How do Social Firms Contribute to Recovery from Mental Illness? A Qualitative Study

& Research Portfolio

PART ONE

(Part two bound separately)

Jenny Svanberg

July 2006

Submitted in partial fulfilment of the requirements for the degree of

Doctorate of Clinical Psychology

Acknowledgements

I would like to thank my supervisor, Dr Andrew Gumley, for his invaluable support and advice, as well as for giving me the initial idea for the research. I would also like to thank Dr Alistair Wilson, for his enthusiasm and interest in this area of work.

I remain indebted to the participants and project leaders of the two emerging social firms included in the study. They were always welcoming, and generously agreed to share their experiences and thoughts in the research interviews. I hope I have done them justice.

On a more personal note, I would like to thank my parents and sister for support and sanctuary. I am very grateful to many of my classmates for some serious peer support, and also to Abbie Easen, Fiona Johnson, and Charlotte Williams. Finally, thanks to Dave for patience and coffee.

Contents

Chapter 1

Small scale research project

What factors affect attendance at a mental health group for female asylum seekers in Glasgow?

Jenny Svanberg*

University of Glasgow

Section of Psychological Medicine, Gartnavel Royal Hospital

1055 Great Western Road, Glasgow G12 0XH

Tel: 0141 211 3920

Fax: 0141 357 4899

jennysvanberg@yahoo.co.uk

*author for correspondence

Prepared in accordance with the author's instructions for Clinical Psychology: Science & Practice (Appendix 1.1)

Abstract

Dropouts in group therapy can cause disruptions for the remaining members of the group and precipitate further dropouts (McCallum et al, 2002). Whilst there is a wealth of research on dropouts across different therapies and client groups, there appears to be little amongst the developing literature on therapeutic work with asylum seekers and refugees.

This retrospective study aimed to investigate the factors affecting attendance at a mental health therapy group run for female asylum seekers in Glasgow, with a view to decreasing barriers to the group and identifying targets for development. The sample consisted of the 101 women invited to attend the eight groups run prior to June 2004.

A number of socio-demographic and cultural variables were investigated in order to draw conclusions about their relationship with attendance. These included: age, area of origin, need for interpreter, presence of children, who the individual was living with, and the season the group was held in.

No significant relationships were found between attendance and socio-demographic or cultural variables. The results are discussed in light of the research literature, and possible directions for future research are suggested.

Introduction

Asylum seekers can be defined as "persons who seek protection under the Convention on Refugees[1] after entering another country on a temporary visa or without any documents." (Silove et al, 2000). They may have experienced high levels of trauma pre-migration, and may be more susceptible to experiencing mental health problems as a result of further stressors post-migration (Silove et al, 1998). This is an issue of local importance: approximately 10,000 asylum seekers were living in Scotland in 2003, mainly in Glasgow (Scottish Refugee Council, 2003).

Whilst research has pointed out high prevalence rates of mental health problems amongst asylum seekers, most notably of post traumatic stress disorder and depression (Turner et al, 2003; Silove et al, 2000), social and economic issues post-migration are often the most pressing difficulties presented by asylum seekers (Summerfield, 2001). These issues may include isolation, cultural bereavement, boredom, anxiety about asylum status, changes of family roles and physical illness (Harris et al, 2000). Women asylum seekers may face particular problems due to their low status in society and the absence of family and community supports (Tribe et al, 1989) and isolation in this group has been highlighted as a key cause of psychological distress (Dumper, 2002). It has been suggested that western therapeutic techniques of psychology and psychotherapy will be unsuccessful unless some of the above issues have been addressed (Watters, 2001).

[1] Under the United Nations 1951 Geneva Convention, a refugee is defined as, "A person who owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of [his/her] nationality and is unable or, owing to such a fear is unwilling, to avail [himself/herself] of the protection of that country."

Asylum seekers have been reported as having difficulties in accessing healthcare services (Scottish Executive, 2001). In examining barriers to mental health services for asylum seekers locally, a lack of information has been found to be a key factor (Douglas, 2004). However, there appears to be little literature on engagement or dropout from therapy for this group, which the present study seeks to address.

Within the group therapy literature there is some evidence for beneficial uses of group-work with asylum seekers, in particular in reducing isolation, reducing anxiety and depression symptoms, improving self esteem and trust, and providing a supportive social network (Tribe et al, 1989; Breton, 1999). Across both individual, group and family therapy, inconsistent attendance is a major problem (MacNair-Semands, 2002), and a greater understanding of what factors influence attendance may allow more focused targeting of services and resources.

Research has given mixed results on the relationship between socio-demographic factors and attendance, with some studies finding that these factors contribute to dropout rates (Bostwick, 1987), whilst others find no relationship (Oei, 2000). The present study will focus on this area in order to investigate the relationships between socio-demographic factors and attendance with asylum seeker women. Cultural factors including interpreter use have also been included to determine whether these factors have any effect on attendance.

Aims and Objectives

The present study aims to explore the relationship between socio-demographic factors, cultural factors, and attendance at a mental health therapy group for asylum seeker women in Greater Glasgow. The study seeks to:

1. Identify factors facilitating attendance at the groups
2. Identify barriers to attendance that may be present.

Method

Participants

The sample consisted of the 101 women who participated in eight, 10-week, 'mental health therapy groups' carried out between 2001 and 2004. The groups were facilitated by professionals from the fields of Art Therapy and Clinical Psychology, all members of the Asylum Seekers and Refugees Mental Health Liaison Team in North Glasgow. The groups were run without interpreters, aiming to reduce isolation, lessen symptoms of anxiety and depression, and improve self-esteem through structured activities. Data were collected from a number of sources, including referral letters, case notes, attendance records and a screening questionnaire designed by the team.

Design

The study used a retrospective design. Attendance at the group was split into 3 categories: low attendance (0-2 sessions), medium attendance (3-6 sessions) and high attendance (7-10 sessions). Non-attendance was defined as a participant missing a session without having informed the team that she would do so.

A number of variables were investigated to determine their effects on attendance. These included: age, area of origin (Asia, Africa, Middle East or Europe), locality, who women were living with (alone, with children, with partner/partner and children), season the group was held in, and need for an interpreter. This final variable was included to find out whether the lack of interpreters at groups was affecting attendance. Country of origin, language spoken and types of mental health problems were also collected as background information on each participant.

Data analyses were conducted using the Statistical Package for Social Sciences (Version 11.5) for Windows. Chi square and correlation analyses were used to investigate the relationships between the above factors and attendance.

Results

Data were collected on 101 women who were invited to participate in the eight groups investigated. There were missing data for some variables due to case notes being inaccessible, or information not being contained within the sources examined. The sample size for each variable is therefore given in brackets where relevant.

Characteristics of the Sample

The mean age of the sample at time of referral was 33.4 (s.d.=8.49; n=93), with a range of 18-54. The women came from 27 different countries (n=99) with the largest groups coming from Turkey (23%), Iran (11%) and the Democratic Republic of Congo (8%). Those involved in the group selection process tried to ensure that no more than 2 women from any one country were invited to attend to avoid sub-grouping of countries. The

women spoke 13 languages (n=99) with the largest groups speaking Turkish (20%), English (14%) and French (13%). The women invited to the groups were dispersed across Glasgow, with the majorities living in North Glasgow (54%) and South Glasgow (29%) where n=99. Most of the women had children in Glasgow (71%, n=85). Out of the sample, 24% lived alone, 41% lived with their husband, or husband and children, and 35% lived alone with their children (n=83). At the time of screening for the group, the women were asked about the presence of partners or children living with them in Glasgow as a measure of isolation. It was recorded for 11 of the women that they had left behind partners or children in their country of origin.

Based on the referral letters, mental health problems of the women were also investigated. The screening process for the group ensured that all women invited had mental health problems of mild to moderate severity. The largest groups (where n=76) were of women with symptoms of post traumatic stress (34%), those with depressive symptoms (22%), and those with co-morbid anxiety and depression (15%). Other mental health problems included depression with post-traumatic symptoms (9%), anxiety (9%), anxiety with post-traumatic symptoms (7%), psychotic episode (3%) and deliberate self-harm (1%).

Attendance

Average attendance across the 8 groups was 4.2 sessions out of 10 (s.d.=3.27; n=101). As can be seen from Figure 1 below, the greatest percentage of women attended only 1 session out of the 10 in each group (22%, n=101). Just under a third of women (30%,

n=102) fell into the high attendance category (those who attended 7-10 sessions), and 40% into the low attendance category (attendance at 0-2 sessions).

Insert figure 1 about here

Relationships between attendance and variables investigated

For the purposes of the analysis, country of origin was collapsed into the variable area of origin, with categories of Africa, Asia, Middle East and Europe. From the sample of 99, the largest group of women came from Europe (44%), then Africa (29%), Middle East (22%), and Asia (4%). The majority of women in the sample needed an interpreter for individual therapy (75%, n=85). The season in which the group was held was also included as a variable: 3 groups were run in winter, attended by 38% of the sample (n=101), 2 in spring and summer, attended by 30% and 22% respectively, and 1 group was held in autumn, attended by 11% of the sample.

Pearson Chi square tests were used to analyse the data for all variables except age, where Spearman's rho was employed. There was no significant correlation between age and the three categories of attendance (rho = 0.035, N = 93, p = 0.742, two tailed). In order to carry out Chi square analyses a number of variables were recoded. Area of origin was collapsed into 3 categories of Europe, Asia and Africa; season was collapsed into 2 categories of spring/summer and autumn/winter; and locality into 2 categories of northeast, and southwest. The results of the Chi square analyses are presented in Table 1 below.

Insert table 1 about here

As can be seen from Table 1, there were no significant relationships between the variables investigated and attendance.

Discussion

From the results, none of the variables tested showed a significant relationship with attendance. The aims of the study; to identify factors facilitating attendance, or causing barriers to attendance; have therefore only been met in terms of having eliminated some of the variables that have no effect on attendance. However, these results reflect previous research that has found no relationship between socio-demographic variables and attendance at group therapy in a non-asylum seeker population (Oei et al, 2000).

The high prevalence of post traumatic stress symptoms amongst the sample is in line with previous research (e.g. Turner et al, 2003). It may be that these symptoms also contributed to the low attendance of 40% of the sample, as high dropout rates from individual therapy amongst people with post traumatic stress disorder has been documented (Foa et al, 1998).

The results show that the highest percentage of women (22%) attended only 1 session out of the 10 in each group. Research has shown that those who drop out from group therapy report experiencing significantly less positive affect (McCallum et al, 2002). Whilst this may be a "common sense" finding, it may be an important one in allowing potential dropouts to be identified early on. Those who go on to drop out of group cognitive

behavioural therapy have also been found to participate significantly less during early sessions (Oei et al, 2000).

A number of limitations of the present study may guide directions for future work in this area. The number of difficulties facing asylum seekers in Scotland is vast, and includes factors internal to themselves, such as mental health problems, and a range of factors outside this, of which socio-demographic variables may play only a small part. Other factors of concern to asylum seekers include fears of being sent home, interviews with immigration officials, separation from a spouse, threats to family, poverty and discrimination (Silove et al, 1998). All of these factors may have some impact on their ability to regularly attend group therapy.

Within the group setting itself, research has suggested a number of factors that may reduce dropout rates. Concurrent individual treatment and early assessment of the group experience may decrease the likelihood of dropouts (Bostwick, 1987). Data were not collected on the numbers of women in this study concurrently participating in individual therapy, and this could also be a direction for future research. Early assessment of the group experience may also allow group facilitators to intervene if experiences were found to be negative.

Problems of intimacy and sub-grouping within groups have also been found to contribute to dropping out (Yalom, 1966). This would be an interesting area for future research as anecdotal evidence from the group facilitators suggested that some sub-grouping did take

place, which may have had a significant effect on attendance. Support groups for refugee women from homogenous populations have been described as a promising technique that enables women to draw on each others' strengths (Chester, 1992), but there seems to be no literature on dropouts from groups of this kind.

In conclusion, this study found no relationships between socio-demographic or cultural variables and attendance at a mental health therapy group for asylum seeker women. This may simply have been because of the complex emotional and practical needs of asylum seekers, and the limited number of variables under investigation. A number of possible directions for future research have been suggested. This study has attempted to add to the expanding literature on how best to meet the needs of the growing population of asylum seekers in Scotland.

REFERENCES

Bostwick, G. (1987). "Where's Mary?" A review of the group treatment dropout literature. *Social Work with Groups.* **10(3).** Pp117-132

Breton, M. (1999). The relevance of the structural approach to group work with immigrant and refugee women. *Social Work with Groups.* **22(2-3).** Pp11-29

Chester, B. (1992). Women and Political Torture: work with refugee survivors in exile. *Women & therapy.* **13(3).** pp209-220.

Dumper, H. (2002). Is it safe here? *Refugee women's experiences in the UK.* Refugee Action.

Foa, E. & Rothbaum, B. (1998). *Treating the Trauma of Rape: Cognitive Behavioural Therapy for PTSD.* Guildford Press, New York.

Harris & Maxwell, (2000). A needs assessment in a refugee mental health project in north-east London: Extending the counselling model to community support. *Medicine, Conflict and Survival*, 16, 201-215

MacNair-Semands, R. R. (2002). Predicting attendance and expectations for group therapy. *Group Dynamics: Theory, Research and Practice.* **6(3).** Pp219-228.

McCallum, M., Joyce, A. S., Piper, W. E., Ogrodniczuk, J. S. (2002). Early process and dropping out from short-term group therapy for complicated grief. *Group Dynamics: Theory, Research & Practice.* **6(3).** Pp243-254

Oei, T. & Kazmierczak, T. (1997). Factors associated with dropout in a group cognitive behaviour therapy for mood disorders. *Behaviour Research & Therapy.* **35(11).** Pp1025-1030.

Scottish Executive (2001). Fair for all.

Scottish Refugee Council Briefing (2003). Asylum seekers and refugees in Scotland.

Silove, D., Steel, Z., McGorry, P., & Mohan, P. (1998). Psychiatric symptoms and living difficulties in Tamil asylum seekers: comparisons with refugees and immigrants. *Acta Psychiatrica Scandinavica.* **97(3).** Pp175-181

Silove, D., Steel, Z., Watters, C. (2000). Policies of deterrence and the mental health of asylum seekers. *The Journal of the American Medical Association.* **284(5).** Pp604-611.

Summerfield, D. (2001). Asylum-seekers, refugees and mental health services in the UK. *Psychiatric Bulletin.* **25.** Pp161-163.

Tribe, R. & Shackman, J. (1989). A way forward: a group for refugee women. *Groupwork.* **2(2).**

Turner. S., Bowie, C., Dunn, G., Shapo, L. & Yule, W. (2003). Mental Health of Kosovan Albanian refugees in the UK. *British Journal of Psychiatry.* **182.** pp444-448.

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine.* **52(11).** pp1709-1718.

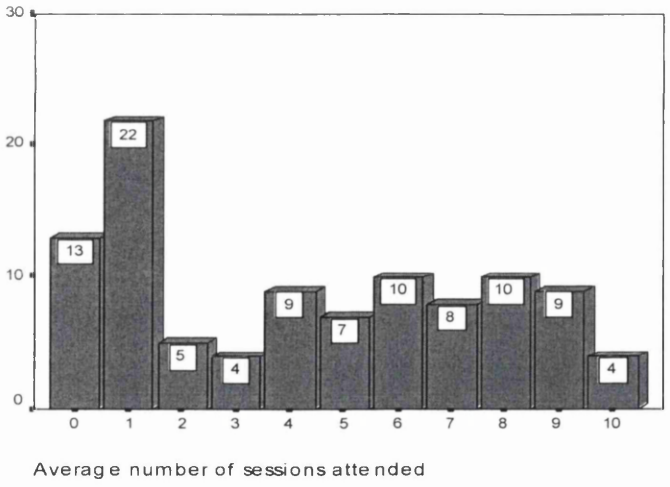
Yalom, I. (1966). A study of group therapy dropouts. *Archives of General Psychiatry.* **14(4).** Pp393-414.

List of Tables and Figures

Table1. Variables affecting the three categories of low, medium and high attendance

	X^2	df	Significance (2-sided)
Area of origin	5.206	4	0.267 ns
Need for interpreter	1.853	2	0.396 ns
Presence of children	0.742	2	0.690 ns
Who living with	3.015	4	0.555 ns
Locality	0.125	2	0.939 ns
Season	3.728	2	0.155 ns

Figure 1: Average attendance across all groups investigated



Chapter 2

Systematic literature review

How do work and vocational rehabilitation programmes contribute to recovery from mental illness? A qualitative review and meta-synthesis

Jenny Svanberg*

University of Glasgow

Section of Psychological Medicine, Gartnavel Royal Hospital

1055 Great Western Road, Glasgow G12 0XH

Tel: 0141 211 3920

Fax: 0141 357 4899

jennysvanberg@yahoo.co.uk

*author for correspondence

Prepared in accordance with the author's instructions for the Journal of Mental Health (Appendix 2.1)

Abstract

Background: There have been mixed results from quantitative literature on the benefits of work and vocational rehabilitation for people with mental illness. Arguably, qualitative studies in this area provide more salient information on the most valued outcomes for this population.

Aims: To appraise and assimilate the findings from qualitative research describing the meaning of work and vocational rehabilitation to people with mental health problems, and to clarify the relationship of work to recovery from mental illness.

Method: A meta-study approach was taken, incorporating both methodological critique and synthesis of research findings.

Findings: The majority of the included studies displayed a number of strengths in their methodologies. However, a number of ethical concerns were apparent. A model of the relationship between work and recovery was developed. This illustrated the differing influences of work on different stages of the recovery process.

Conclusions: Work as purposeful occupation is an important factor in recovery from mental illness. The findings of the synthesis demonstrate the need to assess outcomes meaningful to individuals when investigating the impact of work or vocational rehabilitation on recovery.

Keywords: Recovery, mental illness, work, vocational rehabilitation, qualitative, metasynthesis

Introduction

There are high levels of unemployment amongst people with mental illness in the UK, with estimates ranging from 61% to 80% (Foster *et al*, 1996; Meltzer *et al*, 1995). Amongst those with long-term disabilities where mental health problems were the main difficulty, only 18% were estimated to be in employment in 2000 (National Statistics Office, 2000). This is explained by literature detailing a number of barriers to work experienced by people with mental illness. Whilst managing symptoms of mental illness was found to be a barrier to working, this was mainly in terms of anxiety over job stress exacerbating symptoms and fears of relapse (Henry & Lucca, 2004). Other factors impeding the path to employment included a lack of choice and opportunity, low expectations from family or providers and individual and systemic stigma (Henry and Lucca, 2004; Killeen and O'Day, 2004). Disincentives to work embedded in the benefits system, and the "convoluted maze of social systems and bureaucracies" were also highlighted (Rebeiro, 1999; p4).

Despite these barriers to employment, 30-40% of people with long-term disabilities where mental health problems were the main difficulty were said to be capable of holding down a job (National Statistics Office, 2000), and a number of surveys have suggested that the majority of people with mental illness would like to work if given the opportunity (Hatfield *et al*, 1992; Lehman, 1995). Schneider (1998a) reviews a number of reasons why opportunities for working should be created for people with mental illness: it is a human right, and would promote principles of normalisation and empowerment; the high economic cost of lost productivity due to mental illness; demand from service users

wanting to work; and policy changes focusing on employment and social inclusion. Clinical benefits of work have also been highlighted (Lehman, 1995; Van Dongen, 1996). Due to the barriers to work described above, specialist work schemes may provide a necessary bridge between work and unemployment.

Specialist vocational rehabilitation schemes have been gaining popularity in recent years, and a variety now exist, from the sheltered workshops based in psychiatric hospitals, the transitional employment of the Clubhouse movement, supported employment schemes and businesses such as social firms and social enterprises (see Schneider 1998b for review). In a Cochrane review conducted by Crowther *et al* (2005), supported employment was found to be more effective than more traditional programmes such as pre-vocational training in helping people with mental illness find competitive employment in an ordinary work setting. Bond *et al* (1997) also found that supported employment was more successful than more traditional vocational services in terms of helping clients find employment for more hours and at better rates of pay.

Despite these positive results, some caveats are necessary. Crowther *et al* (2005) acknowledge that only a minority of participants in vocational rehabilitation trials find competitive employment at all (about a third in the most effective trials), and neither supported employment or pre-vocational training were found to improve symptoms, quality of life or social functioning. Honey (2000) suggests that "the complex nature of work performance cannot be reliably explained by....even a number of quantifiable variables" (p4), and points out that the wide variety of vocational outcomes in the

research literature covers mainly quantitative and researcher-defined variables. She appeals for more qualitative research in this area, in order to ascertain and investigate the most meaningful and valued outcomes to clients.

Since Honey's (2000) call to research, there has been a steady expansion in the qualitative literature on the meaning of work to people with mental illness, and the relationship of this to recovery. In accordance with the clinical benefits of work mentioned above, first person accounts have highlighted employment as essential to recovery from mental illness (Leete, 1992), or at least as a contributory factor by providing a way of building a sense of meaning in life (Andresen *et al*, 2003). Andresen *et al* (2003) also proposed a definition of recovery embedded in accounts of people with mental health problems in which, "hope and self-determination lead to a meaningful life and a positive sense of self, whether or not mental illness is still present" (p592). Work or vocational rehabilitation may provide a vehicle in which this process can take place.

