An exploration into how forensic mental health service-users experience work.

Submitted for the Degree of Doctor of Professional Practice

At the University of Northampton

2022

Joshua Jesudunsin Ige

Abstract

Introduction: The aim of this study was to understand the lived experience of mental health service-users based in secure mental health hospitals who were involved in paid or voluntary work. A review of the existing literature discovered that there was a lack of evidence about this group of service-users compared to those living in the community.

Methodology: A descriptive phenomenological framework was employed to ensure that the perspectives of the participants were reflected without the intrusion of the preconceived ideas of the researcher.

Sample: A purposive sample of seven mental health service-users was recruited from a mental health hospital in the United Kingdom.

Methods: Data was collected using semi-structured interviews and recorded on a digital audio recorder. Colaizzi's descriptive phenomenological method was used to analyse the data collected from the semi-structured interviews. These included the following seven steps: general description of the data; identifying statements that directly link to the phenomenon; creating formulated meaning; aggregating the formulated meanings into clusters; exhaustive description of the emergent themes; developing the fundamental structures; and member checking.

Findings: Three themes emerged from the analysis: work is therapeutic; occupational therapists support involvement in work; and involvement in work has challenges.

Discussion: This study identifies the phenomenon of occupational flow, which had not hitherto been represented in the existing literature. It

reveals how occupational therapy models can be used to improve the lived experience of service-users based on the three emergent themes.

Recommendations: Recommendations include ideas on how occupational therapists can support hospital-based mental health service-users to achieve occupational flow, occupational balance, and self-fulfilment at work.

Acknowledgements

To Jesus Christ, the author and finisher of my faith: I owe it all to you. You have started a good work in me, and you will be faithful to complete it.

I am grateful to my wife, Adebimpe and my daughters, Faith and Phoebe, who have provided me with moral and emotional support in my life. Even during tough times, you always give me a reason to smile.

I would like to express my sincere gratitude to my Director of Studies, Prof. Jacqueline Parkes, and my academic supervisor, Dr. Tracey Redwood, for their continuous support of my professional doctorate study. A very special gratitude for their patience, motivation and immense knowledge. Their guidance helped me in all the time of research and writing of this thesis. I could not have imagined having better advisors and mentors for my professional doctorate study.

I am extremely grateful to my parents, Professor and Mrs Ige for their love, prayers, care and sacrifices in educating and preparing me for my future. I would like to thank my brothers, Dr. John Ige, Dr. Daniel Ige and Lieutenant David Ige for supporting me spiritually throughout the writing of this thesis and my life in general.

Finally, but most importantly, I would like to thank each and every one of the participants for their contribution to this project, and for providing its building blocks. Due to the requirements of anonymity, I am unable to name anyone but would like to thank each one sincerely. Thank you also to the research and development department of my research site for giving me the approval to recruit participants for this study. I would also specially thank keyworkers who sacrificed their valuable time to support me to identify potential participants and who gave their consent for participants to engage in this study.

Table of Contents

List of Tables

Table of Figures

Terminologies

- **Forensic mental health services**: Mental health services that provide assessment and treatment of people with a mental disorder and a history of offending or those who are at a risk of offending (Colman, 2015)
- **Forensic psychiatry**: Applications of psychiatry to legal questions, such as diminished responsibility and fitness to stand trial (Colman, 2015)
- **Mental health service-user**: Mental health patient.
- **Work:** Purposeful activity directed at producing a valued good or service (Kelloway et al., 2004)
- **Lived experience**: Personal knowledge about the world gained through direct first-hand involvement in everyday events rather than through representation constructed by other people (Chandler & Munday, 2020)
- **Semi-structured interviews**: A research technique of questioning individuals in which, while there is a broad thrust to the direction of the questions, issues that arise from responses may give rise to new questions and directions of inquiry (Duignan, 2016)

Chapter One – Introduction

1.1. Introduction

Engagement in work has been established to be an effective recovery tool for those with severe and enduring mental health conditions (Grove et al., 2005; Burns et al., 2007; Beck, 2014). This arises from work's ability to occupy time, provide a sense of purpose and achievement and allow the formation of a social identity, which in turn encourages social support. There is limited evidence, however, for the effectiveness of employment programmes from the perspectives of mental health service-users who live within secure hospitals (Samele, 2018). This suggests that mental health service-users in secure hospitals are marginalised within research, which can result in the silencing of their voices and experiences. This thesis details the process and findings of a study designed to give a voice to this population in respect to their narratives of their lived experience of employment. The findings of the study provide valuable evidence of the impact of employment services within secure hospitals and this in turn allows the thesis to provide person-centred proposals to support this impact.

The study was supervised by the University of Northampton in fulfilment of a professional doctorate degree. The data collection was done through semi-structured interviews in a supported employment programme within a secure hospital in the English Midlands.

This chapter describes the background of the study, with a focus on mental illness and forensic mental illness, and on the significance of lived experience in mental health recovery and person-centred care. It describes the aim, context and outline of the thesis.

1.2. Introducing mental health conditions

Even with recent advances in psychiatry, brain imaging and medicine, the subjective experience of mental illness can only be described by individuals who have a lived experience of mental health conditions (Jones, 1997). The fifteenth century *Book of Margery Kempe* is regarded as one of the first narrative accounts in the English language of the lived experience of mental illness (Peterson, 1982). Ober (1985) described Kempe's account as comprising apparitions of evil spirits enticing her to engage in cruel deeds and to abandon her faith. During this period, mental illness was often attributed to possession by evil spirits and was treated by exorcism or other religious interventions. When these religious remedies were unsuccessful, trials and executions for heresy and witchcraft occasionally followed. By the nineteenth century, however, the understanding of mental health had progressed from a religious to a more secular perspective. It was understood to be a disability in the faculty of reasoning (Porter, 1987).

