’ is seen as implying that relationships need to be close or intimate in order to act as an asset. In fact, our participants valued contacts at work which often had little close emotional content. Holmes (2007a) too, found everyday conversations and ‘banter’ to be an important dimension of people’s enjoyment of work as well as a source of creativity. Indeed, acknowledgement of a person’s productive and creative efficacy at work, provided through such non-intimate relationships, may bolster well-being by enhancing self-esteem. According to Jahoda (1982), the value of relationships at work to a person’s well-being may lie precisely in their usually being of less emotional intensity than familial relationships. It is possible that relationships of this kind may be particularly valuable to those recovering from mental health problems, whose family relationships are often subject to particular strain (Biegel et al 2007, Zauszniewski et al 2008, Zauszniewski et al 2009). This could also be because workplace relationships may be governed by a more structured set of norms than in family and wider community life. Herein might lie part of what Strickler et al (2009) perceive as the therapeutic potential of work, whereby working places a demand upon people to draw on and put into practice their illness-management strategies.

As well as missing those positive social contacts when they went on sick leave, some participants reported problematic relationships at work which weighed heavily on their minds during recovery. For these people, the erosion of their bonding social capital at work began before going on sick leave. This process appeared heightened in cases where people cited interpersonal conflicts at work as triggering or exacerbating their mental health problems. Indeed, a range of studies (Fuhrer et al 1999, Melchior et al 2003, Merecz et al 2009, Rospenda et al 2009, Eriksson et al 2011), across different contexts and using differing methodologies, have presented evidence that interpersonal conflict at work can contribute to mental health problems, rather than simply being a consequence of or

associated with them. We found the negative impact went further still. Cultures of high stress, lack of mutual support, and bullying became deterrents to contemplating return to work – a finding which is also indicated by research in other contexts (Ylipaavalniemi et al 2005, Eriksson et al 2011). Thus, it is not surprising that participants worried about what might happen when certain workplace relationships were resumed.

Some feared they might experience stigma on their return. This included what the RSUG described as a fear of being labelled as someone who can't cope. The ASUP related the fear to a social perception that having a mental health problem was a sign of weakness and they considered it a key reason for hesitancy around disclosure. Such fears were present even when significant interpersonal difficulties at work had not yet occurred. Experienced or anticipated stigma, from either managers or colleagues, increased participants' sense of vulnerability; conversely, positive support increased confidence. Our analysis suggested that experienced stigma (from managers or colleagues) and anticipated stigma, while related, should be understood as separate mechanisms which can affect return-to-work trajectories.

Anticipated stigma was often grounded in people's experiences of actual stigma. Michalak et al (2011) report similar findings. However, it also appeared to be related to a process suggested by other authors (Brohan et al 2010, Yanos et al 2010a) of individuals with mental health problems internalising socially stigmatising discourses about mental illness – for example what a RSUG member termed as “media images of scroungers”. Negative thinking arising from participants' mental health problems and increased isolation from being on sick leave may have also fuelled anticipated stigma. This may have produced what an ASUP advisor termed the “double challenge” of disclosure, involving publically showing vulnerability to others and admitting this to oneself in speaking about it.

As shown earlier, some qualitative job-retention-related mental health studies have focused on experiences of stigma (Auerbach and Richardson 2005; Gioia 2006), while others have looked at both fears and experiences of stigma (Provencher et al 2002, Honey 2003, van Niekerk 2009); however, the potential implications of this distinction have not been developed in these discussions. Such a distinction may be important in intervention terms, with Thornicroft et al (2009) and Corrigan et al (2011) suggesting that, as well as countering stigma and discrimination by others, interventions should seek to bolster individual self-esteem. The Retain project appeared to do just this. Fears of stigma were addressed by encouraging the worker to review and reappraise their situation, and

experiences of stigma were addressed by interventions involving educating co-workers. In line with Corrigan's (2004) proposals, supervisors were targeted because of their positional power. As part of this the RSUG judged education was particularly significant and involved elements of encouraging adherence to company policies and equality legislation. Participants were also helped to develop confidence and to evolve strategies to challenge stigma.

Even where our participants had problematic relationships at work, they missed this social world and everyday conversation. When on sick leave, people's membership of their workplace social group was suspended or attenuated. This influenced the extent to which they felt they were part of a wider societal group of employed people. For some, access to bonding social capital was reduced further as a result of their feeling cautious about making public contact with friends from work or elsewhere, for fear of exposure to stigma or unwanted questioning. This is consistent with Brohan et al's (2010) finding that there is an association between increased self-stigma and social isolation; while they considered the direction of the causal link remains uncertain, our findings seem to suggest both produce, and are produced by, the other.

Limitations of bridging social capital on sick leave

Since participants on sick leave no longer felt part of their workplace group, attempts to maintain connections with people at work appear much more akin to bridging than bonding social capital. As McKenzie (2008) suggests, bridging social capital tends to be weaker than bonding capital because ties between groups are often weaker than those within. This may explain the often limited collaboration and co-ordination across the different realms of work, health and personal networks. Participants rarely filled the vacuum created by reduced work-related social contacts while off work. Compared to the regularity of workplace contacts, forming or maintaining friendships when on sick leave requires extra efforts precisely at a time of reduced energy and lowered confidence. Reduced access to bridging capital may be particularly problematic if Usher's (2006) conclusion that bridging social capital appears more important to health and well-being than bonding is transferable to this context.

Portes (1998) and De Silva (2005) suggest that social capital held by some groups can exclude others. A few participants' experiences suggested that they were victims of conscious attempts by co-workers or supervisors to limit their access to workplace social contacts before and after going on sick leave. For most the exclusion did not seem

conscious; rather, it arose as a consequence of the pre-eminence accorded to work, such that, once suspended from the realm of work, participants became excluded from an asset to which they had once had access.

Social networks beyond the workplace

Isolation commonly increased for participants when on sick leave because, being away from work, they had less access to *structural social capital* – where this is defined as “the relationships, networks, associations and institutions that link people and groups together” (Mackenzie 2008, p367). This had direct and indirect causes. The direct cause was the reduced opportunities for access via their workplace to formal or informal workplace social events and networks. The indirect cause was that even social opportunities away from the workplace were more accessible to those who were currently working, for instance, by conferring a ‘legitimacy’ to be engaged in leisure and having the means to pay for it.

The main alternative forms of *structural social capital* available to our participants were family and friends, mental health services, and peer support. The availability of these depended on what existing assets of this kind people had at a micro-level, as well as on the impact of macro-level policies influencing the development and accessibility of various resources.

Family

Confronted with the loss of social contacts and support through work, some participants turned to their families. Not everyone had close family to turn to and responses were not always experienced as positive. RSUG members confirmed this and added that even well-intended support from family members could be experienced as a form of pressure. Some families displayed highly protective attitudes, urging caution with regard to prospects of participants returning to work. Carer narratives suggest that some adult health and social care services neglect or dismiss similar familial concerns (Wilkinson and McAndrew 2008, Kartalova-O’Doherty and Doherty 2009, Singh et al 2010, Lloyd 2011). Arguably, protective attitudes of families could form an obstacle to building bridges and restoring the bonds between individuals and their workplaces. However in our study, such attitudes arose in contexts where there was strong evidence of toxic work environments, or when there had been very limited discussion about how a return to work could happen in a constructive manner. The implication is that family concern was not a barrier in and of itself, but an understandable position emanating

primarily from real problems in the work environment or from inadequacies in return-to-work planning.

Mental health services

Mental health services – acute, day and community NHS mental health services, and the Retain project – were the second main alternative form of structural social capital available to participants. Our findings suggested that these sources of structural social capital were characterised by certain limitations. Consistent with a number of findings (Mind 2004, Garcia et al 2005, Care Quality Commission 2009, The Schizophrenia Commission 2012) and experiences of ASUP advisors, participants who had spent time on acute psychiatric wards experienced these places to be transitory and challenging places where it is difficult to socialise. Important exceptions to this were connections related to having shared identities with co-users of mental health services. Acute and community day services provided more structured opportunities for social contact and ASUP advisors suggested that this may have reduced isolation. However, for our participants, these social contacts did not equate to the degree, nature or regularity of those which most had had at work. Moreover, as Soderberg (2010) found in return-to-work research in Sweden, some participants may have been bonded into mental health networks that did not always have sufficient bridges to the working realm from which they were estranged.

One possible explanation for this is suggested by Marwaha et al's (2009) research, which drew attention to the negative impact of low expectations that clinicians have of their clients' capacity to work. This research was carried out with regard to unemployed people with severe and enduring mental health problems. There was, however, no direct evidence indicating that this attitude was operative to any significant degree within our two case studies. What was more of an issue was that many of the acute mental health service users had absorbed the message from those services that thinking about work could wait, something which echoed the Care Quality Commission (2009) inpatient survey findings. Seymour's (2010) related conclusion, that there is insufficient early support to help people with common mental health problems return to work, suggests that this may have been a problem for the community-based participants had they not been using the Retain project. The problem with services postponing consideration of work issues was that this left people alone, with concerns about their jobs weighing heavily on their minds. Furthermore, preliminary return-to-work discussions and planning, which could have been

helpful to their recovery, may have been delayed. Conversely, where health professionals did engage with participants about their work, this was welcomed and found positive.

One of the strengths of the Retain project lay in the way it built bridges that enabled people to restore or strengthen their connections with their working lives. The RSUG drew particular attention to the practical hands on nature of work-related support in contrast with some experiences of GPs and mental health services. They also challenged me to reconceptualise an initial characterisation of Retain acting as an advocate to one of supporting self-advocacy – though as one advisor was keen to emphasise they were still considered to be “on her side”. By contrast ASUP advisors remarked on a clear need for more work focused support in the accounts which they discussed.

Bridges between Retain and other mental health services, however, appeared less well developed. One of the evidence-based principles for supported employment interventions is that vocational services should be integrated with mental health services (Bond 2004). This was not the case with Retain, yet we found they were still able to deliver high-quality services. Waghorn et al (2011) found that the outcomes of an integrated and a non-integrated mental health employment service were of a comparably high standard in New Zealand, concluding that this suggests “that service integration is important, but neither necessary nor sufficient, for high performance” (p346). It may then be that Retain’s strengths in other areas mitigated for lack of mental health service integration. Alternatively, since job retention clients usually appear to have less severe needs than those receiving supported employment interventions, it is possible that integration is less important – or that it would be more relevant for it to be focused on GP practice and primary care, or in the form of an integrated partner for IAPT services.

Peer support

Peer support formed the third type of structural social capital available to people estranged from their workplaces. This was particularly apparent for users of the Retain support group which the RSUG stressed seemed to reduce feelings of isolation, increase confidence and provide a forum for sharing problem solving strategies. Peer support processes were also manifest in less formal guises for others, for instance the mutual support and empathy shared by some users of inpatient wards, as also found by Jones et al (2010). Mental health research generally has provided theoretical and evidential support for the significance of peer support (Solomon 2004, Lawn et al 2008). I argued in Chapter 3 that careful examination of findings of some research pertinent to job retention suggests

that peer support – of either a formal or informal nature – is valued by participants and may influence positive vocational outcomes. Our findings draw further attention to this; peer support seemed effective in two aspects, both of which can be expressed in terms of social capital. Bonding social capital was evident in the connections people made with others in similar situations, reducing feelings of isolation and self-blame held by some participants. Meanwhile, peer support also facilitated bridging social capital by increasing confidence and providing people with transferable problem-solving strategies that they could use to support a sustainable return to work.

Social capital and resilience

Participants' experiences can be understood, then, as involving a sudden loss of work-related social capital. For some this had already been eroded before they went on sick leave. No studies were identified which have directly considered the loss of social capital experienced by people with mental health problems on sick leave. There is, however, a body of literature which elucidates the operation of social capital within the workplace, explaining how ties and connections between people at work can vary and so have correlative impacts on well-being and health (Morrow 2001, Kouvonen et al 2008, Oksanen et al 2010, Suzuki 2010). This gives some insight into how difficulties in social relationships at work may have contributed to some participants' mental health problems, and how positive support may have helped return-to-work trajectories. It also provides a further explanation for why work remained important to people even while on sick leave.

Social capital can foster resilience (Bottrell 2009, Griffiths et al 2009, Bryant et al 2010, Kretzmann 2010), *Resilient Therapy* literature and resources emphasise the importance of relationships and social networks in providing a resource for resilient practices or 'moves' (Aumann and Hart 2009, Hart 2011). These perspectives support the value of ecological understandings of resilience, as opposed to those which are centred on the concept as an individual attribute (see Chapter 4). McKenzie (2008) suggests there is a similar debate with respect to social capital, showing that those authors who follow Putnam's (2009) writings tend to interpret social capital as a property of groups, whilst those who follow Bourdieu's (2004) interpretation tend to see it as an asset which resides within the individual. My interpretation is that since social relationships involve individuals and their social environment through a process of *interaction*, social capital resides not just within individuals and their environments, but in the interactions between the two. Access to social capital for our participants derived from restrictions and

strengths affecting their internal socialising capacities (e.g. mood, self-esteem, confidence, anxiety, motivation) as they *interacted* with external restrictions and opportunities for social participation (e.g. contacts with colleagues and friends, presence or absence of stigma, arenas for social participation outside work, mental health service provision and ethos). Social capital exerts its influence at both micro- (the direct) and macro- (the indirect) levels (Almedom 2005, Falzer 2007). Without this interaction between the individual and the environment, social capital is not realised and the potential for resilient moves reduced. All three elements would appear to be essential – individual, environment, and the interaction between them. Multi-faceted strategies are therefore needed to help people with mental health problems to retain employment.

Occupational assets threatened and deployed

Just as the social dimension of life involves interactions between person and environment, so too does the occupational. Just as it was difficult for participants on sick leave to replace the regularity of workplace social contacts, the same can be said of replacing the occupation of work. This in turn, helped to keep work prominently in their minds, via two dimensions. They faced the loss of the structure that work brought to their daily lives, and participants were deprived of the activity, or ‘doing’, of work itself. The nature of these changes suggests that, despite some attempts to deploy alternative occupations, people experienced a restriction in ‘occupational’ assets. A suitable term for these assets seems to be *occupational capital*.

Structure, routine, work demands and ‘life-work balance’

The social psychologist Jahoda (1982) considered that a prominent consequence of sudden unemployment is:

the enforced destruction of a habitual time structure for the waking day ... when this structure is removed as in unemployment its absence presents a major psychological burden ... Days stretch long when there is nothing that has to be done; boredom and waste of time become the rule. (p22)

Our participants experienced this sudden destruction when they had to go on sick leave – a point of particular significance to ASUP advisors. Parkinson (2004) noted that acute mental health treatment involves removing people from their usual daily routines and environments. These comprised the twin rationale for her intervention which aimed to restore routine for people using acute psychiatric wards (Parkinson 2004). We found disruption to routine was also a major challenge for participants who were using community-based services – even though dislocation from their home environment was at

a lower level than with users of acute mental health services. They also all faced the additional burden of factors more directly related to their illness which could affect their ability to adopt a habitual time structure – as suggested elsewhere by occupational therapy research (Minato and Zemke 2004, Haertl and Minato 2006, Leufstadius et al 2008, Kelly et al 2010). This could be as a consequence of a range of impairments, such as disturbed sleep patterns (Novak 2010), difficulty concentrating (Baune et al 2010), lack of motivation (Neville-Jan 1995, Nakagami et al 2008), and fatigue (Williamson et al 2005).

Problems with time structure at work, and participants' worries about how they would manage when they returned, may then be explained as arising from the way in which their mental health problem disrupted their ability to sustain routine and from the loss of the scaffolding of a working day to support routine. Yet, in line with Karasek's (1979) job-demand-control model, and consistent with Hausser et al's (2010) related meta-analysis, our evidence suggested that job task demands explained many of participants' concerns. Associations between excessive job demands and taking sick leave (Borritz et al 2006, D'Souza et al 2006) are also congruent with these concerns.

That the time structure imposed by work could restrict other areas of participants' lives, or leave them too tired, runs counter to aspects of some of the well-constructed challenges to the concept of 'life-work balance'. These challenges call into question whether work is always experienced differently from other areas of life (Primeau 1996, Lobo 1998, Runté and Mills 2004, Fincham 2008). Semantic objections could be raised to a term that somehow implies work is not part of life. Perhaps the 'life-work' dichotomy reflects a resentment of the detrimental aspects of the impact of work on a person's quality of life, experienced by a number of our own participants. A critique of the concept of 'life-work balance' need not negate evidence that work can lead to exhaustion (Bradley et al 2000, Bültmann et al 2002), and have negative impact on a person's life away from work (Schieman et al 2009, Kinnunen et al 2010). The experience of our female parent participants was consistent with evidence that women tend to experience the most negative impacts of such time conflicts between work and home life, in the UK (Emslie and Hunt 2009) and internationally (Canivet et al 2010, Deding and Lausten 2011).

Occupational deprivation

Consequences of reduced engagement in activity itself, need also to be considered here. The concept of occupational deprivation offers some understanding of this process. 'Occupational deprivation' is a term which describes the position of individuals or

communities who find that their participation in occupations is restricted, by factors beyond their control, to a degree which risks undermining their health and well-being (Whiteford 2000, Wilcock 2006). The concept has been applied to the position of immigrants, refugees and ethnic minorities (Kronenberg et al 2005, Whiteford 2005, Zeldenryk and Yalmambirra 2006, Brown 2008b); people in prisons or forensic mental health units (Whiteford 1997, Molineux and Whiteford 1999, Farnworth and Muñoz 2009); older people in institutional care (O'Sullivan and Hocking 2006, Hocking and Wright-St. Clair 2011); socially disadvantaged children (Mapham et al 2004, Bazyk 2006); and homeless adults (Duncan 2004). Occupational deprivation is a construct relevant to the situation of people with mental health problems on sick leave. Gruhl (2009) characterises the consequences of some mental health services' insufficient consideration of clients' occupational needs through the concept of occupational deprivation. In a qualitative study of three unemployed women with physical or sensory disabilities, participants risked experiencing occupational deprivation as a consequence of occupational imbalance resulting from the inflexibility of care and support services (Jakobsen 2004).

Our findings suggest that occupational deprivation can be experienced even in relation to jobs that have negative or mixed appraisals. Worries about work did not disappear when participants were on sick leave – indeed, for some they appeared to grow. Despite not feeling able to work, they were struggling to cope with the loss of the regular activity. This added more challenge to those they faced already.

The occupational deprivation of some participants seemed to involve missing stimulating and enriching aspects of working that they had previously valued. This included physical activity and the experiences of positive emotions associated either with achievements or with immersion in absorbing and challenging tasks. Missing experiences of engagement in skilled and challenging tasks is consistent with findings and theories concerning the well-being felt during occupational engagement (Csikszentmihalyi 1992, Creek 1998, Wilcock 2006, Sennett 2009, Gauntlett 2011). If work is a major source of such optimal experiences (Csikszentmihalyi and LeFevre 1989, Jacobs 1994), then this could explain some of the feelings of loss which our participants felt. Participants described using a range of other occupations to try and promote their recovery. Some occupations appeared to fall into Wright et al's (2007) 'positive distraction' category (see Chapter 2), conferring transitory benefits – though both ASUP and RSUG advisors suggested that even if transitory, benefits could be important in terms of "providing a workout for the brain", relieving "boredom" and diminishing the extent to which people

felt overwhelmed by suicidal thoughts. Those described in more enthusiastic terms (e.g. Ben's new hobby and Penny's facilitation of an aromatherapy group on the ward) were, by contrast, aligned with the 'challenge-skills' experience which Wright et al (2007) found had more enduring benefits.

Attempts made by participants and supporters to compensate for the loss of the regularity of work through other activities were restricted by a range of factors. The activities provided by inpatient units and acute day services, although generally valued, were limited – as other studies have consistently found (Sainsbury Centre for Mental Health 1998, Garcia et al 2005, Care Quality Commission 2009, The Schizophrenia Commission 2012). Some were able to initiate activities themselves, but were constrained by difficulties in accessing opportunities and ASUP advisors thought it unfortunate that such occupations often appeared to be of a solitary nature. As Antonio's (2007) personal narrative explains "there are two sorts of 'boring' on the ward" (p33) one type arising internally, the other from the environment. Difficulties arose from internal reasons, such as low motivation, confidence, concentration and fatigue. This is in line with Martin et al's (2012) findings that boredom can arise from internal reasons such as reduced attentional capacity and negative attitudes – features of mental health problems or medication side effects that our participants reported experiencing. Yet external factors caused difficulties too because of restricted availability of opportunities, such as community resources or inpatient programmes, or not being referred to therapeutic activities. Some people expressed a fear of how others might respond to them, particularly if seen publically engaging in activity at a time when they felt that the legitimacy of their absence from work was already in question. ASUP and RSUG advisors as well as participants in research presentations were keen to confirm this finding, and it seems to equate to what Thornicroft (2006) has characterised as 'felt' or anticipated stigma. Consistent with Jahoda's (1982) accounts of the impact of unemployment, none of these activities came anywhere near to filling the void left by cessation of work, either in terms of time or loss of a whole category of activity

Participants missed the sense of being productive, and worried about regaining purpose and achievement. This resonates with recovery accounts (Deegan 2003, Gray 2006, Grant et al 2011) which reveal that recovery is best understood as a journey in which people seek to lead a rich and full life, irrespective of the presence or absence of mental health symptoms. Participants were striving to move forward and to overcome 'stuckness' – a central theme identified by Young and Ensing's (1999) research into service users'

perspectives on recovery. Some also found themselves preoccupied with a more generalised dissatisfaction with their work, involving a lack of identification with its meaning or purpose and with colleagues. These relate to Marx's (1977 [1932]) concept of alienation: firstly from the activity of working – akin to Arendt's (1958) concept of unfulfilling labour; secondly from what is produced; thirdly from other workers; and fourthly even from themselves – sharing communalities with Durkheim's (1997) concept of individual experiences of anomie.

The desire to reconnect with work seemed strong when it was focused on purposeful doing. This questions Eklund and Lefstadius's (2007) prioritisation of meaning over 'doing' (see Chapter 2) but is consistent with those who argue that a drive to engage in productive activity is determined not just by the product of that activity, but also by the experience of doing the purposeful activity (Creek 1998, Wilcock 2006). Many participants found themselves deprived of opportunities for purposeful doing while on sick leave and thus deprived of the potential for positive benefits of purposeful occupation. Negative consequences of this deprivation may be all the greater given that work is such a major arena for productive participation that many have argued forms part of human nature (Arendt 1958, Engels 1968, Leakey 1995, Wilcock 2006).

Occupational capital

In the same way that the established notion of social capital can be used to typify the changes to participants' social worlds, it could be said being on sick leave reduced *occupational capital*. While I am cautious about adding to the growing list of types of capital, and adding to the commodification of human activity by using terminology associated with finance, the term draws attention to what Wilcock (2006) considers to be the neglected occupational dimension in public health. I propose defining occupational capital as a combination of accessible external opportunities and supports for occupational participation and internal capacities and skills to access this. Occupational capital can be seen as what is lost or reduced as a result of occupational deprivation. Where Abbott (2010) discusses the role of participation in social capital and health, he could have used the term *occupational* as well, since some of the health-promoting aspects of participation which he describes relate to the occupational dimensions of participation. Both the range and extent of occupational opportunities, as well as the supports for participation, were diminished while our participants were on sick leave. Capacities (notably confidence,

energy, motivation) that facilitate occupational performance were also restricted by impacts of mental health problems.

Iatrogenic effects of sick leave

Personal, economic, social and occupational assets were jeopardised during participants' recovery. Mental health problems and others' responses to them were two of the major threats. If work is a source contributing to these assets, the act of removing someone from work, by placing them on sick leave, also depleted these assets. This remains the case even where it is agreed that going on sick leave was a necessary measure – as indeed appeared to be so for our participants.