In view of the growth of qualitative literature describing the meaning of work to people with mental health problems and the questions over the relationship of this to their recovery, there is an increasing need to integrate some of the emerging themes. This qualitative review aims to appraise and assimilate the findings from research in this area. By drawing on a broader range of participants and descriptions, it is hoped that the results will be more powerful (Sherwood, 1999), more generalisable (Estabrooks *et al*, 1994), and more widely utilised (Lloyd Jones, 2004).

Methodology

Reviewing qualitative research holds a number of challenges relating to the identification of studies, the evaluation of methodological rigour, and the synthesis of study findings. These are outlined below.

Identification of studies

The iterative nature of qualitative research means that literature searches may need to be broad and inclusive (Barbour & Barbour, 2003), and reviews may need to parallel techniques of primary qualitative research: by reflecting as many of the major schools of thought in an area as possible; by seeking out divergent or disconfirming studies; by searching literature across disciplines; and by using different search techniques such as electronic and manual techniques (Booth, 2001).

In identifying studies for the present review, a broad search strategy was used which aimed to reflect the diversity of possible themes in the area. Studies were included if:

- Participants were adults who had or were currently suffering from a mental illness, including psychosis, bipolar disorder, depression, anxiety or co-morbid difficulties including mental illness and substance abuse. Studies where participants had physical or learning disabilities were excluded.
- Study settings were focused on work or vocational rehabilitation projects, including: Clubhouse settings, supported employment, consumer-survivor or consumer-provider projects, and mainstream work settings. Studies investigating views of unemployed people were also included in order to incorporate potentially disconfirming views.

- Studies used qualitative methodologies such as grounded theory, phenomenology, narrative and ethnographic approaches, or techniques such as in-depth interviews, focus groups and observations if the particular methodology was not specified. However, if qualitative elements were used in a primarily quantitative study, the study was excluded.
- Studies were published in peer reviewed journals. Unpublished dissertations, case studies and book chapters were excluded.

Search Strategy

Electronic search

A number of databases were searched, because of their relevance to the fields of mental health and rehabilitation: CINAHL, AMED, EMBASE, Ovid MEDLINE and PsycINFO. Search terms were chosen from the literature, with checks of terms made to the thesaurus of each database in order to modify keywords where necessary (Barbour & Barbour, 2003). Following the initial search in January 2006, the search terms were supplemented in order to seek out studies containing possible discrepant findings in April 2006. Studies were limited by year of publication (1990-2006), publication in English and human studies only. The final search strategy is outlined below:

1. supp$ employ$ or psychosoc$ rehab$ or psychiat$ rehab$ or occupational rehab$ or soc$ rehab$ or work rehab$ or job rehab$ or sheltered work$ or transitional emp$ or rehab$ counselling or vocation$ rehab$ or fountain-house$ or fountain house$ or club-house$ or clubhouse$ or social firm$ or soc$ firm or soc$ enterprise.

2. mental$ ill$ or mental$ dis$ or mental$ health or psych$ dis$ or schizophren$ or psychosis or psychotic or recovery

3. 1 and 2

4. qualitative or grounded theory or user involve$ or interpretative phenomenology or narrative or social constructionis$ or symbol$ interactionis$ or user experience$ or consumer survivor or consumer-survivor or user view or ethno$ or phenomenolog$ or observational or content analysis or thematic analysis or discourse analysis or focus group or constant comparative or grounded stud$

5. 3 and 4

6. limit 5 to English, human and year = 1990-2006

This produced 322 hits. At this stage, 236 studies were excluded on the basis of their title. Eight further studies were unpublished dissertations, 2 were case studies and so all were excluded. Abstracts were read for the remaining 76 articles, and a further 52 articles were excluded. The remaining 24 articles were read in full which led to a further 9 exclusions, exemplifying the observation that the relevance of a qualitative study is not always clear from title or abstract (Lloyd Jones, 2004). The remaining 15 articles were included in the review.

Manual reference search

The sensitivity of the search strategy was examined by manually reviewing the references of all of the included studies, which identified 3 new studies. Therefore, 18 studies were reviewed in total. The studies are summarised in table 1.

Insert table 1 about here

Evaluation of Studies

In aiming to evaluate qualitative literature on the relationship between work and recovery, a meta-study approach was taken, incorporating both methodological critique and synthesis of research findings. It is recognised that "the conclusions observers draw change relative to shifts in their viewing position" (Sandelowski, 2006; p14), therefore any synthesis of qualitative research findings must involve a critique of the methods used to produce them (Paterson *et al*, 2001).

In order to evaluate the studies included in this review, an appraisal guide was developed which aimed to integrate evaluative criteria from a number of sources (Yardley, 2000; Elliott *et al*, 1999; Mays & Pope, 1995; CASP, 2002; see Appendix 2.2). Criteria were ordered under Yardley's (2000) guidelines of: design; context sensitivity; ethics; commitment and rigour; transparency and coherence; impact and importance. The guide aimed to be flexible, avoiding the concerns over using strict criteria over-prescriptively (Barbour, 2001). It was designed to seek examples of how qualitative techniques; such as grounded theory, purposive sampling, multiple coding, and respondent validation; were applied in order to be sensitive to the use of "technical fixes" in which such terms are used as ways of conferring rigour without clear evidence of application during the research process (Barbour, 2001; p1115).

Following methodological evaluation of the included studies, study findings were synthesised, drawing on Noblit & Hare's (1988) method of meta-ethnography. This can be compared to a constant comparative method, in which the themes and concepts from

each study are compared and translated into each other to form an overall synthesis. Taking a "signal to noise ratio" approach; balancing the weight of a study's message ('signal') with an assessment of its methodological quality ('noise') (Edwards *et al*, 1998; p321), data from the strongest studies methodologically were initially analysed. Following this, data from the next strongest studies were analysed to develop themes further and so on. In this way, a meta-study approach comparable to grounded theory was used to discover and integrate findings from the included studies into a model of the relationship between work and recovery, whilst maintaining a balance between methodological rigour of studies, and the value of their findings.

Validation

Findings of the meta-synthesis were validated in a number of ways. Firstly, emerging coding frameworks were discussed in meetings with two other independent qualitative researchers, and in research supervision, in order to refine codes and relationships. Secondly, a form of respondent validation was used by checking themes and the integrated model against first-person accounts of recovery in the context of work (Barbour & Barbour, 2003).

Findings

A note on methodology

A number of studies demonstrated particular methodological strengths and avoided 'technical fixes' by giving examples of their use of qualitative processes. For example in their study of consumer-staff perspectives on their work, Yuen & Fossey (2003) describe

their use of purposive sampling: "...potential participants with relevant backgrounds to inform the study and provide information-rich data were selected" (p57). They also demonstrate a number of ways in which their participants' perspectives were incorporated into the study design, by developing their interview guide in collaboration with participants, and using respondent validation for participants "to read and clarify any of their responses" (p57).

In their phenomenological study, Gahnström-Strandqvist *et al* (2003) showed transparency and sensitivity to the context of their study, by describing interview questions and acknowledging that "questions were asked and explained in everyday terms so the participant would easily understand the researchers' meaning" (p264). They also described reflexivity: "the researchers attempted to be as open and free of presuppositions as possible and to bracket their preexisting theoretical understanding during the analysis" (p264). Whilst this may be at odds with other, more constructionist qualitative methods, it was consistent with their phenomenological method and therefore evaluated accordingly.

Studies which showed rigorous analysis and presentation of data did so in different ways. Tse & Yeats (2002) presented their coding framework, with themes and sub-themes each illustrated by representative examples from the interviews. This provided transparency of findings, although category construction was less clear. They demonstrate commitment by validating findings in a number of ways, including the testing of their emerging theory against data from six case studies (p53). Rebeiro & Cook (1999) describe their use of the constant comparative method to analyse data and detail their validation techniques, such

as: "a negative case was identified and incorporated as an integral aspect of the analysis and findings" (p179). They also describe triangulation of data obtained through interviews, field notes and reflective journals, improving the rigour of their study.

Ethical issues were a concern in some studies. Although only a third of the studies obtained the approval of an ethics committee, the majority described aspects of the process of informed consent, or a guarantee of confidentiality. Four studies reported no information on their awareness of ethical issues. Buckle (2004) used names of participants and did not report whether these were pseudonyms. Stepney & Davis (2004) give detailed descriptive information about each participant, and report themes individually without analysis, which may identify participants' views. The majority of studies transcribed interviews in order to increase rigour. Metcalfe (1994) illustrated his findings with quotes but reported recording interviews in fieldnotes, calling into question the accuracy of his findings.

The majority of the included studies displayed a number of strengths in their methodologies, by demonstrating sensitivity to contextual and ethical issues, commitment to their chosen methods, transparency in their use of techniques and an impact on the wider literature. However, it seemed difficult to avoid the 'technical fixes' described by Barbour (2001) and some methodological details may have been excluded due to restrictions on lengths of articles. Reflecting this practical limitation, a more detailed methodological evaluation is beyond the scope of this analysis. The methodological strengths and weaknesses of each study are summarised in table 1.

Synthesis of study findings

In order to facilitate comparison of similar concepts between studies, a table was constructed of the themes emerging from each study. These are summarised in table 2. Seven categories evolved from the synthesis: the influence of society; the experience of mental illness and unemployment; the social and interpersonal impact of work and vocational rehabilitation projects; the meaning of work or occupation; the impact on the self; and the importance of work or project environments. Studies focused on themes or the relationships between themes to differing extents. The synthesis of these themes and relationships allowed development of a model of the relationship between work and recovery. For clarity, quotes from participants in the studies are italicised below, quotes from authors are not.

Insert table 2 about here

The influence of society

Participants in eight of the studies articulated experiences of stigma and discrimination against people with mental illness, which were highlighted as barriers to employment (Galvin *et al,* 2000; Krupa et al, 2003; Martin, 1995; Provencher *et al,* 2002; Rebeiro *et al*, 2001; Secker & Membrey, 2003; Stepney & Davis; 2004; Strong, 1997; Tse & Yeats, 2002). Provencher *et al* (2002) pointed out that the isolation and withdrawal associated with mental illness may be self-protective, as described by a participant: *"I haven't bridged the gap between myself and other people because of the way I have been treated in the past. I have been discriminated against and my rights have been trodden on at*

different places I have worked because of my illness and others not understanding it." (p136).

Rebeiro *et al* (2001) suggested that participants found it difficult to become involved in their communities because of stigma and low self-esteem. This could be linked to both mental illness and unemployment, as expressed by a participant: *"Before, I didn't have a sense of purpose, and that was leading to death, an inner death. Now I can say, "I'm working at NISA* [affirmative business]*." There's still that stigma [that] unless you're doing something, you're a nobody"* (p497). This was reinforced by Strong (1997) whose participants described a daily struggle with symptoms of mental illness whilst simultaneously trying to negotiate a social world which "victimised, blamed and labelled" (p33).

Other barriers to employment included low education levels, age, financial constraints and a lack of job security (Krupa *et al*, 2003). Policy barriers included the 'benefits trap' in which participants keen to work more were unable to if their work was paid, as this would result in a loss of benefits and lack of financial security, particularly when ongoing illness-experiences made their employment capacity unpredictable (Krupa *et al*, 2003). However, sensitive support in this area was regarded as beneficial: *"She (from income support) helps me a lot before...before she takes that final payment off she makes sure you've jacked up in a job solid, and secure and you're doing fine and she, she does a good job there. She doesn't just sort of kick you into the deep she keeps you on the*

computer for a few weeks afterwards after you've started work. So that if it doesn't work out you can be linked back in again quite quickly," (Tse & Yeats, 2002; p53).

Participants in Krupa *et al*'s (2003) study also highlighted the 'disability label' of their affirmative business as potentially stigmatising, worrying that it diminished the credibility of their work. However, there was agreement that "the businesses aim to break down labels and stereotypes of psychiatric disability by providing healthy images of employment, strengths and capacities" (p365).

The experience of mental illness and unemployment

The detrimental effects of mental illness were described by nine studies (Gahnström-Strandqvist *et al*, 2003; Galvin *et al,* 2000; Kirsh, 2000; Krupa *et al*, 2003; Krupa 2004; Provencher *et al,* 2002; Secker & Membrey, 2003; Stepney & Davis, 2004; Strong, 1997). As this was often described in the context of 'the time before starting work' a number of studies linked experiences of mental illness to unemployment, as described by one Associate in an affirmative business: *"When I wasn't working here, I was sitting at home all the time, drinking, getting depressed looking at four walls, getting sicker, going to the hospital more often..."* (Krupa *et al*, 2003). Long term mental illness was seen to result in the loss of health, work and social relations (Gahnström-Strandqvist *et al*, 2003), leading to isolation and loneliness, passivity and inactivity and a reduction in confidence (Galvin *et al*, 2000; Kirsh, 2000; Krupa *et al*, 2003; Secker & Membrey, 2003; Stepney & Davis, 2004; Strong, 1997).

Strong (1997) describes stories "of a battle with illness on the fringes of society in an uncertain world of poverty with limited choices or opportunities to exert control" (p33), described poignantly by one of her participants, an employee of an affirmative business: "*You're fighting to keep your sanity, and your thoughts are going so fast, and you're so erratic, and you're constantly fighting to prove your sanity within yourself without bothering other people...*" (p33). A distinction between unemployment and 'underemployment' was described by Kirsh (2000), illustrated by a participant describing an unsatisfying job: "*being underemployed is very frustrating, it caused me to feel anger: I would work quite hard and not be paid very much money and not have enough to make ends meet and I found it very frustrating...*" (p26).

Provencher *et al* (2002) identified three profiles of recovery in the context of work. For the four participants in the first profile, for whom 'recovery was uncertain', emotional problems were overwhelming, symptoms were unstable, days were unpredictable, and it was difficult to maintain healthy eating and sleeping habits. This profile was characterised by fear, poor self-esteem and a sense of personal vulnerability, in which isolation could be protective from the perceived difficulties experienced in the world. However Provencher and her team go on to describe profiles of 'recovery as a self-empowering experience' and 'recovery as a challenging experience', each illustrated by increasing control over symptoms of mental illness, development of coping strategies and a steadily growing sense of self-efficacy, gained at least partly through participation in work or occupation.

The social and interpersonal impact of work and vocational rehabilitation

All studies excluding Martin (1995) described the impact of the social setting on participants. In this category distinctions were apparent in the themes given most significance by participants according to the type of work placement they were participating in. An important theme running through most accounts was the ability of work and vocational rehabilitation to re-establish social networks, increase social interactions and provide support (Buckle, 2004; Gahnström-Strandqvist *et al*, 2003; Galvin *et al*, 2000; Kennedy-Jones *et al*, 2005; Metcalfe, 1994; Provencher *et al*, 2002; Stepney & Davis, 2004; Strong, 1997; Yuen & Fossey, 2003). This was made possible for some participants by an environment of acceptance which fostered a sense of belonging: *"What I get out of NISA* [affirmative business] *is...to feel that I belong, that I have a social existence. The belongingness here has been very much at the heart of things for me. If I don't feel like I belong, then I can't begin anywhere. If I don't belong, I don't exist really."* (Rebeiro *et al*, 2001; p497).

Being amongst others who had experienced similar problems also contributed to this environment of acceptance: *"...I often feel that I am deviant in society, because there the attitudes are quite different. But here I don't find anybody different from me. We are on the same level. There is much more tolerance about the way to behave here. I can be myself. One is allowed to be a bit strange"* (Gahnström-Strandqvist *et al*, 2003; p268). This may be the first time participants have had the opportunity to meet others with similar experiences to themselves: *"I finally met this guy who had it...and he even took*

the same medication as me and I was like, wow...I can even talk about coping with side effects and that" (Kennedy-Jones *et al*, 2005; p122).

Participants of studies looking at consumer-provider projects or affirmative businesses placed importance on being part of a team with a collective responsibility to others, which could be very rewarding. This was particularly apparent in Salzer & Shear's (2002) study, where participants were 'peer support specialists' in a community based programme, using personal experiences of substance abuse and mental illness to help others in similar situations: *"...when I went home, it gave me satisfaction. The fact of knowing that I was able to help someone maybe see something different or do something that they haven't done or even just make a difference..."* (p285). Associates in an affirmative business studied by Krupa *et al* (2003) also acknowledged that having customer contact enabled the development of social skills in a way that felt comfortable.

A number of studies looked at experiences of mainstream work, which highlighted social issues that were not apparent in other types of work setting. In asking about factors that helped people with bipolar disorder succeed in employment, Tse & Yeats (2002) included the need for good management, and support from workmates. However, in Secker & Membrey's (2003) study, unsupportive colleagues were held responsible for the breakdown of an employment project client's job: *"Sometimes I didn't want to go there because they were sarcastic...I don't know, everything, the whole, I cannot say now but you know, bitchy, more bitchy and I didn't like it very much"* (p211). Kirsh (2000) highlighted supervisory and co-worker qualities as highly influential in job retention

amongst her participants, differentiating between the themes from employed and unemployed consumers of mental health services.

A debate highlighted in two of the studies focussing on mainstream work was the choice to disclose a history of mental illness or not. To some, disclosure was a relief that led to helpful accommodations in the workplace: *"I had to tell them, and I was glad I did, because now I've got a job that I can do and there's flexibility and there have been allowances made and I can do the job to the best of my ability..."* (Kirsh, 2000; p28). However, others worried that disclosure would lead to discrimination: *"Yes, oh, I've got the credibility. I've got the...but whether the stigma of the mental illness can overpower the credibility that I've built up is a question I can't answer"* (Krupa, 2004; p12).

The meaning of work or occupation

Across all of the included studies, the meaning of work fell into four sub-themes: structure and routine; purpose and personal meaning; balancing mental illness with work demands; and building competence and confidence.

Structure and routine

Participants in half of the included studies highlighted work as providing a temporal order to the day (Gahnström-Strandqvist *et al*, 2003) or as breaking up the week (Martin, 1995). This provided motivation to maintain daily routines and get up in the morning (Yuen & Fossey, 2003). Organisation and structure was interpreted by Gahnström-Strandqvist *et al* (2003) as providing a framework for a normal life, also stated by a

participant of Kirsh's (2000) study employed in mainstream work: *"There, I'm a worker who does a good job, gets paid and earns a living like anybody else. I'm almost normal"* (p26).

Purpose and personal meaning

Rebeiro *et al* (2001) discussed the need for people to be active and contribute in order to gain personal fulfilment, pointing out that our society bases a large part of personal identity on occupation and economic activity. Work was identified as providing a sense of purpose for participants in ten studies. As with structure, this was seen as normalising, and providing social status in one study: *"Now I am proud of working and not staying home doing nothing, all day long."* (Gahnström-Strandqvist *et al*, 2003; p266). Participation in meaningful activity was also seen as a way of alleviating symptoms of mental illness in itself (Krupa *et al*, 2003). Kirsh (2000) suggested that some individuals saw competitive employment as an important way to contribute to society. However, participants in paid and voluntary vocational projects also expressed this idea: *"I like working in a program like this because it makes me feel like I'm doing something not just for me but for other people and to me that's important..."* (Provencher *et al*, 2002; p139).

Balancing mental illness with work demands

It was important for participants in many studies to find work that matched their abilities and interests. This contributed to the sense of purpose provided by work, but also highlighted the need to balance stress levels and persistent symptoms with work demands (Kennedy-Jones *et al*, 2005; Krupa, 2004; Provencher *et al*, 2002; Tse & Yeats, 2002).

Participants in some studies recognised this as a need to balance challenge and predictability: *"in order to hold a job it had to be something that was sort of mechanical enough or automatic enough that I could perform it when I wasn't well..."* (Kirsh, 2000; p27). However participants also wanted to increase challenges when they felt well enough, and jobs needed to be flexible enough to allow this. Participants in the cooperatives studied by Gahnström-Strandqvist *et al* (2003) were able to alternate between different types of tasks to fulfil this aim.

Building competence and confidence

Where work was meaningful to participants, many spoke of how it increased a sense of competency and self-confidence through attempting and succeeding at different tasks: *"It gives me a sense of accomplishment, to work again, putting in the hours and realising that I can do that and not fall apart and give up"* (Kirsh, 2000; p26). Through succeeding at small tasks, participants demonstrated to themselves that they were capable and competent: *"I learn to make things, things that I would never have done before and never even thought of doing or being able to do. The feeling of incompetence is there, and then all of a sudden you've come to this place and you achieve something and you have a real feeling of self-worth"* (Rebeiro & Cook, 1999; p182). Strong (1997) described how this feeling of competence generalised to participants' wider lives, creating hope for further success in the future. For participants in Provencher *et al*'s (2002) study, as self-efficacy evolved through further participation, work became empowering, and a means of self-actualisation.

