

Employment of People with Mental illness: Understanding the challenges from an employer and employee perspective

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This paper focuses upon a study that sought to identify local employers concerns in relation to the employment of individuals in a phase of recovery from mental illness. Furthermore, the research considered potential barriers to employment experienced by service users living in a local North London Borough.

The study adopted a phenomenological epistemological approach, where six focus groups were held, three with service users and three with employers or employer representatives within a local North London Borough. 15 employer representatives and 28 service users participated across the six focus groups.

The overall aim was to raise consciousness and empower participants by encouraging dialogue, the sharing of good practice and coping strategies amongst participants so that appropriate strategies and resources could be provided to challenge misconceptions and support them.

Findings from the research indicate that there are many stakeholders that are involved in supporting individuals back into employment. They also show that mental health and mentally ill health are poorly understood in workplace environments. The research concludes that while work and employment were thought to be important determinants of mental health, those individuals with diagnosed mental illnesses remain at a significant disadvantage in the employment market. The contribution of this study includes a strategy to develop workplace support for employers and employees (or prospective employees) with mental health problems.

Keywords: Mental health, employers, reflexivity, employment

Introduction to the study

It is estimated that there are 11.5 million working-age people in Great Britain with a long-term health condition. Of those more than half (6.5 million) are classified as disabled under the Equality Act (2010), because they have a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities (DWP, 2013). Pathways to Employment Recovery and Inclusion' (Bevan et al. 2013), shows that those in paid employment are over five times more likely to achieve functional remission than those who are unemployed or in unpaid employment.

The literature suggests that Individuals with psychotic disorders such as schizophrenia and bipolar affective disorder can be valuable and reliable workers (Bond, Campbell and Drake, 2012). Yet 70% of people with schizophrenia in the United Kingdom have experienced discrimination (Bevan et al. 2013) and there are indications that employment is often not even considered as an outcome by clinicians (Bevan et al. 2013). On average, a person with depression is at least 50% more disabled than someone with angina, arthritis, asthma or diabetes (London School of Economic and Political Science, 2012). However much of the research shows that it does not matter what the diagnosis is, or severity of impairment and level of social skills when looking at the relationship to employment outcomes (Bond et al. 2001; MacDonald-Wilson et al. 2001). Having previously had a job, or wanting a job and believing that you can work, have been shown to be the best predictors of success (Grove and Membrey, 2005). There is a longstanding history whereby an understanding of mental illness has been entrenched in a model of illness as opposed to recovery. More recently the objective of traditional health services has shifted to an approach that focuses more on social outcomes, on what an individual with mental illness is able to achieve rather than what they cannot. There is a greater emphasis on recovery, society accommodating disability access and its social aspects of management (Boardman, 2003). All adults have the right to paid employment if they wish to work but for individuals with mental illness there are significant obstacles to be overcome to achieve that right.

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The aim of this study was twofold.

Firstly it sought to gain a deep understanding of the reluctance by employers to employ individuals with a known mental illness who are in a phase of recovery. Secondly it sought to hear about the lived experiences and perspectives on the barriers experienced to accessing or being in employment from a service user's perspective.

Mental illness and Recovery: The Historical Perspective

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

Estimates of prevalence of individuals with bipolar disorder vary with a review by Waraich et al (2004) suggesting a 12-month prevalence estimate of 0.72 per cent for Bipolar Type I. Twelve month prevalence rates across European countries are estimated as ranging from 0.5 per cent to 1.1 percent for Bi-Polar disorder (Pini et al. 2005). In the United States the National Comorbidity Survey Replication (NCS-R) reported twelve-month prevalence rates for Bipolar Type I as 0.6 per cent, 0.8 percent for Bipolar Type II and 1.4 per cent for sub-threshold bipolar disorder (Merikangas et al. 2007).