Mental illness has been acknowledged as comprising a significant portion of the overall burden of disease worldwide (Vos et al., 2013). A recent index of 301 diseases found that mental health conditions account for 21.2% of years lived in ill health worldwide (Vos et al., 2013). Globally,

the total number of people with depression is estimated to exceed 264 million (WHO, 2020). A similar number of individuals are estimated to be currently experiencing a range of anxiety disorders. Depression is ranked by the WHO as the single largest contributor to global disability (7.5% of all years lived with disability in 2015); anxiety disorders are ranked sixth (3.4%). Depression is also the major contributor to suicide deaths, which number close to 800,000 per year (Global Burden of Disease (GBD), 2017).

Severe mental disorders such as schizophrenia are estimated to affect 20 million people worldwide (GBD, 2017). Psychoses, including schizophrenia, are characterised by distortions in thinking, perception, emotions, language, sense of self and behaviour (GBD, 2017). Common psychotic symptoms include hallucinations (hearing, seeing or feeling things that are not there) and delusions (fixed false beliefs or suspicions that are firmly held even when there is evidence to the contrary). The disorder can impact on the livelihood of people by affecting their capacity to be employed or educated.

McManus (2016) identified the incidence of mental illness in the United Kingdom based on general classifications of the condition. This survey stated that 5.9 in 100 people have generalised anxiety disorder; 3.3 in 100 people have depression; 2.4 in 100 people have phobias; 1.3 in 100 people have obsessive compulsive disorders, 4.4 in 100 people have post-traumatic stress disorder; while 7.8 in 100 people have mixed anxiety and depression. Lubian et al. (2016) reported that out of the one in four people that have mental health disorders, one in eight adults (12.1%) are

undergoing mental health treatment, with 10.4% being treated with medication and 3% undergoing psychological therapy. The overlap within the statistics is due to 1.3% of those undergoing treatment reporting receiving both medication and psychological therapy.

1.3. Mental health service-users in secure hospitals

A population of adults with mental health conditions receive treatment within secure mental health hospitals (forensic mental health hospitals). The history of secure hospitals can be traced back to the medieval period, where individuals with mental health conditions were often treated in hospitals and religious institutions (Porter, 1987). This continued in the late eighteenth and nineteenth centuries, when mental illness was viewed as treatable by asylum doctors. Treatment involved the segregation and hospitalisation of individuals with mental illnesses in institutions. This was done to protect the society from the insane by hospitalising them in special institutions in rural areas, where they received medical treatment and were re-educated by means of moral therapy (Oosterhuis & Slijkhuis, 2012).

The growth of the medical field of psychiatry, and its institutionalisation, enabled the progression of forensic expertise in the legal domain. There were several debates about where to detain individuals who were mentally ill and who had committed crimes because of their health conditions. The debates focused on where they should be detained

(in penal institutions or medical facilities), treatment, and whether public safety, or the individual interests of mentally deranged offenders and their reintegration into society, should be prioritised (Oosterhuis & Loughnan, 2014). Even though by the late twentieth century the paradigm of treatment of the mentally ill as a whole had changed from authoritarian to democratic psychiatry due to the general transformations within the healthcare system, secure hospital services were left unchanged. Approaches which challenged and delegitimised secure hospitals, such as community care and deinstitutionalisation, were not viewed as a priority within the mental healthcare agenda. Nonetheless, there was a shift in the understanding of forensic mental health from a social defence to a medical approach (Oosterhuis & Loughnan, 2014).

A report by the Joint Commissioning Panel for Mental Health (2013) estimated that, in 2013, there were 6000 individuals who had been admitted for treatment by the courts or prison system into secure mental health services commissioned in England. This included 680 people in high security units, 2800 in medium security, and 2500 in low security. This represents a 58 percent increase in admissions compared to the year 2008, where there were more than 3,500 people within secure hospitals.

The detention of mentally ill service-users in the United Kingdom is done mainly within the framework of the Mental Health Act (1983). The detention of mental health service-users in secure settings in the UK is independent of criminal responsibility and determined exclusively on the basis of the individual's mental state during the period of sentencing or

transfer (Vollm et al., 2017). The conditions for the detention of mentally ill service-users who have committed a crime are set out in Section 37 of the Act, with these essentially following the same process as that for non-offending patients under Section 3 (MHA, 1983). The difference is that the section 37 is a hospital order made by the court at the time of sentencing.

Within the UK, there are three types of secure hospitals: high, medium, and low security hospitals. Service-users within high security hospitals undergo treatment in environments of high security on account of their dangerous, aggressive or criminal tendencies (NHS Act, 2006). Patients in both medium and low security services have characteristics such as:

> *Long-standing and complex mental health disorders; typically require longer-term rehabilitation and support which either cannot be safely or successfully delivered in open mental health units; are more likely to exhibit behaviour at a level of risk greater than a general mental health service could be expected to safely manage; receive care, treatment, and interventions based on a recovery approach*. *(Joint Commissioning Panel for Mental Health, 2013. p.8)*

Forensic psychiatric services are a costly service, costing approximately £275,000 per annum per patient in high security hospitals and an estimated £175,000 in medium security hospitals (Department of Health, 2013). It is also estimated that forensic services consume £1.2 billion per annum, which is one percent of the entire NHS budget and ten percent of the mental health budget (Joint Commissioning Panel for Mental Health, 2013).

The detention of mental health patients in secure hospitals has therefore continued to be costly for society and highly restrictive for patients, especially those undergoing long-term care (Centre for Mental Health, 2011).