Ivan Illich (1977) used the term *iatrogenesis* in his seminal work on the limits of medicine. His critique has been sustained when the more immodest claims are made for the benefits of healthcare (Abbott et al 2005). Most commonly used to describe negative side-effects of medication, iatrogenesis has the broader meaning of a “state of ill health or an adverse event that is caused by, or is the result of, a well-intended health care intervention” (Mitty and Fleming 2010 p369). Looking at negative impacts of residential institutions on older people, Klein (2002) extends the concept to encompass non-medical interventions. Without using the term, Labriola et al's (2007) large prospective survey of Danish employees provided a degree of evidence of something akin to the iatrogenic effects of sick leave, suggesting that reductions in perceived self-efficacy develop predominantly while on sick leave rather than beforehand. Fleten and Johnsen (2006) made brief reference to the concept (again without using the term itself) considering their postal intervention may have been successful because it prevented the “side effects of being sick listed” (p680) from becoming established.

Iatrogenesis seems very applicable to our findings. It does not necessarily dispute the need for sick leave, it draws attention to its side-effects, or its unintended consequences. Sickness absence needs to be conceptualised as an intervention itself, with advantages and disadvantages, and not merely a consequence of a health condition. It draws attention to the question of how to mitigate these negative effects.

There are parallels to Merton's (1936) unintended consequences which influenced Jahoda's research (1972, 1981, 1982) on how unemployment affects psychological well-being. In this Jahoda developed her theory of the latent benefits of employment – the loss of which presented additional challenges to unemployed people, undermining their psychological well-being. This resonates strongly with our findings. Jahoda identified

five categories of experiences which she considered were unintended consequences of work, *additional* to the manifest benefit of income. The five categories are: time structure, social contact, connection to wider social purposes, status/identity, and activity. While employed people are often troubled by the quality of their experiences in these five categories, unemployment really brings suffering from the diminished experience of these categories *per se*.

Thus, while on sick leave, mechanisms related both to the quality of work experiences and to reduced participation. This influenced participants' well-being, their thoughts and feelings about work, which shaped their capacity and attitude to plan a return to work. Some were preoccupied with the quality of their experiences at work, particularly when they saw their work as a contributory factor to their mental health problems. Concerns were also present: when the pressure of workload was excessive for the time and energy they had available; where social contacts with line managers or colleagues were negative; where they questioned the meaning of their work and its connection with their own self-identity; and where there were aspects of work tasks which they did not enjoy, or found too challenging or unrewarding. There was no substantial evidence that being away from the workplace improved problematic social relationships or negative experiences of work. Dialogue and accommodations being made to facilitate a return to work offered a possibility of achieving that for some. Even in these cases, participants struggled with the consequences of being removed from these categories of experience as a result of being on sick leave.

Scholars from sociology, social-psychology, anthropology, occupational science and applied mental health research have all indicated that disruption to work (especially unemployment) can have negative psychological effects upon people. Our findings suggest that being on sick leave brings similar negative or iatrogenic consequences. These may impact more on people with mental health problems, as they may combine with the symptoms, and the associated stigma and discrimination, in a multiplicative manner (see table 3 below).

Iatrogenic effects	x	Mental health symptoms	x	Stigma/discrimination factors
social isolation		social withdrawal		Lack of understanding of mental health issues
reduced opportunity for stimulation from participation in a range of occupations		anhedonia		being 'shunned'
reduced opportunities for productive accomplishment		low self esteem		social exclusion
diminished opportunity to obtain feedback from occupational participation		distorted cognitive self-appraisal of capacity		excessive criticism

Table 3. Examples of multiplicative combination of iatrogenic effects of sick leave, mental health symptoms and stigma/discrimination factors.

It does not follow that sick leave is an inappropriate intervention. Rather, individuals and services should urgently consider how to minimise its iatrogenic effects.

Issues of rigour, quality and limitations

As indicated in my methods (Chapter 6), I have adopted Healy and Perry's (2000) criteria for judging the quality of realist research. These are: ontological appropriateness, contingent validity, use and acknowledgement of multiple perceptions of participants and peer researchers, methodological trustworthiness, analytic generalisation, and construct validity. In what follows I discuss these criteria, integrating acknowledgements of the limitations, strengths and my thesis's contribution to knowledge.

The first two criteria are focused on ontology. *Ontological appropriateness* asks if the study "deals with complex social science phenomena involving reflective people" (Healey and Perry 2000, p122) and is thereby a suitable topic for realist research. I have sought to demonstrate that this criterion is met in my exposition of the research problem in Part 1. The complexity of the challenges of job retention for people who experience mental health problems should also be apparent from the thesis as a whole. This research tried to make a significant contribution to the limited body of qualitative job-retention mental health research. Furthermore, the methodology and method chapters (Chapters 5 and 6) aim to show that the critical realist approach was suitable for the topic.

The second quality criterion, *contingent validity*, calls for realist researchers to demonstrate that the research approach is seeking to reveal "generative mechanisms and the contexts that make them contingent" (p123). I aimed to demonstrate this in my analysis and discussion. These proposed a range of mechanisms to explain the findings.

Some insights into the contingent nature of these mechanisms, in what contexts they operate and in what they did not, were gained by use of the comparative case study design. The research also differs from much other job-retention mental health research by gathering perspectives of people while they were recovering rather than retrospectively. This has helped to show that concern about work was an active, and often powerfully felt, issue while people were recovering and not just a matter of importance recognised with hindsight. ASUP advisors were struck by just how much had happened to people in what was often a short period of time since they had suspended working, the implication being that the full range of experiences and feelings might not be recalled in a retrospective study.

A clear contingent limitation is that both case studies took place within the South of England in similar areas, and that just one National Health Service Trust and one job-retention project were involved. Furthermore, whilst a broad range of jobs were represented and both men and women were included, there was no diversity in terms of ethnicity (all describing themselves as white British), and older (above 50) and younger workers (below 30) were under represented, and just one person reported having a physical disability. The nature of the recruitment process in the acute study suggests a need for caution in the extent to which it can be assumed that other employed acute mental health services users who did not volunteer may have raised similar concerns.

These limitations are mitigated to some extent by use of the meta-study to underpin the literature review which analysed other research into first-person experiences of job retention from a range of countries and with varying groups of participants. A final contingent limitation relates to the passage of time since the data was collected, these being due to personal, health and work-related factors and to some extent to dissemination activities (though these have added to quality, as outlined below). In particular, it is possible that inpatient mental health service users' experiences of the support that they receive for their work-related needs may have changed. However, recent literature and policy cited in this and the following chapter suggests the situation remains very similar. The passage of time and relatively the small scale of the project has also encouraged me to consider identification of more general theoretical insights that are potentially more transferable to other contexts.

The third criterion is of an epistemological nature. *Use and acknowledgement of multiple perceptions of participants and peer researchers* is identified as a quality criterion in realist research because it shows consistency with the realist view that people have

multiple perceptions of a single reality. I consider that the use of service user collaborators, supervisors and peer researchers in the project helped to meet this criterion. In this, it is also consistent with Staley's (2009) literature review of the impact of public involvement in health and social care research in identifying how collaboration brought new insights and increased our understanding of the research area. Here I consider I have also made a contribution to critical research methodology, by articulating in Chapter 5 a theoretical justification for why a critical realist perspective implies a need for collaborative research that harnesses 'expertise by experience' and by demonstrating one way in which this can be achieved.

There were limitations to the extent of this collaboration. In the acute study, the advisors did not read and discuss all the transcripts. I have also acknowledged that the panel of three people would not claim to be representative of all the participants, let alone of all employed people who use acute mental health services. In the Retain study, for reasons explained in Chapter 6, the advisors only wanted to discuss themes that had been identified by myself and my co-university researcher, rather than transcripts. This clearly limited the possibility of them identifying additional emergent themes, though I have presented evidence of how their contribution led to a substantial revision of our initial interpretations with regard to Retain promoting self-advocacy rather than simply advocating for people.

My study design also sought to meet the third criterion by using multiple interviews in both case studies and by using the meta-study of other first-person accounts. Throughout my research journey, I, often with collaborators, have presented emerging research findings to various forums. These have had predominantly practitioner or academic participants, but in some cases included service users (Appendix Q). I have made use of discussions that have arisen from this activity to bring in further viewpoints – albeit predominantly mediated through my own interpretations. This criterion also implies acknowledgement of my own perspectives where they have shaped the choice of topic, this being an essential reflexive measure which Finlay (2003) has also argued for. Thus, as well as using the collaborators to challenge and question my assumptions and positions, I have also attempted to make my presence clear through the thesis, so that the reader may judge how my perspective has influenced findings. This process has been supported by use of supervision, peer discussion and reflective writing along my research journey.

The final three criteria are of a methodological nature. *Methodological trustworthiness* requires the use of measures which allow the research to be audited; notably, with regard to

processes of data collection and data analysis. I have conveyed these in the methods and findings chapters, with the support of relevant appendices.

The quality criterion of *analytic generalisation* calls for realist research to have a primary aim of building theory. This is achieved by Danermark et al's (2002) final critical realist analytical stage of concretisation and contextualisation (see Chapter 6). It is *analytic* generalisation because it is the theory that has the potential to be generalised and offer explanation relevant to wider contexts. I have certainly aimed to develop existing theory, notably, in this part of my thesis, by advancing ways in which occupational perspectives and resilience perspectives can be applied to a range of job retention and mental health contexts. I have also proposed a new concept of occupational capital based on discerning a distinct category of occupational assets which was both threatened and deployed during people's recovery journey. Resilience theory, though more commonly applied in respect to children, young people and families, appears relevant to understanding people's strengths and challenges because people found themselves in adverse contexts where there was a high risk of negative recovery trajectories risking job loss and toxic work experiences. My concluding chapter calls for both occupational and resilience concepts to each inform the other to increase their acuity. Similarly, I have argued that the existing concept of iatrogenesis can be applied, in a way it has not been before, to help understand some of the distinct challenges faced by people on sick leave. It is for the reader to judge, primarily from the discussion and concluding chapters, whether I have met this criterion of analytic generalisation sufficiently.

Healey and Perry's (2000) final criterion is *construct validity*. To meet this, realist research should be able to show that any theory that is constructed is done so in a manner that is consistent with the findings and the analysis of the research study. This can include the use of other existing theory as well as triangulation of findings. I have aimed to achieve this firstly by a comprehensive presentation of findings from the two comparative contexts and in triangulation with the literature review. Secondly, in the discussion, implications and concluding chapters, I have deployed Danermark et al's (2002) critical realist analysis stages of abduction, retroduction and evaluation of the explanatory power of mechanisms and contexts. My abductive analysis principally involved viewing the findings through the occupational, resilience and recovery frameworks. The use of these frameworks was substantiated by my literature review; this is a step which I recommend should be added to Danermark et al's stages of critical realist explanatory research. With regard to retroduction, I sought to make the reasoning apparent whereby I worked back

from the findings and explored the possible mechanisms which could account for the revealed outcomes – for instance to account for the unfolding return-to-work trajectories and suggest the ways in which financial assets and personal, occupational and social capitals can be depleted and deployed. Similarly, I hope I have demonstrated a consistent degree of critical analysis, which displays how I have weighed the potential contribution and interactions of different mechanisms and contexts; for instance, in justifying the iatrogenic effects of being on sick leave as having a discrete and additional impact on other direct and indirect consequences of having a mental health problem.

Chapter summary

Here explanations for some of our findings were related to the limited existing research into the challenges faced by people with mental health problems on sick leave. Participants in our study were employees who experienced mental health problems which severely disrupted their working lives. They needed to take significant periods of sick leave from work, and some received acute mental health care. This chapter showed that work remained important to them in two opposing but co-existing ways. Firstly, work mattered because of participants' experiences, or fears, that it could exacerbate their mental health problems. Secondly, work mattered because it was an important part of their lives, notably in terms of finance, social life, occupation and identity. These areas of their lives were under threat. Work did not matter just in the negative sense of deprivation. Worker identity, past experiences and future hopes of working, provided a source of resilience that they called upon during their recovery.

Before going on sick leave, many participants were experiencing restrictions to their occupational and social participation as a consequence of their mental health problem and others' attitudes and responses to it. Going on sick leave – which I stress again appeared a necessary measure for all – invariably added to these social and occupational restrictions. They experienced financial loss, or threats of this, and often a reduced level of confidence in their sense of identity. These processes combined to keep the issue of work high on participants' agendas, all the more so because they were away from work. Participants had varying degrees of financial, social, occupational and personal assets, which they were able to call upon to try and mitigate the restrictions and support their recovery and its sustainability. In figure 7 I present a model showing the key assets that were enhanced enabling them to be deployed to increase the likelihood of a sustainable return to work, or how they could be diminished to reduce this likelihood. In Appendix R I summarise the

key assets which were threatened or harnessed, using the subsystems from Clarke and Larson's (1993) model of the human as an occupational being as introduced in Chapter 5.

The final part of this chapter appraised the quality of the research, its strengths, limitations, key contributions to knowledge and contingent qualifications to those. My critical realist methodology has made use of newly gathered and existing evidence, logical reasoning, and theoretical concepts to understand mechanisms and outcomes. In this chapter I have argued that the restrictive and supportive processes experienced by participants can be understood in terms of social, occupational and personal capital. This implies the need for challenges to be addressed and strengths harnessed in a multi-faceted manner. Being on sick leave had consequences that, while related to participants' mental health problems, can be understood as distinct from them. These iatrogenic effects of sick leave, which have not been sufficiently acknowledged in previous research, amounted to an additional challenge to their recovery. The importance of work as a source of, and threat to, recovery, challenges assumptions that somehow the issue of work might not be a significant concern to people with jobs during this period of recovery. The workplace is a potent occupational space which can influence health and well-being – its influence endures even when people are removed from it. The next chapter will present a broad range of implications that arise from this analysis.

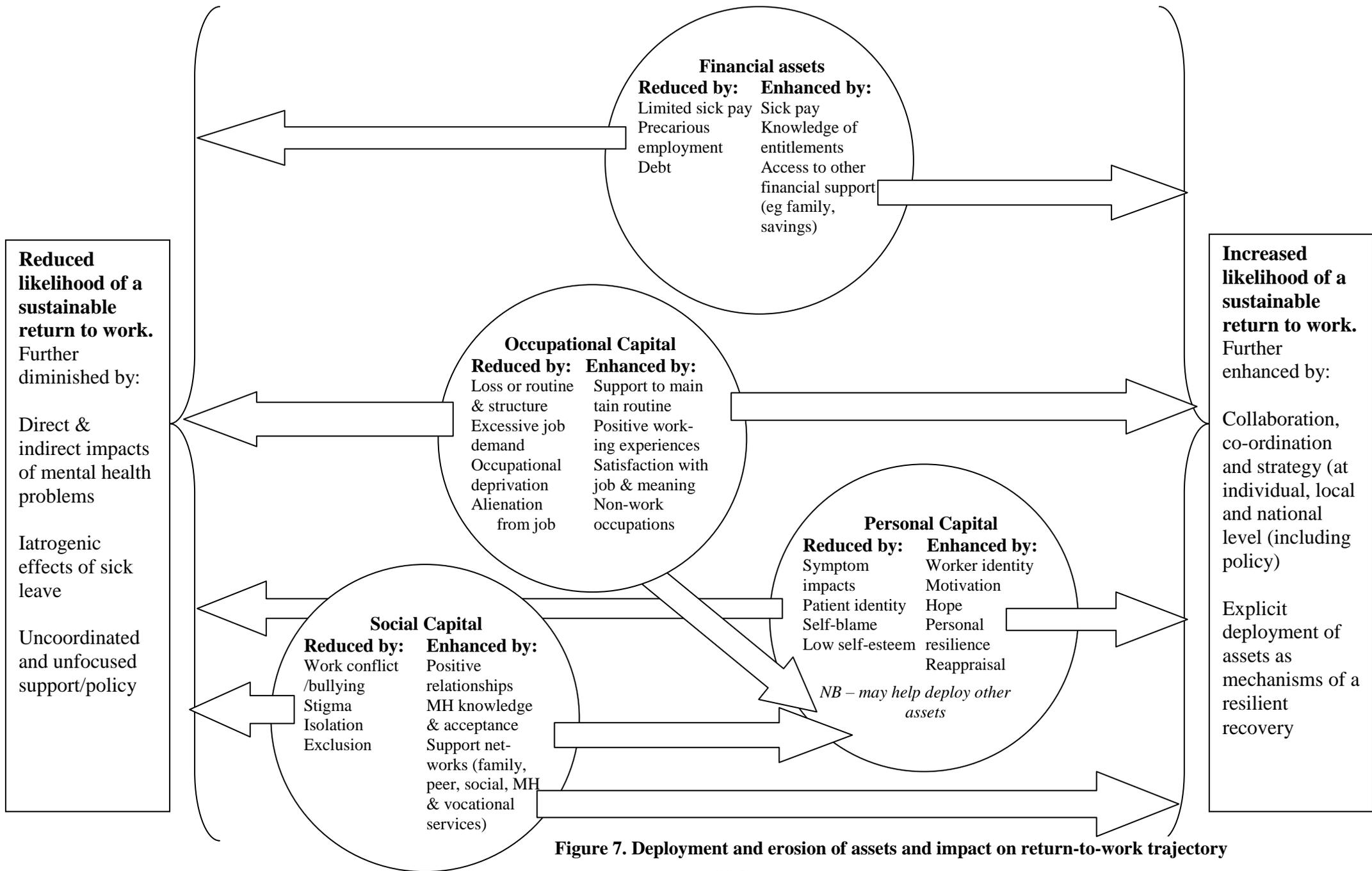


Figure 7. Deployment and erosion of assets and impact on return-to-work trajectory

Chapter 13: Implications

Our participants found themselves in complex situations. In the previous chapter I used theory and related research to bring some order to this complexity. I identified key influences upon the recovery trajectories of people whose mental health problems severely disrupt their working lives. I now develop this discussion, in line with Danermark et al's (2002) final critical realist explanatory research stage of concretisation and contextualisation, in order to make a range of proposals for addressing these disruptions. These proposals aim to be relevant to people in similar situations, as well as to those supporting them – either directly as a colleague, family member, friend or professional; or indirectly as a service developer or policy maker.

The first three sections of this chapter consider implications related to the challenges of being on sick leave. These concern the importance and means of keeping in touch with work; ways of managing the iatrogenic effects of sick leave; and suggestions as to how people can maintain their work orientation and identity. In the subsequent two sections the focus is on return-to-work planning, and how its sustainability can be promoted by the use of 'natural' and specialist support, as well as by making changes to jobs. Next, I consider how these implications relate to NICE guidelines (2009). Finally I outline directions for further research suggested by these considerations, placing particular emphasis on the avenues I consider most suitable for me to follow.

Keeping in touch with work

When people begin a period of sick leave, of uncertain and possibly prolonged duration, their removal from work risks becoming a widening chasm. Our participants benefitted when connections between them and their workplace were sustained (except in cases where there was little of value to preserve). Users of the Retain project were specifically supported to maintain (or restore) dialogue with their workplaces; however, none of the users of the acute services had similar consistently focused support. The implication I draw from this is that people should have access to such targeted support. Mental health services should be prepared to take the initiative in offering to support a person's contacts with their work. This may particularly be the case when people experience acute mental health problems. The severity of mental health problems and dislocation from work might otherwise combine to push a person's working life into the background.

The nature of contacts between people and their workplaces needs to be congruent with where they are in their recovery journey. By demonstrating concern to preserve these links, mental health services can give a positive message that their clients are respectfully viewed as having an identity that is not synonymous with their illness – however severe the impact of their mental health problem may be at any given point in time. Recovery-orientated perspectives (see Chapter 4) may help services achieve this.

Attention to detail is required – particularly in acute services – to ensure that people’s employment status is systematically checked on first contact with services, and to determine what, if any, communication there has been between the person and their employer since they were last at work. Acute Service User Panel (ASUP) advisors pointed out that sick/fit notes can offer an important, albeit limited, on-going link between a person and their workplace when on sick leave. Prompts for such measures could be explicitly included on care pathways and assessments. Details should be double-checked in case the confusion of acute admission results in inaccurate reporting or recording.

Iatrogenic effects of sick leave

I was worried that my findings about the iatrogenic effects of sick leave might be used to implicitly or explicitly criticise the legitimacy of some people’s need to take time off work. My apprehension increased when, after having responded to a call for research-based contributions to the Department of Work and Pensions’ commissioned independent review of sickness absence (Department for Work and Pensions 2011b), I was requested to provide more details about iatrogenesis. In reporting the finding I have emphasized that I found nothing to suggest that participants did *not* need to go on sick leave. Just as the iatrogenic effects associated with a range of medical and non-medical interventions do not render them unnecessary to a person’s recovery, so too sickness absence can be necessary, but also have additional negative impacts. People prescribing sickness absence, as well as people on sick leave and others supporting them, should be aware of the effects on a person’s finances, social contacts and occupational life. These should, for example, be included in discussions between GPs and patients when taking time off work is being considered. Additionally, mitigating measures are advisable to reduce unintended negative consequences.

To address the iatrogenic effect of financial hardship, health services can help people to check that they are receiving sick pay and benefit entitlements by signposting them to accessible support services. This has become one of the seven key principles of the

Individual Placement and Support (IPS) approach (Bond 2004). Our findings imply that the same should be true of job retention support. Concerns about negative financial impacts of otherwise supportive modifications also need to be addressed. In broader terms, there is an argument for all to have access to sufficient sick pay, so that worries about loss of income are less likely to increase anxiety and delay recovery. As Black and Frost's (2011) independent review of sickness absence suggests, it may even in the long term be more economically cost-efficient to provide this; though, as my arguments in the next chapter imply, the economic cost to society should not be the sole criterion which determines support.

Social isolation engendered by sick leave was a major mechanism by which well-being was undermined. People are social beings, and, for those who work, the workplace is often a source of many social contacts. I argued that even the more apparently superficial contacts may increase or preserve well-being. Those going on sick leave should be warned of the potential challenge of isolation. They should be encouraged to maintain social contacts, where possible, with colleagues at work – as long as these relationships are positive and stigma has not been experienced. For some, it may be sufficient 'to give permission' to maintain a social life, and for their employers to be aware of the value of this.

As well as finding their social capital constrained, our participants faced a loss of occupational capital. Being on sick leave dramatically changes the daily routines and occupations of those who usually spend significant time working. Many experienced this to be a void, increased by social isolation and lack of available opportunities for occupational participation. The risk was that boredom and absence of productive activity could undermine recovery. For some the contrast between routines and occupations while working, with those when on sick leave, presented a challenge that seemed difficult to bridge when contemplating return to work. While no participants described occupations which they could do on sick leave that completely filled the gap, some did find – in hobbies and in day and inpatient services – opportunities for them to feel active and in some cases productive. This indicates the potential value of helping people to find meaningful and purposeful occupations which maintain and gradually increase their activity levels. Such occupational participation can also provide an opportunity to appraise what they can and cannot manage at a given point in time.

Some people could be encouraged to resume old activities, or to commence new ones. Others may benefit from opportunities specifically designed for those recovering from

mental health problems. These may help address both social and occupational needs. For example, GPs could offer people who are signed off sick referrals to participate in an environmental volunteering activity or creative therapeutic group. Specialist mental health services should consider what activities they provide for people who are recovering from acute mental health problems, particularly in view of the enduring criticism – now over a decade old – that limited provision is made for this in many acute units (Sainsbury Centre for Mental Health 1998, Mind 2004, Sainsbury Centre for Mental Health 2006, Care Quality Commission 2009).

Short-term mental health day services may have a valuable role to play. People supported at home by crisis and resolution home treatment teams found access to acute day services helpful for both social and occupational needs – but not all had this opportunity. Mental health day services have been refocused with the expressed aim of greater social inclusion and more emphasis on individualised support, as opposed to supposedly buildings-based provision (National Social Inclusion Programme 2008, Swan 2010). The proportion of direct mental health expenditure on day services has declined from over 5% to below 3% of total spend over the last decade (Mental Health Strategies 2011). There is concern that this policy could reduce the collective and peer support that mental health service users gain from such services (Beresford and Bryant 2008, Bryant et al 2010, Bryant et al 2011). Our findings support the provision of short-term day services for those who would otherwise experience a degree of social isolation and occupational deprivation which could delay recovery. It could also provide an arena for providing peer support, as elaborated below.

Maintaining work orientation and identity

The iatrogenic effects of sick leave were experienced alongside the impacts of symptoms, and the actual and perceived societal questioning of the capacity of people with mental health problems to work. This combination challenged participants' work orientation and sense of worker identity. People and services that support employees recovering from mental health problems should consider whether they validate a person's work-related achievements and skills. Even acknowledgement of the fact that they were workers was found to be helpful by users of acute mental health services. Conversely, participants felt frustrated when this did not take place.