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

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

There are many negatives aspects associated with having a diagnosis of mental illness such as stigma, discrimination, loss of self-worth and optimism about the future (Marris 1974; Perkins et al. 2009; DoH 2009b; LSE 2012; Bevan et al. 2013). Individuals with mental illness are considered as being less reliable, less able to perform and more of a risk for employers (RCP, 2003; 'see me' 2004; Perkins and Rinaldi 2002). More significantly having such a condition has serious implications for life expectancies (Schizophrenia Commission, 2012). People with schizophrenia and bipolar disorder die on average 25 years earlier than the general population, largely because of physical health problems (Parks et al. 2006). Of those living with schizophrenia in the community, men experience 20.5 years' reduced life expectancy and women 16.4 years' reduced life expectancy (Brown et al. 2010; Schizophrenia Commission, 2012). When the above statistics are considered alongside those statistics that show the positive impact of employment for individuals with mental illness is it possible that employment could increase their longevity?

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

Initially the trust established a User Employment Programme (Perkins, Evenson, and Davidson, 1995). This was designed to increase access to sheltered or supported employment within mental health services for people who have themselves experienced mental health problems. Between 1995 and 2007, 142 people were supported in 163 posts within the South West London and St George's Mental Health NHS Trust and on the 1st January 2007, 86% of these

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people continued to work within or outside the organisation or were engaged in professional training (Perkins, Rinaldi, Hardisty, 2008). This demonstrates the potential for long-term employment and resulting possible health benefits, where positively supported.

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

This work is encouraging and suggests that the findings of this current research could contribute to a very positive outcome for service users in terms of promoting recovery, social inclusion, and empowerment of service users by promoting employability. However it is not clear from the study above, to what extent individuals were retained in employment outside the trust in 2007 and it is likely that there was a greater awareness of the needs of individuals with mental illness entering employment in a mental health service.

Employment, Mental illness and Recovery: The Social Care Context

Consideration of employment as an option for individuals with mental illness and availing themselves of social care support has been slowly but steadily gathering pace. The *Attitude to Mental Illness* research report (DoH, 2013) reported that out of approximately 1,700 individuals from the general population 60% agreed with the statement that '*People with severe mental health problems can fully recover*' (p24). Health and well-being is also addressed in The Health and Social Care Act (DoH, 2012(a)). It places a new duty on local authorities in England to '*take such steps as it considers appropriate for improving the health of the people in its area*' (DoH, 2012(a): p2). Local authorities must take responsibility for improving health and co-ordinating local actions to protect the public's health and well-being, and for ensuring that health services effectively promote population health. However wording such as '*steps as it considers appropriate*' (DoH, 2012(a): p2), are nonspecific leaving it open for interpretation at local level. There is no specific mention of employment and how it constitutes better mental health in promotion of the population's health. It has similar non-specificity to The Disability Discrimination Act (DDA, 1995), which suggested that employers should '*make reasonable adjustments*' in employing disabled people (DDA, 1995, Section 4A). Yet in the same year as The Health and Social Care Act (DoH, 2012(a)) received Royal Assent one third of new

jobseekers allowance (JSA) claimants reported that their mental health deteriorated over the period of the four-month study, while those who entered work noted improved mental health (McManus et al. 2012). Also in that year The Care Quality Commission (CQC, 2012) survey of community mental health service users found that 43% of the 2,780 respondents said they would have liked support to find or keep a job but did not receive any (Care Quality Commission, 2012). That suggests that consideration of the suitability of the employability of this client group remains patchy and poor and its link to recovery largely unrecognised. This is despite the continued recognition of the relationship between unemployment and poor mental health (Dorling, 2009).

Employment as a route to recovery is included in the Government mental health strategy, *No Health without Mental Health* (DoH, 2011) where the second objective states that '*more people with mental health problems will recover*' (Part 1: p8), with reference to individuals been given the '*skills they need for living and working*' (p 33, p 38) and '*better employment*' (DoH, 2011:p33). The concept of recovery is also picked up in the 'Closing the Gap' report (DoH, 2014). There-in it states '*high quality mental health services with an emphasis on recovery should be commissioned in all areas*' (DoH, 2014: p10), but does not specifically mention employment. It is accepted that employment may not be possible for everyone with mental illness, though the possibility of employment could benefit from more in-depth assessment to support any meaningful shift in the employer attitude about individuals with mental illness and their suitability to employability.