These restrictive conditions include: the number of personal belongings allowed; visitation rights; long-term segregation; use of force during restraint procedures; night-time confinement and long-term segregation (Department of Health, 2011; Council of Europe, 2017). These restrictive conditions limit patients' quality of life during their period of stay (McDonald et al., 2016). Beck et al. (2014) echoed this by stating that one of the restrictions that exist for mental health service-users within secure hospitals is barriers to employment, because living for long periods in hospitals can prevent gainful employment. He argued that it is imperative that employment needs are addressed at the earliest possible stage in recovery. More broadly, research has indicated that work benefits people living with mental illnesses in several ways. Bond et al. (2001b) describes vocational rehabilitation as a means of supporting social integration and social responsibility, using and enhancing skills and capabilities and improving self-esteem. Provencher et al. (2002), meanwhile, linked vocational rehabilitation with reduction in symptoms, higher global functioning, better contentment with finances, and improved feelings of recovery.

The Joint Commissioning Panel for Mental Health (2013) echoed the importance of employment needs in secure services as part of the seven

principles that should guide the commissioning of any forensic mental health service, stating that:

> *Forensic mental health services need to be high quality, patient-centred and recovery orientated. Patients should make a significant contribution to commissioning of secure services and to their development and delivery. Services should promote social and clinical recovery and include access to education, employment and peer support. (p.15)*

Consequently, an important part of the structured and constructive use of time within secure mental health hospitals is the engagement of service-users in work as part of their rehabilitation. In this study, work is defined as "purposeful activity directed at producing a valued good or service" (Kelloway et al., 2004, p. 105). The College of Occupational Therapy (2012) recommended that occupational therapists establish the aims of service-users towards employment at the earliest opportunity during rehabilitation. This view was reiterated by McQueen and Turner (2012), who posited that occupational therapists should encourage supported employment or prevocational rehabilitation as part of occupation-based interventions for service-users.

Historically, secure hospitals have offered work-based programmes within their grounds. The importance of therapeutic work was identified by the founders of the asylum movement, who depended on the labour of patients in farms and workshops for sustenance of these institutions (Jones, 1993). This engagement in therapeutic work supported the reintroduction of patients to community-based employment through special arrangements

with local employers. Secure hospitals have continued this tradition of work programmes for their forensic mental health patients.

Modern forensic mental health service-users have also recognised that having opportunities to develop a sense of self that is independent of the offender identity, such as through vocational experiences, is paramount to recovery (McQueen & Turner, 2012). There is limited evidence for the effectiveness of these work programmes, however, and, in particular, the lack of studies that have explored this topic means that there are few lived experience accounts (Smith et al., 2010; Samele et al., 2018). Indeed, the studies of Smith et al. (2010), McQueen and Turner (2012), Cox et al. (2014) and Macdonald and Bertram (2018) are among only a few to have evaluated the effectiveness of employment interventions targeted at offenders with mental health needs within the United Kingdom. This means that there is currently insufficient evidence to determine conclusively the impact of work programmes on re-offending. Macdonald and Bertram (2018) concluded that limitations in work-based interventions have increased barriers to employment for forensic mental health service-users because being detained for treatment for a lengthy duration as a passive patient will likely result in an inability to find and retain employment.

1.4. Problem statement

The motivation for this study arose from my experiences over a ten-year period as a mental health occupational therapist. I was quite fascinated with the variations of excitement and reluctance of my service-

users when introduced to work placements in a secure hospital. I also observed the challenges that can be faced as service-users are introduced to work, such as a lack of understanding about mental illness, concerns about forensic history, and inability of service-users to sustain interest in work. Nonetheless, in my practice, I have observed the benefits of engagement in work for the recovery of mental health conditions. These have included: a sense of identity, social integration, skill development, effective use of time and improvement in problem-solving skills. Despite observing these features of work, however, I never had the opportunity to capture the phenomenon of work from the perspective of these service-users. Nor have I been able to question my own views about work, underpinned, as they are, by my professional training as an occupational therapist which unambiguously recommends work as part of the therapeutic engagement within secure mental hospital settings.

I began to research the evidence-base about the effectiveness of work as part of the recovery process for my service-users. To understand this phenomenon, a comprehensive search approach was developed encompassing the following electronic databases: NELSON (Northampton Electronic Library Search ONline), Google Scholar, Research Gate and PubMed for the period between 2000 and 2020, using English-only text from established peer-reviewed journals. The search combinations of key terms and inclusion and exclusion criteria are detailed in Table 1.

Since this literature search returned only limited evidence about the lived experience of work for mental health service-users within secure

hospitals, I was encouraged on a quest to find out how these service-users experience work.

This study therefore explored the lived experience of mental health service-users who live in secure hospitals and are involved in work. It created a platform for their voices to be heard in respect to their lived experience of being involved in work.

1.5. Why lived experience?

The diverse lived experiences of severely mentally ill individuals have not been frequently considered or integrated to their treatment procedures (Kaite et al., 2015). This has often denied service-users the use of recovery-based psychiatric treatment. This is because of the existence of institutional responses, drug treatments and coercive interventions in the treatment of mental health conditions (Slade et al., 2014); and a translational gap between knowledge and the application of recovery-oriented practice (Tse et al., 2013). These practices prevent psychiatric treatment based on the rigorous illustrations of the viewpoints of the service-users who are living through the trauma of mental illness and subsequent detention in mental health hospitals (Chandley & Rouski, 2014).