In the same way that Hart et al (2003) have argued there is a need for health and social care staff to develop an 'inequalities imagination', some acute mental health staff may

need to be supported to develop a ‘vocational imagination’ to think about their service users’ work identities. This could be achieved through a combination of pre and post qualification training and a team member championing vocation. However, – as with all imagination – time is also needed to think about issues beyond the immediate.

Addressing some of the consequences of dislocation from work, as considered in the previous section, should also help people maintain a work orientation through activity that is analogous to work, and through social contacts. We found, however, that a person’s capacity to accept a positive self-image of themselves as a worker could be obstructed by feelings of self-blame and guilt. These feelings have been described as a form of self-stigma because they result from internalising negative attitudes about mental illness (Corrigan et al 2011). Many participants felt guilty about not working. They blamed themselves for problems at work or for not being able to overcome them. A focus on themselves as incapable, or responsible for problems, also meant that consideration of issues related to their workplace or their job risked being overlooked.

Users of the Retain project emphasised how they were supported to challenge the limiting consequences of self-stigma by having structured discussion of past achievements and existing skills. They were assisted to explore how aspects of their job or workplace might have contributed to the problems they faced. The reappraisal process helped people retain or reclaim their worker identity; I propose this should be a valuable additional aim of job retention interventions. Similar reappraisal strategies were less consistently experienced by the users of acute mental health services, but valued when they did occur. GPs, and mental health and vocational support services should assess whether their clients are experiencing self-blame and guilt about their work which hinders their recovery. They could then consider helping people reappraise their situation as a first step to identifying possible solutions and planning return to work.

Planning return to work

Difficulties in initiating a process of planning the return to work suggests that it should at least be ‘tabled’ from the onset of a period of absence. The approach of one participant to his employer before going on sick leave explaining why he needed to take time off and how this would help him recover and get back to work was an example of how this could occur (see Chapter 8). That may not be possible in many cases when people become acutely unwell. Caution should be exercised so that placing return to work on the agenda is not experienced as a threat. But our findings suggest that people worried about this even

when it did not feature in on-going discussions; indeed, for some the worry was greater, because the ‘elephant in the room’ loomed in the background without acknowledgement. Tabling return-to-work planning could simply mean a standing item on the agenda of acute mental health services users’ CPA reviews, or patient-GP discussions. ASUP advisors also suggested that the language and processes of health and safety may provide a “safe” way of talking about return to work, though may be problematic for some.

Identifying a person to co-ordinate these discussions can help ensure that they happen and include the relevant people and issues. Ideally, this person should be the employee, as this may promote their capacity to take similar measures in future (a sustainability measure, to add to those below), however, as an ASUP advisor reflected, a person needs to “be and feel strong” to undertake this role. Where the employee does not feel able to undertake this role, the person doing it should do so in a consensual manner. This should include working towards a transfer of the co-ordination responsibility to the employee concerned – the coaching approach advocated by Shepherd et al (2008) and Shaw et al (2009) – and avoid disempowering experiences of professionals reported by some people returning to work in certain international studies (Östlund et al 2003, Soderberg et al 2004, Beardwood et al 2005).

The Retain project encouraged clients to lead this process themselves, while working alongside them. It was striking that the acute mental health service user with the most positive trajectory was the one who was able to undertake the coordination role himself. For other users of acute services there was generally a lack of such leadership and coordination. For these people, the different parties involved – from the worlds of health, employer and employee – had fractured and partial discussions that did not make the best use of pooled perspectives.

There are grounds for concern that our micro-level evidence of separation between the realms of health and work, undermining return-to-work planning, can also be found at the level of policy-making and its strategic implementation. Mental health policy aimed at securing employment for unemployed people with severe and enduring mental health problems has followed evidence that proposes an integration of health and employment support services. At inception, however, Improving Access to Psychological Therapy (IAPT) services – proposed as a major vehicle for job retention – involved liaison with employment support by referral to external agencies, rather than having integral vocational workers (CSIP Choice and Access Team 2008). Additional employment support funding was specifically made available to IAPT in 2009, and some services used this for

embedded support; the latest strategy states that further funding for embedded employment specialists at a rate of one for every eight CBT-trained counsellors will be made available by 2013/14 (Department of Health 2011b). If realised, this should be welcomed, though there are grounds for concern if the added caveat that “the approach taken on this is for local determination” (Department of Health 2011b p8) allows some services not to spend the money on employment specialists.

The separation between health and employment is even greater when Department of Work and Pensions programmes are considered as implemented in England. Despite an acknowledgement that the “quality of their [employment programme] support will be helped by effective relationships with health services” (HM Government 2011 p42) the current Work Programme (like its predecessors, such as Pathways To Work) stands alone. There is no requirement for close embedded links with NHS services – a tendency that arguably is increased by providers of these programmes coming from independent providers, with by far the greater proportion being for profit rather than voluntary sector (BBC Radio 4 2011, Department for Work and Pensions 2011e). There is strong evidence of collaboration with local authorities in a report of the Worklessness Co-Design Project – but any partnerships with health services only occurred when this was initiated at local level in the pilot projects (Department for Work and Pensions 2011a). A need for greater inter-governmental departmental co-operation is implied by Sayce’s (2011) Department for Work and Pensions–commissioned report on employment support for disabled people, which recommended that employment of disabled people should be a “cross-government objective with joint ministerial responsibility” (Sayce 2011 p128). Whilst neither obviating the need for collaboration in front line services, nor resolving tensions between competition and collaboration, such coordination would be a welcome step forward that could remove some of the unnecessary structural complexities and obstacles to planning return to work. By contrast to the experience in England, in the devolved Scottish administration implementation of vocational rehabilitation shows evidence of greater co-ordination primarily though the leading role played by NHS services (and within that Allied Health Professions), as opposed to independent providers, (Scottish Government 2009, Scottish Government 2011, Scottish Government 2012) – as yet there is no direct evidence of whether this is producing better outcomes than in England.

It was not just lack of coordination that explains why the return-to-work planning could be limited. Actions and attitudes were influenced by competing discourses about whether ‘work can be part of recovery’, or whether someone needs to ‘recover first’ before

work is contemplated. The implication here is that there is a need for some people (across all parties involved) to be educated about the potential value of work for recovery. There is a need for caution and balance at local and national levels in presenting this argument. There is a risk that evidence presenting work as *in general* good for recovery is presented as work *always* being good for recovery at all times. There were times when our participants were clearly not well enough to work and to do so would have been detrimental to recovery. Making plans for returning to work are likely to be helped by this balanced understanding.

Ensuring sustainability of return to work

Concerns also emerged about the sustainability of any return to work, and these influenced participants' and others' attitudes to the likelihood of success. The degree of attention to ensuring sustainability may also have influenced the future outcomes. The sustainability implications related to 'natural supports', specialist support and making changes to jobs.

'Natural supports'

Participants had a range of potentially supportive people available to them in their work or personal lives. Natural supports have been defined as "people within the workplace who are not disability or mental health providers ... [who] provide assistance, feedback, contact or companionship to enable people with mental health problems to participate independently in the workplace" (Thomas and Secker 2005b p126). Our findings – alongside those from a range of contexts (Evert et al 2003, Thomas et al 2005, DeRosa et al 2007, Miettunen et al 2007, Lysaght and Larmour-Trode 2008, Svensson et al 2010, Hatchard et al 2012) – suggest that it is valid to extend the notion of natural supports to include family and friends outside the workplace. Peer support also seems to have a particular role to play.

Family members – notably amongst users of acute services – played a protective role, possibly reflecting concerns about the nature and severity of their relative's mental health problem. It may have also been related to the degree to which participants felt exposed to direct negotiations with their workplaces without consistent and targeted support from other agencies. I consider that it would be a mistake to characterise this protective concern as a barrier, or to ignore families. Rather, as research from a range of contexts suggests (Werner 1993, Canvin et al 2009, Svensson et al 2010), concern can be an asset which can help recovery and increase its sustainability. Specialist support and advice, however, may

decrease families' understandable anxieties, allowing for a greater balance between caution and encouragement with regard to return to work.

As for colleagues at work, those participants who felt able to share with them some details about their mental health problem, as well as its current and potential future impact, felt a sense of relief. People who did not want to disclose to colleagues cited very justifiable reasons based on past behaviour and attitudes which they had witnessed. Even without such direct past experiences, fears of stigma should be acknowledged as valid. Not to do so risks alienating people very likely to be aware of the reality of stigma – even if the source of this knowledge is indirect, coming via societal discourses and others' reported experiences. Yet people could be advised – as part of reappraising their situation – that they may receive a better-than-anticipated response. For instance, people could be told that it is likely that many others at work will have had direct personal experience of mental health problems of their own or someone close to them. They could also be given ways to frame such discussions.

Discrimination – enacted stigma – requires that a formal or informal challenge be made to those expressing the behaviour. There is a risk that the burden to do this is put on the individual victim of stigma. This is part of the rationale for a number of high-profile anti-stigma campaigns which provide that challenge themselves (eg: Time to Change 2008, Beyond Blue 2011, See Me 2011). Attempts to evaluate the impact of such campaigns have faced difficulties in measurement; where positive results are suggested, these are related more to changes in public knowledge than in attitudes and behaviour (Lyons et al 2009, Evans-Lacko et al 2010, Schneider et al 2011). It is uncertain how such broad campaigns influence specific individuals, but even changes in knowledge of mental health issues could help increase experiences and expectations of acceptance on return to work.

The Retain approach to disclosure was less prescriptive than that of Gates (2000), and more in keeping with Hatchard's (2008) approach (both described previously), achieving success by focusing on influencing the attitude and behaviour of the line manager. Decisions about what and whether to disclose to colleagues was seen as a judgement that people would make individually in relation to different colleagues.

The anticipated and experienced responses of employers and in particular line managers were – as other research has borne out (Thomas and Secker 2005b, Krupa 2007, Lysaght and Larmour-Trode 2008, Seymour 2010, Chartered Institute of Personnel and Development and Simply Health 2011) – of great importance to participants and their

hopes of an enduring and successful return to work. As with colleagues' responses, people returning to work after experiencing a mental health problem could be helped to take stock and examine reasons behind fears of a negative response from a manager. Where this appears to come from an assumption that negative societal discourses about mental health will be inevitably adopted by their line manager, this could be explored. However, people may benefit from help to address both anticipated and experienced stigma.

Retain users' experiences, confirmed by Retain Service User Group (RSUG) members, suggests that one valuable intervention is supporting individuals to explain to their line manager just how their mental health problem has affected them. This may go some way to redressing the low level of mental health knowledge found amongst employers (Trajectory 2010). It may be helpful for mental health or vocational professionals to provide supporting educational information to the employer (with the employee's consent). It appeared from our study that simply involving an external third party in the process of discussing return to work may have encouraged line managers to observe due process. It is unclear whether the same outcome could be expected from an internal occupational health involvement.

Where one participant described Retain as being "like a union for people with mental health problems", some actual trade unionists might be disappointed that there was little mention of the role of unions in supporting people involved. This might have reflected the weakness of trade union organisation and – in our small sample – the number of participants who were members. For those who did use the support of representation at work, or were considering it, this was done with caution and in a way that was more focused on pay and leave entitlements, rather than challenging stigma or planning return to work. This suggests that trade unions and staff organisations may wish to review the degree to which their often well-developed mental health awareness agenda and resources (TUC 2008, TUC 2011) are embedded and understood by local members and representatives.

Peer support was found to be helpful by many of the Retain project participants – a finding which has had very little explicit attention in other mental health vocational research. Peer involvement has been adopted, often in the form of mentoring or employing service users as vocational workers (Harding 2005, Moll et al 2009), but this does not necessarily entail use of peer support groups. The implication is that services should consider whether they should establish peer support groups for people with mental health problems who are currently on sick leave, or have recently returned. This intervention

could be accessible to users of primary as well as specialist mental health services. A range of models could be explored, from such groups being facilitated initially (as with the Retain group) and then people who have had a period of successful return to work being enabled to join, and participate in running the groups themselves, as a longer-term form of support – possibly in partnership with a mental health charity such as Mind. The Access to Work scheme – which has a disproportionately low level of use by people with mental health problems – has been suggested as a potential source of funding for peer support by the DWP-commissioned Sayce (2011) review of disability employment supports. Specialist mental health services could consider whether their day services have a role to play in enabling peer support – ASUP advisors suggested that acute day services could establish groups for people with jobs to share experiences and consider issues related to return to work. Bryant et al's (2010) participatory action research suggested that through the mechanism of peer support, day services may not be an alternative to social inclusion, but a means to enable it – deploying bonding social capital to enable bridging social capital by providing safe spaces and support networks for people to manage crises, recover and gain confidence and skills to participate in mainstream community life.

The power of peer support seemed in part to derive from how it increased people's confidence and developed their knowledge of strategies they could use to support themselves at work. In this sense peer support was developing people's personal capital – enabling them to act as their own 'natural support'. De Rosa et al's (2007) qualitative survey into the experiences of people who gained work through supported employment found that clients valued the development and use of their own self-support strategies, particularly for longer-term job retention. Self-support could then be added to an understanding of what can constitute natural supports. It can potentially be an outcome of attempts to empower people to take on increasing degrees of leadership of liaison and return-to-work planning, as outlined above. This is in line with a considerable body of both recovery and resilience research, which has pointed to the power of such 'personal medicine' (eg Deegan 2005, Dowrick et al 2008).

Specialist support

The 'natural support' of 'personal medicine' was counterposed by Dowrick et al (2008) to professional support. This is understandable, given the evidence that some professional support can be disempowering, stigmatising and lower the aspirations of people recovering from mental health problems (Marwaha and Johnson 2004, Lauber et al

2006, Brown et al 2009). Our research, however, suggests that many people had a need for specialist knowledge of the kind that can be gained from mental health professionals and vocational workers. RSUG advisors considered knowledge of law and rights and suggestions of possible accommodations could increase a person's confidence. ASUP advisors considered that people should have access to a "supporting back to work person" – and expressed concern that an unqualified support worker might not have sufficient skills and knowledge for such a role. There was however a debate about whether at times this could be done by a "good personnel manager".

Acquisition of specialist vocational and mental health knowledge that is relevant, and does not come at the cost of disempowering the client, can be supported by a consistent client-centred/coaching approach (Shepherd et al 2008). Being 'client-centred' here means that the professional has to learn from and understand the client. Additionally, Shaw (2010b) maintains that healthcare professionals and user groups need to develop skills in the process of sharing knowledge, and for this they recommend Community of Practice approaches. Enabling professionals to learn from their clients which natural supports work for them (Korzycki and Shaw 2008) allows them to share this with other clients – implying that a dichotomy between natural and professional supports is not helpful.

Whilst for some people, avoiding mental health professionals may be more normalising and possibly cost-effective, for others their specialist knowledge appears necessary. Mental health knowledge was needed by our participants, because symptoms did have a direct impact on people's work performance – accommodation was not just about adjusting others' attitudes or eliminating potential triggers or stressors. Avoiding feeling overwhelmed and feeling able to manage symptoms (Provencher et al 2002, Marwaha and Johnson 2005, Millward et al 2005, Stainsby et al 2010) increased confidence in the prospects for a successful return to work. Mental health professionals have specialist knowledge that can help here in understanding and managing the impact of symptoms. Specialist employment knowledge was also needed in relation to both formal discrimination and employment legislation, and in relation to competency and knowledge in the world of employment relations (Sainsbury Centre for Mental Health 2009c). 'Experts by experience', such as peer support workers, may also be potential sources of specialist knowledge related to both employment and mental health.

People did not just have a need for these two areas of specialist knowledge as distinct and separate entities. They needed knowledge of the way in which their experiences of mental health problems and work interacted. There is a risk that people encounter experts

in either of these two realms who have insufficient knowledge of the other (Soderberg et al 2010). The IPS approach in secondary mental health services addresses this by having employment specialists embedded in and integrated into mental health teams, often supported by clinical leads or ‘vocational champions’ (Davis and Rinaldi 2004, Marshall et al 2008, Carolan 2009), but the emphasis in this and wider literature is on developing these roles in community as opposed to acute teams. I recommend that employment specialists, supported by vocational champions, should be present in acute teams (inpatient and crisis resolution and home treatment). Similarly, even though the Retain project – like the non-integrated supported employment service studied by Waghorn et al (2011) in New Zealand – achieved highly effective outcomes, this could perhaps have been improved with more integration with mental health services – particularly if they were to support people with more severe mental health challenges.

Understanding of symptoms and their management should not be confined to a supposedly ‘private’ sphere of health. A discourse – possibly influencing the experiences of some of our participants – which suggests that ‘health is private’ and ‘work is public’, and that therefore each should be kept separate from the other, may need to be challenged. This discourse may be reinforced by the power structures of the health system and the workplace effectively ‘standing off’ from each other. This distancing may arise from the complex challenge of interaction between the two worlds, including when people with status in those worlds elect to avoid the potential challenges to each others’ authorities that might arise from mutual engagement. The problem is that our participants were part of both worlds – in one as a ‘patient’ or ‘service user’, in the other as an employee.

People needed the world of work to recognise that they had a mental health problem, and the world of health to recognise that they were workers. In some instances, this may support the case for more direct involvement of mental health professionals in their clients’ working lives. In other cases, exchange of knowledge between the realms may be supported by ensuring people with mental health problems have the opportunity to discuss their symptoms, not just in an abstract manner, but contextualised in relation to their work – or, as Cunningham et al (2000) concluded, “how one manages one’s illness is less significant than how *one manages one’s life* having an illness.” (p492).

Sustainability of job retention is likely to be helped by allowing positive supports and insights developed from collaborative contacts with mental health professions to be transferred to the work realm. ASUP advisors suggested that this should routinely involve a phone call from a mental health worker to an individual on or after their first day back at

work. It may be helpful to sustain contacts with mental health professionals over time and not just assume that because someone is working that they have recovered and no longer need support. Certainly, recent evidence – again from the better-researched area of supported employment interventions – has suggested that sustained contacts between employees with severe mental health problems and employment specialists is positively associated with job tenure (Bond and Kukla 2011).

The need for integrated mental health and work knowledge is perhaps most stark with respect to assessment of work–mental health interaction. “Continuous and ongoing assessment” used to be one of the original six core principles for the IPS-supported employment intervention (Bond 1998 p12). One of the key reasons for this – highly relevant to job retention – was the acknowledgment that assessment can identify problems in the environment which may need to change (Bond 1998). Some may consider aspects of the process of assessment problematic; firstly, for not sitting easily with a growing emphasis on coaching and collaborative responses (Lloyd et al 2008b, Shepherd et al 2008), notably in light of criticisms that standardised assessment disrupts co-operative therapeutic relationships (Smith 2006); and secondly, given the use of vocational specialists who are not required to have undergone some form of professional training. However, regarding the latter, there is no reason why a professional qualification is necessary for all forms of assessment. Furthermore, just as is emerging with the use of vocational champions in some mental health trusts in the UK, the contribution of assessment from an occupational therapist, or other relevant professional, alongside coaching roles undertaken by a vocational specialist or peer support worker, may produce an effective combination of empowerment and technical and professional expertise (Davis and Rinaldi 2004, Ouellette et al 2007, Carolan 2009). Our research also supports evidence presented in the literature review (Chapter 3), and by Johnson et al (2009), that trust and empathetic understanding are vital elements of effective intervention.

Assessment can contribute to the processes of reappraisal and understanding of the impacts of work tasks on people. Reappraisal, which Retain users found to be so helpful, can be understood as a collaborative structured assessment of their situation which fosters hope and identifies solutions. Assessment needs to find out not just how symptoms impact upon work, but how work and workplaces impact upon a person’s mental health. We found that participants had specific issues related to job tasks or workplaces, which were implicated in contributing to their mental health problem. Clarifying these was a first step for employees and employers to discuss what solutions could be found. Our findings

therefore concur with Black and Frost's (2011) independent review of sickness absence and their proposal for a new Independent Assessment Service – as long as it approaches assessment in this broad manner – rather than simply providing a more cost-effective version of GP assessments for fitness notes.

For those with return-to-work trajectories which are uncertain, and where either employer or employee considers that they may not be successful, there is a strong case for people to have access to the employment specialist-type role provided by Retain, which could be supplemented by specialist assessment of job demands or workplace when needed. Depending on how services are designed, it may be that people providing the employment specialist roles would have some assessment skills (possibly related to a professional qualification), or that there be close links between the employment support worker and agencies which have professionals with the requisite skills, such as occupational therapists. Our research does not indicate whether there is a best method of delivery, but it does suggest, as Rampton et al found (2010), that access to someone with skills which enable assessment of work tasks, roles and environment is likely to be of help in many situations similar to those of our participants. Again, the proposal made in the independent review of sickness absence (Black and Frost 2011) – namely that there be a state-funded job brokering service – appears to go some way to providing this.

In order for health – and especially acute mental health – professionals to provide specialist vocational assessment, it may be necessary for this role to be explicitly identified and ring-fenced. This may help to balance competing demands that perhaps appear more pressing in the short term, but do not make the same contribution to longer-term sustainable recovery. All mental health service users had support from teams that included occupational therapists, but just one received an occupational therapy assessment specifically focused on their work-related needs. This is despite occupational therapists having relevant skills to carry out this role and liaise with employers (Barnes et al 2007, College of Occupational Therapists and National Social Inclusion Programme 2007, Hauck and Chard 2009, Schreuer et al 2009, Arbesman and Logsdon 2011). Whilst I disagree with approaches that simply assume the priorities of a given professional standpoint, as opposed to considering client needs and then asking who is best placed to help them, it does appear that occupational therapy has a potentially considerable role to play in supporting job retention. One of the randomised control trials selected for inclusion in Seymour's (2010) updated review of effective interventions for common mental health problems at work showed that those receiving individual and group-based occupational

therapy which was focused on their work issues, returned to work on average six months earlier than the control – it was thus disappointing that Seymour’s review did not include occupational therapy in the section dedicated to discussing the roles of different practitioners. By contrast, Black and Frost’s (2011) sickness absence review and Scottish Government policy (Scottish Government 2011, Scottish Government 2012) do identify occupational therapy as a profession which could assist clients seeking to retain employment. Enabling occupational therapists and other mental health professionals to provide specialist vocational assessment, and encouraging services users to ask for it, may also demand a shift in the discourse that suggests that health belongs to a private sphere and the world of work to a different, public, realm.

Making changes to jobs

A key task of assessment is to identify changes that may be helpful in both the short and long term to a sustainable return to work. Accommodations that may help people recovering from mental health problems have been proposed, but the evidence base for them remains limited (Schultz et al 2011) – no doubt in part because of the variety of jobs, mental health problems, and of course people, that can be found in different combinations (Gates 2000, Kirsh et al 2006). Simply identifying changes is not enough – with some Canadian research reporting that 25% of accommodations are not implemented (Busse et al 2011). There is thus a need to negotiate and agree how they can be made (Schreuer et al 2009).

Identifying and negotiating implementation of accommodations was a significant part of Retain’s intervention which the RSUG was keen to emphasise and which were also found in an evaluation of a similar Richmond Fellowship project (Pittam et al 2010). Although more examples might possibly have been expected; this may reflect a greater degree of staff skills in areas other than assessment. Acute mental health service users received less support with respect to work and workplace assessment; however, it was apparent that there were aspects of their work or workplaces which participants thought could be improved to support their return to work. A concerning finding was that some had not even considered, or been helped to consider, that relatively straightforward changes (e.g. alterations to shift patterns, modified duties or phased return to work) were even an option.

Adopting a narrow psychological or biological approach focused on the individual employee and their symptoms could result in such potential solutions being neglected. In

effect, the person with the mental health problem could feel they are responsible for not being able to adjust to the problems they face. Given the high degree of self-blame and guilt found amongst our participants, the risks of this outcome are great.