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

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

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

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

Employment would therefore seem to go some way to meeting that definition in terms of it being satisfying, purposeful and meaningful. Recovery is also perceived as providing a further step to developing coping strategies a move on from mere survival or life management to an improved and personally defined quality of life (Wallcroft, 2005). Encapsulated in the concept of recovery is a great sense of hope and possibility, which seems a very long way away from the negative attitudes, associated with diagnostic classification of mental illness (Corrigan, 2007).

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

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

Recovery is about tapping into the individual's strengths and fostering those environments of possibilities. If recovery from mental illness is to be recognised as a possibility, a reality, and that employment of individuals with serious mental illness is possible, does this imply that the

term mental illness needs to be rebranded? Is it time to move from defining people by their labels such as schizophrenia to seeing the potential in the person? Are employers ready to change from holding the locus of control to facilitating the employment of the individual with mental illness? Is partnership between health, social services and employers the new way forward? Promoting recovery as part of government policy is certainly indicated in the white paper, *Liberating the NHS, no decision about me without me* (Department of Health, 2010). If recovery and employment are to be truly accepted there is much work to be done to make this cultural shift a reality. Employment as a means to support recovery from mental illness is postulated in this research. Without that knowledge and understanding the various barriers to accessing and maintaining employment when in a phase of mental health recovery will remain. It should be noted that many workplace factors that would help an employee with schizophrenia stay in work are the same as in any psychologically healthy workplace – creating an environment in which we feel safe and support that is available for all those who need it (Bevan et al. 2013). This principle might cut across employment for all, as we all want to feel safe and supported at work but there may be additional areas identified as promoting the successful employment of individuals in mental health recovery. Strengths based approaches have proven to lead to increases in social harmony, community empowerment and adult employment (Mclean, 2011).

Despite the existence of strength based approaches to support individuals with mental illness in employment the issue of finding the right employment and having appropriate support in maintaining employment continues to be a difficult one. There are a number of supported employment models which have been proven to support individuals with mental illness back into supported employment.

The study sought to answer two specific questions. They were:

1. Are employers' reluctant to employ people in the recovery phase of mental illness? If so what are their possible reasons?
2. Do mental health service users who are in a recovery phase experience any barriers to employment in a North London borough?

Research Design

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A phenomenological epistemological approach was adopted as it had the capacity to capture the rich textured and descriptive experiences of the population participating (Finlay, 2009). This stance facilitated the gathering of information that was the individual lived experience of participants. The epistemological position sought to explore

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

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

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

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

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

sensitising concepts that steer researchers towards a particular outlook with proponents of these persuasions sharing the goal of understanding the complex world of lived experience from the point of view of those who live it (Schwandt, 1994: p118).

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

The underlying assumption is that by researching people in their social contexts, there is greater opportunity to understand the perceptions they have of their own activities (Hussey and Hussey, 1997). The primary concern of this current study was to capture and portray the stories and experiences voiced by the participants as accurately and comprehensively as possible.

Methods

Focus Groups

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

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

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

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

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

Service Users Focus Groups

The researcher has worked for 19 years in the community in which the research took place. As a manager of community mental health services I had an in-depth knowledge of the local population and community of individuals who use mental health services. Based on that knowledge and drawing on guidance set out for planning and recruiting of samples for focus groups (MacDougall and Fudge, 2001) , a list of potential service user participant representatives living in a North London Borough was drawn up. The contact stage involved developing a community based recruitment strategy. I communicated with key contacts who could liaise with the type of participant I wanted to recruit. Those key contacts acted in the roles of explaining the research to prospective participants. Key contacts included managers of day centre facilities, and a number of managers of community supported housing facilities spread across the borough. The next stage involved providing participant information documentation, invitations to participate in the research, with a stamped addressed envelope and response sheets to key contacts to circulate amongst prospective participants.