Understanding the viewpoints of people living with mental health conditions is considered enlightening, and hence possibly supportive to other people who have mental health conditions, as well as to stakeholders, and mental health care providers (Mauritz et al., 2009). This is because the

experts on the lived experience of mental health conditions are the individuals living with such conditions (Rudnick et al., 2011). May (2000) posited that lived-experience viewpoints can be specifically helpful to explore interventions that have been effective or ineffective in clear and useful terms. In best practice, mental health service-users are far from spectators, they are active participants in their own care (May 2000), and as such, their personal causations and values play a significant role in their motivation to respond to treatment. Parkinson et al. (2006) defined values as how individuals perceive what is worth doing, their beliefs about how they should perform, and their goals or ambitions. Parkinson et al. (2006) also defined personal causation as:

> *What persons believe about their effectiveness including: knowledge of capacity, an awareness of and attitude toward one's present and potential abilities, and; a sense of efficacy which includes the perception of whether and how one controls one's own performance and achieves desired outcomes of performance. (p.4)*

From this definition, it can be inferred that service-users' sense of efficacy and belief in what is worth doing will influence the meaning of their reality, and thus their engagement in treatment. Consequently, what shapes a service-user's behaviour in response to treatment is not necessarily what is objective or recommended, but "what the individual thinks is true" (Nestoros & Vallianatou, 1996, p. 280). Inevitably, the active involvement or participation of service-users in therapeutic interventions is based on their understanding of their mental illness, values, personal

causation and the treatment methods being implemented by the multidisciplinary team (Beck, 1991; Parkinson et al., 2006). Within my practice as an occupational therapist, I have encountered situations where non-compliance of service-users to pharmacotherapy was traced back to the perception of how this would affect their capacity as workers, especially considering issues around side-effects such as drowsiness and tiredness. For these service-users, understanding the value they afford to employment, and their viewpoint about the impact of medication side-effects on their employment in terms of their ability to participate actively in work roles, was the turning point in their recovery. This enabled health professionals to schedule their pharmacotherapeutic interventions in a way that it did not affect their ability to participate in work. Hence, they were able to comply with their treatment more effectively.

Rudnick et al. (2011) stated that individuals with mental health conditions have the desire to report their lived experience through first-person accounts. By talking in the first person as part of their recovery journey, they address head-on the societal and professional stigma in respect to their condition. This need to reveal their lived experience in public, and a desire to be celebrated for their resilience, facilitates personal recovery, and supports others who have mental health conditions.

The lived experience of mental health service-users plays a significant role in their personal recovery. This can involve experiences of undergoing marginalisation, oppression and loss of social status that commonly accompany mental health diagnosis and service use (Rusch et al., 2014).

The lived experience of people with mental illness may also involve facing stigma and discrimination (Corrigan & Rao, 2012). This can negatively impact personal recovery when such individuals internalise and endorse public negative stereotypes, resulting in self-stigma. Self-stigma is linked to negative outcomes such as giving up life goals, social withdrawal, non-disclosure of mental illness and awareness of stigma as a threat and stressor that exceeds one's coping resources (Watson et al., 2007; Rusch et al., 2009; Corrigan & Rao, 2012; Harris et al., 2016). Despite the debilitating impact of mental health and associated stigma, individuals with mental health conditions still possess the ability to "bounce back" after trauma or severe stress and initiate their personal recovery (Butler et al., 2007). This ability to "bounce back" is known as resilience. Resilience is defined as "the process of effectively coping by mobilizing internal and external resources to adapt to or manage significant sources of stress or trauma" (Lee et al., 2011, p.2). It is a vital lived experience for people with mental illness because it positively impacts their personal recovery by improving their ability to cope with symptoms and side effects of medication, while also decreasing their stress sensitivity, increasing stress adaptability, and improving their emotional well-being and quality of life (Perlman, 2017; Waugh & Koster, 2015).

Personal recovery is a profoundly individual and distinct process of altering one's attitudes, values, feelings, goals, skills and/or roles. It involves finding a way to live a fulfilling, optimistic and contributing life, even within the constraints of illness, establishing new meaning and

purpose as the individual evolves beyond the negative consequences of that illness (Anthony, 1993). Recovery-oriented practice refers to a shift towards a holistic person-centred approach to treating individuals with mental illnesses (Winship, 2016). It involves shifting the focus of patient care from symptom control towards principles of personal orientation and personal involvement (Slade, 2009). These principles of personal orientation and the personal involvement of mental health service-users in their care are elements of person-centred care (Edvardsson et al., 2015). Person-centred care involves inviting and respecting shared decision-making, choice and control between members of staff and mental health service-users about their care.

The importance of learning from lived experience as part of the person-centred care of service-users is also enshrined in government legislation such as the Health and Social Care Act (2008). This Act makes provisions for care being centred around the needs of service-users. According to the Care Quality Commission (2020), the purpose of the Health and Social Care Act (2008) is to ensure that health facilities implement processes to ensure that service-users receive appropriate care and treatment that is based on an evaluation of their specific needs and preferences. The CQC posited that healthcare providers have an obligation to work in collaboration with service-users to enact any realistic changes in respect to their care, to assist them to comprehend and make informed decisions about their care and treatment options, including the degree to which the individual wants to manage these options themselves.

These positions recognise the significance of lived experience in the delivery of mental health care. Not only is it important for personal recovery, it is also vital for the delivery of person-centred care as enshrined in government legislation. Without the viewpoints of lived experience and the involvement of service-users in their treatment, such treatment cannot be viewed as achieving person-centred care. To understand how forensic mental health service-users engage in work, therefore, it is vital for this study to reflect their lived experience. Collating these lived experience perspectives can give service-users a voice by providing evidence to reform their care. The research aims and objectives below are therefore tailored to enable investigation into the narratives of this population.

1.6. Aim and Objectives

Aim.