For a minority of participants their work was a highly toxic arena. Here work was implicated in the genesis or exacerbation of their mental health problems to the extent that a return to their workplace was not likely to be sustainable or help sustain their recovery. This may be an example of where Seymour's (2010) recommendation for independent case management involvement, when employees are not recovering as expected, is particularly pertinent. It is also a situation where CBT focused on the individual employee and not their context appears most limited. One of the advantages of the Retain project being independent was that the possibility that a particular job was having negative impacts on a client's mental health may have been easier to acknowledge. Retain's independence also made it possible for them to have a broad view of job retention that was not constrained by defining it as returning to an existing job or even employer. Thus, some individuals were supported to retain employment – either in different jobs with the same employer, or with new employers. An occupational health service which is funded by an employer may find it hard to justify providing this role. Given the established roles of occupational health services, at least in the public sector and larger enterprises (Lian and Laing 2007), it may be useful to consider how they might work alongside organisations such as Retain in cases when working for a different employer might be the most sustainable outcome for the individual. Alternatively, such an option could be explored alongside a mental health professional who should have primary allegiance to their service user not to the employer (Schreuer et al 2009).

Some participants felt they lacked control over their work. Devolving control to employees has been identified as a factor which either supports health or buffers negative effects of other factors (van der Doef and Maes 1999, Hausser et al 2010, Schreurs et al 2010). Schreurs et al's (2010) conclusion that employers should consider how they can delegate more control to employees, may be more realisable in professional and skilled jobs than in work which is dominated by repetitive exercise of certain routines and procedures – usually lower-paid working class jobs. Egan et al's (2007) systematic review concluded that participatory workplace interventions can improve health and well-being, but not if general conditions at work are poor. Employees in such jobs were found by Batinic et al (2010) to be more vulnerable to lower levels of well-being due to lower levels of exposure to Jahoda's (1982) five latent benefits of working. Those findings are also

consistent with Karasek's job-demand-control model (1979, 1989) – leading him, like Jahoda, to consider the potential for job redesign or humanisation of employment. This theme will be explored further in the final chapter.

How thesis implications relate to NICE guidance

A number of the implications set out in this chapter are consistent with the National Institute of Clinical and Health Excellence's (NICE) (2009) recommendations for the management of long-term sickness and incapacity for work. Firstly, NICE's recommendation for there to be initial contacts between employers and employees is consistent with implications related to maintaining contacts with work. The second NICE recommendation relates to the value of detailed work-focused assessment informing the development of return-to-work plans – this accords with the implications I have drawn out which relate to planning return to work and professional supports. The third NICE recommendation advises the use, in more complex cases, of co-ordinated, multi-disciplinary, work-focused intervention (alongside use of CBT in some cases); this is again consistent with the implications of this thesis regarding planning return to work and measures to ensure its sustainability. However, a clear difference is that the NICE recommendations charge the employer with taking these actions. The guidelines acknowledge that there is often a need for an impartial case worker involved in co-ordination and assessment – but still charge the employer with appointing this person. They consider that it could be someone from occupational health services. This seems to fail to recognise that an occupational health service commissioned by an employer – whether internal or external – is not independent and might be expected to have primary allegiance to them. Moreover, many employers do not have access to occupational health (Nicholson 2004, Gabbay et al 2011). Some might argue that in the current climate it is not realistic to propose that the state fund a neutral case worker and assessment service (like Retain) – though Black and Frost (2011) present a robust case for its cost effectiveness and the Scottish Government (2012) has gone some way to providing this service. However, given the acceptance of the importance of work to mental health and well-being, for their existing clients at least, mental health services could surely be charged with leading on the processes currently assigned to employers. Thus, a final recommendation of this chapter is that NICE should consider amending its guidelines to give mental health services greater responsibility to implement the recommendations with respect to existing clients on long-term sick leave.

Further research directions

Finally, from these recommendations a number of directions for further research are apparent. Given the limitations of scale, context and participant diversity of the research reported in this thesis (acknowledged in the previous chapter), further research into people's job retention needs in related contexts may bring greater clarity and new insights. Each of the recommendations could form the centre of a research topic in themselves.

I am particularly interested in practice-focused research to further explore the potential for peer support to promote job retention. It may be suitable to conduct this as a form of participatory action research or community of practice approach (Wenger 1998, Cockburn and Trentham 2002, Bryant et al 2010). I consider myself well placed to pursue this by building on the relationships I have established with service users and various service providers. I am currently supervising a Master's student who is exploring how peer support workers and occupational therapists collaborate with each other to support the needs of people with severe mental health problems. As well as the research reported in this thesis, I consider that I can also draw on my experience of participation as an academic partner in the Our Space project (exploring community initiatives to enhance Deaf people's well-being), a strand in the South East Coastal Communities project which was based on a community of practice approach (Community University Partnership Programme 2011). Other forms of qualitative and quantitative research into job retention interventions may help to develop greater clarity into the principles which may inform a complex job retention intervention. This could then be used in larger-scale randomised control trials as with Individual Placement and Support interventions.

In relation to theory generation, research could further explore the validity of iatrogenesis as a concept that can explain sick leave challenges, and the relevance and validity of the concept of occupational capital to a range of contexts. To this end I am supervising another Master's project investigating people's experiences of the occupational impacts of being on sick leave. A third Master's project which I am supervising is a literature review of evidence for the role of occupation in developing resilience for people with physical disabilities. This is an example of how theoretical and applied research can continue the exploration of the resilience and occupational perspectives discussed in this thesis and to which I return again in the next chapter. In turn this may help to provide a synthesis of resilience and occupational perspectives which will in turn promote understanding of the broad range of challenges that people in adversity face, and suggest strategies that may help them.

Chapter conclusion

This chapter has discussed and presented the central implications of my thesis findings – in other words, it has addressed Danermark et al's (2002) explanatory research stage of concretisation and contextualisation. The implications it has drawn out are, first, that people may need to be helped to keep in touch with their workplaces when on sick leave, to prevent dislocation from work becoming a widening chasm. This may particularly be the case for people using acute mental health services. Second, that while we found nothing to suggest that our participants did not need to be on sick leave, we did find that it presented additional 'iatrogenic' challenges. People on sick leave, their families, employers and health professionals should all be aware of these additional challenges. There should be encouragement and, when necessary, support to mitigate these iatrogenic effects through occupational and social participation. Third, that it is helpful for people to maintain their orientation to work and sense of identity as workers. This can be achieved by challenging feelings of guilt and self-blame through reappraising past work experiences. Mental health services in particular should also ensure that they acknowledge and affirm the work identities of their service users. This could be helped by focused training for acute mental health staff to develop a 'vocational imagination' and knowledge of key issues in job retention. Fourth, that there should be a planned and co-ordinated return-to-work strategy. This should be tabled from the onset of a period of absence – not in a threatening way, but in a manner that keeps this issue open to discussion and on the agenda. Failing to table this issue may result in more anxiety for the employee. Structural separations between realms of work and health which restrict co-ordinated return-to-work planning at local and macro levels should be identified and reduced. Fifth, that considerable attention should be paid to ensuring the sustainability of the return to work. This can be achieved through developing 'natural supports' of family/friends, people at work, self and peer support. Supports from employment specialists and mental health professionals can complement these if provided in a client-centred and recovery-orientated manner. Mental health and employment expertise both have a role to play, and should also learn from service user experiences. These should be provided in an integrated manner. Understanding employment issues and mental health issues is of particular importance when there is a need for assessment, to support reappraisal and identify accommodations to jobs. In addition to altering aspects of jobs, for some people a sustainable outcome may be to seek alternative employment. A number of these implications are consistent with NICE guidelines, except that NICE charges employers with their implementation. My

final recommendation criticised this on the grounds that employers and anyone they commission cannot be neutral, and because in reality many employers have no access to occupational health services. Ideally, everyone should have access to an independently funded vocational service when needed – but, in the absence of this, I propose that mental health services be charged with leading on implementing a job retention process for their existing clients.

The identification of these implications and related avenues for further research has been supported by an occupational perspective which looked at the experience of doing work, the consequences of its disruption, and the dialectical interactions between mental health and working. A resilience perspective has drawn attention to the process of recovery from the adversity that participants experienced, *and* that recovery's longer-term sustainability. Finally, I have endeavoured to acknowledge the reality that – for at least some people for some of the time – work can be toxic as well as being a source of well-being. This signals the relevance of debates about the need to question the priorities attached to work and proposals to 'humanise' it. These themes of humanisation, occupation and resilience, as they relate to mental health and work research, practice and life experience, will be discussed in the first part of the following concluding chapter.

Chapter 14: Conclusion

There are three broad implications arising from the research. The first two relate to the value of resilience and occupational perspectives. These combine to inform the third, which shows that there is an on-going need for a critique of the priorities which condition the way in which work is organised and thus experienced in society. I include them here because they are less specific and less immediately realisable than the recommendations outlined in the previous chapter. Moreover, they contribute to concluding some of the key issues raised by this thesis.

Contribution of resilience perspectives

Resilience perspectives are useful given evidence of a range of poor outcomes for employees who experience mental health problems. The research has provided insights into the multi-factorial nature of the adversity faced when mental health problems disrupt people's working lives. This thesis was based on data derived from a cross-sectional interview during recovery, but it was striking how important the sustainability of a future return to work was for participants. Trajectories appeared stronger when there was confidence in future sustainability. Like more established recovery perspectives in adult mental health, resilience calls attention to learning from the people's strengths, as well as their challenges. However, whilst recovery and resilience are related they also have distinct qualities. Both show some concern with the sustainability of recovery, but this is stronger in resilience concepts. In this way resilience frameworks can make great contribution to the analysis of the durability of supports for people with mental health problems.

In my literature review I criticised applications of resilience-based resources which place a greater emphasis on making individuals more able to cope with the pressures of work than on alleviating those pressures. Our findings uphold this criticism. Notably with regard to the risk that a narrow individualised understanding of resilience could reinforce the self-blame felt by many participants and thereby increase obstacles to recovery.

My understanding of resilience, distinguishing it from recovery, has expanded. Where recovery is an individual's journey towards a personally defined state of well-being following crisis or adversity, resilience is a dynamic and evolving outcome of a constellation of interacting internal and external mechanisms which support and sustain that recovery. This new definition draws on Masten's (2001) sense of positive outcome despite adversity, Roisman et al's (2002) emphasis on the emergent nature of resilience

coming out of people's interactions with their environments, and Ungar's (2005a) even greater emphasis on the importance of the environment to foster resilient outcomes.

Therefore this thesis supports ecological understandings of resilience as an attribute and a process arising from the interaction of whole systems – including, as I suggest below, those pertaining to people's interactions with their environments through occupation. This perspective draws attention to external supportive mechanisms as well as to individual factors. I have considered how the sustainability of a return to work can be achieved in relation to the individual, their work, and their workplace. Accordingly, Retain's successes lay in individual-focused interventions, such as supporting reappraisal and self-advocacy; work-focused interventions, such as adjusting work tasks and work roles; and environmental interventions, such as helping bring about changes in managers' attitudes and re-establishing dialogues. Each of these approaches supported the other. Even Gavin's apparently individual display of resilient recovery shows on closer examination how his individually initiated actions brought about wider changes in work and workplace (Chapter 10). Thus his approach to his manager, when he felt he was becoming unwell, had the effect of providing the manager with reassurance, leading to a more accepting attitude. This, in turn, seems to have made his receptive manager more willing to accept his proposals for a phased return to work.

This research has indicated the value of nurturing the antecedents of resilience in the working lives of people seeking to return to work after experiencing mental health problems. Just as Friesen (2007) recommends that recovery concepts should be applied alongside resilience frameworks in children's mental health services, my thesis suggests there should be more systematic attempts to draw on resilience theory and practice to inform and develop adult mental health services – at least with regard to job retention. Appendix S shows how I and collaborators adapted Hart and Blincow's *Resilient Toolkit* (Hart et al 2007) for use in adult mental health. The success of return-to-work trajectories should include measures (quantitative and qualitative) of how sustainable any return to work is and whether the experience of work after return fosters long-term recovery or undermines it. That appraisal needs to consider people's experience of precisely what they do at work – which is part of the occupational perspective.

Contribution of occupational perspectives

Occupational influences on my perspective derived from practice and theory related to occupational therapy and occupational science. While there is a risk that such orientations

may generate findings that support the researcher's pre-existing biases, I hope that sufficient justification for the importance of occupational perspectives are apparent in the literature review, findings and discussion chapters. The thesis has deliberately avoided subsuming occupation into biological, social or psychological categories. To have done so may have risked neglecting the extent to which experiences of *doing* work can either hinder or foster resilient recovery. By giving increased status to the occupational realm, I have also avoided a polarisation between biological models of mental illness and social models of disability which can result in a failure to mutually acknowledge the importance of both biological and social factors (Erickson and Shakespeare 2001, Pilgrim and Rogers 2005).

My literature review revealed that research has tended to emphasise psychological and social factors influencing return to work. This is mirrored in much UK health and social policy which has promoted psychological management (especially through Cognitive Behaviour Therapy and the Improving Access to Psychological Therapies programme) on the one hand, and stigma campaigns and legislation in the social arena on the other (Cross-government strategy: Mental Health Division 2009, CSIP and NIMHE 2011, HM Government 2011). There is a risk that such research and policy emphasis results in the significance of the impact of biological factors (for example, symptoms and medication side-effects) being relatively neglected in relation to return to work, thus becoming more of a '(bio)psychosocial' perspective. Meanwhile, the biomedical continues to dominate mental health more generally – meaning that people may be prescribed medication with limited consideration of its impact on work. The separation of biological and psychosocial realms indicates a further area where occupation is neglected. This is because symptoms often directly impact on occupational capacities and performance, as highlighted in the literature review and in our own findings. In this, there is support for perspectives which can integrate the biological as well as the psychosocial, an example being Clark and Larson's (1993) model of the human as an occupational being – introduced in Chapter 5 and used to summarise findings in Appendix R.

Our qualitative research offered insight into the explanatory mechanisms which shaped the return-to-work trajectories of people recovering from mental health problems. We found that psychosocial attitudes (of self and others) and interpersonal environmental factors were important. Biologically, symptoms also mattered; as did occupational factors involving impairments to activity performance and the experiences and demands of people's jobs. Public and professional discourses about treatment options for mental

health problems frequently present the two broad options of talking therapies or medication, implying that few other options exist (Byng and Gask 2009, Gray 2011, Mind 2012). By contrast, my thesis has found that occupational interventions can be an essential part of supporting vocational recovery. These include adjustments following occupational analysis, or therapeutic use of graded and selected work tasks to promote recovery,

Occupational factors are involved in mechanisms which both promote and inhibit recovery. They are part of the overall complexity, suggesting that the (admittedly rather long-winded) formulation *bio-psycho-socio-occupational* might serve better than ‘bio-psycho-social’ to encapsulate the issues involved in return-to-work challenges. This implication of my thesis is consistent with Wilcock’s (2006) call to raise the occupational perspective of health and well-being to a higher level so that it sits alongside medical and social perspectives. The newly proposed concept of occupational capital could support similar ends. Greater acknowledgement of occupational components may help bridge the gap between the biological and the social, which can otherwise risk users of mental health services feeling that they are alone in trying to integrate advice from psychiatrists or GPs about medication and symptoms, on the one hand, with guidance about social interactions from other professions.

Thus a central conclusion of this thesis is that both occupational and resilience-based perspectives should be given more prominence when attempting to understand and address challenges faced by people with mental health problems who are seeking to retain work. This can be done by understanding how resilience-based perspectives can complement established recovery-orientated ones, and how occupational perspectives can add a new dimension to bio-psycho-social ones. Furthermore, it may be fruitful to consider what a resilience perspective can bring to the occupational, and what the occupational can bring to resilience theory.

Occupational therapy and occupational science theory have had a consistent focus on the process by which individuals interact with their environments through occupations and the relationship this has with their health and well-being. Bringing a resilience focus to this interaction and relationship does not lead to any radical revisions, but can help ensure that questions about the sustainability of this process are consistently asked. Pemberton and Cox (2011) called for “occupational therapists to understand time as a dimension of being, not just a measure for the content of existence” (p80). Whilst resilience was not considered in their otherwise wide-ranging critical review, if time is seen as a dimension of being, this implies that the sustainability of being over time also should be of concern. For

instance, are the demands placed upon individuals by their workplaces ones which call for occupation participation in a manner which enhances health and well-being over the long term? This question further underscores the value of the more ecological understandings of resilience than the individualistic ones present in some of the limited occupational therapy literature (Lopez 2011, Price et al 2012). We found it helpful to consider how the occupational space in which people found themselves could be made more resilient, rather than simply considering how individuals could harden themselves to adversity.

Bringing an occupational perspective to resilience does not revolutionise the latter either. For instance, the Resilient Therapy model (Hart et al 2007) places central importance on the role of learning and play as categories of resilient approaches. An occupational lens would explicitly label such ‘resilient moves’ as occupational, suggesting the value of targeted inquiry into other occupations which can, for some people in some contexts, enhance their resilience (or conversely undermine it). Occupations with excessive psychological, physical or emotional demands that are not adapted to a person’s capacity may be toxic undermining resilience, inhibiting recovery or even triggering mental health problems. Conversely occupations which provide people with experiences of competence, positive social contacts, and satisfaction can be a source of resilience for those faced with challenges – such as those related to mental health problems.

Finally, both occupational and resilience perspectives speak to the issue of the humanisation of work – the final broader implication. An occupational perspective implies that it is intrinsic to what it is to be human to engage in productive occupations, and thus it fulfils a human need (Wilcock 2006). To restrict that opportunity is to deny people access to occupational capital, amounting to occupational deprivation (Whiteford 2000), and is therefore an occupational injustice (Townsend and Wilcock 2004). However, if participation in work occurs in a way which is dehumanising, then rather than providing an affirming occupational experience, work can be experienced as a denial of human nature.

Many people’s enthusiastic participation in hobbies outside of their paid work (Gelber 1999, Gauntlett 2011) can be interpreted as attempts to find avenues for less restricted experiences of productive occupational participation, which compensate for what some might find lacking in their working lives. In more extreme instances, as seen with some of our participants, the coincidental or associated experience of mental health problems meant that participation in work was unsustainable. Supporting the case for a human need to be productive, there was still an overriding desire to be working amongst our participants – although for some of them their specific jobs were in contexts which threatened to

undermine, rather than enhance, their recovery. For their immediate futures, the resilient move was not to give up on the prospect and aspiration to work, but to help preserve their work identity and assist them to find alternative work in less adverse, and ideally more affirming, contexts. Nonetheless, the challenge remains to consider what might happen to the next person in line who fills the vacancy, or to former colleagues to whom potentially toxic tasks may be redistributed. This means asking how working lives for all can be improved, even if that means calling on moral principles of humane experience rather than economic imperatives of efficiency.

Form, function and meaning of employment: Risks of lifeless work and workless life

Central to Clark et al's (1991) call for the recognition of occupational science as a discrete discipline was a recognition of the need for deeper exploration of the form, function and meaning of human occupation (Chapter 4). Our research suggests that whether work has a *function* for people that enhances or undermines their well-being is influenced by its characteristics, or *form*, and the underpinning priorities that determine these characteristics. The outcome of this relationship between the *function* of work and its *form* greatly influenced the *meaning* that it held for people, and thus its potential to be considered a vehicle to mental health recovery, or as an obstacle to – or even cause of – mental health problems.

One of the justifications for supporting job retention advanced by government bodies, user charities, independent think-tanks and researchers is that it is good for the economy to enable people to remain productively active (Oxford Economics 2007, Sainsbury et al 2008, Future Vision Coalition 2009, Perkins et al 2009, Department for Work and Pensions 2011c). It also appears that the occupation of work can have a positive adaptive *function* that promotes health and well-being for people, including those with mental health problems. UK policy documents (for example Health Work and Well-being Programme 2008) have cited Waddell and Burton's (2006) review which supports the positive link between work and good health and well-being. However, behind the headlines of this comprehensive review are acknowledgements that, while in general it is better for people's health and well-being to be working rather than not working, some work can be toxic, or have a maladaptive *function* for some people. The authors emphasise that their findings that work is good for health and well-being are “about average or group effects and should apply to most people to a greater or lesser extent; however, a minority of people may experience contrary health effects from work(lessness)” (Waddell and Burton 2006 p ix).

Our findings suggest that a temporal dimension can be added to this proviso. There are times when some people are too unwell to work and working at that time could undermine their health – even leaving to one side whether they could carry out their job effectively and safely. This further indicates a need to analyse work for its impact on health and well-being.

The relative decline in the developed (but certainly not developing) world of extractive and heavy industry, requiring physical effort on the part of labourers, does not mean that work is necessarily any less toxic for people. Indeed, the same processes of maximising productivity and efficiency, which have driven ever-increasing mechanisation, are arguably responsible for increasing psychological and emotional strain on workers (Walker and Fincham 2011). This creates an occupational *form* that undermines a positive health promoting adaptive *function*. Thus, in 2011 the Chartered Institute of Personnel and Development (CIPD) reported that stress became the most common reason for employees to go on long-term sick leave, for both manual and white-collar UK workers (Chartered Institute of Personnel and Development and Simply Health 2011). In the 2012 survey the CIPD and Simply Health (2012) responded to a reported fall in sickness absence not with celebration, but by suggesting that it could be the result of fear in the current economic climate and represent an increase of ‘presenteeism’ in which workers may be both unproductive and experiencing increased levels of stress and increased mental health problems.

The central importance of the relationship between the employee and their line manager has been confirmed in our study. This is not just because the line manager has immediate responsibility for an employee’s working arrangements, but because of their position being charged with maximising the productivity of workers, while also having responsibility for ensuring their health and well-being as defined by law and organisational policy. Tensions between these two roles may be resolvable in a way that does indeed meet the needs of individual well-being and organisational productivity. Sometimes this may not be so. That may be the situation for many of those who do not return, or would rather not return to employment within their existing organisation.

On the other hand, Bradley et al (2000) have pointed out the tendency of some academics to investigate work in a way which assumes that all work is experienced as a negative dehumanising phenomenon, even when ironically the authors of such studies appear to derive great fulfilment and pleasure from their own work. Studies and narratives of people’s working lives remind us of the great range of occupational *meanings* that

people derive from their experiences of working (Terkel 1977, Noon and Blyton 2007). Yet it remains hard to deny the view, familiar from Toynbee's (2003) book *Hard Work* and the Whitehall studies (Brunner et al 1991, Bosma et al 1997, Steptoe et al 2003, Marmot 2004), that it is tougher at the bottom than at the top!

Debates endure about the extent, methods and contexts in which it is possible to 'humanise' work (Jahoda 1982, Bunting 2005, Hausser et al 2010, Robertson and Cooper 2011) and thereby create occupations whose *form* provides an adaptive life-enhancing *function* as well as enriching *meanings*. In the UK, since 1995, disability discrimination legislation has given people with mental health problems increasing degrees of legal protection against discrimination in a number of areas including work (Sayce and Boardman 2008). Some quantitative research has questioned whether the legislation may have actually had a negative impact (Bambra and Pope 2007, Bell and Heitmueller 2009). Both qualitative (Lyons et al 2009) and mixed methods studies (Biggs et al 2010) have shown that stigma and discrimination against people with mental health problems remain an enduring barrier to participation in employment. Our findings suggest that legislation may be helpful when people can overcome self-blame and feel empowered and entitled to use it in discussion with employers.

There is uncertainty as to whether potential progress is being constrained by the changed economic context. This may have reduced the imperative to maximise participation in the workforce (if not to reduce welfare spending). In the UK there remains a further risk that protective employment legislation becomes a target of policy aims (Cabinet Office 2012) to reduce 'red tape'. We also do not know how much to expect that humanising measures will be introduced in developing or newly industrialised countries. The answers to these questions are beyond the scope of this thesis, but it is clear –from the experiences of some of our participants to the suicides of workers in certain Chinese technology factories (Chamberlain 2011) – that there is a need for the conditions in some workplaces to be challenged. The Marmot Review's (Marmot et al 2010) proposal for a policy objective of fair employment and good work to address health inequality, supports the validity of an appeal to a moral dimension that transcends considerations of mere efficiency. Or as Jahoda argued: "People want to work; they need the categories of experience that employment provides; but they need them under conditions that do not diminish their human nature" (Jahoda 1982 p86). Without this, people with mental health problems may find themselves being caught between options of lifeless work or workless life; finding, in Habermasian terms (Habermas 1984), that their lifeworld is colonized:

either by negative impacts of mental ill-health exacerbated by social isolation, or by alienating work environments.