Participation information sheets clearly addressed issues around confidentiality and participating in the focus group process. Participants took part based on willingness to participate and their availability. Lunch and refreshments were provided in all three groups. All willing participants were provided with a participant information sheet and were asked to sign a consent form. Out of 50 information packs sent out there were 28 willing respondents.

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

Employer Focus Groups

A number of organisations including Reed Employment Agency, The Chamber of Commerce and Job Centre Plus, were approached to try and secure an up to date list of businesses in the North London Borough within which the research was proposed. Business Link advised me that their list was quite old and that they were not aware where I might access a more recent list. After exhausting a number of contacts in an effort to secure an existing list I researched and drew up a list of employers based on available contacts and advice from employers in the North London Borough. Employer representatives were targeted based on it being considered by the researcher that they would hold specific knowledge around the research questions posed.

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

Face-to-face contact improved the possibility of securing interested parties as I was able to convey the potential value of partaking in the research. I was also conscious that given the then current economic downturn (Barr et al. 2012; Evans-Lacko et al. 2013) that willingness to

participate might be very low, and that once employers understood that there was no pressure to employ individuals in a phase of recovery from mental illness they might be more willing to participate.

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

Prospective participants were given a choice of three different times for the focus groups. Participants elected which focus group they would or could attend by completing the confirmation of attendance sheet, which set out the time, date and location of the focus group. It was hoped to have a least five employer participants in each focus group. Nine confirmed attendance for the morning session, but five actually turned up. Seven confirmed attendance for the 1pm session and seven turned up. Six confirmed attendance for the third session and five turned up.

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

SAMPLE FRAME

This research was conducted with a wide range of service users and a wide range of employer representatives within a North London Borough. Biographical and demographic data was gathered from all participants with a view to establishing the diversity of the individuals participating. Employer representatives were invited from diverse sectors, which covered a range of industries, possible occupations,

small and larger organisations and the private and public sector. Employer sectors included large retail employers, a small retail employer, large financial institution employers, a relatively small construction employer, the national health sector, private health sector, and a small employment agency. Out of the 39 employer organisation representatives contacted to participate in the research 16 participated. 28 service users participated across three focus groups, with one group of 16, one group of 7 and one group of 6.

This research phase commenced in 2011 within a North London Borough. The 2011 census figures indicated that the then population of that borough was 312,500. In terms of mental illness in 2011/12, 2,930 of its residents registered with GPs were recorded as suffering from Schizophrenia, Bipolar Affective Disorder or other severe Psychoses, equating to 1.01% of the resident population, which was similar to the London prevalence (1.00%), but above the England prevalence of 0.82%. This was a similar prevalence to that recorded in 2010/11, when 2,805 people or 1.01% of the adult population were identified as suffering from Psychoses including schizophrenia and bi-polar disorder (Director of Public Health, 2012). The researcher was considered to be an insider researcher as she has worked for many years with individuals experiencing mental illness. Work based learning research that is practitioner led is thought to contribute to achieving real organisation change, where the practitioner takes responsibility for knowledge generation modelled on their development endeavours Costley et al (2010). This was considered to strengthen the study framework.

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

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was used to build up a sample which satisfied the needs of the research topic (Robson, 2002). As the researcher had the experience of working nineteen years in the local community that she was considered a 'key informant' in identifying the purposive sample (Barany, 2006). This local knowledge and experience helped to identify informants efficiently and wisely, and to choose the level of analysis necessary to answer certain objectives (Bernard, 2002).

It was accepted that this was not necessarily a representative population and that it would not be generalisable. Non probability sampling was recognised as contributing to internal validity of the study with the interpretation of the data generated confined to the actual population partaking in the study. Transferability of the findings from this study is not truly possible as all observations are defined by the specific contexts in which they occurred (Erlandson et al. 1993). On the other hand it could be equally argued that this research is unique and is an example within a broader context and therefore the prospect of transferability should not be immediately rejected (Stake, 1994; Denscombe, 1998). With these different perspectives and mindful of Lincoln and Guba's (1985) evaluation criteria to establish credibility, transferability, dependability and confirmability, this sampling method was considered to be most appropriate for the study undertaken.