The impact on the self

The influences of an accepting social group and purposeful work on the self were described by twelve studies (Gahnström-Strandqvist *et al*, 2003; Galvin *et al,* 2000; Kennedy-Jones *et al,* 2005; Kirsh, 2000; Krupa, 2004; Krupa *et al,* 2003; Provencher *et al*, 2002; Rebeiro *et al,* 2001; Rebeiro & Cook, 1999; Salzer & Shear, 2002; Strong, 1997; Tse & Yeats, 2002). Being given the 'right to exist' (Rebeiro *et al*, 2001; p496) and freedom to be themselves (Salzer & Shear, 2002) allowed participants to redefine themselves. The growth of competence through achievements, described above, led to a renegotiation (Strong, 1997) or rebuilding (Kirsh, 2000) of a more competent self-identity which changed participants' perceptions of themselves in relation to their mental illnesses: *" I have a different headset when I go out in the morning...Well, I don't see myself quite the same as a loony. I don't see myself as sick..."* (Strong, 1997).

Rebeiro & Cook (1999) described this transition as beginning with an affirmation from an understanding and supportive social group, using Goffman's (1963) concept of 'the own' to illustrate the sense of belonging felt by participants. They suggest that this encourages the idea, "they think I can, therefore, maybe I can" (p181) which then shifts towards, "I did it and therefore, I can" (p181) once participation in the group occupation demonstrates competency. They suggest that these ideas then contribute to actualisation, where individuals view themselves and their situation in a better light, and develop hope for the future: *"I look at it and realize that I did it and think if I can do this, maybe I can do other things too"* (Rebeiro & Cook, 1999; p181).

The importance of work or project environments

Kirsh (2000) identified the nature of the workplace as an important factor in the maintenance and enjoyment of work, which was reflected in the majority of other studies. Whilst the need for participants to balance symptoms with work demands has already been discussed, accommodations of individual needs in the workplace also facilitated participants' ability to remain in work or vocational rehabilitation, particularly if employers or supervisors were flexible over time schedules and work duties (Krupa *et al*, 2003; Kirsh, 2000; Tse & Yeats, 2002; Secker & Membrey, 2003). This also indicated to participants that they were valued and respected (Krupa *et al*, 2003; Kirsh, 2000). However, participants in Krupa's (2004) study described using personal compensatory strategies where employers would not accommodate their needs, including working for irregular hours in order to conceal hospitalisation.

Associates in Krupa *et al*'s (2003) study expressed a sense of ownership for their affirmative business. Instrumental in this was a flexible working environment which promoted a sense of unconditional acceptance, where participants were able to make mistakes without fear of losing their jobs. This was mirrored in Rebeiro *et al*'s (2001) study in which the environment was described as physically and emotionally safe, and where participants had the flexibility to determine their own opportunities: *"There's no other place where you can make your own opportunities, your own mistakes, and allow you to grow from those mistakes, where you can work at your own pace and allow you to find your niche, your special ability"* (Rebeiro *et al*, 2001). However, Martin (1995) also acknowledged the pressures inherent in employment rehabilitation schemes with

potentially conflicting business and therapeutic roles. This is demonstrated by an excerpt from her fieldnotes in which pseudonyms are used: *"Charlie...said that the workshop was not supposed to put a lot of pressure on its trainees. Noel joined in and said that the workshop had to balance being a commercial enterprise with rehabilitation which was difficult and it was sometimes forgotten that trainees were there because they were suffering from mental health problems"* (p277). In speaking with clients employed in mainstream work, Secker & Membrey (2003) identified factors around workplace culture and approaches to management that facilitated adjustment to work, and suggested that these would benefit all employees, not just mental health service users returning to work.

Discussion

The Contribution of Work to Recovery

As evident from the themes described above, participants in the studies spoke of work contributing to recovery both directly, as a coping strategy in itself (Kennedy-Jones *et al*, 2005; Krupa *et al*, 2003) and indirectly, by facilitating self-acceptance (Krupa *et al*, 2003), providing distraction (Kirsh, 2000; Rebeiro & Cook, 1999; Stepney & Davis, 2004) and by providing a way of building self-efficacy through accomplishing tasks (Gahnström-Strandqvist *et al*, 2003; Kennedy-Jones *et al*, 2005; Kirsh, 2000; Provencher *et al*, 2002; Rebeiro & Cook, 1999; Salzer & Shear, 2002; Strong, 1997).

Work settings that facilitated this process were collaborative (Gahnström-Strandqvist *et al*, 2003) and supportive (Kennedy-Jones *et al*, 2005; Secker & Membrey, 2003 Tse & Yeats, 2002), with a safe environment that fostered unconditional acceptance (Krupa *et*

al, 2003) and allowed participants to make mistakes and learn without fear of criticism (Krupa *et al*, 2003; Rebeiro *et al*, 2001). A match was needed between the individual and a job flexible enough to give the predictability needed for someone struggling to balance symptoms with work, as well as more challenging tasks for when the individual was ready to build on earlier successes (Gahnström-Strandqvist *et al*, 2003; Kennedy-Jones *et al*, 2004; Kirsh, 2000; Krupa, 2004; Martin, 1995; Metcalfe, 1994; Provencher *et al*, 2002; Salzer & Shear, 2002; Tse & Yeats, 2002; Yuen & Fossey, 2003;).

Five studies used their findings to develop models of the meaning of work to their participants. Strong (1997) and Provencher *et al* (2002) related these directly to recovery. For Strong (1997), the common theme was "the experience of recovering a new sense of self beyond the limits of the disability" (p36). The meaning of work varied according to differences in the relationship between 'self' and 'illness'. Provencher *et al* (2002) reflected a similar idea whereby the meaning of work to participants varied depending on where they were in the recovery process, moving through profiles where recovery was uncertain, self-empowering, and challenging.

Models in other studies focussed on different aspects of the relationship between work and recovery. For Gahnström-Strandqvist *et al* (2003) the main constituent theme was the normalisation provided by the cooperatives studied. Tse & Yeats (2002) emphasised the need for a "goodness of fit" (p55) between an individual's coping with their mental illness, and how well individual need was accommodated by employers. In a 'vocational integration model', interacting components of 'individual', 'support', 'work' and 'wider

context' were given different levels of importance depending on an individual's stage of recovery. Rebeiro & Cook (1999) developed a 'model of occupational spin-off', (p180/184), referring to the evolving sense of competency and self-confidence expressed by their participants.

The findings of the included studies were integrated into a synthesis of the relationship between work and recovery, building on the themes of Provencher *et al* (2002) and Strong (1997). This is illustrated in figure 1 below:

Insert figure 1 about here

As evident from the included studies, the relationship between recovery and work is a dynamic one, in which individuals move between different stages of recovery that may require shifting definitions of the meaning of work. When an individual initially enters a place of work, at a time when their mental illness may be unpredictable, work provides distraction from the mental illness and a way of engaging with 'non-illness-focused activities' (Strong, 1997). This is facilitated by an understanding social group and an accepting environment, which may need sensitive training and support from colleagues and management in mainstream settings (Secker & Membrey, 2003). Once at work, engagement in purposeful and meaningful activity provides a process of feedback which demonstrates to the individual that they are capable. At this stage work can become empowering, and the emphasis is on providing flexibility in order to allow individuals to increase the challenges they give themselves to reinforce the growing definition of

themselves as able, competent and confident. As this process continues, individuals may set themselves larger goals and greater challenges, impacting on their lives and wider contexts.

Validation of results

In a process similar to respondent validation, the synthesis findings were checked against twelve first person accounts (Caswell, 2003; David, 2005; Davis, 2005; Fekete, 2004; Henderson, 2004; Lee, 2005; Markwood, 2005; Morisey, 2003; Schiff, 2004; Thomas, 2000; Tsai, 2002; Weingarten, 2005). These were drawn from the 'first person account' and 'coping with' series of the journals Schizophrenia Bulletin and Psychiatric Rehabilitation Journal. All accounts that mentioned work or activity in relation to recovery, and were available in full text on the Ovid database, were included, limited to years 2000 to 2006.

Many of the first person accounts narrated processes of recovery and the importance of work at different stages of this. Inherent barriers to working were also related: Henderson (2004) spoke of being told that she would never work again, whilst Morisey (2003) had experienced negative comments and a loss of work due to mental illness. The need for a good match between an individual's ongoing mental health needs and employment was evident. Henderson (2004) emphasised the need to adapt to job tasks without necessarily being symptom free, reflected also by Lee (2005) who spoke of preparing lesson plans carefully as she knew that hearing voices continued to be distracting.

Moving through a process of recovery and using occupation in different ways was articulated clearly in the accounts. David (2005) and Caswell (2003) discussed how they developed purposeful activities and social contact to provide distraction. Indeed, Caswell (2005) created his own job to escape from a "prison of isolation" (p193) by opening doors for people entering and leaving a local store. Davis (2005) talked about how her activities and contact with friends allowed her to feel more at ease with herself, which led to a wish for larger goals. This is comparable to the shift described in the synthesis from work as distraction and normalisation, to work as empowerment, facilitating a redefinition of self.

The importance of having an occupation with personal meaning was discussed by Thomas (2000) who left a well-paid job to go back to college. This was also evident in the eight accounts of individuals working as peer specialists, consumer advocates or consumer providers of mental health services. Schiff (2004) described her work as a consumer-professional as providing empowerment and self-actualisation, and for Markwood (2005) it provided a new life. Fekete (2004) felt that working as a peer specialist was more affirming and empowering than the traditional doctor/patient relationship he had previously been part of.

Many accounts described gaining support from vocational counsellors, employment rehabilitation centres and a Clubhouse (Tsai, 2002), and also promoted the use of routine, healthy eating and sleeping patterns, exercise, medication and therapy in order to create optimum mental health. Weingarten (2005) pointed out that the low self-esteem of many

individuals in early stages of recovery means that they do not appreciate how much they can do when they are symptomatic. However, he suggests that with support to take reasonable risks, individuals can succeed. These first person accounts provided greater depth to the different aspects of the synthesis described above, and so granted further validation to the findings.

Conclusion

This review and synthesis aimed to integrate qualitative findings relating to the meaning of work, and in doing so clarify the relationship between work and recovery. A wide variety of qualitative methodologies were reviewed, of varying quality. Whilst the majority of studies were methodologically sound, many did not clarify or justify their use of their chosen methods and used different qualitative techniques without reference to the theory or philosophy behind their use. Where studies did describe their use of techniques intended to confer rigour, there was often a lack of transparency over how these techniques were used in practice. However, in an attempt to balance methodological quality with content and incorporate Edwards *et al*'s (1998) 'signal to noise ratio' approach, it was found that the themes emerging from methodologically weaker studies did reflect those of the more rigorous studies, thereby conferring validity on those themes. Whilst it is understood that there may be practical difficulties in displaying each step of the research process, the lack of consideration to ethical issues apparent in a number of studies was cause for concern.

In relation to the study findings, the synthesis supported the view that work is highly important to the process of recovery from mental illness. However the type of work was significant and the occupation needed to be meaningful to the individual. This was particularly evident in the studies exploring the views of consumer professionals, reflecting Deegan (1996) who used her experience of mental illness and mental health services to foster a sense of having a vocational calling. Support from a sensitive social group was also important, whether from peers, work colleagues or through accommodations being made to allow an individual to adapt mental health and occupational needs to each other.

Notably, when participants in the included studies spoke of recovery, their definition was consistent with that promoted by Andresen *et al* (2003), Anthony (1993) and first person accounts from the 'survivor' movement such as Deegan (1996). Recovery is described as a process of developing purpose and meaning in life with or without ongoing symptoms of mental illness. The findings of the synthesis relating work and recovery echo the five-stage model of recovery developed by Andresen *et al* (2003), drawn from qualitative studies of recovery. Their stage of 'Moratorium', characterised by confusion and isolation, corresponds to a time where 'recovery is uncertain' and occupation can provide much needed distraction. This distraction may provide a sense that life beyond mental illness is possible, Andresen *et al*'s (2003) 'Awareness', and allow consideration of how to continue this process, 'Preparation', when coping strategies and increasing self and illness knowledge allow the individual to begin to take control, and 'recovery is self-empowering'. At this stage occupation can be used to provide further challenges,

demonstrating the possibility of success and increasing a sense of competence, self-confidence and self-esteem. Andresen *et al*'s (2003) final stages of 'Rebuilding' and 'Growth' resonate with the stage of 'recovery as ongoing growth and development', when occupation provides the chance to take further risks, and can contribute to self-actualisation.

The studies included in the present review support Honey's (2000) claim that work performance may be difficult to explain by quantifiable variables, and begin to explain why. For example, in the Cochrane systematic review carried out by Crowther *et al* (2005), the primary outcome measure was the number of clients in competitive employment at different time points. Bond *et al* (1997) measured hours of employment and rates of pay. However, in assessing the benefits of vocational rehabilitation, such outcomes may be less meaningful to users than the type of work, the match between job and individual, levels of perceived support, and the flexibility of the occupation towards meeting individual need.

It may be difficult for some mainstream work settings to meet these needs, with their increased pressure and commercial demand. The literature on barriers to mainstream working reflects this (e.g. Henry & Lucca, 2004). However, Secker & Membrey (2003) suggested that the type of support participants with mental health problems found useful related to the more general employment literature on promoting mentally healthy workplaces (Docherty *et al*, 1999). This gives credence to the wider 'recovery movement' which is instigating changes in service and policy development in order to

promote concepts of empowerment and advocacy (Department of Health, 2001; Scottish Executive, 2003).

The importance of many vocational rehabilitation settings appears to be in the provision of a safe physical and social environment in which the individual, isolated and overwhelmed by mental illness and its consequences, is able to find unconditional acceptance and develop trust, thereby allowing the recovery process to begin. This is reminiscent of the literature on attachment, suggesting that an appropriate occupational environment may act as a 'secure base' (Fonagy 2001) in which a vulnerable individual can safely explore and develop, facilitating a shift from insecure to secure attachment during a recovery process. Goodwin (2003) discusses the relevance of attachment theory to adult mental health services but acknowledges that service developments tend to be defined by political and economic demands. The policy changes driven by the 'recovery movement' may provide an environment in which service providers acknowledge the importance of occupation for recovery from mental illness, and create further environments in which this can occur.

References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Andresen, R., Oades, L. & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry, 37,* 586-594.

Anthony, W.A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16,* 11-23.

Barbour, R. S. & Barbour, M. (2003). Evaluating and synthesizing qualitative research: The need to develop a distinctive approach. *Journal of Evaluation in Clinical Practice, 9(2),* 179-186.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *BMJ, 322,* 1115-1117.

Bond, G. R., Drake, R. E., Mueser, K. T., & Becker, D. R. (1997). An update on supported employment for people with severe mental illness. *Psychiatric Services, 48*(3), 335-346.

Booth, A. (2001). *Cochrane or cock-eyed? How should we conduct systematic reviews of qualitative research?* Paper presented at the Qualitative Evidence-based Practice Conference, Taking a Critical Stance. Coventry University, May 14-16 2001, available at www.leeds.ac.uk/educol/documents/00001724.htm

Buckle, D. (2004). Social outcomes of employment: The experience of people with mental ill health. *A Life in the Day, 8(2),* 17-22.

Caswell, J. S. (2003). Coping with open doors. *Psychiatric Rehabilitation Journal, 27*(2), 191-197.

Critical Appraisal Skills Programme (CASP). (2002). © Milton Keynes Primary Care: www.phru.nhs.uk/casp/critical _appraisal_tools.htm#qualitative

Crowther, R., Marshall, M., Bond. G. & Huxley, P. (2005). Vocational rehabilitation for people with severe mental illness. *The Cochrane Database of Systematic Reviews: The Cochrane Collaboration, 4.*

Davis, G. (2005). Coping with: Coping with mental illness. *Psychiatric Rehabilitation Journal, 28(3),* 299-302.

Deegan, G. (2003). Discovering recovery. *Psychiatric Rehabilitation Journal, 26(4),* 368-376.

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal, 19*(3), 91-97.

Department of Health. (2001). *The Journey to Recovery – The Government's Vision for Mental Health Care.* London: Department of Health.

Docherty, G., Fraser, E., & Hardin, J. (1999). Health promotion in the scottish workplace: A case for moving the goalposts. *Health Education Research, 14*(4), 565-573.

Edwards, A. G. K., Russell, I. T., & Stott, N. C. H. (1998). Signal versus noise in the evidence base for medicine: An alternative to hierarchies of evidence? *Family Practice, 15*(4), 319-322.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38(3),* 215-229.

Estabrooks, C. A., Field, P. A. & Morse, J. M. (1994). Aggregating qualitative findings: An approach to theory development. *Qualitative Health Research, 4,* 503-511.

Fekete, D. J. (2004). Coping with: How I quit being a "mental patient" and became a whole person with a neuro-chemical imbalance: Conceptual and functional recovery from a psychotic episode. *Psychiatric Rehabilitation Journal, 28(2),* 189-194.

Gahnstrom-Strandqvist, K., Liukko, A., & Tham, K. (2003). The meaning of the working cooperative for persons with long-term mental illness: A phenomenological study. *American Journal of Occupational Therapy, 57(3),* 262-272.

Galvin, K., Sharples, A., Hume, S., & Dumbrell, A. (2000). Users' perspectives of work rehabilitation with horticultural therapy. *British Journal of Therapy and Rehabilitation, 7(6),* 262-265.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* New York: Simon & Schuster.

Goodwin, I. (2003). The relevance of attachment theory to the philosophy, organisation, and practice of adult mental health care. *Clinical Psychology Review, 23,* 35-56.

Hatfield, B., Huxley, P., & Mohamad, H. (1992; 1992). Accommodation and employment: A survey into the circumstances and expressed needs of users of mental health services in a northern town. *British Journal of Social Work, 22(1),* 61-73.

Henderson, H. (2004). Coping with: From depths of despair to heights of recovery. *Psychiatric Rehabilitation Journal, 28(1),* 83-87.

Henry, A. D. & Lucca, A. M. (2004). Facilitators and barriers to employment: The perspectives of people with psychiatric disabilities and employment service providers. *Work, 22,* 169-182.

Honey, A. (2000). Psychiatric vocational rehabilitation: Where are the customers' views? *Psychiatric Rehabilitation Journal, 23(3),* 270-281.

Kennedy-Jones, M., Cooper, J., & Fossey, E. (2005). Developing a worker role: Stories of four people with mental illness. *Australian Occupational Therapy Journal, 52(2),* 116-126.

Killeen, M. B. & O'Day, B. L. (2004). Challenging expectations: How individuals with psychiatric disabilities find and keep work. *Psychiatric Rehabilitation Journal, 28(2),* 157-163.

Kirsh, B. (2000). Work, workers, and workplaces: A qualitative analysis of narratives of mental health consumers. *Journal of Rehabilitation (Washington), 66(4),* 24-30.

Krupa, T. (2004). Employment, recovery, and schizophrenia: Integrating health and disorder at work. *Psychiatric Rehabilitation Journal, 28(1),* 8-15.

Krupa, T., Lagarde, M. & Carmichael, K. (2003). Transforming sheltered workshops into affirmative businesses: An outcome evaluation. *Psychiatric Rehabilitation Journal, 26(4),* 359-367.

Lee, J. P. (2005). Coping with. hearing voices and seeing pictures. *Psychiatric Rehabilitation Journal, 29(1),* 73-76.

Leete, E. (1992). The stigmatized patient. In P. J. Fink & A. Tasman (Eds.), *Stigma and Mental Illness.* Washington, DC: American Psychiatric Press.

Lehman, A. F. (1995). Vocational rehabilitation in schizophrenia. *Schizophr Bull, 21*(4), 645-656.

Lloyd Jones, M. (2004). Application of systematic review methods to qualitative research: practical issues. *Journal of Advanced Nursing, 48(3),* 271-278.

Markwood, B. (2005). Coping with: Nowhere to go except home. *Psychiatric Rehabilitation Journal, 28(3),* 303-304.

Martin, M. J. (1995). Employment rehabilitation schemes for people with mental health problems. *Health and Social Care in the Community, 4(5),* 271-279.

Mays, N. & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal, 311* 109-112.

Melzer, H., Singleton, N., Lee, A., Bebbington, P., Brugha, T. & Jenkins, R. (2002). *The Social and Economic Circumstances of Adults with Mental Disorders.* London: HMSO.

Metcalfe, A. J. (1994). Just what I needed: An ethnographic study of Nile House. *Occupation 2(1),* 22-33.

Morsey, A. (2003). Coping with. recovery: Always a work in progress. *Psychiatric Rehabilitation Journal, 26*(4), 427-428.

National Statistics Office (2000) *Labour Force Survey.* London: National Statistics Office.

Noblit, G. W. & Hare, R. D. (1988). *Meta-ethnography: Synthesising qualitative studies.* Newbury Park, CA: Sage.

Paterson, B. (2001). The shifting perspectives model of chronic illness. *Journal of Nursing Scholarship, 33(1),* 21-26.

Provencher, H. L., Gregg, R., Mead, S., & Mueser, K. T. (2002). The role of work in the recovery of persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26(2),* 132-144.

Rebeiro, K. L. (1999). The labyrinth of community mental health: In search of meaningful occupation. *Psychiatric Rehabilitation Journal, 23(2),* 143-153

Rebeiro, K. L., & Cook, J. V. (1999). Opportunity, not prescription: An exploratory study of the experience of occupational engagement. *Canadian Journal of Occupational Therapy - Revue Canadienne d Ergotherapie, 66(4),* 176-187.