Thesis summary

My thesis reports on research which used a comparative case study design within a critical realist methodology to investigate the situation of employees who experience mental health problems that could jeopardise their employment. Specifically, my research aimed to understand participants' experiences and perspectives of their work-related needs and of the support which they received or would have liked to have received. It also aimed to identify mechanisms which can explain these experiences and inform job-retention interventions. This research has added to the limited body of mental-health-related job-retention research and the very limited amount that has gathered perspectives obtained during recovery, rather than retrospectively. These methods have helped reveal the intensity of the feelings and concerns that our participants had about their work at this point.

A distinct and novel finding was that work mattered to people during their recovery because they often felt guilty about not working or blamed themselves for the problems they faced at work. Some feared that work had exacerbated their mental health problems, or could do so in future. Such fears co-existed with a strong sense that work was an important part of people's lives in terms of finance, social capital, personal capital and occupational capital (a newly proposed concept). These assets of people's lives were under threat. They also had the potential to be deployed to support people's vocational and general recovery.

People found themselves on a complex and uncertain return-to-work journey marked by internal and external obstacles. Barriers arose from the direct impacts of mental health problems, external and internalised stigma, job task demands and the workplace environment – particularly relationships with colleagues and, above all, managers. The concept of iatrogenesis was newly applied to being on sick leave. Whilst sick leave was a necessary measure, it brought additional challenges which risked delaying recovery and the return to work. Positive return-to-work trajectories were supported when these challenges were addressed and the aforementioned assets harnessed as part of coordinated and collaborative strategies, as we often found in the Retain job retention project.

Implications, including specific recommendations based on these findings, were detailed in Chapter 13. These recommendations can be summarised as follows:

- There is a need to help people keep in touch with work in a way that is sensitive to where they are in their recovery journey and that displays attention to detail.
- The iatrogenic effects of sick leave should be acknowledged with mitigating measures devised to reduce negative impacts on finance, social isolation, and occupational deprivation.
- Supporting people to maintain work orientation and identity can be facilitated by explicit affirmations of their work role, achievements and skills, and by assistance to challenge feelings of self-blame and guilt.
- Pre and post qualifying training for acute mental health staff is indicated to develop a ‘vocational imagination’ and promote awareness and understanding of the needs of service users who have jobs.
- Systematic and co-ordinated planning is likely to increase the success of return-to-work trajectories. This should include ‘tabling’ the issue, in a non-threatening manner, from the outset of a period of absence.
- Attention should also be paid to ensuring the sustainability of return to work in terms of natural supports, specialist support and by making changes to jobs.

The last recommendation in the list above included a range of specific points. Natural supports can be fostered amongst work colleagues, friends and family, and indeed people could develop skills – for instance of self advocacy – to be their own natural support. Peers constituted a potentially valuable source of support, which has received limited research attention and has not often been applied in job-retention interventions. People may benefit from support to negotiate changes to their jobs. For some people, the most sustainable return to work outcome may be for them to find new employment.

The issues related to providing support prompted considerable discussion amongst, service user advisors, my supervisors and myself. This related to questions of professional power and roles and to the valorisation of expertise by experience and tacit knowledge. My view, broadly shared by the research collaborators, is that specialist support, in the form of job-retention, mental health services (including peer expertise), need not be counterpoised to natural supports; rather, each can nourish the other. Specialist support is best provided by agencies which are independent of employers. It should be available to all who need it, and should effectively integrate mental health knowledge, vocational knowledge and interventions. It should include assessments aimed at understanding the impacts of mental health challenges on work, as well as of the impact of work on mental

well-being. As such, it can make a significant contribution to helping people reappraise their situations and identify changes to their work or career.

I acknowledged there were many potential avenues for further research. Given the limited literature to date more studies were recommended into job retention needs in a range of settings beyond that presented in this thesis. I am keen to explore further the potential for peer support to promote job retention and collaboration between peer support workers and occupational therapists. Such research could contribute to defining a complex job retention intervention which could then be used in larger randomised control trials in the same way that has happened with individual placement and support interventions. Amongst the theoretical concepts advanced or adapted in my thesis, iatrogenesis, occupational capital and synergies between resilience and occupation all merit further exploration.

In terms of methodology, this thesis has implemented a critical realist research project based on Danermark et al's (2002) approach. In doing so I have provided some evidence that, contrary to Yeung's (1997) critique, critical realism can be more than a philosophy in search of a method. I consider I have made a modest contribution to developing that method. I have proposed that the use of a structured literature review to substantiate the selection of frameworks for abductive analysis should be added to Danermark et al's stages of explanatory critical realist research. I have also endeavoured to address Speer's (2007) critique of limited use of reflexivity in critical realist research by a consistent endeavour to acknowledge and examine my own presence and influences at all stages of the research. A greater contribution is the demonstration that collaborative research practices which harness 'expertise by experience' are consistent with the critical realist epistemological aims to use multiple perspectives to gain insight into shared social phenomena. Indeed, perhaps one important achievement of the research is that through this process of collaboration the capacity of people and their networks to engage in job retention and wider mental health research has been increased.

Finally, three broader implications were presented as central conclusions of my thesis in this chapter. The first two emphasised how occupational and resilience-based perspectives could be integrated to help understand the challenges which people with mental health problems face when seeking to retain their employment. The third drew on these perspectives to uphold the legitimacy of a critique which calls for work to be organised in a way which is centred on the needs and well-being of people, and not just economic efficiency. I am sorry to say that the Retain project reported in this thesis is no

longer running (as no permanent funding was found once the charitable pilot funds were used), though our research has been shared to inform a range of related retention projects run by the Richmond Fellowship (Appendix Q). In itself this is a demonstration of the need to disseminate and develop job retention research. I hope this may challenge policy makers and those who fund services to respond to the needs of people like Clive, introduced in Chapter 1, so that they may return to their work in a way that promotes their mental health recovery rather than undermining it.

Glossary

Accommodation: Adjustment made to work environment, task or role to support the participation of a person with a disability or long term health condition in employment.

Acute Service User Panel (ASUP): Panel of service user advisors for the acute case study.

Disclosure: Sharing of selected information about a health condition or disability to an employer or colleagues. May be made to support a process of agreeing accommodations.

Employment/vocational specialist: A person whose role is to support people with health conditions or disabilities find or retain employment. They are not usually required to have a specific professional qualification but may have previous experiences in the field of employment or expertise derived from personal experience of a health condition or disability.

Fit note/sick note: Certificate issued by a medical practitioner (often a GP) confirming that someone is unable to work. From 2010 in the UK the 'sick note' became the 'fit note' allowing the medical practitioner to record circumstances in which a return to work may be possible (eg reduced hours/selected roles).

Improving access to psychological therapies (IAPT): Programme in the English National Health Service offering psychological therapies for common mental health problems (eg depression and anxiety).

Individual placement and support (IPS): Evidence based supported employment intervention developed to support people with severe mental health problems find and then retain mainstream work through ongoing support.

Job retention: Interventions aimed to support people in work who have a disability or health condition to retain employment.

Presenteeism: To go to work but not be fully productive. In this sense it is similar to and yet distinct from absenteeism. Suggested to increase in periods of heightened job insecurity. Presenteeism while unwell may undermine a person's health and well-being as well as their productivity.

Retain Service User Group (RSUG): Group of users of the Retain job retention project who advised on the community case study.

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Appendices

Appendix A: Literature review strategy and summary tables

The search aimed to identify peer reviewed primary research reporting the first person experiences and perspectives of employees with mental health problems in relation to their work related needs.

Meta-study research question:

What are the experiences and perspectives of employees with mental health problems of their work related needs and support?

Inclusion/exclusion criteria

Inclusion

- Peer reviewed primary research reporting first person experiences of job retention challenges encountered by people with mental health problems
- Published between 1996 (initially 1999) and May 2009.

Exclusion

- Quantitative research
- Research where first person experiences were not captured in depth (eg brief survey data)

Search terms

Key concepts related to the question were identified and then related terms for each were listed so that they could be used in electronic database searches. This process was helped by reference to other published reviews related to mental health or employment and by my own knowledge of the field. Terms for the concept of first person experience were not deployed in the search as it was found to be more successful to identify whether the research was focused on first person experiences at the stage of abstract screening.

Concepts	Terms
Employment	Employ*; occupation; vocation*; industr*; work*; jobs
Mental health problem	Mental health; mental ill*; psychiatr*; stress; depress*; anxiety; schizo*; bipolar disorder; personality disorder; psychosis;
Work related needs during recovery	Absentee*; return to work; re entry; retention; retain; stigma; discrimination; bullying; job prospects; sick leave; sickness leave; sickness absence; job loss;

Online electronic databases were chosen which covered key areas for this research (mental health, social science, business and management studies):

Allied and Contemporary Medicine (AMED);
British Nursing Index (BNI);
Business Source Premier (BSP);
Cumulative Index to Nursing and Allied Health Literature (CINAHL);
EBSCO E-Journals;
The International Bibliography of the Social Sciences (IBSS);
PsycARTICLES;
PsycINFO.

Key authors (eg Kirsh) and journals (eg *Work*) identified were then also searched. Cited references in articles which were screened in full were also checked.

Paper selection:

Identified titles and abstracts were initially screened to eliminate studies which did not meet the inclusion criteria. Full text copies of remaining papers were then obtained when possible (including ordering from British library).

Selected papers were individually screened supported by the first two screening questions of the Critical Appraisal Skills Programme (CASP) (2006). Then the remaining 15 papers which were identified and available were appraised using the CASP (2006) and Greenhalgh and Taylor's (1997) appraisal tools. A summary of this appraisal for each article is shown in the following table:

Table of selected literature review papers:

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
Auerbach, E. S. and Richardson, P. (2005). "The long-term work experiences of persons with severe and persistent mental illness." <i>Psychiatric Rehabilitation Journal</i> 28(3): 267-273.	1) What was it like for individuals "to decide to try work" 2) Factors which participants thought helped retention.	Grounded Theory. Semi-structured interviews.	6 people with Severe Mental Illness (SMI) who had worked for min of 18 months in last 3 yrs. USA	Motivation to work helped participants to make use of supports – notably human ones, but also adjustments – to overcome a range of obstacles.	Achieves a logical and coherent explanation of experiences. 4 of 6 participants were employed by mental health services - this is acknowledged in limitation section, but discussion about how might have influenced the results is not developed.
Cunningham, K., Wolbert, R., et al (2000). "Moving Beyond the Illness: Factors Contributing to Gaining and Maintaining Employment." <i>American Journal of Community Psychology</i> 28(4): 481-494.	1) To understand factors associated with the ability of individuals with SMI to gain and retain employment 2) To explore reasons why Assertive Community Treatment (ACT) has mixed results re vocational success.	Interpretative qualitative design. 3 purposively selected comparative groups. Semi structured interviews.	17 people with SMI engaged in one ACT programme. 3 groups: 1) employed at time of study 2) able to obtain work but not maintain > 4 months 3) unsuccessful at obtaining employment. USA	Individuals' awareness and attitude to their mental health problem impacted on ability to get and retain work. a) To get a job a clear perspective of illness was important b) To retain work seeing illness as not defining who they were was important. c) Regarding gaining and retaining work: "how one manages one's illness is less significant than how one <i>manages one's</i> life having an illness." (p492) The authors suggest interventions could try and help people develop this perspective before working.	Evidence of generally robust design making effective use of comparative groups. Arguably could have been improved with more reflexivity re researcher's stance and user validation or commentary on researcher's interpretations. Whilst not using the term mechanisms the study did advance some factors as explanatory and not just as associations.

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Dunn, E. C., Wewiorski, N. J., et al (2008). "The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study." <i>Psychiatric Rehabilitation Journal</i> 22(1): 59-62.</p>	<p>To determine how individuals with successful recovery perceive work and its effect on recovery from mental health problems.</p>	<p>Grounded theory methods of analysis to illuminate and interpret participants' experiences. Used data collected from a parent study into the recovery process.</p>	<p>23 participants who had experienced psychosis and whose life "had been going in a positive direction" for 2 years or longer (p60). 18 currently working, 4 had previously worked and were job seeking (other not stated). USA</p>	<p>Work had strong meaning for participants with established work identities and desire to work during recovery. Participants worked even well unwell and heavily medicated. Work promoted recovery by enhancing self-esteem, with people feeling valued at work in a way not experienced elsewhere in their lives. The routine and occupation of work was also perceived to be stabilising and help management of symptoms. Financial rewards of work were also considered to promote participants recovery.</p>	<p>Use of positive recovery experiences gives insight into some possible explanations for successful work experiences. Data was from a parent study in which individuals were interviewed about recovery generally: this may have reduced the depth of material related to work. Credibility of analysis was enhanced by use of a team of 4 analysts, including one person with a mental health problem. Apart from this, and the inductive approach, there were no other reported measures to reduce bias or enhance trustworthiness. Authors acknowledge the highly select group limits generalisability of findings. An unacknowledged additional limitation may be that some participants worked supporting others with mental health problems – and therefore may have had particularly supportive workplace contexts.</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Gates, L. B. (2000). "Workplace Accommodation as a Social Process." <i>Journal of Occupational Rehabilitation</i> 10(1): 85-98.</p>	<p>1) To review literature related to social processes in workplace accommodation 2) To describe a psychoeducation intervention to support accommodations by addressing social process issues.</p>	<p>1) Narrative literature review 2) Qualitative analysis of pilot intervention using data from the process (structured and semi structured interviews, case notes and case tool used by case worker).</p>	<p>12 workers with psychiatric diagnosis on short term sick leave and their work supervisor and colleagues. USA Municipal employer.</p>	<p>Understanding that accommodation is a social process requiring coordination of the worker, healthcare provider & workplace increases potential for successful accommodation.</p>	<p>Logically sound and strong empirical basis for thesis using literature review (though narrative). Pilot findings coherently presented with effective and logical reasoning. Significant limitations in methodology re: clarity of recruitment; and analysis strategy. Suggesting claims should have been more tentatively made and further research proposed to address limitations. Inconsistent presentation of the aims of the research. At one point it was stated that their aim was to describe a psycho-social intervention then later this develops in pilot testing them and on a third occasion to "explore its potential for the workplace and serve as a basis for hypothesis building leading to future, controlled effectiveness testing." (p93).</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
Gewurtz, R. and B. Kirsh (2007). "How consumers of mental health services come to understand their potential for work: doing and becoming revisited." <i>Canadian Journal of Occupational Therapy</i> 74(3): 195-207.	The purpose was to analyse the interaction of the concepts of doing and becoming from occupational science/therapy theory and apply it to understanding work recovery experiences among mental health service users.	Constructivist approach to grounded theory. Single semi structured interviews.	10 clients of urban mental health services in Canada with a story to tell related to work experiences & perspectives and their recovery. All had current work related goals. Some not working some part time paid/voluntary . No full time.	Through doing work & becoming people with possible work futures participants developed ideas about their future work potential.	Clear account of analysis and trustworthiness measures – though it is open to question whether the methodology was fully consistent with how the constructs of doing and becoming were involved in data collection and analysis. Despite use of trustworthiness measures it is unclear how these contributed to results notably with regard to the use of the reflexive journal.
Gioia, D. (2006). "Examining Work Delay in Young Adults with Schizophrenia." <i>American Journal of Psychiatric Rehabilitation</i> 9(3): 167-190.	To explore the subjective experiences of work delay of young adults diagnosed with schizophrenia.	Narrative approach using grounded theory methods of constant comparative analysis in analysis. 2-3 semi structured interviews per participant.	20 first episode young adults diagnosed with schizophrenia who had been working before diagnosis and who had actively sort to return to work (19 had gained at least one job 1 had not). USA.	Illness related factors (eg symptoms, medication & non illness related factors (eg childcare, training) influence delay between diagnosis and return to work for young adults with first episode of schizophrenia. Concludes that professional, family members and benefits system could help people achieve vocational success by helping people to reclaim a “vocational trajectory of growth & development” (p186).	Clear account of how data was obtained. Rigour of analysis supported by use of 2 coders using constant comparative methods. Unclear to what extent pre existing concepts were brought to the data or whether analysis aimed to allow themes to freely emerge from the data. No evidence of reflexivity regarding the researcher’s stance or of related measures such as reflexive diary. No member checking or equivalent measures. Whilst the 2 overarching categories could be questioned the individual themes were supported with consistent reference to the data. Not clear what happened to job pre illness.

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
Hatchard, K. (2008). "Disclosure of mental health." <i>Work</i> 30(3): 311-316.	To demonstrate the potential utility of the model of occupational competence (using dimensions of individual, occupation and environment) to support return to work of employees with mental health problems (notably with regarding to disclosure and implementation of accommodations).	Single case study design drawing on lived experiences of the employee and their occupational therapist.	48 year old woman in finance industry. Divorced and living alone. New diagnosis of bipolar mood disorder (previous misdiagnoses with related mental health conditions). Small town in Canada.	The research concludes that the use of the occupational competence model to inform return to work process (notably with regard to disclosure and identifying and implementing accommodations) can promote collaboration and a shared understanding of the employees' needs.	This study is able to effectively present and discuss in a logically consistent and coherent manner the return-to-work challenges and processes of one individual in relation to the occupational competence. The recognised limitations of a using a single individual case study is added to by lack of clarity about what data was used, no evidence of reflexivity which would have been useful given the author appears to have been the employee's therapist,; and no evidence of respondent validation of the author's interpretations.

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Honey, A. (2003). "The impact of mental illness on employment: Consumers' perspectives." <i>Work</i> 20(3): 267-276.</p>	<p>To illuminate and interpret mental health service users' perspectives of the impact of mental illness on employment experiences.</p>	<p>Grounded theory methodology to collect and analyse data – predominately through unstructured individual interviews. There were also 2 focus groups.</p>	<p>41 mental health service users recruited from a number of sources (teams and consumer groups). Australian study.</p>	<p>Participants' goals to maintain good mental health (eg through stress avoidance) at times influenced decisions they made about work in ways which could be understood to be negative in employment related terms. Performance at work was, for many, negatively affected (directly or indirectly) by having a mental health problem. Even when performance was not affected some still experienced stress and reduced job satisfaction attempting to sustain work. Lack of confidence in their ability to work was common and suggested to be a more useful concept than that of worker identity which it was argued all shared.</p>	<p>This study drew on a rich and for qualitative research large amount of data. That participants were recruited from a range of sources and included workers and non workers is presented as a strength in terms of supporting the transferability of the findings to other people with mental health problems. It could be seen as a limitation for those wishing to transfer the findings to more specific sub groups – eg employed people. There was evidence of a generally rigorous application of grounded theory as both a methodology and its methods. This appeared to be the main basis by which the research adjusted for bias as there was no evidence of reflexivity. The grounded basis for the findings could have been enhanced if the sample quotes had been presented in a more integrated manner.</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Killeen, M. B. and O'Day, B. L. (2004). "Challenging Expectations: How Individuals with Psychiatric Disabilities Find and Keep Work." <i>Psychiatric Rehabilitation Journal</i> 28(2): 157-163.</p>	<p>To gain insight into the systemic & programmatic barriers to employment encountered by people with mental health problems & to understand what factors contributed to successful employment (gaining and retaining work).</p>	<p>Semi-structured interviews designed to elicit participants' experiences and views of gaining and retaining work and the barriers that they had encountered. Some evidence of purposive sampling.</p>	<p>32 people with severe mental health problems. Half of these were working half were unemployed. US state – urban and semi urban, broad ethnic and gender mix.</p>	<p>Participants received negative messages about potential work capacity from professionals, friends and family. Discussion focused on illness and illness management rather than a person's abilities, talents and interests. The benefits system and participants' understanding of it acted as a disincentive. Barriers were experienced in training and education. Having a clear vocational strategy, which was believed in and persisted with, was found to be important. Factors identified as supporting retention and career development were: receiving positive messages and resisting negative ones; having a collaborative relationship with a mental health professional; return to education for some. All had relied on some form of peer support (formal or informal). The study concluded policy and services need to reform themselves. No one approach was recommended – rather a range should be used depending on individual needs.</p>	<p>This study used an effective recruitment strategy to obtain an appropriate and for qualitative research large sample for the research aims. It is clear rich experiences were obtained which were coherently presented and interpreted. Conclusions were consistent with the findings. Unfortunately the method of analysis was not clear and there was no information reported about measures to ensure rigour and trustworthiness in the process.</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Kirsh, B. (1996). "Influences on the process of work integration: The consumer perspective." <i>Canadian Journal of Community Mental Health</i> 15(1): 21-37.</p>	<p>To "illuminate psychological, social, and environmental factors" (p25) which supported participants success in gaining and retaining work (p25).</p>	<p>Qualitative semi structured interviews using by grounded theory methods of analysis.</p>	<p>5 employed mental health service users . Recruited through user groups. Canada.</p>	<p>The four primary themes which participants described as influencing successful experiences in employment were: recognition of the importance of the mind body link; the importance of a sense of personal empowerment/control; meeting of needs for skills (notably problem solving, coping and communication) and supports (notably family, services, peers); and, a work environment which was structurally adaptable and had an open and supportive culture.</p>	<p>The justification for the methodology is well established and the methods used are clearly documented. Development of themes is well set out in the findings. There is effective use of literature throughout (introductory literature review, findings and discussion). The main limitations are the absence of any clear reflexive measures and the small sample size with a possible bias in recruiting from user groups affecting representiveness and potentially explaining why social contact was not found to be a motivator for work which Kirsh identifies as a difference from other studies.</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Krupa, T. (2004). "Employment, recovery, and schizophrenia: integrating health and disorder at work." <i>Psychiatric Rehabilitation Journal</i> 28(1): 8-15.</p>	<p>To advance theory about the processes involved in the recovery of work participation for individuals with schizophrenia.</p>	<p>Explanatory multiple case study design (Yin 1994).</p>	<p>3 individuals with a diagnosis of schizophrenia – 2 working one not working. Canada.</p>	<p>The overarching challenge confronting participants was the integration of the experience of their mental health problem at work. This involved negotiating issues arising from interaction of their mental health problem and their job or work environment. It also involved developing “a positive self identity in the work realm that was distinct from, but accommodated features of the disorder”(p10). Two phases were identified. Firstly to assume control over their illness when it was overwhelming them. The second phase involved synthesising issues of health and illness at work. Disclosure was seen as increasing the likelihood of experiencing discrimination – though concealment was also seen as accepting social prejudice and undermining acknowledgement of impacts of illness.</p> <p>The author concludes that recovery in relation to work can be more meaningfully understood in relation to these phases and associated tasks of integration than in terms of “recovery of work function” which is described as a “...misnomer” (p14).</p>	<p>The article would have benefitted from more transparency in a number of areas: recruitment; the contribution role of secondary data sources to the findings; how and to what extent the interviews were structured. Appraisal may have been helped by more reflexive acknowledgement of the impact of the researcher on research process.</p> <p>Member checking was used. The use of a range of secondary data was a measure which enhanced the trustworthiness of the data. The multiple case study design was justified in terms of its potential to develop theory, but the constraints on this placed by the small number of participants did not seem to have tempered the breadth and depth of claims made. One participant was not working at the time of interview to provide a contrasting base on which to develop a consistent theory. It was not clear from the presentation of the data how useful this contrast was.</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Millward, L. J., A. Lutte, et al (2005). "Depression and the perpetuation of an incapacitated identity as an inhibitor of return to work." <i>Journal of Psychiatric and Mental Health Nursing</i> 12(5): 565-573.</p>	<p>"to conduct a qualitative investigation of attitudes to work among people diagnosed with clinical depression" notably "the role played by illness in attitudes to recovery" (p565).</p>	<p>Interpretative analysis using Interpretive Phenomenological Analysis (IPA). Qualitative semi structured interview.</p>	<p>Purposive sample. 19 people who had at some point left work due to uni polar depression. Recruited via mh networks notably day centres. All had been off work for minnum of 10 weeks. 6 men 13 women aged 28-52. UK.</p>	<p>Many participants overwhelmed by symptoms and had taken on a sick role with external locus of control. Fluctuating symptom severity restricted future plans. For these participants work not seen as important. Negative past experiences reasons for why they would never work and overrode contrary positive evidence. Sick role challenged by those who viewed themselves in recovery/transition. They were more "vocationally orientated" (p568). This helped when noticed improvements to symptoms. Also helped by adopting alternative identities (to sick role) and social contact with "ordinary people". Working supported resumption of work identity. A partial view of illness as a defining characteristic helped prevent relapse. Being diagnosis and signed off sick seen as legitimising illness identity. Statements from health profs and family re not being able to work reinforced illness identity. MH services (esp day services) indirectly reinforced illness identity. Some felt guilty doing activities which they enjoyed. Some normalised lives using MH services. Others disliked disconnection from 'normal' life and for them this was a motivation for recovery. All identified how they were different from others and/or their past selves.</p>	<p>Relatively large sample for IPA study though acknowledged that many all attended the same day service. Consequently the apparent common theme of day services being an endpoint rather than stepping stone may reflect that particular service. Strong justification for IPA as method of analysis – also clearly detailed. The underpinning interpretative methodology was less coherent with a stated aim to try and understand experience on the one hand, whilst also making claims about revealed processes seemingly more consistent with a realist orientation. 2 researchers independently analysed data – member checking referred to. Reported use of reflexivity - though not detailed. Themes presented in findings cohered with supporting data. By contrast 2 discussion points (related to medication and goal setting were introduced which had not been referred to in the findings).</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Provencher, H. L., Gregg, R., et al (2002). "The role of work in the recovery of persons with psychiatric disabilities." <i>Psychiatric Rehabilitation Journal</i> 26(2): 132-145</p>	<p>To explore the role of work in the recovery of both employed and unemployed people with mental health problems.</p>	<p>An interpretative qualitative design using semi structured interviews.</p>	<p>14 participants recruited from 2 mental health centres and two peer support organisations in New Hampshire USA. Range of severe and enduring mental problems (6 schizophrenia, 2 schizo affective disorder, 2 bipolar disorder, 2 depression, 2 post traumatic stress).</p>	<p>Six themes framed the experiences of recovery: self-definition, empowerment, connection to others, meaning of work, vocational future, and meaning of recovery.</p> <p>Variable responses to these enabled identification of three profiles of recovery. Those in profile 1 saw recovery as uncertain; felt overwhelmed by emotional problems; faced health, self care and routine challenges; had a dominant self identification as a psychiatric patient; saw work as a means to pass time and/or a stressor; and faced internal and external barriers to work.</p> <p>Those in profile 2 saw recovery as a self empowering process to which work made a significant contribution by: building self efficacy, emotional coping skills, providing enjoyment and an increased source of income. Peer support jobs were experienced as particularly meaningful. They also reported significant barriers to work.</p> <p>The 2 individuals in the third profile saw recovery as a challenge to rise to. Generally, stressful events were seen as challenges. Work was a means to self actualisation alongside other multiple roles. It was suggested these profiles may represent stages in recovery.</p>	<p>Unclear whether the organisations which referred participants for the study selected them purposively according to any additional criteria other than that of having mental health problems. This may have some influence on the subsequently identified profiles. Credibility of results enhanced by sufficient information being given about content of semi structured interviews based on a literature search by 4 experts one of which had mental health problems. There was no explicit reflexive discussion of the impact of the researchers' own role and stance might have had on the study design and analysis. The analysis process was clearly described and involved multiple coding but no participant validation was reported. Conclusions were made which were consistent with the reported findings and suitably tentative given the limited number of participants.</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Strickler, D. C., Whitley, R., et al (2009). "First Person Accounts of Long-Term Employment Activity among People with Dual Diagnosis." <i>Psychiatric Rehabilitation Journal</i> 32(4): 261-268.</p>	<p>"To elicit and examine first person accounts of work activity over a 16 year period from people with dual diagnosis." (p261).</p>	<p>The data was collected by adding 6 open questions related to employment to structured individual interviews held as part of a wider study into dual diagnosis. This was inductively analysed using qualitative content analysis.</p>	<p>120 participants who were part of a longitudinal study into dual diagnosis. Recruited from mental health services in New Hampshire USA. Distributed across 4 natural groups – never or hardly worked; worked intermittently; worked fairly consistently; worked very consistently.</p>	<p>Employment both required and supported illness management for consistent workers who perceived work as promoting recovery. For non or less regular workers the demands of managing illness and its impacts (notably symptoms) was perceived to be a barrier to sustaining work which in turn was viewed as a source of stress. Consistent workers tended to be satisfied with their jobs. Irregular workers left jobs due to physical, mental or emotional aspects of work. Consistent workers were more motivated to work and seek support or independently find work or overcome challenges at work. There were conditioning effects of working or not working which reinforced working or non working trajectories over time.</p>	<p>Large sample for qualitative research though depth of data appears limited as gathered as part of an interview of a broader study and responses were to specific questions which were recorded in writing. This may explain the arguably surprising absence of any reference to experiences of stigma or discrimination. Multiple coding strategy and consensus in identifying themes enhanced the rigour of the analysis by reducing investigator bias. There was no participant validation or involvement reported. Whilst seeing work as both demanding and encouraging illness management, the conclusions leave open questions about whether a number of the differences between those who worked most regularly and those who did not were likely to be causal or consequential of different engagement in work. It could be seen as a strength that the authors were not tempted to make a firm commitment either way.</p>