To understand how service-users within a secure mental health hospital unit experience work.

To achieve this aim, the study intends to:

1. Understand the facilitators or challenges to engagement in work from the perspective of mental health service-users living in a secure hospital.
2. Understand the impact of engagement in work on the mental health of service-users in a secure hospital.

3. Understand if mental health service-users' lived experience of work in a secure hospital can influence their future engagement in work after discharge.

1.7. Rationale for this study

Since work is considered to be an integral part of mental health rehabilitation, this study will contribute to the gap in knowledge about work within forensic and secure mental health hospitals. It is also anticipated that this study will reveal the successes and challenges faced when introducing mental health service-users to work. This will be completed from the perspectives of the mental health service-user in line with the methodological guidelines of this study.

1.8. Organisation of the study

This thesis comprises seven chapters.

Chapter one describes the background of the study, with a focus on mental illness, the significance of lived experience in recovery and person-centred care. It describes the aim, contexts and outline of the thesis.

Chapter two reviews the existing literature about the phenomenon of work among mental health service-users. This includes: the historical philosophies of work as a social norm in Western societies; the impact of mental illness on engagement in work; and employment provisions in respect to people with mental illness

Chapter three explores the paradigms and methodologies of this study. It details the ontological position of this study and how Husserl's descriptive phenomenology method is used to answer the research question.

The methods of this study are found in Chapter four. This includes: the research design, the participants, the ethical process and data collection process. It details how Colaizzi's (1978) phenomenological analysis was used to analyse the data. This includes the following seven procedural steps: general description of the data; identifying statements that directly link to the phenomenon; creating formulated meaning; aggregating the formulated meanings into clusters; exhaustive description of the emergent themes; developing the fundamental structures; and member checking.

Chapter five presents the findings from the analysis of data.

Chapter six is a comparative chapter highlighting the importance of these findings in relation to current knowledge.

Chapter seven is the concluding chapter, developing recommendations and implications for practice from the findings of this study. The limitations of the study are also discussed, and recommendations are provided for further studies.

The appendices contain figures and tables that were used within the study to present sizeable amounts of complex data in a space-saving, easy-to-understand way.

Chapter Two – Literature review

2.1. Introduction

Chapter one described the background and presented the aim of the study together with an outline of the thesis. This chapter reviews the existing literature about the phenomenon of work among mental health service-users. The first section explores the understanding of work as a vital social norm for individuals living within societies and discusses its importance in mental health rehabilitation. The second section analyses the impact of mental illness on engagement with work. The third section provides insights into current provisions to support individuals within mainstream mental health services to access work. The fourth section analyses lived experience studies that have evidenced the impact of work provisions on individuals within secure hospitals. This section, likewise, identifies the gap in knowledge in current studies and makes recommendations for research.

2.2. Historical philosophies of work as a social norm.

To understand the significance of work as part of societal norms, it is vital to understand historical philosophies of work and how these have influenced the current understanding of work within societies. Svendsen (2013) stated that two main viewpoints stand out when considering

historical perspectives of work: that of antiquity, that work is a meaningless curse; and that of the reformation, that work is a meaningful vocation.

The Greek philosophy of work was one of the dominant views during antiquity. The Greeks used the word "ponos" to refer to work, which mainly carried the meaning of strenuous but not essentially productive actions. Lis & Soly (2012) stated that many Greek elites and philosophers viewed work as humiliating and a task which slaves were forced to do. Free male citizens dedicated their energies to politics rather than work. Despite this view that work is a meaningless curse, some Greek philosophers extolled the virtues of work. Svendsen (2013) stated that the poet Hesiod had the view that people can be blessed by the gods through engagement in work. He concluded that the distinction between these contrasting views was that work done voluntarily was noble while paid work was considered humiliating. The Greeks believed that paid work was subjected to the wishes of the customer and as a result the labourer was lacking in autonomy. McPherran (2010) stated that Plato viewed paid work as denigrating because the manual labour involved wore down the mind and body, making it unfit for military and political purposes. This view of work was regarded as the standard Greek view of work.

Hill (1996) posited that the Judeo-Christian belief system had a significant impact on current societal beliefs about work and that this came to the fore in the reformation period which gave birth to industrialism.

The Judeo-Christian belief system had a similar belief system to the Greeks, differentiating work as a vocation and as a cursed necessity. In the

Bible, the narrative about work is described in Genesis. There, the account of creation described God engaging in the first act of work by creating the heavens and the earth (Genesis 1: 1-31). God saw the earth and it was formless and empty, an indication of chaos. This chaos epitomised potential and God's innate need to create order through work. God went on to work for six days, creating all living creatures. In Genesis 1:26, God created humans in his own image. This indicated that he created humans' innate need to engage in work. Humans encounter chaos daily, just like God did, and use their consciousness to participate in the process of creating order. Work, however, was initially a leisurely pursuit as the need for survival was catered for by the fruits within the garden of Eden (Genesis 3:2). With the expulsion of the first humans from the garden of Eden because of their disobedience, the engagement in work became a necessity to survive. The Bible described the cursed necessity of work by stating that "By the sweat of your brow you will eat your food until you return to the ground, since from it you were taken; for dust you are and to dust you will return" (Genesis 3:19).

Hence, the Judeo-Christian belief was that work was a curse but also a necessary duty.

Early Christians engaged in work as a duty to improve themselves, support others and pay obeisance to God (Svendsen, 2013). In the New Testament, there are references to the importance of work such as "Yea, a man may say, thou hast faith and I have works; shew me thy faith without works and I will shew thee my faith with works" (James, 2:18). It concluded

by stating that "For as the body without the spirit is dead so faith without works is dead also" (James 2:26). These verses indicate that early Christians viewed the measurable quantity of work to be the quantifiable evidence of faith in God. Work functioned as a means of satisfying the physical needs of one's family and community, and to avoid idleness which resulted in sin (Tilgher, 1930).