Rebeiro, K. L., Day, D. G., Semeniuk, B., O'Brien, M. C., & Wilson, B. (2001). Northern initiative for social action: An occupation-based mental health program. *American Journal of Occupational Therapy, 55(5),* 493-500.

Salzer Shear, S. (2002). Identifying consumer-provider benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal, 25(3),* 281-288.

Sandelowski, M. (2006). "Meta-Jeopardy": The crisis of representation in qualitative metasynthesis. *Nursing Outlook, 54(1),* 10-16.

Schiff, A. C. (2004). Coping with: Recovery and mental illness: Analysis and personal reflections. *Psychiatric Rehabilitation Journal, 27(3),* 212-218.

Schneider, J. (1998a). Work interventions in mental health care: Some arguments and recent evidence. *Journal of Mental Health, 7(1),* 81-95.

Schneider, J. (1998b). Models of specialist employment for people with mental health problems. *Health & Social Care in the Community, 6(2),* 120-129.

Scottish Executive (2003). *National Programme for Improving Mental Health and Well-being Action Plan 2003-2006.* Available at www.scotland.gov.uk/Publications.

Secker, J., & Membrey, H. (2003). Promoting mental health through employment and developing healthy workplaces: The potential of natural supports at work. *Health Education Research, 18(2),* 207-215.

Sherwood, G. (1999). Meta-synthesis: merging qualitative studies to develop nursing knowledge. *International Journal for Human Caring, 3(1),* 37-42.

Stepney, P., & Davis, P. (2004). Mental health, social inclusion and the green agenda: An evaluation of a land based rehabilitation project designed to promote occupational access and inclusion of service users in north somerset, UK. *Social Work in Health Care, 39(3-4),* 375-397.

Strong, S. (1998). Meaningful work in supportive environments: Experiences with the recovery process. *American Journal of Occupational Therapy, 52(1),* 31-38.

Thomas, J. M. (2000). Coping with. A problem-solving approach to symptom management. *Psychiatric Rehabilitation Journal, 23(3),* 289-291.

Tai, A. (2002). Coping with. the story of my recovery. *Psychiatric Rehabilitation Journal, 25(3),* 314-315.

Te, S. & Yeats, M. (2002). What helps people with bipolar affective disorder succeed in employment: A grounded theory approach. *Work: Journal of Prevention, Assessment & Rehabilitation, 19(1),* 47-62.

Van Dongen, C. J. (1996). Quality of life and self-esteem in working and nonworking persons with mental illness. *Community Mental Health Journal, 32(6),* 535-548.

Weingarten, R. (2005). Calculated risk-taking and other recovery processes for my psychiatric disability. *Psychiatric Rehabilitation Journal, 29(1),* 77-80.

Yadley, L. (2000). Dilemmas in Qualitative Health Research. *Psychology and Health, 15,*215-228.

Yuen, M. S. K. & Fossey, E. M. (2003). Working in a community recreation program: A study of consumer-staff perspectives. *Australian Occupational Therapy Journal, 50,* 54-63.

List of Tables and Figures

Figure 1: Relationship between work and recovery

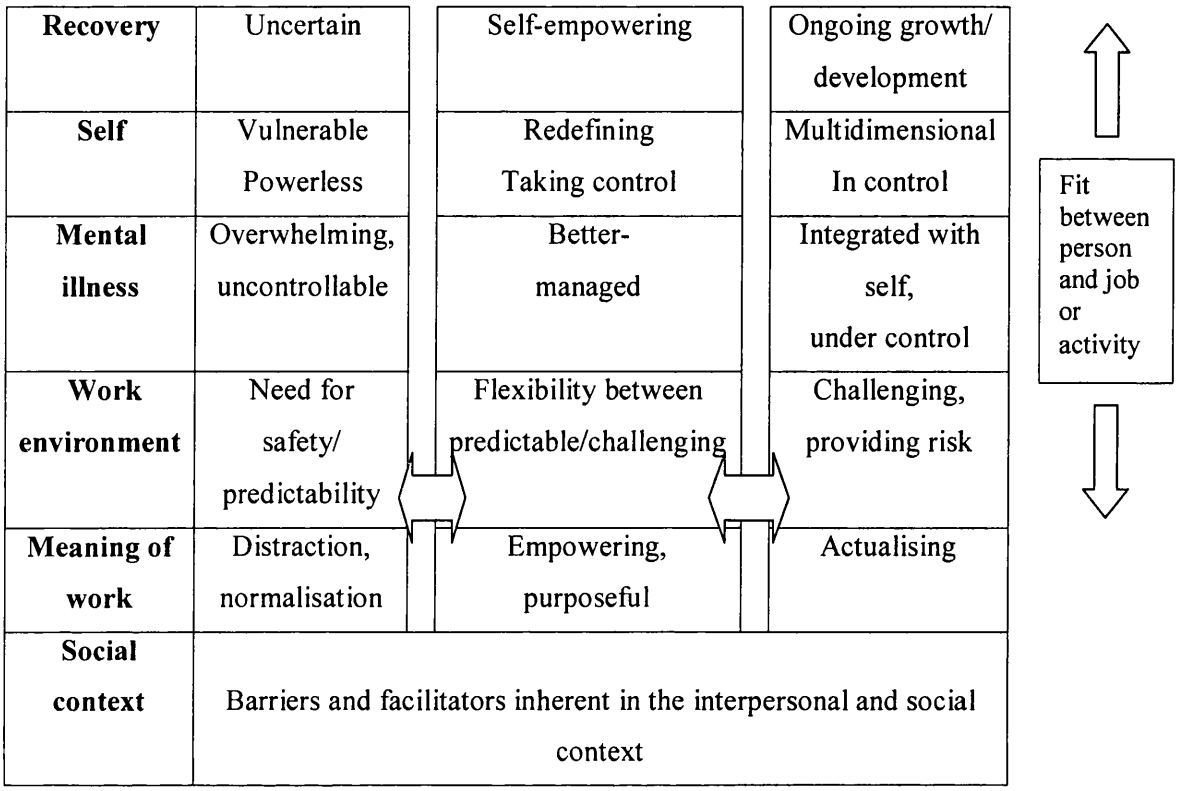


Table 1: Summary characteristics of included studies

Author/ Country	Sample	Type of project investigated	Method/ techniques	Summary of findings	Summary of methodological strengths/weaknesses
Buckle, 2004 UK	12 'self-selected' ppts	Emp/unemp members of supported employment project	No method specified. Int used	5 headings: Psychosocial benefits of work; increased social contact; effect of employment on existing friendships; friendships in and out of the workplace.	Use of interviews only mention of method so difficult to assess– little justification, little demo of commitment, methods not transparent. Analysis not reported at all, neither are ethical issues. Can seem selective.
Gahnström-Strandqvist et al, 2003; Swe	18ppt	Social working cooperative	EPP method	A meaning structure: the cooperative as a 'normalising life-world', with 3 phases contributing to normalisation	Method justified, and commitment demonstrated throughout, with transparency of processes resulting in clear and integrated narrative.
Galvin et al, 2000 UK	27 volunteers	Perspectives on a work rehab project	Qual methods Int, thematic content analysis	3 themes of 'users' social worlds', 'stigma and discrimination' and 'moving on', each with a number of component categories.	Qual method used, moderate commitment to method, some 'fixes' and possible misunderstanding of techniques e.g. use of saturation? Relationships between categories could have been explored further.
Kennedy-Jones et al, 2005 Aus	4 members of a Clubhouse	Work –related experiences in Clubhouse	Narrative approach Int, written timeline of events	4 'impelling forces' lead to 'sense-of-self-as-worker': support from significant others; personal meaning of work; experiences within Clubhouse; ongoing struggle with illness.	Strong method – embedded in context, demonstrates commitment to method and process is transparent. Respondent valid, no multiple coding or triangulation. Memos - self-reflective. Themes illustrated clearly by data.
Kirsh, 2000 Can	36 consumers, 17 emp, 19 unemp	Meaning of work from consumer perspectives	Mixed method, qual aspect - Semi-struc int., Inductive analysis	3 themes: meaningfulness of work to consumers; impact of the organisation on job satisfaction and tenure; supervisory/co-worker relationships and attitudes.	Thorough review. Commitment difficult to assess as little transparency-much unreported, no evidence of validation, ethical concern as DK if names were pseudonyms. Well illustrated reporting of themes. Impact discussed wrt management theory and practice
Krupa, 2004 Can	3 ppt – 2 employed, 1 unemployed	Recovery of work participation for people with schizophrenia	Multiple case study Int	2 distinct phases of integration at work: 1) Assuming control, and 2) Synthesis of health and disorder at work, with 6 distinct tasks.	Rich information pulled from cases and developed into coherent narrative. Collection and analysis demonstrate commitment to method, analysis less transparent but well validated.

Author/ Country	Sample	Type of project investigated	Method/ techniques	Summary of findings	Summary of methodological strengths/weaknesses
Krupa et al, 2003 Can	32 associates; 8 staff	User experiences of affirmative business	Qual not specified Focus groups	Experiences presented in 2 categories: 'rewards of participation' and 'points of tension', with sub-categories.	Collection and analysis show commitment to qual techniques, with illustrations of use. Mixed method design with qual and quant techniques complementary
Martin, 1995 UK	36 trainees, 8 staff	Exploration of the role of an employment rehab workshop	Qual - PO, Int	3 headings of 'rehabilitation and skills training', 'goals and outcomes' and 'a supportive but 'business-like' environment'.	Method thorough but no validation of themes reported and interviews not transcribed (though this justified). Themes, illustrated by fieldnotes, integrated & coherent.
Metcalfe, 1994 NZ	14 members	Clubhouse	Ethnography: ppt obs and int	Findings grouped under: 'involvement', 'membership', 'comparisons', 'changes', and 'future'	'Impressions' reported rather than analysed themes, and headings imposed by researcher. Lack of transparency of processes so appears weak in method.
Provencher et al, 2002 Can	14 ppt, 6 employed in different jobs, 8 not	Mainstream work/peer support/ unemployed	Method not spec Int, content analysis, CCM,	6 themes of recovery developed into 3 recovery profiles: 'recovery as uncertain', 'recovery as a self-empowering experience', 'recovery as a challenge'.	Sensitive to context and impact of findings discussed clearly. Some commitment demonstrated, although possible technical fixes, and method not always transparent. Ppts paid but implications not considered – little reflexivity demonstrated.
Rebeiro et al, 2001 Can	9-11 people in 4 focus groups	Consumer-run, occupation-based MH prog	Mixed method, qual = ppt obs Focus groups	3 major themes described, highlighting participants' 'being', 'belonging' and 'becoming' needs.	Strong methodology with clear demonstrations of techniques, and coherent, integrated narrative. No ethical info given.
Rebeiro & Cook, 1999 Can	8 members of woman's group	Occupation-based group	Qualitative design Int, ppt obs	3 themes: person, occupation and environment, encompassing 10 analytic categories, expressed in a model of 'occupational spin-off'.	Demonstration of some commitment to method, but possibility of 'fixes' e.g. negative case analysis mentioned but not described. Novel framework developed and linked to theory and practice.
Salzer & Shear, 2002 USA	14 consumer-providers	Role of consumer-providers in peer support	Qual: Int, Thematic analysis	29 thematic categories reported, in 7 meta-themes. Benefits to each individual also reported.	Shows commitment to method, techniques demonstrated, though less transparency over analysis. Overall narrative appears integrated and clear.
Secker & Membrey, 2003 UK	17 unemployed / employed clients	Workplace factors associated with job retention	Qual? Not specified Int, staged analysis	4 main themes: 1) training and support to learn, 2) relationships with colleagues, 3) Workplace culture, 4) Staff management.	No qual method specified, tho used techniques appropriately. No validation reported. Some transparency of processes. Little ethical info reported. Part of wider study.

Author/ Country	Sample	Type of project investigated	Method/ techniques	Summary of findings	Summary of methodological strengths/weaknesses
Stepney & Davis, 2004 UK	10 volunteers, focus gps with 7 ppts and 7 staff	Evaluation of land-based work rehab project	Mixed method; Qual not specified - Int, focus groups	Themes grouped under headings: 'changes in attitude to work and the future'; 'changes in confidence and how they came about'; 'relationship between activity and mental health'	'Qual' used but other than use of interviews method not specified. Analysis not reported, ppts comments reported individually – identifying? Overall data not integrated coherently.
Strong, 1997 Can	10interviews & 2 members in focus group	Meaning of work in affirmative business	Ethnographic approach: ppt obs, int, focus gp	3 themes: 1) Themes framing the meaning of work (4 categories); 2) Barriers and supports to meaningful occupation; and 3) Ideas for change.	Contextually sensitive paper with clear demonstrations of strong methodology, clearly illustrated by data. No ethical issues reported but consumer advisory committee provided feedback on impact of study.
Tse & Yeats, 2002 NZ	67 people with BPD, 7 family members	Vocational outcomes amongst people with bipolar disorder	GT	6 related factors contributing to 4 key components of: the individual; support; work; wider context. 'vocational integration model'	Strong commitment to method, transparency of collection and analysis. Narrative seems to integrate the complexity of data. Validation very thorough. Impact of researchers not considered.
Yuen & Fossey, 2003 Aus	3 consumer-staff	Consumer-staff views of rewards and challenges of their work	Naturalistic Inquiry involving Int, CCM	8 themes drawn out from consumer-staff views, covering different rewards and challenges of working.	Sensitive to lit, collaborative int guide developed. Demonstrates commitment to method, and generally transparent in process.

Abbreviations: ppt = participants; emp/unemp = employed/unemployed; SE = Supported Employment, PO = Participant Observation; Int = Interviewing, GT = grounded theory; rehab = rehabilitation, CCM = constant comparative method of analysis; EPP = Empirical, Phenomenological, Psychological; Can = Canada; Swe = Sweden; NZ = New Zealand; Aus = Australia

Table 2: Summary of findings from included studies

Author	Mental illness/ not working	Social	Occupation	Self	Setting	Recovery	Wider social context
Buckle, 2004		Increases social contact	Gives structure: something 'normal' to talk about				
Gahnström-Strandqvist et al, 2003	Unsatisfying context: passive, isolated	Being with others, better social contacts, more active in home	Productive at meaningful task at own pace. Structure, status, pride: "normalising life world"	Better view of self, develop confidence	Collaborative – accommodations support person		
Galvin et al, 2000	Isolation	Develop friendships	Develop skills. Meaningful. Unpaid work justifies benefits.	Valued: confidence, self-esteem, control	May maintain isolation due to mental health label	Move on with life	Stigma of mental illness & unemployment
Kennedy-Jones et al, 2005		Social interaction, belonging. Shared experiences	Purpose, achievement, regular activity, structure. Instils hope.	"sense of self as worker"	Feel welcome, receive support	Work alleviates symptoms. Stress/symptom balance	
Kirsh, 2000	Down, depressed, lonely	Acceptance, respect. Influence of co-workers/ supervisor. To disclose or not.	Community participation. Distraction/normalising. Challenge/achievement leads to self worth	Work allows rebuilding of self	Change v predictability of job. Accommodations convey respect	Need to balance positives with stress	
Krupa, 2004	Overwhelming	Office politics – dealing with hostility. Disclosure debate	Disorder v work demands – work gives meaning, demonstrates capacity	Work v illness identity. Relapse prevention	Compensatory strategies needed if no accommodations	Medication can help. Need to accept illness	
Krupa et al, 2003	Boredom, apathy, inactivity, too much sleep, loneliness, isolation	Collective responsibility. Social interactions – connection to public	Legitimate work meeting actual need. Generalisable skills. Economic wellbeing, but benefits trap.	Respect, sense of ownership.	Flexibility shows respect. Relaxed atmosphere, able to make mistakes and learn – unconditional acceptance	Limits depression, alleviates symptoms, facilitates acceptance.	Better conditions than mainstream. Disability label, but empowering.
Martin, 1995			Rehab v skills training: must be meaningful. Focuses week. Transferable skills		Clarity needed over setting – business v rehab.		Obstacles to employment – stigma, low confidence.
Metcalfe, 1994		Meet others, gain support	Focus to day, meaningful activity, learn new skills		Should allow flexible involvement		
Provencher et al, 2002 (processes)	Overwhelmed, poor health, no control → coping strategies → self efficacy	Isolation → increasing connection → strong support, reciprocal relationships	Way of passing time → way of coping & building self-efficacy → job satisfaction, self actualisation	Vulnerable, passive → active, setting goals → regaining different roles		Uncertain → self-empowering → ongoing process giving opportunity & self-acceptance	Stigma and limitations

Author	Mental illness/ not working	Social	Occupation	Self	Setting	Recovery	Wider social context
Rebeiro & Cook, 1999		Affirmation in social environment, belonging	Confirmation of evolving identity – distraction and competency through accomplishment	Shift to competent, confident → actualisation	Anticipate sense of belonging & further accomplishment.	Model of "occupational spin-off"	
Rebeiro et al, 2001		'belonging'	'becoming' need to be active & contribute to community for personal fulfilment.	'being': self worth, redefining self, restoring dignity	Physically and emotionally safe. Flexible – make own opportunities & mistakes	Time to recover	Lack of sense of community and need for this
Salzer & Shear, 2002		Helping others' recovery: satisfying. Appreciated, supported	Gives confidence, self esteem. Gain skills & experience for future	Allowed to be self	Flexibility, enjoy challenge	Practice own recovery through helping others'.	
Secker & Membrey, 2003	Unemployment/ illness reduce confidence	Supportive peers aid job retention, increase comfort at work	Impact of illness. New jobs intimidating, need support and training.		Accommodations reduce intimidation. Need accepting and caring culture.		Stigma, negative attitudes affect confidence
Stepney & Davis, 2004	Boredom, low mood, withdrawal	Improved social interaction, skills – teamwork	Positive impact on mental health – distraction		Pleasure of working outside – safe but dynamic environment		'labelling by system', barriers to aspirations
Strong, 1997	Sense of failure. Daily struggle with illness	Increased social roles, relationships, new friends. Shared experience	Daily work effort demonstrates capability. Small goals create hope of larger.	Renegotiate self, take responsibility		Become active participant in life – non-illness focused activities	Labelled, victimised, limited choices.
Tse & Yeats, 2002		Need for support & good management	Qualifications/good work record advantageous. Satisfaction & meaning. Gives routine. 'goodness of fit'	Need for determination. Faith helpful.	Flexibility. Routine (safe/boring) v creative (interesting/stressful)	Needs effective illness management & accommodations	Stigma: need to have support from policy context.
Yuen & Fossey, 2003		Re-establishes social networks. Rewarding to help others, work in team	Purpose, motivates, 'reason to get up early'. Important value to self – pay.			Balance of work/symptoms. Stress v symptoms.	

Chapter 3

Major research project proposal

How do Social Firms Contribute to Recovery from Mental Illness? A Qualitative Study

Jenny Svanberg

Project Summary

Traditionally, the concept of recovery from mental illness has been defined as symptom cessation in a medical model. However, the 'user movement' within mental health is promoting an understanding of recovery as a complex process involving a number of different components and stages. This is adding momentum to the drive for 'recovery-oriented services' which call for mental health services to promote choice, involvement, empowerment and inclusion in order to facilitate recovery through personal growth.

Organisations such as social firms may sustain recovery by fostering environments which encourage self-confidence and self-acceptance. The ethos of social firms seems to correspond closely with models of recovery-oriented services. The proposed study seeks to develop understanding of factors promoting or hindering recovery by interviewing people using four social firms in Glasgow. Interviews will be analysed using a social constructionist version of grounded theory methodology. Emerging concepts and themes will be considered with reference to literature on recovery, resilience and psychological wellbeing.

Introduction

Recovery from mental illness has become a controversial issue in recent years. Personal accounts of experiences of mental illness and recovery (e.g. Deegan, 1988; Leete, 1989) have added momentum to the 'survivor' or 'user movement' which opposes dehumanising practices in mental health services, and campaigns against people being stigmatised as 'mentally ill'. Instead, it emphasises concepts of self-help, empowerment and advocacy (Frese & Davis, 1997; Chamberlain, 1990). This has posed a challenge to the predominant biomedical model of mental illness, which has been accused of being overly pessimistic about the prognoses of severe mental illnesses such as psychosis (Andresen et al, 2002).

It is now widely accepted that recovery from mental illness is not only possible, but happens regularly (Levant, 1999), and a diagnosis of a mental illness is not necessarily a 'prognosis of doom' (Deegan, 1997). Long term studies looking at outcomes amongst people with chronic mental illnesses have demonstrated significant improvement in over half of all people followed up (Harding et al, 1987; Harrison et al, 2001). Cross-cultural studies implicate social and cultural variables in chronicity (Kruger, 2000). In addition, mental health services themselves have been accused of contributing to the chronicity of problems they profess to treat (Anthony, 1993).