Author/Date	Aim of study/paper	Study design/Information	Participants & Setting	Main Findings/Conclusions	Strength & Limitations
<p>Van Niekerk, L. (2009). "Participation in work: A source of wellness for people with psychiatric disability." <i>Work</i> 32(4): 455-465.</p>	<p>"To explore the influences that impacted on the work lives of people with psychiatric disability" (p455).</p>	<p>Interpretive biographical design within a declared post modern orientation. Average of three narrative interviews per participant. Biographies constructed by researcher in addition to interview data.</p>	<p>17 participants (majority competitively employed). Range of severe mental health problems – notably schizophrenia (6) and bipolar disorder (7). South Africa.</p>	<p>Work helped people to challenge negative self perceptions by evidencing their competence. Having a mental health problem lead to feelings of isolation which was reinforced when they did not disclose their mental health problem at work but this was markedly reduced when they did disclose. After initial diagnosis most thought there was little hope of future success at work. Worker identity was only developed by working in "real" jobs. This identity was undermined where people had: limited previous work experience; lost jobs after relapses; symptoms which affected work performance and choices. Having a job to return to supported recovery. Participants who displayed flexibility in responding to the impact of their mental health problem had more successful work experiences.</p>	<p>Collected rich data from participants from interviews over period of at least 6 months. The interpretive biographical design was coherently justified in relation to gathering and interpreting the experiences of participants. The declared post modern orientation was justified in relation to the study's concern with a marginalised group with lives in flux. However it could be argued that this paper had more of a realist orientation in its attempt to collectively interpret the narratives and present conclusions as relevant to other contexts. Trustworthiness was enhanced by participant involvement in development of themes. There is evidence of reflexivity in the researcher challenging a key assumption brought to the study as a result of the findings. The conclusions cohered with the findings but would have benefited from a more explicit consideration of limitations and transferability.</p>

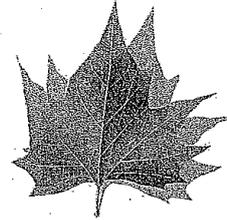
Appendix B University of Brighton research sponsorship letter

Faculty of Health



University of Brighton

Direct line



Clinical Research Centre
for Health Professions
Professor Ann Moore PhD GradDipPhys
FCSP DipTP CertEd FMACP
Director of Centre

15th December 2005

Aldro Building
49 Darley Road
Eastbourne BN20 7UR
Telephone 01273 643647
Fax 01273 643944

www.brighton.ac.uk/sohp/research/index.htm

Dear

University of Brighton research sponsorship

I am writing to confirm that the University of Brighton will act as research sponsor as required under the Department of Health's Research Governance Framework, for the project entitled *Acute Mental Health Service Users' Experiences and Perspectives of their Work Related Needs During Recovery – A Qualitative Interview Based Study Using a Phenomenological Methodology* to be carried out by Josh Cameron.

If there are any general questions about the university's approach to research governance, please contact Ronnie Boyce-Stevens, Academic Research Officer on 01273 644184 or V.Boyce-Stevens@brighton.ac.uk

Yours sincerely,

Professor Ann Moore PhD, GradDipPhys, FCSP, DipTP, CertEd, FMACP
Director of Research

Appendix C: NHS Local Research Ethics Committee Approval



Local Research Ethics Committee

28 June 2006

Mr Josh Cameron
Occupational Therapy Lecturer/Practitioner
East Sussex County Healthcare & University of Brighton
School of Healthcare Professions, University of Brighton,
Robert Dodd Building, 49 Darley Rd,
Eastbourne
BN20 7UR

Dear Mr Cameron

Full title of study: Acute Mental Health Service Users' Experiences and Perspectives of their Work Related Needs During Recovery - A Qualitative Interview Based Study using a Phenomenological Methodology.
REC reference number: 05/Q1905/146

Thank you for your letter of 22 June 2006, 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 Alternate Vice-Chair.

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.

Site Specific Issues

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Research Ethics Committees to be informed or SSA to be carried out

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.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	Part A	20 December 2005
Investigator CV		19 December 2005
Protocol	2	19 December 2005
Covering Letter		22 June 2006
Covering Letter		19 December 2005
Summary/Synopsis	2	19 December 2005
Letter from Sponsor		15 December 2005
Compensation Arrangements	Appendix 8 of Interim Research Governance Guidance document.	19 December 2005
Interview Schedules/Topic Guides	3	27 June 2006
Questionnaire: Supporting Information	1	20 June 2006
Letter of invitation to participant	2	19 December 2005
Participant Information Sheet	3	01 June 2006
Participant Consent Form	3	01 June 2006
Response to Request for Further Information		
Professionals letter		19 December 2005
Work Environment Impact Scale assessment information	2.0	01 January 1998
Worker Role Interview assessment information	9.0	01 January 1998
Research Governance Risk Assessment Checklist	1	20 December 2005
Academic Supervisor Checklist	1	20 December 2005
University of Brighton Interim Guidance on Research Governance in Health 2004/2005	1	01 January 2004
Information and support information for participantsq	1	19 December 2005
Summary CV for Supervisor		15 December 2005

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q1905/146	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project

Yours sincerely



Appendix D: University of Brighton ethics approval letter for community mental health study

(addressed to research collaborator Dr Carl Walker)

01273 644763



Dr Carl Walker
School of Applied Social Science
Mayfield House
Falmer

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Dear Carl

Title of Proposal: Employment and Mental health in the South East
FREGC Application Number: 07/61

We are writing to confirm that the above-mentioned proposal has been approved by the Research Ethics and Governance Committee of the Faculty of Health and Social Science (FREGC) after an independent scientific and ethics review.

Although approval has been given to start the research work, it is the ultimate responsibility of the researchers to ensure that the work is conducted within the Research Ethics and Governance Framework of the University of Brighton, and if applicable, those of the Department of Health and any funding body. Approval of project is given for the duration of the research indicated in the application form, although FREGC may review this decision at any time and has the right to suspend or terminate this approval.

You are required to notify the Committee in writing if there any substantial changes in the research methodology or any serious adverse events or accidents during the conduct of the study. As a requirement of the Governance Framework, please submit annual progress and completion reports to the Committee. You may not be need to prepare a separate progress report for the Committee as we would be happy to receive a copy of annual report submitted to funding body, NHS or other relevant body to satisfy this requirement. Please see the Guidance Notes of the Application Pack (Section 7) for further information.

Yours sincerely

Professor Julie Scholes RN DipN.DANS MSc Nursing D.Phil
Chair of Faculty of Health Research Ethics & Governance Committee

Appendix E: Letter of information to health and social care professionals (acute study)



University of Brighton

School of Healthcare Professions

J.Cameron@Brighton.ac.uk

Letter of information to health and social care professionals

Date

Dear colleague,

Re: Acute Mental Health Service Users' Work Related Needs During Recovery Research Project

I am writing to let you know about this research project which some of your clients might be invited to participate in. Details of the project are set out in the attached participant information sheet and synopsis of the research protocol.

I also would like you to consider whether any of your clients might be suitable participants for the study.

The inclusion criteria (people eligible for the study) are:

- People who are currently receiving a service from the working age adult acute mental health services in the XXXX NHS trust. These include inpatient, acute day hospital and Crisis Resolution and Home Treatment services.
- People who had a paid or voluntary working role prior to their current episode of care from the acute mental health services.

The exclusion criteria (people not eligible for the study) are:

- People who are currently subject to a section of the Mental Health Act.
- People whose anxiety levels, in their opinion, or the opinion of their care team, will be exacerbated by taking part. It is anticipated that for most people the interview will be a positive experience - but it is acknowledged that some people recovering from acute mental health problems may be at risk of increased anxiety due to the nature and severity of their mental health problem.
- People who will not be able to remain sufficiently focused to meaningfully participate in the proposed interview in either their opinion or the opinion of a professionally qualified member of their care team.
- People who pose a current significant risk to self or others, in their opinion, or the opinion of a member of their care team.
- People who are active clients of the research interviewer.

If you think one of your clients would be suitable I would like to ask you or a colleague to follow the following steps:

1. Approach them and give them the participant information sheet so that they can consider taking part.
2. Then once they have had at least 24 hours to consider this I will arrange for someone *not* involved in their care to ask them for their decision and sign the consent form with them.

I am an experienced occupational therapist and am carrying out this research as part of my studies for a doctorate at the University of Brighton. I also hope the results will help mental health services to understand better the work related needs of people recovering from acute mental health problems.

Participation will involve an interview with me to discuss issues related to their recent work and current recovery from mental health problems. They can also choose to have an occupational therapy assessment of their work related needs.

The reason why I would like you or a colleague to approach your clients in the ways described above is so that they don't feel pressured by a researcher approaching them directly.

The study has been reviewed and approved by the XXX Local Research Ethics Committee. It has also been approved by the University of Brighton and by the XXX NHS Trust following its research governance procedures.

If you would like any further information (for instance to discuss any issues further or to request a copy of the full protocol) please do not hesitate to contact me at the address at the head of this letter

Yours faithfully,

Josh Cameron
Professional Doctorate Student
Senior Lecturer in Occupational Therapy, University of Brighton
NHS Research Development & Support Unit Advisor

Appendix F: Participant information sheet and consent form – acute study



University of Brighton

Acute Mental Health Service Users' Work Related Needs During Recovery Research Project

Information sheet: For people thinking about taking part in an interview for this project.

What is the project? The project is about the experiences and views of people recovering from acute mental health problems. In particular it wants to find out about their work related needs.

What is the research trying to find out? I would like to talk with people who are recovering from an acute mental health problem and who have recently had either a paid or voluntary job. The acute mental health services involved are provided by XXX NHS Trust. In your case this is the acute mental health services based at XXX.

I want to find out what needs, if any, you think you have related to your work. I hope that this information will help mental health services to better understand and help people in a similar situation to you. I also want to find out what support you would need to be able to get involved in a possible future project aimed at helping people with their work related issues.

Why have you been given this information sheet? A member of your care team has given you this as you said you might consider taking part in this research. I want to give you as much information as possible to help you decide. If you do decide that you want to take part you will be given a consent form to sign which will then be passed to me. I will then contact you to arrange a time for your meeting.

How long will I want to talk to you for? The first meeting will last from 30 – 90 minutes. If you decide to have an occupational therapy assessment of your work related needs, this will take the form of a second interview that will take 60-90 minutes.

Who will interview me? You will be interviewed either by Josh Cameron (the person leading the research) or a member of XXX Trust staff (but not by anyone who is currently directly involved in your care).

Can you have an occupational therapy assessment of your work related needs without participating in the project? Yes. You do not have to agree to participate in the project to have your work related needs assessed. You can either ask the person who gave you this sheet or a member of your care team to arrange one.

Will you be asked to do anything else? You will be given a brief supporting information questionnaire which you can complete before or at the beginning of your meeting.

Do you have to take part? You don't have to take part if you don't want to. You can say you don't want to take part right now to the person who gave you this information sheet or another member of your care team. Even if you do say you would like to take part and sign the consent form you can still say you want to stop. You can say you want to stop taking part at any time without giving a reason. If you stop the person who first contacted you about taking part will not be told. Stopping or not agreeing to take part will not affect your care in any way.

Who will know what you have said if you take part? With your permission the interviewer will tape-record the discussions. However, nobody apart from Josh Cameron and your interviewer will know that it is you who was talking. I would like your permission to use anonymous direct quotes in written or spoken presentations, and will ask for your written consent to do this. Of course, when I write or speak about your opinions or experiences in my reports I will not use your real name or include other information which might identify you. Any of the professionals who work with you will not know that it was you who told me what I have written about unless you tell them.

There are two situations in which information which identifies you might be shared. Firstly, if you choose to have an occupational therapy assessment of your work related needs you will be asked if you would like this to be shared with people involved in your care so that they can use this information to help you. Secondly, if you say anything which suggests that you or someone else might be at risk of some significant harm the interviewer is obliged to pass this on to a member of your care team.

I will keep the tape recordings of our discussion and any paper or computer discs in a locked cupboard at the University of Brighton. This will be kept for 10 years and then destroyed.

Will taking part affect you in any way? Taking part won't affect your physical health in any way. It won't affect your care in any way unless you choose to have an occupational therapy assessment of your work related needs. If you do decide to have this assessment you can decide to share this information with your care team so that they can help you with issues that you have raised. However, you might have had some difficult experiences in connection with your work and your mental health problem. This means you might get upset if you choose to talk about them. If you get upset your interviewer will be understanding and offer you support. You will be given an information sheet about other support that is available.

Will you hear about the findings? At the end of the project a report will be written and I will send you a summary of it.

Who is doing this study? The project is being undertaken by Josh Cameron. I am carrying out this research for an educational qualification at the University of Brighton. I am also an experienced occupational therapist and senior lecturer at the University. I also hope the results will help mental health services to understand better the work related needs of people in your situation.

Who has approved the study? The study has been reviewed and approved by the XXX Local Research Ethics Committee. It has also been approved by the University of Brighton and XXX Trust managers.

How can you complain about the project? You can complain about this project in a number of ways:

- To a member of your care team.
- To [details of senior Trust contact]
- To Professor Angie Hart who is Josh Cameron's educational supervisor at the University of Brighton. Her address is: XXX

How can you find out more? Further information can be obtained either by asking the person who gave you this information to ask me to contact you, or you can contact me directly:

Josh Cameron, University of Brighton, School of Health Professions, Robert Dodd Building, 49 Darley Rd, Eastbourne, BN20 7UR. Tel 01273 643774

You will be given a copy of this information sheet to keep. If you decide to take part please telephone Josh Cameron on 01273 643774. You will also be approached *once* by a member of staff who is not in your care team to ask if you would like them to pass on your decision. You may prefer this to ringing yourself. You do not have to have to tell them your decision, or whether you have contacted me already, unless you want to. You will not be put under any pressure to participate. If you agree to take part you will also have a signed copy of the consent form to keep.

**THANKYOU VERY MUCH FOR READING AND CONSIDERING
PARTICIPATING IN THIS PROJECT.**

Josh Cameron, University of Brighton



Consent Form

Title of Project: Acute Mental Health Service Users' Work Related Needs During Recovery.

Name of Researcher: Josh Cameron

Please initial box

- 1. I confirm that I have read and understand the information sheet dated ...16.01.2007 version.....4.....) for the above study and have had the opportunity to ask questions.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my health care or legal rights being affected.
- 3. I agree to take part in the above study.
- 4. I agree to my interview being recorded.
- 5. I agree to anonymised quotes from my transcript being used in oral and written presentations and publications.

Name of Service User	Date	Signature
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Name of Person taking Consent	Date	Signature
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Researcher	Date	Signature
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Appendix G: Participant information sheet and consent form - community study

University of Brighton

INFORMATION SHEET

EMPLOYMENT AND MENTAL HEALTH

You are being invited to take part in a research study. Before you decide whether you take part it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with friends and relatives if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study and why is it important?

You may be aware that mental health difficulties can have an important impact on a company and its employees. This project aims to help us explore attitudes to mental health from the perspective of people who use or have used the Retain service and to contextualise the different barriers to employment and job retention that exist in a number of public, private and voluntary organisations in the South East. We intend that the results of this study will eventually help to more effectively meet the needs of employees who are affected by mental health at work.

Why have I been chosen?

You have been chosen simply as someone who has worked with Retain recently. The reason for your being chosen is not related to the way you currently address mental health issues at work, simply as a user of Retain. We are canvassing a number of Retain service users in order to understand their experience of employment and of Retain.

Do I have to take part?

It is up to you to decide whether or not to take part. This study relies on voluntary participation, and its success depends on the goodwill and co-operation of those asked to participate. You will have the duration of the project (approximately six months) to decide whether you wish to take part.

What if I change my mind about taking part?

You can decide to end your involvement at any time without giving a reason for your withdrawal.

Is the study confidential?

We take very great care to protect the confidentiality of the information we are given. The study results will not be in a form that could reveal your identity. Although everyone who takes part will be allocated a study number, only the research team and the Retain research steering group will know this. The service users on this steering group will not have information on the identity of participants. We guarantee that these numbers will be held securely, in the strictest confidence. All of the anonymised information that we do keep will be stored in a purpose-built, locked room at the University of Brighton. Neither individuals nor organisations will be identifiable in any published or disseminated material. Also, any information that you disclose will not be available to your employer.

What will happen to me if I take part?

We will simply arrange a semi-structured individual interview. It will last around 45 minutes at a time of your convenience at the Richmond Fellowship in XXX. The interviews will touch upon your experience of being a Retain service user. The interviews will be recorded. It should be noted that some of the questions cover issues that some may consider to be sensitive or distressing. Should you be distressed by any of the questions on the interview schedule then you will have the opportunity to have a break, cancel the interview and/or speak to the key worker on duty at Retain should you so wish.

Who is organising and funding the research?

This study has been funded by the University of Brighton and The Richmond Fellowship. The principal investigators are Dr. Carl Walker (01273 643475) and Josh Cameron (01273 643774).

Participant consent form (community study)

UNIVERSITY OF BRIGHTON

Employment and the experience of Retain service users in the South East

- ◆ I agree to take part in this research which is to understand better the employment experience of Retain service users.
- ◆ The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.
- ◆ I have had the principles and the procedure explained to me and I have also read the information sheet. I understand the principles and procedures fully.
- ◆ I am aware that I will be required to answer questions in an interview format.
- ◆ I understand that any confidential information will be seen only by the researchers and will not be revealed to anyone else.
- ◆ I understand that my responses will be taped.
- I agree to anonymised quotes from my transcript being used in oral and written presentations and publications
- ◆ I understand that I am free to withdraw from the investigation at any time.

Name (please print)

.....

Signed

.....

Date

.....

Appendix H: Sample acute study service user advisor meeting notes

Notes of Research team meeting

Issues:

1. Introductions.

2. Role of Advisors

- a. To bring service user perspective to how research is carried out.
- b. To bring a balance/challenge to Josh's professional perspective.
- c. To participate in analysis of the interviews.
 - i. This will be done by discussing anonymous transcripts in our group meetings: to find themes and possibly link them to build explanations. **Action – to look at a transcript in the next meeting.**
- d. Potentially (if interested) to participate in letting other people know about the research (eg conferences, meetings, articles).
- e. However Josh is responsible for any shortcomings in the research and for producing the research thesis for his University studies.

3. Arrangements for payment. Proposed to follow the Sussex Partnership guidance re rates plus expenses in accordance with Univ rates. Josh waiting response from email on how to process payment:

4. Support issues if any of us become distressed by issues discussed. Agreed that some issues may trigger feelings of distress (eg if someone's story/experiences are similar to our own). We agreed that acknowledging this was important – including giving permission for these feelings to be felt. Josh has supervision arrangements. Agreed that it would be important to check what support the advisors had. Also suggested that it might be useful to make contact the following day either re any feelings or ideas that may have come up after a meeting. **Agreed Josh would text day after meetings.**

5. Recruitment of people to research study. x agreed with y's comments in previous meeting re some people may find they need much more than 24hrs before they feel able to reach a decision about whether to participate. Josh stated that other criteria re not approaching people who considered too unwell (by either self or care team) would hopefully reduce this risk. **But Josh also agreed to make sure that staff involved in recruiting people in the study see 24 hrs as a minimum and do not pressurise people into making a decision if they are not ready.**

6. Discussed definition of some research terms

7. Future meetings:

- a. Agreed evenings appear to be best time for us all to potentially attend.
Acknowledged that likely to be meetings when some people can't come.
Josh stated that aim was for each meeting to be accessible even if a person had not been able to attend the previous meeting.