Work still played a secondary role in relation to God, however, because prayer and meditation, which were symbols of Faith, were deemed more essential (Ephesians 2:8). The Church discouraged its followers from pursuing profit in order to prevent them becoming distracted from their quest for grace and so that the competition would not cause the less skilful to suffer (Roth, 1999). Hence, early Christians were regularly forced to make difficult choices between better material comforts in this life, or eternal salvation as promised by the Church (Roth, 2014).

This philosophy of work changed during the Reformation in the 1600s. The leaders of the protestant movement, such as Martin Luther, linked the acquisition of profit and wealth to hard work and to the measures of grace deserved (Roth, 2014). He established the philosophy of a "vocation or calling" through the belief that the best way to pay obeisance to God was to devote oneself to a profession. Braude (1975) explained that other church leaders, such as John Calvin, reinforced the philosophy of vocation by teaching that engagement in work was a continuum of God's creation process. He proposed that all men must work, even the rich, because engagement in work was God's will to reshape the world in the

fashion of His Kingdom. This change of attitude towards work came to be referred to as the protestant work ethic. Rose (1985) stated that the unique characteristics of this protestant work ethic were conscientiousness, punctuality, deferment of fulfilment and the importance of the work domain.

Wolfe and Poolos (2015) described how the philosophy of work changed from the Reformation to the Industrial Revolution. During the Reformation, or preindustrial period, poverty was a constant state and a quarter of the European population was below the poverty level. The dependence on subsistence agriculture and simple tools of production meant that food production was not sufficient. This, combined with the steady movement of people to the growing urban centres, and thus away from agricultural production during the early industrial period, drove up food prices and thus exacerbated poverty. Bernstein (1988) posited that the protestant work ethic misunderstood the morality of this poverty; believing that work was readily accessible for those interested in it, and that the poor were indolent.

Wolfe and Poolos (2015) explained that these economic problems led to innovation and associated technological breakthroughs that helped to increase production in the cotton, textile, and agricultural sectors. This ushered in the Industrial Revolution. The increased production, acquisition of colonies, operation of chartered companies and growth of colonial markets funded the development of roads and canals that formed trade routes. This did not lead to improved living conditions, however, because

the protestant work ethic meant that workers were willing to accept poor working conditions (Anthony, 1977). Hard work attained respect and contributed to the social order and welfare of the community. The dignity with which society viewed work brought dignity for workers as well, as well as contempt for those who were idle or not involved in work (Hill, 1996). Work in the form in which we identify and engage in it, as central to societal norms, was invented, then subsequently generalised through industrialism (Lis & Soly, 2012).

Work within the current information age (i.e., from the twentieth century to the present) still reflects the principles of the protestant work ethic (Sheehy, 1990). Jobs within this age require considerable thinking and decision-making on the part of workers (Miller, 1986). Employees are empowered to engage in decisions that involve the needs of customers and correlate with the goals of their companies (Maccoby, 1988). Roth (2005) termed this organisational involvement in work as the development ethic. He explained that the goal of the development ethic was developing and pushing the limits of the enjoyment of positive human potential. Hill (1996) posited that the development of human potential in workplaces ensures that higher levels of education, coupled with problem-solving skills, management skills and the application of the latest information for productive tasks, have become a necessity within workplaces in the information age. Sheehy (1990) proposed that the work ethic still plays a significant role in today's workplace because workers expect that talent and hard work should be the basis for success rather than chance or luck.

Svendsen (2013) posited that the protestant work ethic therefore remains the foundation of the working culture within our current society. Engagement in work is still venerated and viewed as a social norm which produces order and the welfare of the community. Thus, workers have continued to be held in high esteem and those not involved in work or idle are regarded with disdain. The focus has changed, however, from a philosophy of work as part of one's duty of devotion to God, to a philosophy that everyone should engage in work that gives them the most meaning, satisfaction and the fullest realisation of individual potential. An individual who is to be fully integrated in today's society must, therefore, be involved in work. Crowther et al. (2001) suggested that a high rate of unemployment among those with mental health conditions, is evidence of their social exclusion.

2.3. Work and concepts of occupation

Work is one of the three areas of occupational participation including leisure and self-care (Kielhofner, 2002). Individuals create their occupational identity through participation in work. Parkinson et al. (2004) defined occupational identity as a "composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation" (p.7). When individuals engage in work, they build their belief in their ability and effectiveness, increase their understanding of the types of employment that they find interesting and fulfilling, understand who they are, as defined by their roles and

relationships at work, recognise their values and obligations as regards work, engage in familiar routines that will ensure a successful engagement in work, and increase their insights into the environment and how it can support their engagement in work. According to the Model of Human Occupation (Kielhofner 2002, 2008), a person's occupational participation, such as engaging in work, emerges out of the interaction between a person's internal components and their environment. There are three elements to that interaction that make engagement in work possible. These are volition (motivation), habituation and performance capacities.

2.3.1. Volition and work

Kielhofner (2008) defined volition as "a pattern of thoughts and feelings about oneself as an actor in one's world which occurs as one anticipates, chooses, experiences, and interprets what one does" (p. 16). These volitional thoughts and feelings include three components that define a person's volition to engage in work—personal causation, values and interests. Personal causation refers to "one's sense of capacity and effectiveness" (p. 13). Personal causation is used in the sense that a person can experience themselves as being capable of engaging in work and producing outcomes. Personal causation to engage in work is displayed through a sense of personal capacity within the person and an overt self-efficacy, which is evident in the way they relate with the world. While individuals can experience a sense of capacity, they can also experience

incapacity when they encounter difficulties in engaging in actions that are important in their lives, such as work.