Roberts and Wolfson (2004) outline the characteristics of the medical model which have been criticised by the user movement, including: a focus on psychopathology and diagnosis, rather than distressing experiences and personal meaning; seeking compliance

for treatment as opposed to exploring choices for personal growth and discovery; seeing recovery as a cure or return to normal rather than a process of transformation. Despite acknowledging the tensions between these viewpoints, Roberts and Wolfson (2004) are optimistic that a 'recovery model' of mental health services could unite service users and professionals in a common goal.

What is recovery?

Rather than seeing recovery as a cure, and looking for cessation of symptoms, a paradigm shft is occurring towards a concept of recovery as a process, not an outcome (Frese & Davis, 1997). A number of studies have attempted to develop constructs of recovery enbedded in survivor accounts, and a variety of different component processes have energed. The importance of hope resonated throughout most studies, as well as factors such as: self identity and a positive sense of self; finding meaning and purpose in life; taking responsibility for oneself; being supported by others; growth and moving on with life (Andresen et al, 2003; Kelly & Gamble, 2005; Ridgway, 2001; Noordsy et al, 2002).

Andresen et al (2003) also proposed a psychological definition of recovery embedded in survivor accounts in which: "hope and self-determination lead to a meaningful life and a positive sense of self, whether or not mental illness is still present". This corresponds to the widely accepted definition suggested by Anthony (1993) in which recovery is described as: "...a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness." Andresen et al (2003) suggest a process model of recovery, drawn from the literature. They describe five stages: Moratorium, characterised

by ientity confusion, denial and hopelessness; Awareness, where a 'turning point' (Toch et al, 2003) signifies the awakening of hope; Preparation, where the person begins to reonnect and take stock of their self, strengths and weaknesses; Rebuilding, in which the \ork of recovery takes place; and Growth, which is characterised by a positive sense of sef and the future. Resilience and psychological wellbeing are both thought to influnce the growth stage of recovery, although this relationship is as yet unclear (Ancesen et al, 2003; Ridgway, 2001).

Servce Developments in the UK

Recovery-based services need to be based on what people in recovery have found helpful (Antbny, 1993). This may include aspects of self-management, flexibility, valuing diverity and developing a common language between professionals and patients (Robrts & Wolfson, 2004). A number of services following these principles have been develped, such as the Early Intervention movement within psychosis services (Birchwood et al, 2002), and the Tidal Model currently being implemented around the UK (Jarker, 2000).

Looking at specific requirements of recovery-oriented services, Repper (2000) highlights the importance of strategies for social inclusion: facilitating access to roles and responsibilities. In describing an environment of hope, one of the fundamental requirments for recovery, Turner (2002) included characteristics such as: high expecations; taking risks, failing and trying again; involvement within the community; and esablishing skills for work, education and creativity. It can be argued that schemes

such as social firms allow this integration into the community by allowing "patients and professionals to work in partnership to provide a service to the public" (Leff, 2001).

The Social Firm

A social firm is a "business created for the employment of people with a disability or other disadvantage in the labour market" (Grove et al, 1997). Social firms are strongly embedded in a model of empowerment: as well as the economic goals of any business, they also have a social mandate to promote the physical, social and mental health of their members (Savio et al, 1993). Social firms emerged at the time of a major reform of mental health services in Italy in the 1970s, which saw a shift from an 'invalidating system of care of the mentally ill' (such as the asylum) towards a system of care that utilised peoples' own resources, affirmed the right of citizenship of those with mental illness, and restored the value of work and a productive role (Ducci et al, 2002).

There were 200 social firms in the UK by 1998 (Ducci et al, 2002). In an evaluation of one such organisation, people undergoing a programme of activities, training and social support were found to perform beyond the expectations of them predicted by diagnostic assessments. A qualitative aspect to this evaluation suggested that reasons for this included gains in confidence, motivation and self-esteem due to the meaning of inclusion to the participants (Stepney & Davis, 2004). This fits well with the attributes a recovery-oriented service requires, such as environments that encourage self-confidence, self-esteem and self-acceptance through fostering awareness and growth (Coleman, 1999).

A the literature is moving towards a consensus of what recovery is, there remains a need tcinvestigate the factors that promote and sustain recovery, as well as barriers to recovery (Roberts & Wolfson, 2004). It can be argued that aspects of social firms integral tctheir ethos may facilitate recovery from mental illness, due to their philosophy of enpowerment and social inclusion. In order to explore these issues, a qualitative study is pnposed amongst people using social firms in Glasgow.

Ams

Tle study aims to explore experiences of recovery amongst people using social firms. By dong this, it aims to develop an understanding of the aspects of these organisations that suiport recovery from mental illness and emotional distress. The following questions will beaddressed:

- How do people using social firms describe their experiences of these organisations?
- What do they find helpful about social firms?
- What do they find unhelpful?
- How do they describe recovery in this context?

Plan of Investigation

A series of interviews will be carried out with people using four social firms in Glasgow. Analysis of these interviews will begin after the initial interview, in line with grounded theory methodology (Glaser & Strauss, 1967). This process will allow each interview to incorporate and expand on themes emerging from previous interviews. Interviews will

continue until theoretical saturation has been achieved, i.e. when all data fits with the concepts already in existence, and no new themes emerge from interviews. In this way, the concepts arising from the interviews can be placed in a theoretical model wholly grounded in the data.

Participants

The study will seek to recruit people using the Common Wheel, Boomerang, Coach House Trust and Galgael social firms in Glasgow. The unifying themes of these projects are their aims of social inclusion and empowerment through providing educational and employment opportunities to people often excluded from mainstream society because of problems including mental illness, substance addiction, physical disabilities or learning disabilities. As the aim of the study will be to explore peoples' experiences of helpful aspects of the projects, their participation in these projects will be taken as the only inclusion criteria. However, as the study progresses, participants may be sampled in order to actively seek out disconfirming data and so increase the validity of the study and clarity of the emerging concepts. This is discussed further in the 'sampling' section below.

Recruitment

Project leaders in the social firms will be given information about the proposed study. Information will also be distributed around each organisation. This material will take the form of information sheets in written and audio format (appendix 3.1), and posters inviting members of the organisations to take part in a study looking at recovery

(appendix 3.2). Contact details of the principal researcher will be included in the information, and the principal researcher will be available to answer any questions from interested people. Fully informed consent will be sought from those agreeing to participate in the study (appendix 3.3). It will also be made clear that they may decide to withdraw from the study at any point.

Design & Procedures

- **Sampling**

Initial sampling will be focused on the members of the four social firms in order to access the most 'information-rich' sample relevant to the study (Patton, 1990). Following the analysis of the initial interview, purposeful sampling will be used in order to pursue and clarify themes emerging from the analysis. This may result in sampling decisions being made within the social firm context, for example if 'length of time involved with social firm' emerges as a significant issue. The constant analysis may also lead to sampling outside the social firm, for example by seeking participants from vocational projects that are not social firms in order to compare emerging narratives.

Interviews

Interviews will consist of two parts. The first part will involve a small number of open questions, in order to allow the ideas and concepts most important to participants to emerge. More 'closed' questions will be avoided to prevent an imposition of the researcher's own views on participants' experiences. Probing questions will be used to

investigate issues further where necessary. The final part of the interview will involve collection of demographic information.

Prior to the initiation of interviews, participants will be reminded that interviews will be confidential, and that they may terminate interviews or withdraw their consent to participate in the study at any time. Interviews will take place in locations decided on jointly by participants and the researcher, taking into account health, safety and risk factors.

- **Transcription**

All interviews will be transcribed verbatim by the researcher. This will include errors in speech and colloquial terms made by either the researcher or participant. All non-anonymised data will be removed. Raw data will be destroyed once transcription has taken place, and all transcriptions will be held by Glasgow University for five years before being destroyed.

Settings & Equipment

Interview settings will be decided on by the researcher and participant, taking into account risk factors and practical requirements. The interview procedure will be used as described in figure 1 below. This is a flexible procedure and will evolve as the study progresses, according to themes and concepts emerging from subsequent interviews. All interviews will be recorded using Sony digital recorders.

Figure 1: The basis for the interview procedure

Part 1: Open questions

- What do you understand by the word 'recovery'?
- How have you found [project name] helpful?
- Has anything outside the project been helpful?
- What sort of impact has it had on you? How has it affected you – coming here?
- Is there anything unhelpful about it?

Probe questions

- Could you tell me a bit more about that?
- Can you give me an example of that?
- What did that make you think of?

Part 2: Collection of demographic information

This will include details about: age, sex, length of time involved with project, previous contacts with health or mental health services, current contact with health or mental health services, whether currently on medication, any known diagnoses.

Data Analysis

In line with original grounded theory methodology, data from the initial interview will undergo a process of microanalysis. This will involve a detailed, line-by-line analysis of the first interview to generate initial categories and begin to suggest relationships

between categories (Glaser & Strauss, 1967). Data analysis will then be alternated with data collection in a cyclical fashion. This will allow theoretical sampling based in the concepts emerging from the study, and will also permit concepts conflicting with the data to be modified or discarded.

The study will take a social constructionist version of grounded theory (Charmaz 1990; 2003) which sees 'meaning' as something that individuals attribute to a situation, mediated by history, culture and language. This means that the process of data analysis will view interviews as narratives constructed jointly by the researcher and participant.

Data analysis will be supported by the use of the Non-Numerical Unstructured Data Indexing Searching and Theorising (NUD*IST) computer programme for qualitative data analysis. Following the initial analysis, data collection and data analysis will be alternated allowing emerging concepts to be extended and validated as they develop. This will continue until theoretical saturation is achieved, i.e. when no new information seems to emerge during coding (Charmaz, 1990).

- **Transparency and validity**

In order to allow ease of assessment of the study, relevant aspects of data collection and coding processes will be recorded in the form of memos kept by the researcher. Memos will also be recorded to allow reflection on the researcher's own beliefs and attitudes and their influence on coding decisions.

In order to increase the validity of emerging concepts, data may also be gathered from other sources as outlined above, for example members of vocational projects that are not social firms. This will allow inclusion of potentially differing perspectives in order to actively seek disconfirming or unexpected data (Yardley, 2000). Samples of data may also be analysed by independent sources.

Focus groups will be held towards the end of the research process in order to validate findings with participants.

- **Sensitivity to context**

Whilst grounded theory aims to develop theories embedded in the data from which they emerge, it is important to ensure that analyses remain sensitive to the data. To promote this aim, unexpected findings, or categories which conflict with the researcher's understanding will be actively sought, examined and accounted for (Yardley, 2000). Any theory emerging from the data will also be corroborated with empirical evidence wherever possible, and concepts will be considered with respect to psychological theory, for example resilience and wellbeing (Ridgway, 2001; Andresen, 2003).

Taking a social-constructionist version of grounded theory corresponds with Yardley's (2000) requirement to take into account socio-cultural influences when carrying out qualitative research. This includes an appraisal of any influence brought to the study by the researcher, as grounded theory methodology acknowledges that 'attempts to remain "neutral" when observing and interviewing are futile" (Yardley, 2000). Factors such as

age, gender and status of researcher and participants will be taken into account, and any power imbalances will be considered.

Practical Applications

It is hoped that this study will contribute to an understanding of the aspects of social firms that contribute to recovery from mental illness and emotional distress. By doing so, it may contribute to the shift towards recovery-oriented services. This is highly relevant to current policy issues. For example, Roberts and Wolfson (2004) describe the convergence between the user-led perspective and recent NHS policy, and the NHS is moving towards valuing patients as 'experts in their own experience' (Department of Health, 2001a), and has incorporated the recovery model into the National Service Framework for Adult Mental Health (Department of Health, 2001b).

Timescale

October 2005	Major Research Project Proposal submitted.
	Ethics application submitted.
November 2005	Written and audio information sheets and posters distributed to participating organisations
December 2005	Begin data collection and data analysis. This will be ongoing until data saturation is achieved.
April 2006	Focus groups held to feed back and validate results with study participants.
May 2006	Writing up.

July 2006 Submission.

Ethical Approval

An application for ethical approval will be submitted to Greater Glasgow Primary Care Trust Ethics Committee.

References

Andresen, R., Oades, L. & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry,* **37,** pp586-594.

Anthony, W.A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal,* **16,** pp11-23.

Barker, P. (2002). The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of psychiatric and mental health nursing,* **9(2),** pp229-232.

Birchwood, M., Fowler, D. & Jackson, C. (2002). *Early intervention in psychosis: a guide to concepts, evidence and interventions.* Chichester: John Wiley & Sons Inc.

Chamberlain, J. (1990). The ex-patients' movement: where we've been and where we're going. *Journal of Mind and Behaviour.* **11,** pp323-336.

Charmaz, K. (1990). 'Discovering' chronic illness: using grounded theory. *Social Science & Medicine.* **30(11),** pp1161-1172.

Charmaz, K. (2003). *Medical Institutions.* In Reynolds, L. T. (Ed) & Herman-Kinney, N. J.(Ed.). (2003). Handbook of symbolic interactionism. Walnut Creek, CA, US: AltaMira Press.

Coleman, R. (1999). *Recovery: An Alien Concept.* Handsell Publishing, Gloucester.

Deegan, P. E. (1988). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal,* **11,** pp11-19.

Deegan, P. E. (1997). Recovery and empowerment for people with psychiatric disabilities. *Social Work in Health Care,* **25,** pp11-24.

Department of Health. (2001a). *The Expert Patient: A new approach to chronic disease management for the 21st century.* London: Department of Health. (available at www.ohn.gov.uk/ohn/people/expert)

Department of Health. (2001b). *The Journey to Recovery – The Government's Vision for Mental Health Care.* London: Department of Health.

Ducci, G., Stentella, C. & Vulterini, P. (2002). The Social Enterprise in Europe. *International Journal of Mental Health,* **31(3),** pp76-91.

Frese, F. J. & Davis, W. W. (1997). The consumer-survivor movement, recovery, and consumer professionals. *Professional Psychology: Research and Practice,* **28(3),** pp243-245.

Glaser, B. G. & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies in qualitative research.* Chicago: Aldine.

Grove, R., Freudenberg, M., Harding, A., *et al* (1997). *The Social Firm Handbook.* Brighton: Pavilion Publishing. (definition also available at www.cefec.de)

Harding, C.M., Brooks, G.W., Ashikaga, T., Strauss, J.S. & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness I: Methodology, study sample and overall status 32 years later. *American Journal of Psychiatry,* **144,** pp718-726.

Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., Dube, K.C., Ganev, K., Giel, R. an der Heiden, W., Holmberg, S.K., Janca, A., Lee, P.W., Leon, C.A., Malhotra, S., Marsella, A.J., Nakane, Y., Sartorius, N., Shen, Y., Skoda, C., Thara, R., Tsirkin, S.J., Varma, V.K., Walsh, D. & Wiersma, D. (2001). Recovery from psychotic

illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry,* **178,** pp506-517.

Kelly, M. & Gamble, C. (2005). Exploring the concept of recovery in schizophrenia. *Journal of Psychiatric & Mental Health Nursing.* **12(2),** pp245-251.

Kruger, A. (2000). Schizophrenia: recovery and hope. *Psychiatric Rehabilitation Journal,* **24,** pp29-37.

Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin,* **15,** pp197-200.

Leff, J. (2001). Can we manage without the mental hospital? *Australian and New Zealand Journal of Psychiatry,* **35(4),** pp421-427.

Levant, R. (1999). Proceedings of the American Psychological Association, Incorporated, for the Legislative Year 1998. *American Psychologist*, **54**, pp605-671.

Noordsy, D., Torrey, W., Mueser, K., Mead, S., O'Keefe, C. & Fox, L. (2002). Recovery from severe mental illness: An interpersonal and functional outcome definition. *International Review of Psychiatry,* **14(4),** pp318-326.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park, CA: Sage Publications, Inc

Repper, J. (2000). Adjusting the focus of mental health nursing: Incorporating service users' experiences of recovery. *Journal of Mental Health,* **9(6),** pp575-587.

Ridgway, P. (2001). Restorying psychiatric disability: learning from first person recovery narratives. *Psychiatric Rehabilitation Journal,* **24(4),** 335-343.

Roberts, G. & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in psychiatric treatment,* **10(1),** pp37-48.

Savio, M. & Righetti, A. (1993). Cooperatives as a social enterprise in Italy: A place for social integration and rehabilitation. *Acta Psychiatrica Scandinavica.* **88(4),** pp 238-242.

Stepney, P. & Davis, P. (2004). Mental Health, Social Inclusion and the Green Agenda: an evaluation of a land based rehabilitation project designed to promote occupational access and inclusion of service users in North Somerset, UK. *Social Work in Health Care,* **39(3-4),** pp375-397.

Tooth, B., Kalyanasundaram, V., Glover, H. & Momenzedah, S. (2003). Factors consumers identify as important to recovery from schizophrenia. *Australasian Psychiatry,* **11,** pp70-77.

Turner, D. (2002). Mapping the routes to recovery. *Mental Health Today,* **July,** pp29-31.

Yardley, L. (2000). Dilemmas in Qualitative Health Research. *Psychology and Health,* **15,** pp215-228.

Chapter 4

Major research paper

How do Social Firms Contribute to Recovery from Mental Illness? A Qualitative Study

Jenny Svanberg*

University of Glasgow

Section of Psychological Medicine, Gartnavel Royal Hospital

1055 Great Western Road, Glasgow G12 0XH

Tel: 0141 211 3920

Fax: 0141 357 4899

jennysvanberg@yahoo.co.uk

*author for correspondence

Prepared in accordance with requirements for submission to the Journal of Mental Health (see Appendix 2.1)

Abstract

Background: A definition of recovery drawn from qualitative literature and the 'consumer/survivor' movement suggests that recovery should be seen as a way of developing satisfaction and purpose in life, whether or not symptoms of mental illness are present. A qualitative review suggested that meaningful activity may facilitate recovery by providing a sense of purpose in life. Social firms may be well placed to offer this activity, due to their ethos of empowerment, their community integration and their similarity to 'recovery-oriented services'.

Aims: To explore experiences of recovery from mental illness in the context of two emerging social firms.

Method: A social constructionist version of grounded theory was used to develop a model of recovery through participation in the emerging social firms. Multiple coding, triangulation and respondent validation were used to increase the rigour of study findings.

Findings: A model of recovery in the context of the emerging social firms was constructed. This was influenced by characteristics such as a flexible structure, meaningful and diverse activity, an accepting social group and inclusive leadership.

Conclusion: Social firms may provide an important model for 'recovery-oriented services'. Clinical, research and policy implications of findings are discussed.

Keywords: mental illness, recovery, social firm, qualitative

Introduction

The 'user' or 'survivor' movement of people who have experienced mental illness and mental health services is driving a change in the concept of recovery from mental illness. The definition of recovery is shifting away from recovery as cure or symptom cessation, and towards a concept of recovery as an ongoing multidimensional process (Frese & Davis, 1997). Andresen et al (2003) proposed a psychological definition of recovery embedded in qualitative accounts in which: "hope and self-determination lead to a meaningful life and a positive sense of self, whether or not mental illness is still present" (p592). This corresponds to the widely accepted definition suggested by Anthony (1993) in which recovery was described as: "...a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness" (p527). There has been a call for mental health services to become 'recovery-oriented' by including aspects of self-management, flexibility and value for diversity (Roberts & Wolfson, 2004). Consistent with these proposals, the qualitative literature has highlighted a number of components. The importance of hope resonated throughout most studies, as well as factors such as: self identity and a positive sense of self; finding meaning and purpose in life; taking responsibility for oneself; being supported by others; growth and moving on with life (Andresen et al, 2003; Kelly & Gamble, 2005; Ridgway, 2001; Noordsy et al, 2002).

Andresen et al (2003) suggests that employment may be an important factor in recovery as a way of building a sense of meaning in life. This corresponds to first person accounts of recovery which highlight employment as essential to recovery (e.g. Leete, 1992) by providing a purpose and vocation, particularly in the case of service users who go on to

become mental health professionals (Deegan, 1996). The benefits of working with regards to staying mentally healthy are well established, including a positive impact on self esteem (Lehman, 1995) by facilitating access to responsible roles and promoting social inclusion (Repper, 2000). However, many barriers to employment exist for people with mental health problems, such as a lack of choice and opportunity, stigma, pressures of working whilst coping with symptoms of mental illness (Henry & Lucca, 2004; Killeen & O'Day, 2004), and disincentives to employment embedded in the benefits system (Rebeiro, 1999; Seebohm & Scott, 2004). Specialist vocational rehabilitation schemes have developed as a method of addressing some of these barriers and providing a bridge into employment (Schneider, 1998a).

A variety of vocational rehabilitation schemes now exist (Schneider, 1998b), and supported employment in particular has been found to have some success in helping people with mental illness regain employment (Crowther et al, 2005; Bond et al, 1997). Qualitative studies offer further clarity over the benefits of work and vocational rehabilitation (see Chapter 2 for a review), emphasising the need for meaningful work to be well matched to individuals, and offered alongside sensitive support. This underscores the importance of having a range of vocational rehabilitation services available, in order to meet the wide spectrum of individual need.