Service Users Focus Groups and Ethics Considerations

Consideration was given to the ethical issues of conducting research with vulnerable adults. Particular attention was given to adhering to good practice and professional codes of practice such as the Human Rights Act 1998; the Mental Capacity Act 2005; Equality Act 2010. The initial contact stage involved developing a community based recruitment strategy which involved isolating key contacts who could liaise with service users living in the community who considered themselves in a phase of mental health recovery the type of participant required for the study. Those key contacts acted in the roles of explaining the research to prospective participants. Key contacts included managers of day centre facilities, and a number of managers of community supported housing facilities spread across the borough. These key contacts knew potential service user participants well and were able to determine that the vulnerable adult had the capacity to consent to participation in the research and that they would feel able to decline to participate in the research

if they wanted to. The key contacts allowed time for service users to ask questions and to ensure potential participants fully understood the nature of the study. Both informed consent and process consent were sought throughout this study. This is a process whereby informed consent is initially obtained and then confirmed at each subsequent contact (Munhall, 2007; Long & Johnson, 2007). Key contacts were provided with packs of participant information documentation. This included invitations to participate in the research, with a stamped addressed envelope and response sheets. These invitations were circulated to prospective service user participants once the nature of the research had been fully explained to them. Participation information sheets clearly addressed issues around confidentiality and participating in the focus group process.

Participants took part based on willingness to participate and their availability. Lunch and refreshments were provided in all three groups. All willing participants were provided with a participant information sheet and were asked to sign a consent form.

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

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

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Data Analysis

The method for data reduction and for capturing the complexities of meaning within the data employed was that of thematic analysis. This involved moving beyond counting explicit words or phrases to focusing on and describing ideas that are both explicit and implicit in the data, which are known as themes (Guest, McQueen and Namey, 2012).

1. Becoming familiar with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Fig 1: Phases within the Thematic Analysis Framework

(Guest, McQueen and Namey, 2012).

Initially in phase one of Braun and Clarke's model (2006) each audio recording was listened to from start to finish. Each one was listened to a second time in an effort to become more familiar with the stories or dialogue within.

The content of each audio recording was then transcribed. This was a very slow process. Often parts of each recording had to be played over and over again so that the accuracy of the conversations was caught. Transcription took place over a number of weeks. Once transcription of all six focus group was complete phase one of Braun and Clarke's model (2006) continued to be followed. This exploratory approach involved reading and rereading of transcripts until the researcher felt completely familiar with all six transcripts. The process although lengthy allowed the researcher to re-immers herself in the participant's shared narratives and lived experiences. It brought the focus group sessions to life again. The researcher proceeded to access the field notes that were recorded by the research assistant during each focus group recording. Each set of field notes were matched to the relevant focus group transcription.

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

Phase three of analysis commenced when I used the sets of data collated to search for themes within it. Those that held the same or similar codes were compiled together. Braun and Clarke (2006) use the analogy of a house to capture this stage of moving from phase two to phase three. If it can be imagined the assigning of codes or labels to important features of the text as the 'bricks and tiles' in a brick and tile house then searching for themes could be visualised as the 'walls and roof panels'. They also suggest that this aspect of analysis is like coding your codes. Searching for themes within the data required intense engagement with the data and the lists collated. This analysis was done from an inductive perspective and was not driven by a pre-existing theoretical framework.

It became apparent that whilst different phrases and terminology were used it seemed to point to similar patterns or connections in the transcriptions. During the remaining phases the 'verbatim principle' (Stringer, 2007: p99) was followed ensuring that only terms and phrases shared by participants were selected. Conducting thematic analysis manually in this way allowed the researcher to be 'close to the material' (Creswell, 2005: p.234), but this method is 'not considered easy as it typically takes more time and energy than quantitative techniques (Boyatzis, 1998: p161).

Reflexivity during the analytic process

Being alert to the implications of the role of inside researcher (Robson, 2002) and truly not able to escape that consciousness was considered as very important, as it is known that subjects of research are eager to comply with the wishes of the researcher and to provide the type of responses that the researcher is looking for. The tensions that come with the role of inside researcher were accepted as being an accepted risk involved in the research process, as noted in other work based learning studies, see for example Weller, 2009. It was not as if they could be escaped from. It did bring up different issues in each focus group type.