The second component of volition is the values that people hold that can encourage or discourage engagement in work. Values are associated with two concepts. These are a sense of obligation and personal conviction. Values bind people to actions through a sense of obligation (Kielhofner, 2008), while personal convictions are what people believe to be important, such as their standpoints and worldviews. For example, since engagement in work is ingrained within societal and personal values in Western societies, a person's sense of dignity and self-esteem can be negatively affected if their ability to work is inhibited. Spirituality can also be described as an example of personal values. Spirituality generally refers to a deep-seated individual sense of connection through which each person's life is experienced as contributing to a valued and greater 'whole', together with a sense of belonging and acceptance (Dein et al., 2010). Within religious communities where involvement in work is viewed as a form of reverence to God, unemployed individuals may be treated with disdain. In turn, a failure to be gainfully employed may lead to a loss of dignity and self-esteem because their sense of obligation to engage in work. This can intensify excesses of self-blame and perceptions of unredeemable sinfulness, which can in turn weave into obsessive or depressive symptom patterns which could be more distressing in individuals with mental health conditions (Tepper, 2001).

The third component that drives volition is interest. This component can be divided into two subcomponents, namely: attraction and preference. Parkinson et al. (2004) stated that attraction represents a natural disposition to find pleasure in specific activities or specific facets of performance. Preference represents the knowledge that one enjoys specific ways of performing specific activities over others. This indicates that for a service-user to be interested in work, there must be an attraction to engage in work and preference to choose certain types of work. Involvement of service-users in preferred choices around work is vital to a person-centred approach during the process of engagement in work. Encouraging preferences gives mental health service-users control, and links services to achieve the outcomes important to them, hence empowering them to make choices in their recovery. Shanley and Jubb-Shanley (2007) agreed with the importance of empowerment to take control as a vital element of mental health recovery. This was evidenced in their recovery-alliance model in which they posited that mental health service-users are capable of making choices and exercising control in choices affecting their lives, such as choices at work. Davidson et al. (2005b) had a similar view about the importance of control in their definition of mental health recovery. They stated that recovery involved regaining control and establishing a personally fulfilling, meaningful life.

Jacobson and Greenley (2001), meanwhile, also stated that it is important that service-users are seen as actively engaging and having the right to choose from a variety of choices during their recovery, even when

an element of risk is involved. Becker and Wolfe (2001) recommended that the consideration of service-user preferences and choices influences better vocational outcomes. Becker et al. (1996) had a similar view that mental health service-users whose interests were considered during their introduction to work had more satisfaction within their jobs and retained such jobs for twice as long as those who worked in nonpreferred areas. This was also echoed by Mueser et al. (2001), who discovered that there was a positive relationship between working in a chosen area and, on the other hand, satisfaction, and length of time of employed.

Some studies have challenged the view that mental service-users should be involved in choices about their work preferences. McCrum et al. (1997) stated that choosing work based on individual preferences and choices could lead to impractical and unsuitable prospects, consequently leading to job failure. They indicated that mental health service-user's needs at work could often be unrealistic in such a way that employers would be incapable of providing for such needs. Nonetheless, Becker et al. (1996) recommended that service-users that have been involved in supported employment were more likely to express job choices that were practical and consistent with job roles within paid employment.

The concept of volition provides a deep understanding about how service-users engage in work. For a person to be motivated to initiate and sustain engagement in work, they have to possess a sense of being capable of engaging in it; a sense of obligation and personal conviction about it; and an interest to engage in it.

2.3.2. Habituation and work

Even with motivation (volition), individuals require the habits of occupational performance to engage successfully in the role of work. This includes patterns of occupational performance to perform work-related tasks; e.g. working in the role of a garden shop assistant may involve getting to work at specific time, tidying the shop before customers arrive, and interacting with customers. These responsibilities of occupational performance attached to a job will most likely occur on a daily basis. Habits are the automatic occupational performance areas that could enhance a worker's role. For example, to engage successfully in the aforementioned role of a shop assistant, a person has to have a daily routine of personal care alongside other habits, such as waking up early enough to be punctual. This includes occupational performance areas such as grooming and wearing clean clothes.

Roles are the functions assumed by individuals, and the internalisation of roles is a process that provides individuals with an identity (Park et al., 2019). A sense of obligation that comes with an identity subsequently influences behaviour to satisfy the role requirements moulded by social systems. The recurrent patterns of work behaviour that make up a significant portion of work are the result of an internalised worker role and habits. The process of obtaining, and then the repetition of these patterns of occupational performance is referred to as habituation (Parkinson et al., 2004). Habituation serves the purpose of reducing the conscious decision-making underpinning actions. Habits and roles combine

to allow individuals to distinguish features and circumstances in the environment that can underpin automatic behaviour. Roles guide how one performs within social positions such as work, while habits regulate other characteristics of an individual's routine and ways of performing occupations. People who are motivated to engage successfully in the role of work, therefore, must imbibe the occupational performance associated with the social positions within those roles and the habits needed to support their effective engagement in that work.

2.3.3. Performance skills and work

The third element of interaction with the environment to allow successful engagement in occupational participation is performance skills. These include communication and interaction skills, motor, and process skills. To engage in specific tasks within a workplace, workers engage in purposeful actions. Using the example of a garden shop, a worker may be assigned the task of cleaning the shop before customers arrive. To complete this task, the worker must engage in purposeful actions such has handling the vacuum cleaner, gathering tools and returning them to their cases, sequencing the steps necessary to arrange the flowers alphabetically or according to their seasons. These actions that make up the task of tidying the shop are referred to as skills. Skills are goal-directed actions that a person uses while performing a task (Parkinson et al., 2004). To complete the task of cleaning the shop, a worker that must possess motor skills for handling and gathering the tools, communication skills to interact

with the manager to enquire about expectations of the task, and process skills to sequence and time the constituents of the task.