McDermid (2005) suggests that social firms may be well placed to respond to this need, with their provision of a range of employment options. In a social firm, over half of the income of the firm should come through sales, and over a quarter of the paid workforce

should be people with disabilities or other disadvantages (Social Firms UK, 2001). This ethos embeds them strongly in a model of empowerment, with a social mandate to promote the physical, social and mental health of their members (Savio et al, 1993). This fits well with the attributes a 'recovery-oriented service' requires: an environment that encourages self-confidence, self-esteem and self-acceptance through fostering awareness and growth (Coleman, 1999). Anecdotal evidence suggests clinical benefits for employees of social firms, including a reduction in the use of statutory mental health services and medication, reduced social isolation, and increased confidence and motivation (McKeown et al, 1992). Social firms may also provide an environment integrated with the community whilst being understanding of mental illness, so that employees can work at their own pace without facing the discrimination characteristic of many mainstream work settings (Secker et al, 2003).

Whilst there is a growing literature on the meaning of work and vocational rehabilitation to people with mental health problems, few studies appear to have focussed on the specific impact of social firms on the recovery process.

Aims

The aim of the present study was to explore the experience of recovery from mental illness in the context of two emerging social firms. These projects were viable businesses that did not yet employ their workers at market level wages, but were working towards this aim (Secker et al, 2003).

Methodology

Design

A social constructionist version of grounded theory was used in the present study. The meanings that emerged from the study were therefore understood as active interpretations of the interactions between researcher and participant, mediated by the history, culture and language of both (Charmaz, 2006). A number of factors from the researcher's background are therefore likely to have influenced the data produced, including her training in clinical psychology, previous experiences with qualitative research, a longstanding interest in user-led research, voluntary and vocational projects, and also personal experiences.

In order to improve methodological rigour, criteria for assessing the quality of qualitative research were incorporated into the study design (Yardley, 2000; Elliott et al, 1999; CASP, 2002), and techniques to refine and validate findings were used, such as triangulation of data, multiple coding and respondent validation. In order to avoid charges of 'technical fixes' (Barbour, 2001), use of these techniques has been illustrated with examples wherever possible.

Ethical Approval

Prior to commencing the study, ethical approval was obtained from the NHS Greater Glasgow Primary Care Division Local Research Ethics Committee (Appendix 4.2). Approval was also granted from the NHS Greater Glasgow Primary Care Division Research and Development Directorate (Appendix 4.3). The research procedure was

designed to minimise any discomfort or distress to participants, and fully informed, written consent was taken prior to participation (Appendix 3.3). Confidentiality and anonymity were discussed prior to each interview, and all participants were assured that involvement was voluntary, and that they could withdraw consent to participation at any point throughout the research process.

Sampling

Participants were recruited from two emerging social firms in the West of Scotland, in loose partnership with each other. The unifying themes of these projects were the aims of social inclusion and empowerment through the provision of meaningful activity to people excluded from mainstream society because of problems such as mental illness. The activity in one project was focussed around bicycle maintenance and restoring second-hand bicycles. There were also a number of other activities in which the project was involved, including participation in an annual city festival and manufacture of bicycles, tricycles and bespoke bicycles for people with physical and learning disabilities. The activities of the second project were woodworking and furniture making.

Initial contact with both projects was made through the project leaders, who distributed posters about the study in their organisations. The author then attended the projects to discuss the project further and to give out information sheets to project members, answer any questions and invite participation. A further meeting was arranged with those interested in participating, usually one week later, at which written informed consent was obtained. If project members required more time to make a decision regarding

participation in the research, a further meeting was arranged. Prior to and during the research process, the author also attended tea and lunch breaks, and observed activity in the workshops. The purpose of this regular and informal contact was to be available to answer questions about the research; meet participants more fully; and become familiar with the day-to-day activity of the projects.

Initial sampling was carried out purposively from one of the emerging social firms in order to access the most 'information-rich' sample relevant to the study (Patton, 1990). Initial participants were therefore people who had been involved with the emerging social firm for at least 6 months. Collection and analysis of data were carried out in a cyclical fashion, and theoretical sampling was used to further extend the sample according to the emerging categories (Charmaz, 2006). Sampling was thus extended to participants who had joined the emerging social firm in the last 6 months; participants involved with a different branch of this project; and participants involved with the second emerging social firm. In this way, theoretical sampling was used to ensure heterogeneity in terms of testing and developing emerging codes and categories.

Triangulation of data occurred towards the end of data collection, through the interviewing of 2 project leaders and a volunteer with the project. Participation was also invited from a local Clubhouse, in order to explore differences in the experiences of members of a vocational rehabilitation project other than a social firm. However, members of the Clubhouse declined to participate in the research and therefore none were involved.

The overall sample therefore consisted of 12 members of one emerging social firm, 3 of whom attended a different branch of the project; 4 members of a second emerging social firm; 2 project leaders and 1 volunteer. Participants were 15 men and 1 woman between 19 and 64 years of age (median = 35.5) who had experienced mental illness. Self-described diagnoses included bipolar disorder (5 participants; 31%) depression (3; 19%), psychosis (2; 13%), or comorbid depression with another disorder (psychosis: 3, 19%; anxiety: 1, 6%; addictions: 1, 6%). One participant did not wish to disclose his diagnosis. Seven participants had been involved with the emerging social firms for less than 6 months, and 9 for over 6 months (range = 0.75 to 48 months; median = 15 months).

Procedure

Interview schedule

A small number of open-ended interview questions were used as a point of departure (see Chapter 3, p77). The questions were designed to allow participants to discuss themes relating to their experiences of recovery and the emerging social firms, without imposing any preconceived frameworks on their ideas. The interview schedule was piloted in the initial two interviews and feedback gained. At this stage the questions were thought to be appropriate and no changes were made. However, following initial interviews a number of participants voiced the impression that the first question, 'What do you understand by recovery?', or, 'What does the term recovery mean to you?' was difficult to answer early on in the interview. Later interviews were therefore begun with a more general discussion of the individual's experiences of the project they were attending, and the impact of this on recovery was addressed later in the interview.

Altogether, 16 interviews were carried out with project participants, ranging from 11 to 68 minutes in length (median = 30.29). In regards to this, a theme which emerged from a number of interviews was participants' appreciation of the emphasis of the projects on 'doing' rather than 'talking'. They knew they were not at the projects to discuss their problems or histories, and this came as a relief to many. The brevity of some of the research interviews may have reflected this emphasis and interviews were not prolonged if participants felt that they had discussed the points most important to them. Interviews were recorded using a Philips Voicetracer 7780 digital recorder, and transcribed verbatim. The interviews were manually coded line by line (see Appendix 4.4 for example) and codes were developed into themes and categorised, supported by the computer programme QSR NUD*IST version 4.0 (1997).

Throughout the process of data collection, the method of constant comparative analysis was used (Glaser & Strauss, 1967) to distinguish and categorise codes and themes, searching for similarities and differences within the data (Charmaz, 2006). For example, comparing those who had been at the projects for longer than 6 months to those who had not suggested that greater length of time with the project contributed to a stronger sense of identity and belonging to the project. A greater emphasis on having gained enough skill and confidence to help others, and the impact of this on self-worth, was also discussed by participants.

Further to the use of data triangulation described above, a number of other techniques were incorporated into the study design in order to increase methodological rigour

(Yardley, 2000; Barbour, 2001). Multiple coding was carried out by one independent researcher, a trainee speech and language therapist with a background in linguistics, who coded four interview transcripts. This allowed codes and categories to be refined and discussed. The emerging coding framework was also discussed with the author's research supervisor, at regular meetings of a qualitative research group, as well as with participants in one of the projects involved in the study. This added depth and validation to a number of the categories, as well as further emphasis to categories participants felt were particularly important, such as the flexibility, diversity and participatory aspects of the emerging social firms.

Memos were used to note down personal reflections following each visit to the projects and during coding of data (Charmaz, 2006). These were used to support the construction of themes, increase awareness of the researcher's influence on data and suggest areas which needed further exploration. In order to increase transparency further, participants were aware that the author was carrying out the research as part of the requirements for her Doctorate in Clinical Psychology. However, they were also aware that research of this type would be useful in raising awareness of their projects, and of social firms in general, and many expressed enthusiasm in participating for this reason.

Rather than seeking theoretical saturation, theoretical sufficiency (Dey, 1999) was aimed for in the present study. The main themes had emerged by the eighth interview, after which point theoretical sampling was introduced. This was done to ensure that the further

sampling would develop preliminary categories and specify the relationships between them (Charmaz, 2006).

Findings

The themes which emerged from participants' interviews were organised into a number of categories: the meaning of recovery; the experience of mental illness; working in an emerging social firm. These categories and their sub-themes are reported in this section. Excerpts from interview transcripts are included throughout, in order to increase transparency and illustrate the data from which themes emerged (Elliott et al, 1999). For each excerpt, a code is given for the participant in order to maintain anonymity. Throughout the findings, 'P' denotes a participant and 'PL' a project leader.

The Meaning of Recovery

There was no consensus over what the concept of recovery actually meant to participants. There was a general agreement that recovery was about getting better and getting on with life by being active, able to get up and leave the house and by developing goals in life as a contrast to the impact of mental illness:

> *P4: "I'd been going through a lot of unhappiness, a lot of depression, that had become quite debilitating, that was completely impinging on my normal life, er, so, and that's to me what recovery is, it's getting, you know, what your life, what you think your life should be, have an idea what I want out of life and recovery is maybe helping you come a bit closer to achieving that".*

A number of participants described recovery as an individual process that was not a smooth journey and could take varying lengths of time, sometimes a lifetime:

> *P13: "You can have times when you're down but you're still well, as in you're not having major psychiatric problems where you're so ill you have to go into hospital, the problem with it is that it does get, I mean at the dips you think you're not well again, and you get all upset about it, then it goes back to normal and you forget about it, and then you have another dip. I don't think a lot of people understand that mental illness is sometimes for life"*

For some the meaning of recovery was less clear, and could seem like an impossible goal:

> *P16: "What does recovery mean? I don't really know to be honest with you. I think I've got, I think I'm stuck in the way I am, you know what I mean, I don't think I'll ever get any better. I suppose it means, sometimes I'm really bad and I cannae go out and that, and then I come out of it, and I've been taught strategies to cope, so I suppose that's recovering isn't it. But recovering is to be normal, whatever normal is, I don't think there is such a thing as normal is there?"*

However, some participants described successfully using medication or coping strategies to gain some control over ongoing symptoms of mental illness:

> *P15: "You get insight and sometimes you'll think of something and you can pull back and say that's a bit....I'm not feeling too well if I'm thinking that you know, when I was first ill I believed all these delusions you know."*

JS: "So is it kind of like separating yourself from the illness?"

P15: "It is aye, yep, you can see aswell when you're starting to think things, for example thinking things about whatever, you can tell yourself, I thought about this before and that's when I wasnae well you know, so it's not true, so you kind of realise, you can separate your illness from the reality."

The Experience of Mental Illness

In describing their experiences of the emerging social firms, participants inevitably contrasted this with their prior and ongoing experiences with mental illness and mental health services. Participants had received different diagnoses from mental health services, as described on page 94. However, there were striking similarities between different participants' experiences, which revolved around profound feelings of fear, distress and isolation:

P8: "It was like being in a deep well and you cannae get out of it, and the thing is you're scared and all the time you started trying to climb out but it'd just come back at you and you'd go back into it again."

P6: "I was one of these full o' the joys of life people, you know, and to suddenly [interruption] and I still feel the same. I know it might not seem like that talking to me, but you get up in the morning and it's like, oh my god another day, I want to go under those covers. And it's like a wee battle goes on inside your head to say right ok let's, let's get up and out from under the covers."

Participants had contrasting views of mental health services, according to their own experiences. Finding a professional who knew about mental illness was thought to be valuable:

> *JS "Do you think they balance each other out? Do you need both sides? [support from mental health services and the emerging social firm]*
> *P11: "Aye I do aye. I think, I mean, for people like that have got mental issues talking's one of the most important things if you can speak to somebody and somebody actually you know, knows, you know, they're professional and they know what they're talking about, aye you need that, you need to be able to speak to people."*

In general, medication was also seen to be helpful in providing some control over symptoms of mental illness. For the following participant, this control then allowed an increase in activity:

> *P15: "I mean basically the main factor for me was a change in medication, and my illness gradually improved once I was on that, and it's made me able to keep busier and busier if you see what I mean, I don't know if there's any particular method or way or whatever, but my personal experience it was just getting decent medication that agrees with me, you know.."*

However, whilst mental health services were generally seen as helpful, some participants felt that this help was limited to the provision of medication. The need to use mental

health services also increased some participants' sense of being shunned by society, which was contrasted with the feeling of being part of the emerging social firm:

> *JS: "How would you compare the sort of support you get from the mental health system with here?"*
> *P7: "As I say in here you would never know anybody has a mental illness, you know, you just come in and fix a bike or whatever, so you don't feel like a loser basically, you know, you feel like you've got a purpose, whereas I feel, being in the psychiatric system it's a reminder that you're flawed, you know, you feel you're at the bottom."*
> *JS: "Is there anything they could do to improve things?"*
> *P7: "No, no, I mean, all the psychiatric system can do is prescribe antipsychotics and mood stabilisers and that and that's fine, that's cool, you know, but it's just, being in that environment, it's just not a nice place to be, you know?"*

This point was elaborated further with the suggestion that mental health services were limited because of the high expectations placed on them by staff and users to produce a full recovery. However, the erratic nature of recovery alluded to in the previous section meant that this was not always possible. One participant felt that the emerging social firms were able to pick up where mental health services left off:

> *P4: " I mean I've sort of come to the conclusion that, I mean it's not just psychiatrists but just general doctors, GPs and that, people afford them, or place on their shoulders too much of the responsibility of recovery, and there comes a point when they can't do any more. And places like this [emerging social firm]*

really do pick up the baton so to speak, for me anyway, of continuing the process."

Working in an emerging social firm

Participants' experiences of the social firms were varied, and described contrasting perspectives around a number of themes. These focused on the areas of: the structured activity; the social group; the project environment and the project leaders. These sub-themes interacted with each other and had a cumulative impact on the individual, described further in the next section.

The structured activity

Both projects were structured in that participants had to be there on certain days at certain times. This was seen as an advantage, as it provided a focus for the week and a reason to get up and out of the house on those particular days:

P6: "It's gave me a kinda maypole for my week, it's gave me a real fixed point to work around, and that's..."
JS: "And that's helpful?"
P6: "Oohhhh you wouldn't be overestimating it to say that it's gave me a focus for my life. It's actually a pinpoint that you can say, you get a bit worried when it's the holidays and things, you know – oh god, what'll I do, see now, so I'll do the [project name] in my house, I'll get a bike and I'll do that, I'll stand there doing it all day, just like folk here, you know"

The need to have somewhere to go and something to do was contrasted with situations when this had been lacking in participants' lives, with a resulting deterioration in their mental health:

> *P10: "Because it gets people out of the house, gets them involved and active. Because that's what I need at the moment because, when I came out of hospital I was just sitting about the house getting agitated and negative, then I started getting involved with this and I feel like I was doing something productive."*

Once participants had started at the project, the activity itself started to affect them, whether this was bicycle repair, or woodwork. At first, it provided a distraction, particularly because of the intricate nature of much of the work and the need for concentration:

> *P13: "Last week I had a wee stint of paranoia, very slight, very very slight, but I could feel it, and I went to [project name] and by about 12 'o' clock I'd forgotten about it, because I was busy with doing stuff, and when you're working with wood and intricate things and putting nails in you have to be careful so you don't bang your, hit your finger or, I don't know, drilling holes and gluing stuff together, I don't know. It's not rocket science but it keeps your mind occupied."*

The fact that participants were building something meant that the activity had a visible purpose, they were learning valuable and useful skills, and they were able to see what they had made after their efforts which gave a tangible sense of achievement:

P16 "Aye you get something that's good, it makes you feel good when you make something and it's alright to look at you know what I'm saying. When you're depressed it's good to know you've got some use."

For some of the participants who had been at the projects for a longer length of time, this feeling of achievement had begun to have a positive impact on confidence levels that had previously been shaken by mental illness. This was reinforced by further successes and began to generalise to other aspects of participants' lives:

P2: "You know you see yourself sorta doing small things mechanically, then you think to yourself well if I can do that, something I thought that I would never be able to do and then when I did do it, it was such an achievement, and then I started to think, well if I can do that maybe I can do other things in my life, whether it be think about decorating my flat, just try to improve maybe the way I dress, or improve as I said my food"

For the following participant, the confidence imparted by his work at the project seems to allow him to begin to address ongoing difficulties by focussing on his objects of interest instead of his fears. Despite setbacks, he remains positive about his progress:

P6: "... well what it's done is, because of my involvement here, I've then went onto the internet and looked about and thought right, I'm frightened of people, let's see what I can do about being frightened of people and we deal here with

old bicycles, and I put the two things together, people and old bicycles and ah, bicycle sales. And I looked up police auctions and I found out, I searched out where the police auctions are, that sell the old bicycles. Now I'm scared of big crowds, just absolutely terrified, so what I did was, I got a friend, and got him interested in it too, and him and I went and searched this place out, so now we go once every 10 weeks and we go a big giant run on the train... and then we go to the, the old thing, and there's an auctioneer doing the thing, which these are quite charged situations, and most of the time I feel generally alright because I focus on the bicycles, I don't focus on the people. And now I've actually done it where I've went by myself when my friend can't go. And I've had my setbacks, I've had my wee setbacks and sometimes I go, and my head just gets so I can't do it and I come back out but every move I make towards that is a positive step."

This growth of self-confidence appeared able to happen partly because of the flexibility embedded within the structure of the projects. Participants were not put under any pressure, which meant they had time to learn at their own pace in a supportive environment. This was contrasted to mainstream work environments, which were seen as more highly pressured:

JS: "Is it different from, say if it was a job, why do you think this is a good place to come as an in-between?"
P5: "Because there's not much pressure on you here, you know, I mean you can't sit about all day, if you take your time over something it doesn't matter, you know, there's no time limit, this has to be done by... this time, you know. If you were in a workplace where time is money, you know, you have to get it done, and

you have to get it done on time and it has to be right. Here if you get it wrong you've got time to do it again, you know."

This flexibility was also reflected in the wide variety of activities that made up the work in both projects. This meant that the work could be very individual and matched to different participants' abilities, and because every skill was valued, each participant was able to feel purposeful and useful. The role of the project leader in facilitating this was also reflected on:

P2: "Everyone in here doesn't have to be top mechanics, some people cannae do certain things and that's what's great in here. It's sorta tailored to the person, it's no sorta tailored to the mechanics, it's more tailored to the person's sorta ability and sorta skill set, you know what I mean, cos some people in here are maybe more medicated in a certain way, which you're no judged about in here"

PL1: "Day to day the reason why it works is because we don't talk about it and it's a distraction activity so you come in and really you can leave what else is troubling you at the door and there'll be some problem put in front of you and you will be able to solve that. Usually, ideally. And part of my job is picking problems that I know people can solve, so you give different kinds of work to different people."

The involvement of one of the emerging social firms with additional activities such as bicycle manufacture and participation in an annual city festival also had an impact on participants of that project. It gave participants the option to get involved in activities

outside the project, which contributed to community integration and the feeling amongst participants that they were part of something dynamic:

> *JS: "So there's all these different things going on. What sort of impact would you say it has on you, as someone who comes along to the project?"*
> *P8: "Well it's like being in a growth industry, the whole design of it is, there's quite, some big ideas, you know, and you feel you're a part of something that's, ok it's no General Motors or anything but it's something that's got a bit of future in it."*

The social group

The benefits of the structured activity of the projects - having somewhere to go and something to do - were closely intertwined with the social setting of projects. As well as beginning to gain a measure of their own ability from the work of the projects, participants were able to interact with an accepting social group, which also seemed to aid recovery:

> *P12: "When you're not self confident you tend not to interact with other people too much... because it's such a small mix, the set up, then, well you don't have to but you obviously interact and obviously end up chatting about lots of... random social rubbish but it gets you talking again and that helps lift your spirits a bit and get you on the road to recovery."*

For participants who had been members of the projects for six months or more, being part of this social group with a shared activity began to build a sense of belonging, with a shared identity that was recognised and encouraged by project leaders:

> *P4: "Well I think it's, you know, we like tinkering with bikes, we like fixing bikes, and we all get on with each other, it's almost like a base, it is like a base where we belong, and that's what makes me feel good, it's whatever the conditions are like when I'm coming here, that's what makes me feel good, I'm going somewhere where I feel I belong, you know."*

> *PL1: "People are generally, we try and make them feel part of the team. And you get this identity from coming here. And you can spot our work, we've got the little dealer stickers, and that was a big morale thing. You can spot our work out in the streets."*

The sense of belonging and the supportive atmosphere of the projects were sometimes sharply contrasted to the isolation and fear participants had previously felt. The projects provided hope, and this seemed to strengthen the sense of membership and identity developed by participants:

> *P6: "It wouldnae matter what job they gave me in here, they've been so supportive. It doesnae matter whether I'm wiring up dynamo systems or making the tea or sweeping or anything, anything at all, you just feel the place and it's good to feel part of something, anything at all. Because you feel so isolated in your own life, and you just feel so not part of society outside, the traffic's all*

going, you just don't want to go out there, there's nothing out there for you, all there is is being scared so there seems no reason, so it takes a lot to get you up and get you out there, but once you find that you can get here it starts getting better almost immediately."