- b. Meeting with Josh's research supervisors and other collaborators. Agreed that wanted to leave this until we had had a few meetings as a group first.

Appendix I: Community study sample user group meeting notes

Retain Service User meeting 10.2.2009

The discussion began with Josh responding to a question about what the size of the sample means for interpretation of the results. Josh responded by saying that in terms of qualitative research 14 was a good number. He then talked about the value of qualitative research in terms of providing an in depth look at what process were going on in the project and how this enabled 2 things:

1. To evaluate the outcomes of the project as experienced and articulated by the project users (in contrast to employment status outcomes which did not show whether someone actually felt happy in the job that they had retained, or, that perhaps someone felt that it was the right outcome for them to leave their job – this point was strongly supported by those present especially one Retain user).
2. It provides an opportunity to unpick the complexity of all that the project did – and take a step towards seeing which particular approaches might be most effective for which people and in which circumstances.

One retain user then asked about negative outcomes and whether they would be included. Josh responded by saying yes – though there were very limited “negative “ findings. Josh stated that the possibility that this might be influenced by a desire to be positive about the service people receive should be acknowledged. However the willingness of people to participate in the research and the fact that interviews were conducted by external researchers counterbalances this [*post meeting note – also the clear authenticity of the words of the interviewees*].

Then Josh referred to the different views of interviewees re the support group (see document and discussed the further issue of whether the 4 people whose employment status could in one sense be viewed as negative was really negative re worker experiences. Related to this Josh shared with people issue of possible mitigating influences on outcome – physical health, bullying, age, implication of work in cause of mental health problem.

The meeting then looked in more detail at the draft Retain results document focussing in particular on the sections which reported the findings in relation to interventions and outcomes (see separate doc).

In broad terms the meeting validated the document (content & presentation). A number of specific points were raised:

- There was strong confirmation of the important issue of self blame/guilt . One Retain user linked this to perfectionism.

- There was also similar strong agreement with the very important role that the intervention described in the draft document “reappraisal” played.
 - It was suggested by one Retain user and agreed by the meeting that the term “reframing” might be a clearer term to describe this.
- It was also suggested that the term “normalising” be used either to describe the intervention used or an outcome of the intervention. Josh agreed that this would be consistent with the data.
- The meeting liked the use of the term “worker” to denote the retain service user re alliance with worker identity but pointed out that it would need clarifying to avoid confusion with Retain project worker [*and for this precise reason the term Retain service user has been used in these notes*].
- One person found particular resonance with the change to work performance approach being an important outcome. They described this as involving shifting a person’s internal being. This prompted Josh to acknowledge that this could be seen as a worker directed intervention as well as a work focused intervention [*post meeting thought – or may be a worker focused intervention with a work focused outcome?*]
- This then lead into discussion questioning whether Retain acted as an advocate for the worker – (possibly a distinction from the Avon Pilot and other job retention projects?). Though one Retain service user at the meeting said that she felt that the Retain worker was “on her side”.
- This then lead Josh to introduce discussion of approaches used by Retain and related this to the Sainsbury Centre “making recovery a reality report” in which a coaching role is recommended (alongside and involved rather than above and distant).
- The meeting agreed that the word collaboration should be included in the approaches list either as part of the humanistic approach in brackets or separately – Josh agreed that this would certainly be consistent with the data.
 - The meeting closed with a discussion about what would happen next re presenting the results. Josh said that he would carry on working to complete the results document which would then be used produce a paper for publication in a mental health research publication and also an evaluation report. He suggested that Retain might want to consider how the report could be made more visual.

Appendix J: Excerpt of pilot interview and data analysis

Excerpt from Pilot of Interview and Data Analysis Methods

As final ethics approval remains outstanding this paper will present a pilot of the interview and data analysis methods. It should be noted that this was carried out outside of work time with an acquaintance of the researcher who is not currently an NHS service user. An important difference of this pilot interview from the proposal is that the respondent is being asked to report retrospectively about her experiences.

The format for presenting the transcript and preliminary analysis set out below is from Wengraf (2001). It was selected because it is consistent with the theoretical stance of the researcher one which considers that the material world is apprehended through the subjective experience of the individual. Thus the inclusion of the 'objective referent' and 'subjectivity' columns. The process of apprehension is considered to be socially constructed hence the importance of seeking to identify discourses to discern the contextual factors influencing and revealed in the interview.

		Discourse	Objective referent	Subjectivity
1	JC: Can you tell me when you were recovering and were off work were you thinking much about work at the time?	Phenomenologically influenced discourse aimed at understanding R's perspectives and experiences re the importance of work during recovery.	Adapted second question from the schedule to reflect fact that the interviewee is being asked retrospectively about her experience of recovery. Emphasis on R.'s perspective.	Feelings of novice anxiety related to the first recorded pilot interview.
2	R: No not really because I had actually lost the job, I had failed my probationary period because I couldn't fulfill all the tasks and I came back down to Brighton so my main feeling was that of failure and disappointment. Added to that I couldn't possibly go back to that type of work so I'd have to look for something different.	Discourse about loss and sense of failure, and consequences.	Loss of job. Moved in consequence. Decision that needed different type of job.	Feelings of failure and disappointment. Sense of resentment at having to look for something different

		Discourse	Objective referent	Subjectivity
3	JC: And so you describe having some hopes and some fears can you tell me a bit more about your hopes and your fears in relation to the career you had at that time?	<p>Discourse about hopes and fears in recovery.</p> <p>Related to hypothesis that people have hopes and fears about their work during recovery..</p>	<p>Question drawn from a possible prompt on schedule.</p> <p>Inaccurate in referring to R describing 'hopes' as well as fears.</p> <p>Emphasis on R.'s perspective.</p>	<p>Was interviewer failing to pay 'double attention' to both schedule and what R said?</p> <p>Was interviewer wanting to heal the story by imposing hopes?</p>
4	R: I had hoped that there could have been a way around it. They had changed some of my duties so I didn't have to do the shelving or anything too repetitive, but colleagues were getting very fed up, because they were having to do more of the routine jobs that I couldn't do. So I just sort of dismissed it really as a career that I wouldn't be able to do anymore.	Discourse about loss and sense of failure, and consequences.	Evidence of some employer support. Example of adjustments. Experienced colleague attitude (negative) re impact on them of adjustments.	<p>Wanted more positive outcome.</p> <p>Dismissed career.</p>

		Discourse	Objective referent	Subjectivity
5	JC: Had you made any other plans about work whilst you were recovering?	<p>Phenomenologically influenced discourse aimed at understanding R's perspectives and particularly experiences.</p> <p>There is also a strong influence of a hypothesis that people who have work when they become unwell may feel the need (for intrinsic or extrinsic reasons) to make work related plans.</p>	<p>Question from schedule (adapted to reflect restropective account).</p> <p>Emphasis on R.'s experience and gaining a narrative account.</p>	<p>Is the interviewer 'rushing through the questions' possibly due to anxiety and/or inexperience (particularly with this interview)?</p>
6	R: I had started looking into different bits of voluntary work. Just to sort of test out other careers and the like. And yes so I was sort of like testing the water of various little sort of voluntary jobs. And seeing whether I liked them and going to careers services and the like.	<p>Discourse turns to cautious attempts to investigate new options ?sense of belittling voluntary jobs</p>	<p>Voluntary jobs as testing opportunities.</p>	<p>Desire to begin to explore new job possibilities during recovery.</p>

		Discourse	Objective referent	Subjectivity
7	JC: Had anybody else been helping you?	<p>Discourse about role of support in recovery.</p> <p>Formulated to begin to address hypothesis that people do not always receive suitable help with their work related needs during recovery.</p> <p>Also continues to explore R's experiences and perspectives.</p>	<p>Question from schedule (adapted to reflect restrospective account).</p> <p>The interviewer again misses an opportunity to probe more about previous response.</p> <p>Emphasis on R.'s experience and gaining a narrative account.</p>	
8	R: I got referred to - because I'd lost my job on health grounds - I'd been referred to the job centre, they registered me as disabled and made me go to see a Disability Employment Advisor. But all they wanted to refer me to was very menial low paid unchallenging jobs that made me just made me feel even more fed up.	Returns to loss disappointment discourse – unsuitable help	<p>Involvement with employment services.</p> <p>Referred to Disability Employment Advisor (experienced as compulsion to see)</p> <p>DEA offered jobs which R perceived to be low paid and unchallenging</p>	Felt “even more fed up” by the type of low paid and unchallenging jobs she was referred to by DEA.

		Discourse	Objective referent	Subjectivity
9	JC: So the voluntary work which you were looking at was that ones that you had found yourself?	Discourse about role of support in recovery continues from 7.	<p>This is the first instance of a probing which has been spontaneously constructed in relation to R's previous response and not simply drawn from the schedule's possible prompts.</p> <p>A closed question which yields a one word response.</p> <p>Emphasis on R.'s experience and gaining a narrative account.</p>	The interviewer appears to be increasing in confidence and listening more carefully to R.
10	R: Yes.		Found voluntary work independently of employment services.	

		Discourse	Objective referent	Subjectivity
11	JC: What about informal help? Did you have any help from friends, relatives?	Discourse about role of support in recovery continues from 7.	Spontaneous probing continues. In part of necessity due to response previous closed question Emphasis on R.'s experience and gaining a narrative account.	Increased confidence in role continues.
12	R: Yeah my mum was the one that helped me find the voluntary work through her contacts really and making suggestions. My main source of help was her contacts really.	Discourse re attempts to address new options – with support ? reliance on mum.	Support of mother most useful in finding contacts.	Reliance on mother.
13	JC: Were there other types of help that you didn't get that you would have liked to have got?	Discourse about role of support in recovery continues. Particularly exploring hypothesis that people do not always receive suitable work related help.	Question adapted from a suggested prompt in the schedule. Possible missed opportunity to ask more about how she felt about receiving help from her mother. Emphasis on R.'s perspective.	Is the interviewer failing to pay adequate double attention again and returning to the schedule for security and possibly a sense of control over the process?

		Discourse	Objective referent	Subjectivity
14	R: I think, er, back at the original job at the university I would have liked it if there had been some careers advice there. For the medical side they referred me to physiotherapy but there was nothing to help me once they had worked out that I didn't have a career with them, there was no real suggestion of alternative employment within the organization. So I would have liked some more support from them.	Returns to loss disappointment discourse – unsuitable help	Didn't have careers advice from employer. Had help for condition treatment form them.	Wanted more help from employer (about different careers).
15	JC: Were there any other types of help you would have liked? Or different types of help from those that did help you?	Discourse about role of support in recovery continues.	Spontaneous probing. Two questions put – potentially confusing. Emphasis on R.'s perspective.	
16	R: I think that the Job Centre and the Employment Service, it would have been nice if they were more geared up for graduate level work and not just to assume that anybody who was disabled, or who had health problems, can only do really basic work. It would be nice if they had had the training to be able to look at alternatives – possibly retraining and the like. You know it was like “this is all you can manage here and that's that” really.	Loss disappointment discourse re unsuitable help continued.	Experienced the employment services as offering little to her as a graduate. Experienced the range of possibilities discussed as limited – they did not suggest retraining	Critical of employment services: 1) for not meeting needs of her as a graduate. 2) for low expectations of the potential of disabled people.

		Discourse	Objective referent	Subjectivity
17	JC: Finally we've been thinking about setting up a project to help people in a similar situation to the one you were in. Thinking back to the time then. If you were to get involved in such a project at that time, what kind of support, help or training do you think you might need so that you could actually help others in a similar situation?	Discourse about role of support in recovery continues.	<p>Missed opportunity to probe further about experiences referred to above and particularly about perspectives (notably feelings).</p> <p>Question adapted from schedule to reflect retrospective context.</p> <p>A complex question – could be broken down into a number of questions.</p> <p>Emphasis on perspective.</p>	Returning to security of the schedule.
18	R: I think to look at researching areas themselves. So you know those sort of skills to help people look for themselves.	<p>Discourse re tentative possibility of developing self help skills</p> <p>Employment services can't help graduates and have low expectations of people with health problems.</p>	From R's experience needs of self help job search skills identified.	

		Discourse	Objective referent	Subjectivity
19	JC: Do you think you would have felt confident about helping other people at that time?	Here am I being influenced by the 2 discourses of loss/disappointment and the cautious/tentative discourse re options or even from a broader external societal discourse about people's limited potential during recovery.	Spontaneously constructed question. Could be considered a 'leading question'. Missed opportunity to explore further R.s suggestions raised in previous question. Emphasis on perspective.	Possible signs of being emotionally influenced by R.'s account.
20	R: Probably not straight away but a couple of years down the line. In terms of acting a bit like a sort of mentor showing people that "I managed it so can you". I wouldn't have been able to do it too soon because I was still feeling pretty low and also finding my feet.	Tentative/cautious discourse continues – possibly reinforced by my own leading question. Within this there is an aspiration for instillation of hope.	Did not think able to help others at the time (re mood and rebuilding own life).	Low mood and attempts to rebuild life meant she questioned how much she could have supported others at the time [<i>but note interviewer's questions may have imposed a discourse which lead to this</i>]

		Discourse	Objective referent	Subjectivity
21	JC: Is there anything you would like to add about the things we have been talking about?	These words are often used at the end of interviews and questionnaires.	Adapted from schedule. Again missed opportunity to explore further R.s suggestions and to acknowledge feelings	Was the interviewer wanting to close the session down perhaps because of uncertainty/confusion about role as research interviewer faced with feelings being expressed which would normally be responded to with a therapeutic discourse.
22	R: Not really (laughs) no.	May be influenced by the 'final question discourse'.	Reports nothing further to add.	Possible relief at finishing revisiting a distressing period of her life.

Evaluation of the interview process

Wengraf identifies five key points pertinent to conducting a semi structured interview: double attention; rushing through the questions rather than working with the answers; power and emotion within the interview process; modelling the mode of answering; facilitation and challenge, questions and alternatives to questions (2001, p194-202). These will be used to structure the evaluation of the interview process with power and emotion in the interview process being addressed last as this factor appears to largely explain the shortcomings noted in the other points.

‘Double attention’ refers to interviewees responses and to interviewers’ needs of questions. On reflection, discussion in supervision, and consideration of the transcript the degree of double attention was not adequate. Most notably it is suggested to be a factor in the interviewer posing a question referring to ‘hopes and fears’ when the respondent had cited only fears (transcript unit 3). It may also be a factor influencing the limited degree of probing or invitations to elaborate. This probably arose in part from another of Wengraf’s key points: ‘rushing through the questions rather than working with the answers’. There were a large number of instances when questions were put from the schedule instead of the answers being worked with (units: 5, 7, 13, 17, 19, 21). At these points opportunities could have been taken to ‘model the mode of answering’ with verbal or non verbal prompts to indicate the depth and specificity required. Similarly, these may have been opportunities to enrich the dialogue by making a statement to the respondent or to have sought to have encouraged a question from them rather than relying purely on a didactic question/answer format – thereby paying close attention to the process of ‘facilitation and challenge, questions and alternatives to questions’.

This in turn is partially influenced by the interviewer’s sense of novice anxiety related to using the schedule – so carefully developed- for the first time. This then is an aspect of the ‘power and emotion within the interview process’ revealing the interviewer’s anxiety and possibly consequential concern not to share more of the control of the interview.

Analysis of the transcript can identify issues of both power and emotion in the interview process in relation to the interviewer and interviewee. For the interviewer the presence of novice anxiety is acknowledged as present from the start of the interview (transcript unit 1) and possibly having an impact on the how questions were put (or not put) to the interviewee (transcript unit 5 and 17). It is noted that increased confidence is associated with attentive listening, productive probing and follow up questions absent from elsewhere (units 9 and 11). Related to this theme of anxiety, and also to issues of power and emotion, is the interviewer’s confidence in their role. Uncertainty and possibly confusion in this role (in contrast to a more familiar therapeutic role) is noted (unit 21).

Here the interviewer's formal discourse itself is related to the exercise of power to foreclose the interview. Though it should be noted that this final invitation was present in the schedule – it may be useful to consider how it could be rephrased to appear as a genuine and open invitation to raise any further issues. Throughout the process, the combination of both anxiety and role confidence, are seen as possibly contributing to the interviewer returning to the security of the schedule rather than exploring the respondent's previous statement (units 13 and 17). The interviewer's emotions are also considered potentially to be influenced by those of the interviewee in unit 19 when a 'leading' question is put to the respondent - possibly in response to the interviewer's interpretation of the respondent's ongoing loss and disappointment discourse. A similar emotional response is discerned when the interviewer is seen as potentially 'healing the story' and also again in the closing of the interview (unit 3 and 21).

For the respondent power and emotion are clearly significant issues in relation to the experiences and perspectives which she is sharing (see below) – but the analysis also suggests that, as with the interviewer, they have influenced the interview process itself. The potential presence of a 'belittling' tone in the discourse the respondent uses to describe the voluntary jobs which she investigated could be a manifestation of a comparison of these with the power and status of the interviewer's full time professional career (unit 6). This points to the power relationship as exercised in the interview one half of which has already been described above. For the respondent the leading question may have been met by the answer it presumed, expected, or, imposed (unit 20). Likewise, the declining of an opportunity to add any further comments, could be ascribed to polite acquiescence to the interviewer's coded closure of the process. It was also thought possible that the decision not continue further may be a result of the respondent feeling she did not want to spend more time revisiting a distressing period of her life.

Appendix K: Acute study semi-structured interview

- I understand that you have been working recently – Can you please tell me what you were doing?
 - *Possible prompts: how long have you had this job, What was it like? What did you most enjoy about this work? What were its stresses- if any?*
- Can you please tell me whether you have had any thoughts about this whilst you have been recovering from your current problems?
 - *Possible prompts: Have you thought much about your job? Have you had any hopes or fears about your job?)*
- Have you been making any plans about your work whilst you have been recovering?
 - *Possible prompt: What plans if any have you made about your work? Have you been in touch with anyone from your work?*
- If you haven't been making any plans why do you think this might be?
- If you have been making any plans – has anyone helped you with this?
 - *Possible prompts: Has anyone helped you with plans about your work? Have you talked about your work with anyone? Do you think you might change your job in any way?*
- If you haven't had any help – would you like some?
 - *Possible prompts: What kind of help? Who do you think might be able to do this for you?*
- If you were to be involved in a project to help people in a similar situation as yourself with their work concerns, what support, help or training do you think you would need to do this?
 - *Possible prompts: Can you imagine trying to help yourself and other people in a similar situation as yourself with their work? If you wanted to do this – what might stop you? What might help?*
- Do you have anything else you would like to say on the subject we have been talking about?

Appendix L: Community study interview schedule

I'm aware you are receiving support from the Retain project can you tell me about how this came about?

(Possible prompts if needed from orientating questions below:)

Mental health experience

What kind of issues have you experienced that led to your becoming involved with Retain?

How did you come to know about Retain?

Have you experienced this difficulty or similar difficulties previously?

If so, how did it affect your work?

Have you visited your GP regarding your mental health issue?

If so, what was your experience of this?

How do you deal with the issues surrounding your own mental health in normal social situations?)

In what ways if at all do you think your mental health problems have affected your ability to do your job?

(Possible prompts if needed from orientating questions below:)

The work experience

Mental health and work

How has/had your recent experience impacted on your ability to actually carry out your job?

Are you currently taking any medication for your mental health difficulties?

If so, how has/did this influenced your performance and your relationships at work?

How did you feel when you went back to work?

Did you experience any difficulties and, if so, what were they?

What has been the attitude of your employer towards you?

(Possible prompts if needed from orientating questions below:)

How did your employer respond to the difficulties that you were experiencing?

Have there been any adjustments made in your work as a result of your difficulties?

Have/did you disclosed your mental health issues at work?

If so, how did you approach disclosing your mental health issues?

Did you discuss any adjustments to your job?

If so, what were they and were they put in place?

What has been the attitude of your employer towards you?

(Possible prompts if needed from orientating questions below:)

How do you feel that the colleagues that you work/ed with on a day to day basis reacted to the difficulties that you were experiencing?

Have your mental health difficulties had an effect on your friendships at work?

Did colleagues reactions have a bearing on the way that you felt about returning to work?

If so, how?

In what ways, if at all do you think the Retain project has helped you?

(Possible prompts if needed from orientating questions below:)

The Retain experience

How have you used Retain and what has been your experience of the service?

How do you feel that Retain has impacted on the difficulties that you were/are experiencing?

Has Retain had an effect on how you are able to do your job?

Did Retain have any influence over your relationships at work? If so, in what ways?

What do you think would have happened if you had not made contact with Retain?

Has Retain communicated with your employer?

In what way has Retain communicated with your employer?

How did you feel about this?

Did Retain help you get back to work? If so, how did they do this?

How did Retain fit in with other services/organisations who supported you?

The Retain support group

How long have you been involved in the support group?

What happens during these support group meetings?

What does this support group offer you?

Have any other services, organisation, friends of family helped you with some of the work and mental health issues you have spoken about?

In what ways do you think services like Retain which support people with MH problems at work could be improved?

A better service

How could Retain be improved to better meet your needs?

What are your greatest hopes or fears for the future?

Appendix M: Examples of analysis of interviewer questioning

<Internals\P4 Penny> - § 2 references coded [2.76% Coverage]

Interviewer: So it sounds like you're saying, if I'm right in saying, you're not just talking here about money, in fact you said something about the status, or the... having that... that role?

Penny: I just felt like I needed some structure to the day of, you know, of a paid job, that that would give me. I was...I was... because I was getting quite... I was finding it really difficult to fill my time when the children were at school and when I was on my own and I was spending a lot of time sort of ruminating and brooding and getting quite depressed when I thought if, you know, if I was out in the world of work it would be sort of healthier for me, sort of mentally really.¹

1) Is now saying that she thought structure and purposeful occupation of work was a motivation to take this job on.

REFLECTION: I am concerned how much some of these responses may be made for my benefit - having a health background and thus having some insight into my occupational perspective.

Reference 2 - 0.54% Coverage

Interviewer: And do you think that those thoughts would um... make it impossible to do your work at the moment, or very difficult, or...?

R: They'd make it difficult, yeah.²

2: Says suicidal thoughts that keep going through her head would make work difficult

REFLECTION: -[but note my leading question here and lack of follow up]

<Internals\P5 Hilary> - § 2 references coded [2.60% Coverage]

Interviewer: Because sometimes it's a bit of a sort of... maybe it's a cliché and a stereotype about um... people who experience an elated mood um... sometimes with a, you know, the label of bipolar depression, sometimes people describe sort of creative energy and um... people hypothesise that people can be at their most creative, can't they, but obviously that sounds like that's not something that fits with your experience.³

3 REFLECTION: I seem influenced by this 'romanticized' stereotype perhaps - and notice this participant is challenging it.

Reference 2 - 1.81% Coverage

Interviewer: How much do you think um... having at least an idea of a way forward would be helpful in terms of helping you cope with your feelings of depression or when you're feeling...?⁴

4) REFLECTION: I ask a bit of a leading question here

<Internals\P6 Yvonne> - § 1 reference coded [0.13% Coverage]

Interviewer: And so on... and it was the sick note that had the words...?5

5) REFLECTION: I as interviewer haven't said "the words" [her mental health diagnosis] does this show the influence of the power of stigma on me?

<Internals\P7 Daniel> - § 1 reference coded [0.35% Coverage]

Daniel: This is what I find strange, my counselor... I thought the counselor...the counselling, we... we went through it all as well. Like I did with x.