For example participants from the employer focus groups were likely to see the researcher as holding a bias position as a manager of community mental health services. The researcher was probably seen as holding a dual position of being an employer and a person who works closely with people with mental illness every day and would therefore have a very different view of employing an individual with mental illness than that of a bank manager or a construction site foreman or the local hairdresser.

It was noticed that employer participants were initially very guarded about what they said. There was a sense of nervousness that had to be overcome in each employer focus group before participants became relaxed and felt on an equal playing ground. The researcher noted the need to communicate quite clearly that there was no expectation that employers would be expected to employ an individual with mental illness as a result of participating in the focus group. The researcher was also very aware of having a strong empathy towards individuals with mental illness and that participants were likely to sense this despite my best attempts to stay neutral (Gray,2014:390).

In the service user participant focus groups the researcher felt a greater sense of closeness and understanding of experiences shared. Again the researcher really tried to 'bracket' this so as not to influence participants' responses. Bracketing is an existential phenomenological stance, which suggests that in order to achieve the

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technique of 'bracketing' that the individual has to bracket one's own ideas, assumptions and prejudices so that you can hear the description of the client's experience from the first person point of view. This was a tough thing to do consistently and Spinelli (1994) acknowledges this and points out that this can only be an aspiration rather than something that can be fully achieved. Efforts were made not to confirm or repudiate the participants' subjective experiences, but instead consciously staying with them which enabled further illumination of experiences and exploration of what was being shared.

Findings

Employer representative focus group

The participants were made up of twelve females and four males aged between their mid-20s and mid-50s. There were four major themes identified in the employer representative data set. There are also nine sub themes identified, three to main theme one, two to main theme two, three to main theme three and one to main theme four. The themes identified are as follows:

Theme 1 Employers are reluctant to employ individuals with Mental Illness

- 1.1 Employers view employing individuals with Mental illness as a burden and added cost
- 1.2 People in a phase of mental health recovery are seen as less able or less competent
- 1.3 Employers fear that employment will cause stress, which will have a negative impact on mental health and vice se versa

Theme 2 Understanding and Knowledge of mental illness

- 2.1 Familiarity with anxiety and depression but very poor understanding of schizophrenia
- 2.2 Employers from a caring background or who had experienced mental illness were more caring and empathetic towards individuals with Mental Illness

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

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3.1 Employers have a negative association with the label Mental Illness

3.2 People with Mental Illness and in Recovery are Dangerous
3.3 Mental Illness is associated with illness not recovery

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

4.1 There are factors that facilitate employment

Service User Focus Groups

Focus group one was set up by service users at an established day care centre, and the other two groups took place within a mental health care setting in a rural part of North London. Service user focus groups were diverse and were made up of: 10 Females, 18 Males with participants indicating their ages ranging from in their 20s to mid-60s. The groups were multi ethnic consisting of 16 British participants , 5 African Caribbean, 3 Black British, 1 English Italian, 1 Asian British, 1 Burindiz, and 1 of Mixed Race. Through the theoretical freedom and flexibility that thematic analysis provides five major themes, and a number of sub themes were identified from the service user focus group data (Braun and Clarke, 2006:p7). A summary of these are set out in below.

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

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

1.2 Flexibility in employment to accommodate people with MI.

1.3 Employment opportunities tend to be voluntary and unpaid.

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

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

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

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

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

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

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

4.1 Keeping people on long-term benefits contribute to unemployment of individuals in mental health recovery.

Theme 5 People with mental illness feel employment is very important to them.

5.1 Individuals with Mental illness would like to be given the opportunity to work again.

Discussion

The themes that were isolated from the employer data identify reluctance on behalf of employer participants to employ individuals in a phase of recovery. They also highlight that employers have a poor understanding of the more severe and enduring forms of mental illnesses especially schizophrenia. There is evidence of stigma associated with beliefs linked to labels of mental illness, but despite that employers have not ruled out the possibility of being able to employ an individual with a diagnosed mental illness in mental health recovery.