Participants' growing level of skill at the project tasks also meant that they could begin to contribute to the project by helping newer members. This allowed them to reflect on their own progress through the project, see the progress of others and also seemed to create a highly supportive atmosphere:

P6: "It just kind of draws you in, it's like a kind of spider's web, and then before you know where you are, you are a part of it, and then someone else will come in, and you're there already, and you know, you can identify with how they feel, and you're more than happy to help them, someone's helped you, and it's this snowball kind of effect, you know?"

The projects also had a wider social impact because of the nature of their work. Participants now had a purpose in their lives, and this gave an identity that was noticed by others in participants' immediate social circles, even if this just meant having something to talk about at a party:

P13: "It gives you more pride, as I said, being at a party, it helps because you say what you say and you don't feel really crappy afterwards, like when you go to a party and you leave early because there's nothing to talk about. I think it

does aid recovery, doing something constructive and having a sense of achievement."

The nature of the work also meant that participants were providing a service to their community, which may not always have been as welcoming to the participants, possibly due to the stigma attached to mental illness. In the following quote, the sense of having somewhere to belong seems to allow the participant to feel that he is contributing to the community in which he works:

P2: "It's the sorta, having somewhere to go, and somewhere you feel welcome, you feel like you're doing something good for the community, know what I mean, because I don't feel like I live in a community really, because I isolate and that, so this is me trying to put something back and say that I am sort of half normal and that I do want to be a part of this sorta community".

The project environment

The supportive environment of the projects seemed to be partly a result of a shared activity and an accepting social group, as described above. However, one aspect of the projects that was consistently highlighted as contributing to this environment was the balance between projects' dual roles as both workshops and therapeutic projects. There was an understanding in the projects that participants were not there to talk about their mental health problems or histories, although they were able to access support from project leaders should they wish to do so. Being able to choose to talk about issues or not

seemed to be welcomed by many participants and was contrasted with the illness-focus of mental health services:

> *JS: "I guess there's advantages and disadvantages on both sides, mental health services and projects like these, but would you say in general you've felt supported by either side, or what are the differences for you?*
> *P1: "Well when it comes to the professionals it's like well you know what's wrong with you, they know, and that's the main focus, whereas here it's like it's nice knowing that obviously I feel that if I wanted to speak to [project leader] I can go to [project leader] or anything like that but it's not, you know it's for me if it's something I want to do if I want to talk about it whereas you know sometimes you've got these appointments and you don't really feel like talking about it... "*

The focus of the projects on their activities meant that participants felt that they were part of a normal working environment that was not focussed on mental illness. Whilst mental health issues were acknowledged and accepted, they were not given any particular importance, which for some participants was fundamental in allowing the process of recovery to take place. Agreement between participants and project leaders was apparent on this point, with the project leader pointing out that fast customer service was not a priority of the projects, and necessarily so:

> *P4: "This is first and foremost a bike shop, a workshop, and you know, you come in and say yeah yeah you've got mental illness, right fix this. And it's that kind of attitude... but the fact that you've got mental health issues is definitely subsidiary*

to getting on with helping you learn new skills and that sort of thing here. And that's the key point, that's what makes, for me, coming here and this process of recovery much more possible I think."

PL1: "There's a constant tension between being a bike shop and being a therapeutic project. And you have to balance it out. And the way that usually happens is the customer has to wait. But because we have that tension, it keeps us aware of what we're doing, and that's really quite important. You've just got to think, what's happening here."

Whilst the social group and shared activity contributed to this supportive project environment, the attitudes of the project leaders were felt to be fundamental in maintaining this environment.

Project leaders

The project leaders appeared to be instrumental in creating an atmosphere of acceptance and inclusion. Participants felt that this was partly because of their patience in teaching the skills needed for the project activities, allowing participants to make mistakes and learn at their own pace:

P1: "... and again just the way [project leader] kinda uses words he'll tell you if you're not doing something right but he'll give you that extra bit of confidence that'll show you that you can, you know that way where you can do it but you're just not doing it."

The enthusiasm and expertise of project leaders regarding the particular activities carried out seemed to be contagious to participants. The knowledge and skills that participants were developing were seen by some as providing opportunities for future careers, particularly for participants that had a specific interest in the area:

> *P7: "I'd always wanted to work with bikes as I say, as a full time gig, and I thought this would be a good opportunity to try and get my foot in the door you know, and as I say [project leader], he really knows his stuff, so I'm learning from a maestro you know.... So I'm seeing this, as I say as a step to getting back into work"*

The atmosphere of acceptance also seemed to be facilitated by the inclusive ethos of the project, again reinforced by project leaders who include participants in day-to-day decision making of projects:

> *P6: "You're included. They include you, in if you like the running of the place, well not so much the running, but in the day to day things, maybe they're getting in new tools, well we're going to get this tool, and they actually include you, and speak to you, which is really really nice, and you know... "*
> *JS: " So it's quite sort of equal?"*
> *P6: "Yeah, aye. You don't feel as if you've done anything to deserve this – there's no many situations where you come across that, but that's very much, it's a very inclusive thing – you're very much included in what's going on."*

This equality between participants and project leaders seemed to provide a way of interacting with others based on respect and honesty which was then modelled by project members. This was fundamental in providing a foundation on which the positive impact of the activity could take place:

> *P4: "It's like, [project leaders] don't sort of, they've never ever looked down their noses in any sort of way, you know, consciously or unconsciously patronised us, they treat us as equals. And because they treat you like that, and they treat everyone like that, and we all treat each other like that, you forget about the fact that those mental health problems were ever there, and you can come here and spend an entire day and not think about at all the fact that you have any of these problems. And it sort of sets you free to focus on, also focus on the learning, the new skills and fixing bikes and all of that."*

Project leaders recognised the equality of their standing with participants as part of the project's philosophy. This created an atmosphere that valued each individual's contribution to the projects as part of a team that was able to work together in creating a positive impact within and outside the project boundaries:

> *PL2: "Part of this vision I think which secures the camaraderie between clients and staff is that I'm not really aware of a division between clients and staff. We all kind of knit together, doing something that's good for the environment, good for people, good for society, good for the community, and it's that feeling of bringing things together, bringing good things together, bringing people together."*

The enthusiasm of project leaders for their work was also apparent, and there was a sense of balancing the structure and predictability of projects with new challenges in order to allow participants to continue to learn and progress:

> *PL1: "Essentially it's, what we're doing is fun. And it is tremendous fun what we do. Mainly because [project leader] and I have a bit of day-to-day autonomy in the workshop, so you've got that level of control. And we try and give the clients a modicum of control, you know, we might offer a choice of jobs, you know? But it's also quite exciting for them to come in and not know exactly what's going to happen, you don't know what's going to happen from day to day, although you've got a pretty good idea."*

The emerging social firm: an environment of recovery

Whilst participants were not all clear on the meaning of recovery when asked directly, their experiences of the emerging social firms seemed to describe a process of recovery, in which participants drew on different aspects of the project depending on their immediate needs. The flexibility embedded within the projects meant that participants could use activity to distract from ongoing symptoms or problems; find belonging amongst an accepting social group respectful of individual difference and ability; experience success and an accumulation of achievements; and develop their skills further in helping other participants, thus consolidating a more positive sense of themselves as competent, accepted and able. The type of work done by the projects also meant that participants could contribute to the wider community by serving customers and

participating in community events, promoting integration into the community. These qualities of the emerging social firms seemed to interact in such a way that recovery occurred almost as a by-product of involvement in the projects:

> *P6: "The course helps, it lets you sorta reassemble your life, and it lets you see that you can do things, maybe not the same things you done before, but you feel useful to yourself, you feel as though you can do things. Even just to sit and be part of something."*

The idea of the emerging social firms providing an 'environment of recovery' is illustrated in figure 1 below:

Insert figure 1 about here

Participants were able to move between the interacting facets of the projects as they moved through a shifting process of recovery, facilitating a more positive sense of self and an identity beyond mental illness. The flexibility of the projects also allowed for the possibility of relapse, and participants could draw on different levels of activity and support depending on their particular needs at different times.

Discussion

It is now widely accepted that recovery from mental illness is possible. Long-term studies looking at outcomes amongst people with chronic mental illnesses have demonstrated

significant improvement in over half of all people followed up (Harding et al, 1987; Harrison et al, 2001). However, the participants in the present study seemed to have contrasting views of recovery. If recovery was understood as a 'cure', symptom cessation, or a return to 'normal', participants seemed to feel that this was beyond reach and that recovery was not possible for them. However, the definitions of recovery described by Andresen et al (2003) and Anthony (1993) seemed closer to participants' accounts of coping with ongoing symptoms and developing goals in life despite these symptoms.

The flexibility of the emerging social firms supported a dynamic process of recovery in which the activity and interpersonal environment influenced participants in different ways depending on their individual needs and stages of recovery. This is consistent with other qualitative studies of the relationship between work and recovery, reviewed in chapter 2, where work, or purposeful activity, provides an opportunity to experience success and facilitates a shift towards a more positive self-concept (Strong, 1997; Provencher et al, 2002).

The emerging social firms supported this process by providing an environment which saw participants as more than just their mental illness, and gave opportunities for them to belong, succeed and develop, creating a more hopeful future. Hope and a sense of belonging have been described as the first essential components required to allow people with schizophrenia to move outside their illness (Davidson, 2003) and develop a 'non-illness identity' (Strong, 1997). This echoes elements of attachment theory, where the

project environments acted as a 'secure base' (Ainsworth et al, 1978) from which individual participants could feel safe, and begin to explore and develop. The concept of reflective functioning suggests that individuals need to be 'held in mind' in order to develop an integrated and secure sense of self (Fonagy et al, 2004). Within the emerging social firms, participants seemed to be 'held' by the interpersonal environment and purposeful activity, facilitating this shift in identity.

Purposeful activity in a non-pressured environment appeared to continue this shift in identity by providing clear evidence of participants' abilities. The tangible sense of achievement described by participants consolidated their identity as able, competent members of a group with a shared purpose. Again, this is consistent with other qualitative studies (see chapter 2) and with Davidson's (2003) model of recovery from schizophrenia, where accumulative successes and pleasure enhance a sense of personal agency and belonging. This then leads to active efforts to cope, reflected in the generalisation of participants' successes to other areas of their lives (see quote p105, this chapter). The importance of helping others was also highlighted by participants in the present study, which reflects studies of affirmative businesses in which participants provide a service to other people with mental illness, or to their community (e.g. Krupa et al, 2003). Krupa et al (2003) describe how participants value their work as a way of developing social skills in a comfortable setting. Providing opportunities for participants to become contributing members of society not only influences their self-worth, but also promotes social inclusion and community integration (Davidson et al, 2001).

Due to the methodology used in the present study, participants' views must be limited to the context and conditions of the study (Hutchinson, 1993) and are understood as one possible interpretation of the data. However, there is now a persuasive body of qualitative literature promoting the therapeutic value of meaningful activity in environments such as those described in this study. There is room for further empirical research in this area. Goodwin (2003) described the implications of attachment theory for adult mental health services, but this may also be applied to settings such as the emerging social firms in this study. The impact of established social firms on recovery should also be explored, as different influences in such settings may come to bear on participants' experiences.

The importance of developing the 'environments of recovery' described in this study is captured in the move towards 'recovery-oriented services', driven by service and policy developments (Department of Health, 2001; Scottish Executive, 2003). The aim is to shift services away from the 'illness-focus' commented on by participants, and towards aspects of self-management, flexibility, valuing diversity and developing a common language between professionals and patients (Roberts & Wolfson, 2004). These changes are also being felt outside the sphere of statutory mental health services. The far-reaching influence of the 'recovery movement' is reflected in the recent calls for mental health and wellbeing to be placed on employment and education agendas (Sainsbury Centre for Mental Health, 2006). The prominence of user led research in promoting these changes is striking and personal experiences of recovery from mental illness continue to deepen our understanding of this process. Many of these narratives resonate with the findings from

the present study, providing further validation of these views (e.g. Scottish Recovery Network, 2006).

The recent report by Layard (2004) recognised the value of work for mental health and suggested that people with mental illness should be supported in returning to work. However, the barriers to mainstream work have been discussed, and it is likely that specialist services will be required to provide a bridge to employment, or as employment in themselves. The views of participants and project leaders in the present study suggest that social firms could have a valuable role to play as therapeutic work settings creating environments which facilitate recovery:

> *PL2: "Some of them have expressed that idea very eloquently, we have some people who come to this project who are very articulate. [project member] expressed the idea very powerfully to me once when I was doing interviews before you came along, and he put it so well, he thought that the way bikes are put together, recycled bikes from waste materials was a metaphor for the way people come through the project, people who are kind of wasted by society are brought back on line, reintegrated back into doing something meaningful and useful. Just like materials are discarded, people are discarded. And people go from that state into a state of feeling meaningful and purposeful in life again. It's a really powerful idea I think."*

References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Andresen, R., Oades, L. & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry, 37,* 586-594.

Anthony, W.A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16,* 11-23.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: A case of the tail wagging the dog? *BMJ, 322*, 1115-1117.

Bond, G. R., Drake, R. E., Mueser, K. T., & Becker, D. R. (1997). An update on supported employment for people with severe mental illness. *Psychiatric Services, 48*(3), 335-346.

CASP (2002). © Milton Keynes Primary Care: available at: www.phru.nhs.uk/casp/critical _appraisal_tools.htm#qualitative

Charmaz, K. (2006). *Constructing Grounded Theory: a practical guide through qualitative analysis.* London: Sage Publications Ltd.

Coleman, R. (1999). *Recovery: An Alien Concept.* Handsell Publishing, Gloucester.

Crowther, R., Marshall, M., Bond. G. & Huxley, P. (2005). Vocational rehabilitation for people with severe mental illness. *The Cochrane Database of Systematic Reviews: The Cochrane Collaboration, 4.*

Davidson, L. (2003). *Living outside mental illness: qualitative studies of recovery in schizophrenia.* New York: New York University Press.

Davidson, L., Stayner, D. A., Nickou, C., Styron, T. H., Rowe, M. & Chinman, M. L. (2001). "Simply to be let in": inclusion as a basis for recovery. *Psychiatric Rehabilitation Journal, 24(4),* 375-388.

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal, 19(3),* 91-97.

Department of Health. (2001). *The Journey to Recovery – The Government's Vision for Mental Health Care.* London: Department of Health.

Dey, I. (1999). *Grounding grounded theory.* San Diego: Academic Press.

Elliott, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229.

Fonagy, P., Gergely, G., Jurist, E. L. & Target, M. (2004). Attachment and reflective function: their role in self-organisation. In P. Fonagy, G. Gergely, E. L. Jurist & M. Target, *Affect regulation, mentalization, and the development of the self* (pp23-64). London: H. Karnac (Books) Ltd.

Frese, F. J. & Davis, W. W. (1997). The consumer-survivor movement, recovery, and consumer professionals. *Professional Psychology: Research and Practice, 28(3),* 243-245.

Glaser, B. G. & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies in qualitative research.* Chicago: Aldine.

Goodwin, I. (2003). The relevance of attachment theory to the philosophy, organisation, and practice of adult mental health care. *Clinical Psychology Review, 23,* 35-56.

Harding, C.M., Brooks, G.W., Ashikaga, T., Strauss, J.S. & Breier, A. (1987). The Vermont longitudinal study of persons with severe mental illness I: Methodology, study sample and overall status 32 years later. *American Journal of Psychiatry,* **144,** pp718-726.

Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., Dube, K.C., Ganev, K., Giel, R. an der Heiden, W., Holmberg, S.K., Janca, A., Lee, P.W., Leon, C.A., Malhotra, S., Marsella, A.J., Nakane, Y., Sartorius, N., Shen, Y., Skoda, C., Thara, R., Tsirkin, S.J., Varma, V.K., Walsh, D. & Wiersma, D. (2001). Recovery from psychotic illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry,* **178,** pp506-517.

Henry, A. D. & Lucca, A. M. (2004). Facilitators and barriers to employment: The perspectives of people with psychiatric disabilities and employment service providers. *Work, 22,* 169-182.

Hutchinson, S. A. (1993). Grounded theory: the method. In P. L. Munhall & C. A. Boyd (Eds.), *Nursing research: a qualitative perspective, 2nd Ed.* (pp180-212). New York: National League for Nursing Press.

Kelly, M. & Gamble, C. (2005). Exploring the concept of recovery in schizophrenia. *Journal of Psychiatric & Mental Health Nursing. 12(2),* 245-251.

Killeen, M. B. & O'Day, B. L. (2004). Challenging expectations: How individuals with psychiatric disabilities find and keep work. *Psychiatric Rehabilitation Journal, 28(2),* 157-163.

Krupa, T., Lagarde, M. & Carmichael, K. (2003). Transforming sheltered workshops into affirmative businesses: An outcome evaluation. *Psychiatric Rehabilitation Journal, 26(4),* 359-367.

Layard, R. (2004). *Mental health: Britain's biggest social problem?* Available at www.strategy.gov.uk/downloads/files/mh_layard.pdf

Leete, E. (1992). The stigmatized patient. In P. J. Fink & A. Tasman (Eds.), *Stigma and Mental Illness.* Washington, DC: American Psychiatric Press.

Lehman, A. F. (1995). Vocational rehabilitation in schizophrenia. *Schizophr Bull, 21*(4), 645-656.

McDermid, L. (2005). *Bridging the gap: A discussion paper for reforming welfare to work in the UK.* Social Firms Scotland. Available at www.socialfirms.org.uk

McKeown, K., O'Brien, T. J. & Fitzgerald, G. (1992). *The European project on mental health in Ireland 1989-1991: An evaluation.* Dublin, Irish Social Firm Initiative.

Noordsy, D., Torrey, W., Mueser, K., Mead, S., O'Keefe, C. & Fox, L. (2002). Recovery from severe mental illness: An interpersonal and functional outcome definition. *International Review of Psychiatry, 14(4),* 318-326.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park, CA: Sage Publications, Inc

Provencher, H. L., Gregg, R., Mead, S., & Mueser, K. T. (2002). The role of work in the recovery of persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 262),* 132-144.

Reveiro, K. L. (1999). The labyrinth of community mental health: In search of meaningful occupation. *Psychiatric Rehabilitation Journal, 23(2),* 143-153

Repper, J. (2000). Adjusting the focus of mental health nursing: Incorporating service users' experiences of recovery. *Journal of Mental Health, 9(6),* 575-587.

Ridgway, P. (2001). Restorying psychiatric disability: learning from first person recovery narratives. *Psychiatric Rehabilitation Journal, 24(4),* 335-343.

Roberts, G. & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in psychiatric treatment, 10(1),* 37-48.

Sainsbury Centre for Mental Health. (2006). *The future of mental health: a vision for 2015.* London: The Sainsbury Centre for Mental Health.

Savio, M. & Righetti, A. (1993). Cooperatives as a social enterprise in Italy: A place for social integration and rehabilitation. *Acta Psychiatrica Scandinavica. 88(4),* 238-242.

Schneider, J. (1998a). Work interventions in mental health care: Some arguments and recent evidence. *Journal of Mental Health, 7(1),* 81-95.

Schneider, J. (1998b). Models of specialist employment for people with mental health problems. *Health & Social Care in the Community, 6(2),* 120-129.

Scottish Executive (2003). *National Programme for Improving Mental Health and Well-being Action Plan 2003-2006.* Available at www.scotland.gov.uk/Publications.

Scottish Recovery Network. (2006). *Journeys of Recovery: Stories of hope and recovery from long term mental health problems.* Glasgow: Scottish Recovery Network. See also www.scottishrecovery.net

Secker, J., Dass, S. & Grove, B. (2003). Developing social firms in the UK: a contribution to identifying good practice. *Disability & Society, 18(5),* 659-674.