Interviewer: Now your counselor is with... are they part of this team or part of...?6,

9 Reflection – I should have picked up on what he found strange??? Was it repeating the story?

Appendix N: Sample acute study NVIVO free nodes

Free Nodes		
Name	Sources	References
anxiety in crowds	1	3
attitude to work in general	1	2
becoming unwell	1	4
CMHT input	1	2
communication with employer whe	1	1
Communication with others diffs	1	1
confidence	1	3
Contact with work on sick leave	3	5
Contacts with work	2	3
coordination and collaboration of s	1	3
Creative groups	1	1
Crisis team input	2	9
Day service input	2	10
Disclosure	3	10
Employer input	2	4
Empowerment	1	1
Family attitude	1	1
Fear of job loss	1	2
fear of symptoms	1	2
Finance concern	3	7
GP input	3	6
Guilt	1	3
illness - attitude to	1	3
illness management	2	8
Inpatient input	2	4
job - attitude to	2	9
Job accomodation	1	5
Job task experiences	2	4
Job type	3	7
leisure	1	1
liasion with work	2	3
Manager attitude	3	11

Appendix O: Sample coding (condensed meaning units and associated interpretations)

Transcript excerpt
<i>Gavin: I was thinking about that I might lose my job because of my illness, even though I declared it at the beginning of... when I was taken on officially about... nearly two and a half years ago. And thankfully I told them honestly that I had suffered with bipolar, so they... they knew about the situation so it wasn't just out of the blue when I said one day um... a couple of weeks ago, that I was feeling particularly unwell.¹</i>
Condensed meaning unit
1 Despite fears of job loss on becoming unwell did not repeat past approach of walking out of a job when unwell decided to get help and try to keep job.
Interpretation
INTERP: Past disclosure made it easier for P1 to tell employer he was becoming unwell at an earlier stage than in the past. This helped him to maintain some control when becoming unwell and decide to take positive actions to keep his job (getting help, communicating with employers) and to avoid past negatives actions (delaying responding to illness and walking out of jobs).

Transcript excerpt
<i>Interviewer: So you've been supported... when you came out of work, you were supported then for the couple of weeks by the crisis resolution team?</i> <i>Gavin: Yes for about three weeks yes. About three weeks and they were extremely good and they wanted at all costs for me not to have a hospital admission because it could be counter-productive in the long run. If I've had a... I've had hospital admissions in the past and that's usually taken me six weeks in hospital, plus another seven weeks after to rehabilitate myself into normal daily life, so this time it worked very well, um... I was treated at home, I had... they were phoning me. Um... I came into the TST and day services here and did structured groups like pottery, creative art, gardening, things that would distract you from maybe suicidal thoughts or self-harm, um...</i>
Condensed meaning unit
<i>Crisis team (including structured day service activities) has meant acute care episode has been shorter than when was admitted in the past.</i>
Interpretation
Has valued CRHT input (home treatment and day services) as an alternative to inpatient admission, This has supported faster recovery in part because has not been removed from normal daily routines and provided structured activities (as opposed to time spent on wards ruminating). Was this in some ways mimicking combination of home life and work life?

Transcript excerpt
<i>I didn't want to lose my job so I kept in regular contact with work, explained what was going on, um... sent my sick notes off in the post straight away to them so they knew exactly where they stood</i>
Condensed meaning unit
Motivated to keep job and maintain communication with employer to support that
Interpretation
Despite acute illness Gavin was motivated to keep job and able take positive actions himself to support that. Work thus remained on his recovery agenda. [What if his illness/other factors affected either motivation or ability to maintain contacts?]

Appendix P: Sample service user coding notes (acute study)

(Service user advisor comments noted in bold)

<i>INTERVIEWER. What do you enjoy most about your job?</i>
PARTICIPANT. Um. I enjoy working with the general public. The customers that come and buy the chickens – its nice to talk to them, and have some interaction. Also, er, the other staff, er, at the supermarket are nice as well. Quite friendly. You get a bit of camaraderie with the er, with the other people you work with so its nice.
ADVISOR COMMENTS: Likes job & public contact.

<i>INTERVIEWER. And um what about stresses on the job? Things that you don't enjoy so much?</i>
PARTICIPANT. Um, yes. Sometimes if we're short staffed. We're er, expected to do er sort of more more work than we would if we're fully staffed if someone's off sick or if someone's on holiday. Sometimes they don't get cover for the department. So you end up doing two people's job rather than just your own normal job and that can, that can be a bit stressful because you like have to work twice as hard and twice as fast to get all the jobs done. Um. But most of the time its not too stressful.
ADVISOR COMMENTS: Reports sometimes stress in job – How does he handle the stress? Does he vocalize? Is it apparent in some other aspect of his behaviour?

[...]

<i>INTERVIEWER. Sounds like that's [customer contact] a particular important part of this job to you.</i>
PARTICIPANT. Yeah, yeah, one of the good points. You're providing a service. If you provide good service to the customers and they're quite satisfied that's a good aspect of it.
ADVISOR COMMENTS: Showing pride in job. Satisfaction with job (in contrast to previous jobs).

<i>INTERVIEWER. Right ok. Um. Can you tell me have you been thinking much about your work at all while you've been um, unwell recently?</i>
PARTICIPANT. Yeah. I've been thinking a lot about my work. Um, mainly because I was in a similar situation a couple of years ago where I had to take time off for being ill with depression. Um sort of put me under a bit of stress because I feel I should be able to cope and go back to work sort of in a short period rather than having a long period of time off I feel like I'm letting my employers down a bit by not sort of being able to cope and be reliable so that worries me6 and also the financial aspect. Cos we er, only have a small amount of um, sick pay allowance. Its only for er, don't know exactly what it is but its only for about two or three weeks. Then when that period runs out you go on statutory sick pay – which is quite a big drop from full wage to getting statutory sick pay – I'd I'd lose a bit of money because I'm on a tight budget I'm, I'm worried about sort of that happening – of losing some money because of being off sick. So that's sort of quite worrying.
ADVISOR COMMENTS: Worries: Financial re off for too long. Employers may not like him being off for too long. Underlines stigma issue MH seen as a weakness – if under stress won't be able to cope with job. Do these suggest also worries re how much to discuss with employer.

[...]

<i>INTERVIEWER. And er what happened about returning to work then?</i>
PARTICIPANT. Um. I just kept in contact with work and said I was keen to come back when I was feeling better. The were quite understanding ¹⁰ and when I went back it was sort of it was difficult getting back into it because I had been off for five or six weeks I was out of a routine, and um, not used to being in a work environment. It was quite difficult when I went back for the first day or two but er gradually things got better it wasn't too bad.
ADVISOR COMMENTS: Previous success of getting back to work after being off for MH problem. Showed past perseverance.

<i>INTERVIEWER What was particularly difficult about going back then?</i>
PARTICIPANT I suppose the crowds. ¹³ Also with talking to people at work, my colleagues who asked why I was off work I didn't like to go into too much detail I told them a bit, that I was sort of off. They was quite understanding because they knew that my father had died recently so they knew that it was related to that. They was quite understanding because of that aspect.
ADVISOR COMMENTS: Showing following characteristics here: Thoughtful; Insightful; Understanding what causes him "grief"; ability to explain the situation he is in well.

<i>INTERVIEWER: And this time have you been in touch with your employers, You said you were last time.</i>
PARTICIPANT Yes I've been down twice to the personnel office to um hand in my sick notes and I had a quick chat with my personnel manager. She was quite understanding sort of. She knew why I was off. They said that they wanted me to get better, to look after myself and come back when I was ready. So that was quite positive.
ADVISOR COMMENTS: Sick notes offering important contact link. Certain amount of contact useful

[...]

<i>INTERVIEWER: How do you feel about sharing the reason why you're off with people?</i>
PARTICIPANT Yeah its quite uncomfortable. I feel there's a stigma with er mental illness which makes it a bit awkward telling people and also I feel awkward embarrassed myself cos I feel that having depression is a bit different to other people. Maybe I'm not as good or not not able to cope as other people whereas people at work they manage to work year in year out they don't have any time off work – I've had a couple of sick episodes so I feel embarrassed by that.
ADVISOR COMMENTS: Use of word "depressed" – misused in public – makes it hard to say and be understood. Difference between personal world & work. Damning himself. Low self esteem. Embarrassed. How different to other people. Black & white thinking? Are bigger companies better?

[...]

<i>INTERVIEWER: Are there other things that you're feeling about work either er positive or or negative things</i>
PARTICIPANT Yeah positive – when I go back it'll be nice to see some of my colleagues and friends. I've got quite a few friends cos I've been there 5 years now. So it'll be nice to sort of go back and chat to people. Some of the customers I get on quite well with – it'll be nice to sort of see them. Also it'll be nice to get back into the routine, I like the routine of having work occupies my day. It gives me something to do - having too much time on my hands can be a problem.
ADVISOR COMMENTS: Loss of routine. Has positive thoughts. Likes the routine that work provides him. He is owning the positive thoughts for recovery. Work provides him a sense of purpose and source of self esteem.

INTERVIEWER: Do you feel that's a problem for you at the moment while you're off work?

PARTICIPANT Yeah. It is a bit of a problem. That's why I like coming down to the Day Unit and doing some of the group therapy. It occupies my time. I find it hard sometimes if I've got nothing to do. I find it a bit of a struggle trying to do things off my own back.

ADVISOR COMMENTS: Value of getting there? Forcing a routine: getting up, getting there, having to be somewhere at a certain time. Day services reducing isolation? Important for him. Doesn't say what he's doing at Day Hospital – but recognizes what good it is doing for him. Is the sense of purpose replaced?

INTERVIEWER: What have you been doing then during times when you haven't been coming here?

PARTICIPANT I did try and go swimming last week. I like to go swimming occasionally if I have the time. I find it quite sort of relaxing and it's a good bit of exercise. I found that a bit difficult because the swimming pool was crowded - there were students. So I found that a bit hard to deal with. Sort of. Only I swum for a short period. Um I've just been doing day to day things like shopping and er cooking at home. The rest of the time just er read and listen to music – which I do in my spare time anyway.

ADVISOR COMMENTS: Trying to do something. Shopping and cooking – done on his own – not with others unfortunately. Courageous

INTERVIEWER: What about socializing do you um?

PARTICIPANT Not yet um. I'm hoping to go to a drop in group this week organized by Mind a mental health charity they run a drop in so I'll find out some details about that and may be go to that – it'll give me something to do as a social event.

ADVISOR COMMENTS: Wants to get his confidence back.

[...]

INTERVIEWER: What about um have you had any support from the mental health services at all about work?

PARTICIPANT Er no not really.

INTERVIEWER: What about from any friends or family? Have you talked through any of your work issues with them at all?

PARTICIPANT Um – not really any great detail no.

INTERVIEWER. Would you like an opportunity to talk about some of your work concerns with anybody?

PARTICIPANT Um - Yeah I suppose so - just basic things.

INTERVIEWER: What kind of things?

PARTICIPANT Um just about confidence really to be able to cope, to manage to go back, to go back to work full time – sort of been a bit nervous about whether I'll be able to manage. I suppose just talking about things like that would be a good thing.

ADVISOR COMMENTS: Needs more support?

INTERVIEWER: Do you think, have you made any plans in your own mind or with other people about how you might return to work or when?

PARTICIPANT Um I've set a date which is about 9 or 10 days time. Um I going to leave it probably nearer the time to prepare myself and make my plans to go back. That's the sort of date that I've set myself. The doctors signed me off till that time. So that's the date and nearer the time I'll prepare myself with plans to go back I think.

ADVISOR COMMENTS: Says he's set a date – then below says the doctor has.

INTERVIEWER: How did you set that date?

PARTICIPANT Um the doctor, the doctor suggested it to take an extra couple of weeks

off cos I was thinking about going back last week. Cos I was sort of anxious to go back to work cos of the money and not wanting to let them down and things like that. But he suggested that I leave it two weeks to make sure that I'm better and sort of got over my depression and was feeling ready to go back to work.

ADVISOR COMMENTS: "Got over my depression" in 2 weeks – set up to fail – false hope

INTERVIEWER Is this your GP or a psychiatrist?

PARTICIPANT My GP.

INTERVIEWER: This is your GP.

PARTICIPANT Yeah I've been to see him.

ADVISOR COMMENTS: Sometimes attitude of GP is to get people back to work quickly. Why is the GP doing this role? Is it the sick note issue? Has the GP had feedback from psychiatrist/other MH professionals? May not feel able to talk to GP enough.

INTERVIEWER: And have you spoken much about your work with him and the concerns you mentioned to me?

PARTICIPANT Yeah I did speak briefly. Just said that er I didn't feel that I was ready to go back to work right about cos of being anxious in crowds – things like that. I also told him that I'd like to go back as soon as I'm feeling better.

ADVISOR COMMENTS: This is not a discussion

INTERVIEWER: Had you thought about, um, at all, going back and perhaps not going back full time but part time initially – building up, or would you

PARTICIPANT I'd like to but the financial aspect might make it a bit tricky. Cos I don't know whether if I go back part time I think I wouldn't be able to manage on the money because I live in rented accommodation. So I've rent to pay, all sorts of outgoings that I have to pay. Bits is a bit difficult because of financial commitments.

ADVISOR COMMENTS: Financial anxiety.

[...]

INTERVIEWER: Um have you thought about going back and perhaps not doing all of your duties – still working full time but doing some of your duties initially, as part of getting yourself back into your job?

PARTICIPANT Um – not really. I've been thinking maybe of changing my hours. So I was doing day shifts rather than evening shifts. Sometimes I don't like working in the evening.

ADVISOR COMMENTS: Needs to negotiate hrs

INTERVIEWER: Have you discussed that with work at all that idea?

PARTICIPANT No not yet no. I'm still deciding whether I wanted to do that.

ADVISOR COMMENTS: Should have access to a supporting back into work person. A support worker not qualified enough. [DEBATE follows]

- A good personnel manager.
- advocate?
- Sometimes you need to do it yourself.
- Needs strength of character to ask for help.
- Needs meeting with manager to negotiate a plan.

INTERVIEWER: Do you think that would be – What do you think work would say about that?

PARTICIPANT Um yeah they might be able to. It depends whether maybe they could sort of accommodate it.

INTERVIEWER: Um and why do you, do you think that that would be may be better for

you at the moment?

PARTICIPANT Yeah. Yeah sometimes because I have to travel, travel to work in the dark when I come home in the evenings, sometimes I get a bit scared being in the dark. So that could be a problem. If I was doing a day shift I could home sort of 5, 6 o'clock it might be a bit easier – less anxiety.

ADVISOR COMMENTS: Has a date but not plan. Needs a plan. Needs info (eg benefits).

[...]

INTERVIEWER: Would you like to be able to talk more openly about it with more people at work? Or not?

PARTICIPANT Er yeah, I think so yeah. I think sharing things is a good thing wherever possible.

INTERVIEWER: So do you think that that might be part of the confidence thing? About supporting you to find more ways to be more open about it? To educate may be others about it really.

PARTICIPANT Er yes I suppose so. If I get may be the opportunity to share things with people at work. If I wasn't making myself vulnerable – if I wasn't putting too much pressure on myself. I suppose it would be a good thing to share, to share, a bit of my experience.

INTERVIEWER: But it sounds like you don't want to make yourself vulnerable so you've got some concerns about that?

PARTICIPANT: Yeah yeah generally.

INTERVIEWER: Is that based on any kind of past experience at all?

PARTICIPANT: Not really no I just thing its just sort of just generally I don't want to sort of make myself vulnerable with other people um I wouldn't want sort other people to think I'm weak or looking down on me or some sort, sort sort of view that they might hold.

ADVISOR COMMENTS: Knows it's a good idea to educate others but not clear on how he could educate others on his own. Extrovert/ introvert. Male gender issues re expressing self. Has a desire to tell people why he has been away – but found hard to do – worry re how he will be perceived in future. A very British attitude – men don't talk?

Double challenge: 1 showing publicly to others your vulnerability 2 admitting this to yourself as you speak about it.

Appendix Q: Dissemination activities

Publications:

Cameron, J., & Hart, A. (2007). Ethical issues in obtaining informed consent for research from those recovering from acute mental health problems: a commentary. *Research Ethics Review*, 3(4), pp. 127–129.

Cameron, J., Walker, C., Haslam, I., & The Retain Support Group. (2009). Working well: how the Retain project has supported workers in Brighton with mental health problems. Brighton: University of Brighton.

Walker, C., Fincham, B., & Cameron, J. (2011). Techniques of identity governance and resistance. In C. Walker & B. Fincham, *Work and the mental health crisis in Britain* (pp. 65-95). Chichester: Wiley-Blackwell.

Cameron, J., Walker, C., Hart, A., Sadlo, G., Haslam, I., & The Retain Support Group. (2012). Supporting workers with mental health problems to retain employment: Users' experiences of a UK job retention project. *Work*, 42(4), 461-471.

Presentations:

Cameron, J. (2008, March). *Beyond the carrot and the stick, work related needs of mental health service users*. Workshop presentation at the School of Nursing and Midwifery 9th Annual Mental Health Conference, University of Brighton, UK.

Cameron, J., King, M., Christoforou, A., Cheng, A. (2008, March). *Service user and carer involvement in interprofessional education*. Workshop presentation at the Interprofessional learning & development – reflections, relevance & reality conference, Brighton & Sussex Medical School, University of Sussex, UK.

Cameron, J., King, R., Calkin, J. (2008, June). *More than symptoms and self care – needs in acute mental health recovery*. Oral presentation at the College of Occupational Therapists, 32nd Annual Conference, Harrogate, UK.

Cameron, J. (2008, October). *Vocational research – the story so far*. Seminar presentation at the Sussex Partnership Trust Occupational Therapy Conference, University of Sussex, UK.

Cameron, J. (2009, April). *Job retention for people with mental health problems – emerging results of research into user experiences of a voluntary sector job retention project*. Oral presentation at the Southern Universities Alliance for Doctoral Education - Professional Doctorate Conference, University of Brighton, UK.

Cameron, J. Walker, C. (2009, July). *Brighton Retain project: research findings*. Presentation to Richmond Fellowship Executive Board, Richmond Fellowship HQ, London.

Cameron, J. Walker, C. (2009, September). *Brighton Retain project: job retention, working well research findings*. Seminar presentation at Richmond Fellowship Best practice job retention forum, Richmond Fellowship HQ, London.

Cameron, J. (2010, June). *Developing Resilient Therapy in adult mental health*. Oral presentation at the Pathways to resilience II conference: the social ecology of resilience, Dalhousie University, Halifax, Canada.

Cameron, J., Hart, A., Arnold Jenkins, H. (2010, September). *Resilience, recovery and equalising service user, academic and practitioner knowledge through partnership*

working. Symposium presentation at the Refocus on recovery conference, Institute of Psychiatry & Rethink, London, UK.

Cameron, J., Peschier, J., Arnold Jenkins, H. (2011, April). *Resilience 'at work'*. Symposium presentation at the Resilience – Why bother? Conference, University of Brighton, UK.

Cameron, J., Hart, A., Sadlo, G. (2011, September). *Work matters for mental health recovery: supporting job retention of employees with mental health problems*. Poster presentation at 15th World Congress of Psychiatry, Buenos Aires, Argentina.

Cameron, J., Hart, A., Sadlo, G. (2011, September). *Iatrogenic effects of sick leave. The experiences of employees recovering from mental health problems in a United Kingdom research study*. Poster presentation at 15th World Congress of Psychiatry, Buenos Aires, Argentina.

Cameron, J., Hart, A., Sadlo, G. (2011, September). *Resilience 'at work': the relevance of resilience to understanding and promoting sustainable recovery of employees with mental health problems*. Oral presentation at 15th World Congress of Psychiatry, Buenos Aires, Argentina.

Cameron, J. (2012, October). *Resilience and mental health: do we need another 'R' word?* Seminar presentation to members (practitioners/parents) of East Sussex Resilience Therapy Community of Practice, Eastbourne, UK.

Research informed teaching:

Development and delivery of new MSc module: *Vocational interventions for people with mental health problems*. Option in the Graduate Programme for Health and Social Sciences, University of Brighton, UK.

Lecture/Seminar for Professional Doctorate and pre-registration occupational therapy students: *Service user collaboration in research (university researcher perspectives)*. University of Brighton, UK.

Enhancements to occupational therapy pre-registration curricular at the University of Brighton relating to vocational rehabilitation.

Development and delivery of interprofessional sessions on the topic of: *Work and mental health* for pre-registration occupational therapy, social work and medical students at the Universities of Brighton and Sussex.

Appendix R: Key assets threatened or harnessed grouped by Clark and Larson's (1993) subsystems

Model of the human as an occupational being (Clark and Larson 1993) – subsystems (see Chapter 5)	Assets threatened or harnessed
<p>Transcendental <i>Meaning given to experiences as part of an unfolding life.</i></p>	<p>Worker identity remained important as a central aspect of people's life – contributing to a need for on-going connections with working lives. A form of personal capital disrupted, but also harnessed as a motivational mechanism. A positive alternative to more passive 'patient' identities, enhanced by reappraisal strategies. A source of resilience and powers for return-to-work trajectories.</p>
<p>Symbolic evaluative <i>Systems used to appraise the individual's valuing of occupations (e.g. economic, aesthetic, moral and emotional)</i></p>	<p>Occupational deprivation resulted in reduced opportunities to benefit from on-going positive appraisal of work. Negative appraisals of work remained, and even increased, despite dislocation from work. Occupational capital diminished on sick leave – but also acted as a resource in terms of in terms of past positive appraisals.</p>
<p>Sociocultural <i>Social and cultural expectations that influence occupational participation</i></p>	<p>Social relations at work suspended or made more tenuous – threatening social capital. Some on-going problematic relationships. Experienced and anticipated stigma an important influence on return-to-work trajectories. Family and health/vocational professions a source of support (with some limitations). Peer support promoted recovery by enhancing bonding and bridging social capital. Social expectations to work fed into desperation to maintain work role: a source of stress where no sustainable return to work plan; but also a potential motivation for recovery.</p>
<p>Information Processing <i>Cognitive process used in occupational performance</i></p>	<p>Problems with concentration affecting work experienced by some as a result of mental health symptoms (possibly exacerbated by iatrogenic effects of sick leave and consequences of stigma and discrimination).</p>
<p>Biologic <i>Living systems that are involved in biologic adaptation</i></p>	<p>Loss of structure and routine provided by work presented an additional adaptive challenge. Financial challenges experienced as an additional strain undermining resilience and recovery and therefore capacity to sustain successful adaptation. Biologic 'urge' to engage in productive occupation restricted, but also a potential source of motivation to resume work.</p>
<p>Physical <i>Influences of physiochemical process on occupational performance</i></p>	<p>Symptoms (notably those affecting energy, self-esteem and confidence, motivation). Possibly multiplied by iatrogenic effects of sick leave and stigma.</p>

Appendix S: Resilient Therapy for adult mental health

Resilient Therapy – (Adapted by Cameron, Hart and Arnold-Jenkins, from Hart & Blincow 2007 - for Adult Mental Health)					
	BASICS	BELONGING	LEARNING & Work	COPING	CORE SELF
RESILIENT MOVES	Good enough housing;	Find somewhere to belong;	Make work & learning as successful as possible;	Understanding others expectations and deciding which to meet, challenge or negotiate	Instil a sense of hope;
	Enough money to live;	Help understand place in the world; and that others may face similar situations		Being brave;	
	Being safe;	Tap into good influences; (eg peer support)	Engage mentors	Identifying & solving problems; (reduce self blame and guilt)	Promote understanding of others
	Access & transport;	Keep relationships going; (eg educate/support partners/carers/family)		Putting on rose-tinted glasses; Reframing/reappraising	
	Healthy diet;	The more healthy relationships the better;	Map out career or life plan;	Fostering their interests;	Help the person to know her/himself;
		Take what you can relationships where there is some hope;			
	Exercise and fresh air;	Get together people the person can count on;	Help self organisation	Calming down & self-soothing; Support reflection Not to feel overwhelmed by illness	Help the person take responsibility for her/himself; Self advocacy
		Responsibilities & obligations;			
	Enough sleep;	Focus on good times and places;	Highlight achievements;	Remember tomorrow is another day;	Foster talents;
		Make sense of where the person has come from;			
	Leisure and work occupations	Predict good experience of someone/ something new;	Develop life skills;	Lean on others when necessary;	There are tried and tested approaches for specific problems, use them;
		Make friends and mix			
NOBLE TRUTHS					
ACCEPTING <i>Interpersonal skills Empathy</i>	CONSERVING <i>Interpersonal skills Trust</i>	COMMITMENT <i>Ongoing support issues</i>		ENLISTING <i>Self (eg not passive), Family, Friends, MH profs, GP</i>	