The themes from employer representative focus groups seem contradictory in effect, on the one hand indicating poor understanding and unwillingness to employ this type of individual whilst on the other hand implying that employability could be made more of a reality if certain measures were put in place. Following the

completion of the three employers' representative focus groups, three service user focus groups were organised.

It would seem that there is compelling evidence that employers remain reluctant to employ individuals in a phase of mental health recovery. While the question posed seemed very straightforward it is evident that the answer to it is not so.

Employers highlighted many 'good reasons' why they were reluctant to employ this client group. They were seen as likely to cost more money, less able thus not worth considering. Employers indicated that they had 'no spare capacity'. This may be related to the study taking place during a recession when it is recognised that there is increased economic hardship and that the social exclusion of people with mental health problems may intensify (Evans-Lacko et al. 2013). Overall the themes that emerged from the employer focus groups point to the need to package employment as a means to promoting and maintaining good mental health.

The themes that emerged from the service focus groups have indicated that people with mental illness are faced with many obstacles when trying to access employment opportunities.

According to this cohort of participants' people with a diagnosed mental illness still face significant obstacles when trying to access suitable employment. Service user participants felt that their employment prospects could be enhanced if employers had a greater understanding of mental illness, if they could offer some greater flexibility around posts advertised. Some individuals conveyed that they are fulfilled in voluntary posts whilst others would like the opportunity to be in paid employment. Many of the participants in these three focus groups had previous work experience but most had not managed to secure employment since the onset of their mental illness. Service users felt that they are seen as less able and less competent as a result of the label of mental illness. Whilst employers might be reluctant to employ individuals with a mental illness, service users themselves worried about how stress might cause them to relapse. They also believed that prospective employers had preconceived ideas about people with mental illness.

These were mostly associated with an employer not being able to see what an individual with mental illness has to offer, not seeing their potential.

Some participants struggled with low self-esteem, poor motivation and lethargy as a side effect from medication. These self-defeating personal barriers were seen as difficult for individuals to break out of. Alongside these personal barriers there were real concerns about financial security. Some service user participants felt safe and secure while on benefits whilst others welcomed the possibility of breaking out of the benefits system and getting into the employment market. Service user participants conveyed that they would like to be considered for employment. They do not want that choice removed from them because of a diagnosis of mental illness. Employment was considered as important to these people with a diagnosed mental illness in a phase of recovery. They conveyed that employment gives them the possibility of greater autonomy, independence, social integration and identity.

There was a sense of doom in relation to employment prospects as a result of having a diagnosis of mental illness. It was experienced like bereavement (Marris, 1974), as service user participants felt that despite their previous work experience or qualifications they are removed from the prospect of employment because of a diagnosis of mental illness. The employer participants corroborated this in that they did not understand mental illness and tended to view it as a permanent state that cannot be recovered from.

Individuals reported difficulties they experience as a result of having low confidence and side effects from being on anti-psychotic medications. There were concerns around benefit loss in the event of re-entering the employment market.

Service user participants felt worried about engaging in employment in case they relapsed and were then left with no money. They indicated that they want to work, but thought that employers or individuals involved in the employment pathway had negative preconceived ideas about individuals with mental illness. They thought that employers need to be educated about mental health, mental illness and the role of employment in an individual's life. Poor understanding of mental illness by employers is a theme that was flagged up by both participant types. Most recently education, direct contact, interaction with people who have mental illness and

protest to change behaviour and challenge attitudes are three strategies identified to address stigma and discrimination experienced as a result of having mental illness (Davies, 2014). It is worth noting that direct social contact was found to be more effective than education in reducing stigma for adults with mental illness (Corrigan et al. 2012).