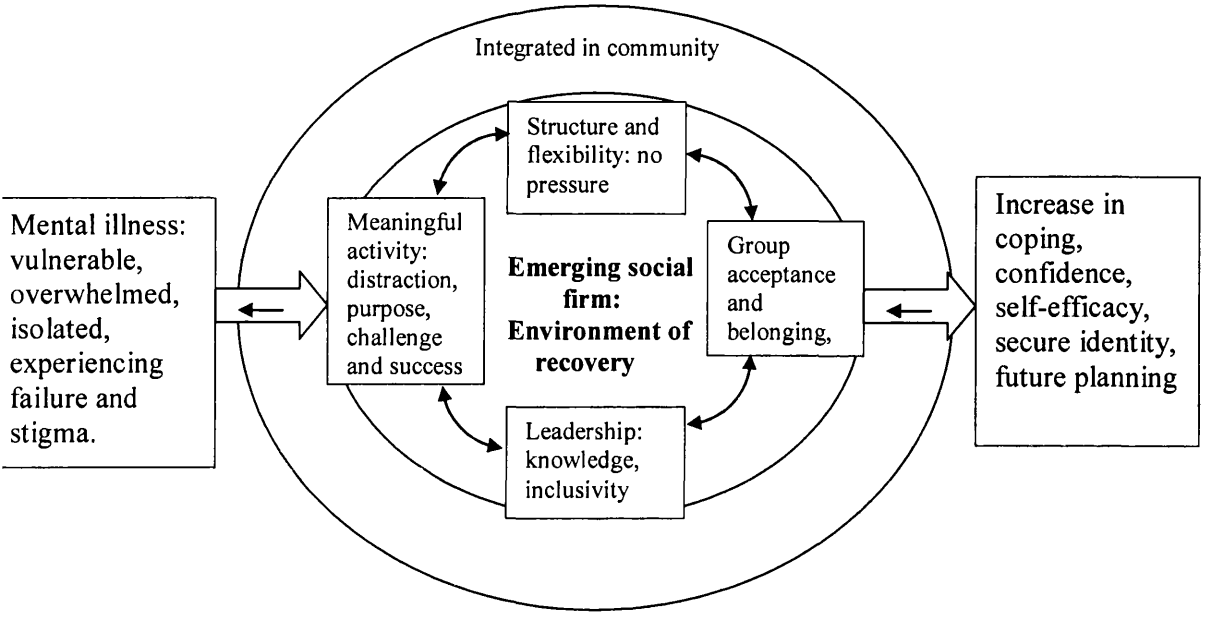
Seebohm, P. & Scott, J. (2004). *Addressing disincentives to work associated with the welfare benefits system in the UK and abroad.* London: The Social Enterprise Partnership.

Social Firms UK. (2001). *Understanding the social firm model.* Redhill, Social Firms UK.

Strong, S. (1998). Meaningful work in supportive environments: Experiences with the recovery process. *American Journal of Occupational Therapy, 52(1),* 31-38.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health, 15,* 215-229.

Figure 1: Emerging social firms as environments promoting recovery



Chapter 5

Single case research study

Functional Analysis of Challenging Verbal Behaviour in a Client with Severe Traumatic Brain Injury

RESEARCH ABSTRACT

Full study bound separately (see Part Two)

Jenny Svanberg*

University of Glasgow

Section of Psychological Medicine, Gartnavel Royal Hospital

1055 Great Western Road, Glasgow G12 0XH

Tel: 0141 211 3920

Fax: 0141 357 4899

jennysvanberg@yahoo.co.uk

*author for correspondence

Prepared in accordance with requirements for submission to Brain Injury (Appendix 5)

Abstract

A comprehensive functional analysis is reported which aimed to clarify the factors influencing and maintaining challenging verbal behaviour in a client with very severe traumatic brain injury and paraplegia. It was hypothesised that increasing the frequency of positive interactions with different staff groups would result in a lower frequency of challenging verbal behaviour in sessions with those staff groups, and that a higher density of positive interactions would alter staff attributions of the participant's behaviour, assessed using the Challenging Behaviour Attributions Scale (CHABA). The functional analysis informed a systemic intervention which used verbal and written feedback and recommendations to staff to influence the participant's interpersonal environment. The frequency of challenging verbal behaviour was found to be significantly lower in situations involving a higher frequency of positive interaction, and increasing opportunities for these interactions reduced the participant's frequency of challenging verbal behaviour. Following intervention, there was some change in staff attributions of the participant's behaviour towards emotional and physical causes. However, there was a high level of individual variance in staff attributions. The clinical implications are discussed, with the recommendation that particular attention may need to be paid to the interpersonal environments of participants with very severe traumatic brain injury, particularly when they may have little opportunity to make choices or control their surroundings.

APPENDICES

CONTENTS **Page**

Appendix 1

Small Scale Research Project

Appendix 1.1: Author's instructions for Clinical Psychology: Science & Practice

Clinical Psychology: Science and Practice

Published on behalf of the Society of Clinical Psychology, Division 12 of the American Psychological Association

Edited by:
Philip C. Kendall

Author Guidelines

Clinical Psychology: Science and Practice follows publication policies and ethical principles of the American Psychological Association (APA). Authors are assumed to be familiar with and are responsible for adherence to the policy. Among the tenets, the policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications or from publishing any manuscript that has already been published in whole or substantial part elsewhere. Authors are obligated to consult journal editors concerning prior publication of any material upon which their article depends.

Although the vast majority of papers will be review and discussion articles, occasionally papers representing programs of research or papers drawing on such research will be published. Compliance with APA ethical standards in the treatment and protection of the sample as elaborated in the APA Ethical Principles is expected by the journal.

Manuscript Format
Manuscripts are to be prepared in accordance with the *Publication Manual of the American Psychological Association* (5th ed.). Typing instructions (all copy must be double-spaced) and instructions for preparing tables, figures, references, metrics, and abstracts appear in the manual. Manuscripts of regular articles are to be accompanied by an abstract containing a maximum of 960 characters and spaces (which is approximately 120 words), followed by three to six key words. Abstracts, tables, and figure captions should be typed on separate pages, and manuscript pages for any tables or figure captions should be placed at the end of the manuscript for production purposes.

Submitting Manuscripts
Manuscripts are to be submitted in quadruplicate to:

Philip C. Kendall, PhD, ABPP
Clinical Psychology: Science and Practice
Program in Clinical Psychology
Temple University - Weiss Hall

1701 N. 13th St.
Philadelphia, PA 19122-6085
USA

All copies should be clear, readable, and on paper of good quality. The title page should contain the names and affiliations of all authors, as well as the corresponding author's name, address, and phone, fax, and e-mail numbers for use by the editorial office and the publisher. Authors have the option to consider their manuscript under anonymous review. This option, if elected by the author, should be specified in the submission letter, and the identity of the authors should be removed from the manuscript to permit this review process. The manuscript will be returned to the author in cases where the request for anonymous review has been made but the manuscript is not prepared accordingly. In all cases, authors retain a copy of the submitted manuscript to guard against loss.

Appendix 2

Systematic Review

Appendix 2.1: Author's instructions for the Journal of Mental Health

Instructions for Authors:

Click here to check the status of your accepted article

Further information about the journal including links to the online sample copy and contents pages can be found on the **journal homepage**.

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form. See the **Evaluation Criteria of Qualitative Research Papers** and the **editorial policy document** for more details.

Submissions. All submissions, including book reviews, should be made online at Journal of Mental Health's **Manuscript Central site**. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. **Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting.** Authors will be asked to add this information in section 4 of the on-line submission process.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to **Martin Guha**, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should

acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords. Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. Manuscripts should not exceed 6,000 words unless previously agreed with the editor. Language should be in the style of the APA (see *Publication Manual of the American Psychological Association* , Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned *Publication Manual of the American Psychological Association* , and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes *et al* ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of *all* authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should *not* be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging, 18* , 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management* . London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should *not* be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should *not* be used.

Accepted papers. If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased at the author's preferential rate of £15.00/$25.00 per copy.

Copyright. It is a condition of publication that authors transfer copyright of their articles, including abstracts, to Shadowfax Publishing and Taylor & Francis Ltd. Transfer of copyright enables the publishers to ensure full copyright protection and to disseminate the article and journal to the widest possible readership in print and electronic forms. Authors may, of course, use their article and abstract elsewhere after publication providing that prior permission is obtained from Taylor and Francis Ltd. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.

Appendix 2.2: Guide for Appraisal of Qualitative Research Papers

The wide variety in qualitative methodologies has led to differences in the demonstrations of rigour within qualitative research. This guide is therefore intended to be a flexible, non-prescriptive method to facilitate the appraisal of qualitative studies. As highlighted by Barbour (2001), there can be no formulaic criteria to mark qualitative research against, and such "technical fixes" do not confer rigour automatically. As such, examples of 'how' a study has demonstrated a methodological technique is of more value than the mention of the technique alone.

Title of paper under review:

Research design

- Is the method appropriate to the research question, and has this been justified (CASP, 2002)?
- Has knowledge of the philosophical background of the method been demonstrated (Yardley, 2000)?

Sensitivity to Context

1. **Relevant literature, empirical data:**
   - Has immersion in the relevant literature been demonstrated (Yardley, 2000) ?
   - How have themes been abstracted or linked to the work of others (Yardley, 2000) ?

2. **Sampling:**
   - How was the original sample selected? Was this strategy appropriate to the study aims? (CASP, 2002).
   - Is there evidence of purposive sampling (Barbour, 2001)? (Also see data analysis section)
   - Is theoretical sampling used to challenge or extend emerging themes?

3. **Sociocultural setting:**
   - How has awareness of normative/ideological/historical/linguistic/socio-economic influences on partipants' beliefs and expectations been demonstrated (Yardley, 2000)?

4. **Perspectives of participants:**
   - How have differing perspectives been sought and incorporated?

Ethical issues:

- Are there sufficient details to ascertain how the research was explained to participants?
- Have issues around informed consent and confidentiality been addressed?
- Has approval been sought from an ethics committee (CASP, 2002)?

Commitment and Rigour

5. **Commitment:**
   - Is there evidence of an in-depth engagement with the topic, with demonstration of competence and skill in the chosen method (Yardley, 2000)?

6. **Data collection:**
   - Are methods of data collection justified in terms of the methodology (CASP, 2002)?
   - Is the data collection complete (Yardley, 2000)? E.g. is there a demonstration of data saturation (grounded theory)?
   - Has data triangulation been used to broaden the perspectives obtained or refine any emerging theory, e.g. data gathering from various sources by various methods? (Barbour, 2001; Mays & Pope, 1995)
   - Were interviews transcribed

7. **Data analysis:**
   - Is analysis appropriate to the method used?
   - Have negative cases or conflicting themes been demonstrably sought and presented?
   - Does analysis feed back into further theoretical sampling where appropriate?

8. **Validation**
   - Where appropriate, have emergent themes been checked with participants (respondent validation) in a sensitive way (Barbour, 2001)?
   - Has multiple coding with independent researchers been used to refine coding strategies and data interpretation (Barbour, 2001)?

Transparency and Coherence

9. Data collection and analysis

- Have methods of data collection been made explicit, including the form(s) of data (CASP, 2002)?
- Has the process of analysis been made explicit (CASP, 2002)?
- Are coding frameworks discussed, and does presented data illustrate the analysis (Elliott et al, 1999)?

10. Reflexivity

- How has the social context of the relationship between investigator and participants been considered and incorporated into the study design (Yardley, 2000)? i.e. has the researcher examined and disclosed their own role, potential bias and influence during design, data collection (CASP, 2002) and coding?
- Have memos or reflexive diaries been used/have these informed coding of data?

11. Clarity:

- Has a coherent and integrated narrative been produced, reflecting the nuances of the data (Elliott et al, 1999)?

Impact and Importance

12. Theoretical importance:

- Has a theory emerged from the data (grounded theory)?
- Has the work produced a novel insight or perspective into the area?
- Are findings discussed in relation to existing research (CASP, 2002)?
- Are future directions for work considered?

13. Sociocultural impact:

- Have wider socio-cultural or political implications been considered (Yardley, 2000)?

14. Research-Practice links:

- Is there evidence of an impact on the community for which the research was intended?

Overall impresssion of paper/any further comments

References

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *British Medical Journal,* **322,** pp1115-7.

CASP (2002). © Milton Keynes Primary Care: www.phru.nhs.uk/casp/critical _appraisal_tools.htm#qualitative

Elliott, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology,* **38,** pp215-229.

Mays, N. & Pope, C. (1995). Rigour and qualitative research. *British Medical Journal,* **311,** pp109-112.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health,* **15,** pp215-229.

Appendix 3

Major Research Project Proposal

Appendix 3.1: Participant information sheet

How Does Your Work Help Recovery?

UNIVERSITY *of* GLASGOW

You are being invited to take part in a research study. Before you decide whether or not to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information.

Recently, there has been a lot of research looking at how people recover from things like being very distressed, or having a mental health problem. There are different views about what helps people recover. Some research concludes that recovery is a process helped by things like support from friends and family, work and taking responsibility. Other research sees other things as more important in recovery, such as support from health or mental health services, or medication.

Research has started to look at the experiences of people who are recovering or have recovered from mental health problems to find out what helped them. This is important because it means that better services can be developed, and that peoples' experiences are valued.

Aim of study: This study aims to explore how work helps recovery by exploring the experiences of people working in organisations such as this one. It aims to find out about what people think is important in recovery and seeks to respect each person's experience.

Why have I been chosen?: Everyone working in this project, and other similar projects around Glasgow, is being invited to take part in this study.

It is up to you to decide whether or not to take part. If you decide to take part now you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your work or the standard of care you may be receiving.

What will I have to do? If you take part, you will meet with the researcher on one or two occasions. These meetings will probably take one to one and a half hours. The number and length of meetings depends on how you find the interview, and will be flexible. If

you have any questions or concerns, the researcher vill answer them at the first meeting. The researcher will ask you if the meetings can be recorded, but you are free to stop the recording at any time during the meetings.

In the meetings, you will be asked a bit about what you think recovery is. You will also be asked about your own experiences and your worl in this project. The research hopes to find
out about what you think helps people recover, fromyour own experience, and sees you as the expert. There are no right or wrong answers, the research just wants to find out about what you think.

All information that you give will be kept strictly confidential. Any written information about you will have your name and address removec so that you cannot be recognised.

By collecting information in this way, the research hopes to understand what helps people recover, and design services that will include the views that come out of the research. Towards the end of the study, in April-May 2006, meetings will be held to give you information about the results of the study and make sure your views have been understood. The final results and conclusions of the study will be published in a scientific journal and will form part of the researcher's Doctorate qualification in Clinical Psychology. All identifying information of people participating in the study will be removed from any publications.

The possible disadvantages of the study are that meetings will take up some of your time, and might cover things that you find difficult to talk about. However, you will be able to end the interview at any time.

If you would like any more information, please contact the researcher, Jenny Svanberg, on 0141 2110607 or email recoveryproject05@yahoo.co.uk

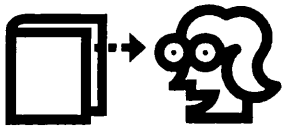
Thank you very much for reading this!

Appendix 3.2: Poster for projects involved

How Do You Think Work Helps People Recover?

A research study to find out what you think helps people recover from distress or mental illness

The study will involve meeting with a researcher to talk about what you think helps people recover, or what prevents people from recovering.



If you would like more information about the study please take an information sheet.

You can also contact the researcher, Jenny Svanberg, on 0141 2110607, or email recoveryproject05@yahoo.co.uk

Appendix 3.3: Participant consent form

UNIVERSITY
of
GLASGOW

CONSENT FORM

How Does Work Help Recovery?

Please tick box

1. I confirm that I have been given an information sheet about the study and have had the opportunity to ask questions. ☐
2. I know that I don't have to take part in the study, and if I don't take part it won't affect my support or work in any way. ☐
3. I understand that the interview with the researcher will be recorded. ☐
4. I agree to take part in the above study. ☐

Name	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

One copy of this form will be left with you and one with the researcher.
Researcher: Jenny Svanberg, Trainee Clinical Psychologist

Appendix 4

Major Research Project Paper

Appendix 4.1: Letter of approval from NHS Greater Glasgow Primary Care Division Local Research Ethics Committee

rimary Care Division

Divisional Headquarters
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW G12 0XH
Telephone 0141 211 3600
www.nhsgg.org.uk

NHS
Greater Glasgow

Miss Jenny Svanberg
Trainee Clinical Psychologist
Department of Psychological Medicine
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Date 12 December 2005
Your Ref
Our Ref

Direct line 0141 211 3824
Fax 0141 211 3814
E-mail anne.mcmahon@gartnavel.glacomen.scot.nhs.uk

Dear Miss Svanberg

Full title of study: **How do Social Firms Contribute to Recovery from Mental Illness? A Qualitative Study**

REC reference number: **05/S0701/129**

Thank you for your letter of 21 November 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Committee held on 08 December 2005. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

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:

Document	*Version*	*Date*

Application	ONE	26 October 2005
Application	Part A - Version 2	21 November 2005
Investigator CV	js	26 October 2005
Investigator CV	ag	26 October 2005
Protocol	ONE	26 October 2005
Interview Schedules/Topic Guides	one	20 October 2005
Advertsement	one	20 October 2005
Participant Information Sheet	ONE	20 October 2005
Participant Information Sheet		21 November 2005
Participant Consent Form	one	20 October 2005
Response to Request for Further Information		21 November 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.

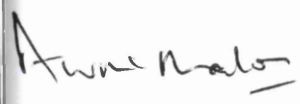
Statement of compliance

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/S0701/129	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely



A W McMahon
Research Ethics Co-ordinator (Manager) on behalf of Dr Paul Fleming, Chair

Email: Anne.McMahon@gartnavel.glacomen.scot.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
Standard approval conditions
Site approval form

NHS
Greater
Glasgow

RESEARCH ETHICS COMMITTEE

Meeting held on: **8 December 2005**

Boardroom
Division Headquarters
Gartnavel Royal Hospital
1055 Gt Western Road
Glasgow
G12 0XH

Committee Members present:

Dr Paul Fleming	Consultant Clinical Psychologist (Chair)
Dr Jacqui Anderson	Consultant Psychiatrist
Dr Susan Carr	Consultant Family Planning & sexual Health
Mr Martin Hattie	Senior Clinical Nurse Specialist
Mr Cameron Langlands	Lay Member
Ms Gillian Notman	Head of Profession (AHPs)
Dr David Watt	Consultant in Occupational Health

Comments Received - Mr Philip Dolan

NHS Greater Glasgow Primary Care Division (Community & Mental Health)

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	05/S0701/129	**Issue number:**	1	**Date of issue:**	12 December 2005
Chief Investigator:	Miss Jenny Svanberg				
Full title of study:	How do Social Firms Contribute to Recovery from Mental Illness? A Qualitative Study				

This study was given a favourable ethical opinion by NHS Greater Glasgow Primary Care Division (Community & Mental Health) on 08 December 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

05/S0701/129

Principal Investigator	*Post*	*Research site*	*Site assessor*	*Date of favourable opinion for this site*	*Notes* [1]
Miss Jenny Svanberg	Trainee Clinical Psychologist	The four social firms: Commonwheel, Boomerang, Coach House Trust, Galgael in Glasgow	NHS Greater Glasgow Primary Care Division (Community & Mental Health)	12/12/2005	

Approved by the Chair on behalf of the REC:

..... (Signature of Chair/Administrator)
(delete as applicable)

..... (Name)

Appendix 4.2: Research and Development letter of approval

Primary Care Division

Research & Development Directorate

Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
Tel: 0141 211 3600
www.nhsgg.org.uk

NHS
Greater Glasgow

Miss Jenny Svanberg
Trainee Clinical Psychologist
Department of Psychological Medicine
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Date	15 December 2005
Your Ref	
Our Ref	BR/AW/approve
Direct Line	0141 211 3661
Fax	0141 211 3814
Email	annette.watt@gartnavel.glacomen.scot.nhs.uk

Dear Miss Svanberg

Project Reference Number: 05CP24
Project Title: How do Social Firms Contribute to Recovery from Mental Illness? A Qualitative Study

Thank you for completing the Research & Development (R&D) Management Approval Application for the above study. I am pleased to inform you that R&D management approval has been granted by Greater Glasgow Primary Care Division subject to the following requirements:

- You should notify me of any changes to the original submission and send regular, brief, interim reports including recruitment numbers where applicable.
- Your research must be conducted in accordance with the National Research Governance standards. (see CSO website: www.show.scot.nhs.uk/cso)
  Local Research Governance monitoring requirements are presently being developed. This may involve audit of your research at some time in the future.
- You must comply with any regulations regarding data handling (Data Protection Act).
- Brief details of your study will be entered on the National Research Register (NRR). You will be notified prior to the next submission date and asked to check the details being submitted.
- A final report, with an abstract which can be disseminated widely within the NHS, should be submitted when the project has been completed.

Do not hesitate to contact the R & D office if you need any assistance.

Thank you again for your co-operation.

Yours sincerely

Brian Rae
Research Manager

Appendix 4.3: Sample of coding from interview transcript

JS: Um, so, in terms of recovery, it is thinking about whatever you think of when I say recovery, so what does it mean to you?

P8: Well, [laughs] it's hard to put....right **[difficult to answer]**. I wouldnae say I'm actually recovery from my illness **[recovery: not in recovery]**, but what is happening here is that I'm getting a bit of therapeutic value **[project: therapeutic]** inasmuch as I've got something one day every week I come here and I've got something to do **[project activity: having something to do]**, and at the end of the day I've done something you can say I've built a bike up or I've built wheels up or whatever, you know at the end of the day you've done a task **[visible achievement, having done something]**. And although you're no getting paid for it you get a bit of satisfaction out of doing that **[satisfaction of doing]**.

You're also getting satisfaction when a customer comes in and picks up one of these bikes that you've fixed or the other guys have fixed and you see them going away quite happy with it **[help to others: customers]**. And we've had very few returns. [project leader] was actually talking about one today that came back but it's very seldom that you get one back **[not often returned: implication of quality of work]**. But as far as the working conditions nobody's putting you under pressure in here, you can have a break whenever you feel like it, eh, the only pressure you're under's your own pressure **[not under pressure]**, [project leader]'ll just make sure there's always something in front of you **[always something to do]**.