Service users suggested that employment meant that they had an identity, a role in life a chance to be involved in society, which in itself contributes to better mental health. There is evidence that individuals in mental health recovery who are in paid employment are over five times more likely to achieve functional remission than those who are unemployed or in unpaid employment (Bevan et al. 2013). As there is less money available and increased demand for mental health services (DoH, 2012); Schizophrenia Commission, 2012) there is a strong case for building on what already exists, no need to reinvent the wheel. There are a number of existing models and strategies that could benefit from further development.

There is a possibility that huge personal and socio- economic benefits can be had for the individuals in mental health recovery and those involved in the patient employment pathway. This recommendation to adopt a cross agency improved employment pathway for individuals in mental health recovery is supported by the CIPD (2014) where employers have been encouraged to address labour shortages by improving the pay and employment conditions package and investing more in human capital (CIPD, 2014). The development of a Patient Employment Pathway (PEP) for individuals in mental health recovery could aid this integrative process.

CONCLUSION

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

The findings have unveiled a range of challenges and these are necessary to

consider with regard further developments. What has been uncovered is that mental illness in relation to employment prospects has been considered in illness terms for too long. Mental illness, employment and mental well-being need to be considered alongside each other, as there is an interrelationship between all these areas. They would benefit from being parcelled together as essential components of mental wellbeing. However the solution or solutions are not straightforward even if the research findings have found some answers to the questions posed.

Considering the wider picture and noting that although there have been clear benefits established by having people with mental illness in employment the unemployment rates for individuals with severe mental illness remain high worldwide. Specialist treatment for service user participants in this study and for individuals experiencing mental illness has to be a prerequisite to achieving better employment outcomes for this client group.

The rates of individuals absent from work every year because of mental illness and the levels of those continuing to be unemployed as a result of mental illness indicate that there has to be a seismic shift in policy and practice if the challenges for better labour market inclusion of people with mental illness are to be addressed. The following is suggested.

1. All employers, individuals involved in the employment pathway, need to fully understand mental illness and how to support individuals in a phase of mental health recovery back into work. (For the Unemployed)
2. All employers and employees, across all industries, large and small, private sector, public sector, need to be fully conversant with mental illness and have staff trained in recognising its earliest warning signs in work place environments. First aid training could be extended to include training on mental illness as a legal requirement.
3. All employers, individuals in the employment pathway, and employees, need to be educated on how they can support an individual with mental health issues regardless of diagnosis when they are in employment following a diagnosis of mental illness.

There is a case for arguing that what would benefit from greater scrutiny is prevention of the development of mental illness in the first place. Creating greater mental health awareness in workplace environments that allow mental illness to be discussed openly is essential. Employers and employees need to be educated and supported in managing mental health at work. Evident from this current study is that there is still great stigma associated with labels of mental illness. This raises concerns about how employers will meet the legal requirements under the EQA (2010). This is further complicated by the other major emergent theme from this study that employers have a poor understanding of mental illness. If employers lack understanding of the various types of mental illness how can they then begin to support individuals in mental health recovery back into work or whilst in work.

This study highlights the need for training and guidance on the principles of disability discrimination so that employers can meet the legislative requirements and that there is improved outcomes for those individuals in mental health recovery who want to work. The study findings indicate that while a common protocol for managing mental health well-being at work might be useful it will not be sufficient in itself. The fragmented employment pathway for individuals who are trying to get back into employment needs to be given greater scrutiny. That could be an agency, an individual or an employer. It is recognised that the challenges will be different depending on employer size, employment type, whether a public or private sector employer. These challenges could be addressed from the development of a pathways approach which combines NHS patient care and employment pathways.

Future goals for the outcomes of this research are to build the case for employment being an essential component of recovery. Efforts to promote more integrated employment mental health pathways will be made. Employers will be encouraged to invest in developing healthier mental wellbeing work place environments. Given the importance of employment, as a precondition to full citizenship efforts will also be made to drive policy change locally and nationally by engaging policy makers and commissioners locally and nationally.

The findings indicate that the answers to the research questions pose significant

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challenges for those involved. They suggest that there is a need for greater communication between all stakeholders involved in getting individuals recovering from mental illness back into work. It also point to a need to pool and consolidate what has been developed already in a more co-ordinated way.

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