2.3.4. The Working environment

The environment impacts involvement in work by providing resources or opportunities and producing situations that constrain or make demands upon a person. The environment is divided into the physical domain, i.e. spaces and objects, and social domain, i.e. groups of persons and the forms of occupation that they perform (Parkinson et al., 2004). Parkinson et al. (2004) defined spaces as the natural and fabricated contexts in which people behave. These include physical facilities that improve self-care, productivity and leisure, privacy and accessibility and stimulation and comfort. Examples are accommodation, social amenities, accessible buildings, and local shops. Environments where such spaces are readily available will support engagement in occupational participation such as work. An ideal work site should make provisions for self-care and sanitary facilities, accessibility to the site for all employees, break rooms, etc. Objects are defined as both natural and fabricated things with which persons may interact. These are physical resources that directly influence engagement in work such as finance, equipment and tools. Without such resources, engagement in work would be challenging.

Kielhofner (2008) explained occupational forms as the social groups that define expectations for roles and provide a social space in which those roles are performed and in which recognisable, coherent and purposeful

aspects of performance are sustained in collective knowledge. Individuals within such social environments will recognise familiar occupational forms that are part of the group's typical performance and have a language to describe them. For example, mechanics would be familiar with the phrase let me get the dipstick which means checking the levels and quality of car oil by using a graduated rod that can be used to indicate depth.

Creating an ideal environment for engagement in work will require the combination of factors within the physical and social environment. A workplace will have a common knowledge of tasks to perform which will be readily available to workers, as well as the resources and space to execute work tasks. A good working environment and conditions can increase job satisfaction and make it more likely that employees will give their best (Jung & Kim, 2012; Sekhar, 2013). Mahazril et al. (2012) also researched the importance of social environments at work. They concluded that social cultures such as recognition and rewards may motivate workers to increase productivity. They posited that recognition enhances the level of productivity and performance in employment, whether it is a first-time performance or a repeated action at the job that progressively reinforces the behaviour of employees.

2.3.5. Relationship between a worker's internal components and the work environment.

When the internal components of a worker do not match the demands of the working environment, it could lead to frustration as a result of a lack

of fulfilment. Neveanu (1978) described this as an intricate act of emotional imbalance fostered at the level of personality because of a failure to fulfil needs, and as a result of material and emotional deprivation. Laplanche and Pontalis (1994) explained that this frustration occurs when an individual is denied the satisfaction produced by the fulfilment of a certain need. Lazarus and Folkman (1984) constructed the transactional model of stress to explain the relationship between frustration and poor coping skills during stressful situations. The transactional model of stress hypothesises that incidents (such as frustration and lack of fulfilment at work) that are perceived as threatening will trigger a secondary appraisal process to determine if there are adequate coping resources to manage the stressor. It is predicted that the outcome of this appraisal will affect occupational stress levels. In the event of occupational stress elevations, coping resources are activated. On the other hand, if the stressful experience is very low or non-existent, then coping skills may not be activated. This means that the stress is required to be at a sufficiently distressing level to initiate coping actions. The outcome of these coping actions, if triggered, may result in higher levels of occupational stress if the individual's coping skills are unable to resolve the stressors.

Saveedra et al. (2016) identified that the most important source of stress for mental health service-users was conflict management at work. This included service-users struggling to accept and react appropriately to criticism at work. They identified that such situations could arouse negative feelings which are sometimes difficult to cope with. Savla (2013)

acknowledged problems with shortfalls in the recognition and expression of emotions associated with serious mental illness in workplaces. Rodriguez et al. (2017) proposed that when responding to perceived stress, individuals can engage in conscious and unconscious exertions to control the emotional reaction, known as emotion regulation (Gross & Thompson 2007). In individuals who may have negative emotional states due to their mental illnesses, the ability to regulate emotions is likely to be degraded (Baumeister et al., 2007). Raio et al. (2013) further proposed that continuous exposure to stress can hinder effective emotional regulation abilities and increase emotional exhaustion and dysregulation over time. This results in a lack of interest and engagement within work roles and the occurrence of symptoms characteristic of a burnout. Demerouti and Bakker (2008) defined burnout syndrome as a mental state categorised by emotional exhaustion and distancing oneself from one's work role through pessimism. According to Maslach et al. (2001), burnout is linked with various forms of job withdrawal—absenteeism, intention to leave the job, and actual turnover. It leads to lower productivity and engagement for individuals who remain in the work role.

When an individual's internal components (i.e., motivation, habituation, and skills) match the demands of the working environment, occupational flow is likely to occur (Csikszentmihalyi, 1990). Emerson (1998) described occupational flow as a subjective mental state which happens when an individual is completely engaged in an activity. Characteristics of the flow experience include concentrating on a clear goal,

a loss of self-consciousness, an altered sense of time, and a sense that the activity is rewarding. Kielhofner (2008) associated the attraction individuals might have to specific occupations with the concept of "flow". He explained that flow experiences occur when the demands of an activity optimally match the capacities of the individual. The implication is that enjoyment, and therefore interest, typically increases when individual capacities match activity demands. This could in turn lead to an increased motivation to engage continually in work. Intrinsically motivated employees are continuously interested in the work they are involved in and would continually engage in their employment and are fascinated by the tasks they perform (Csikszentmihalyi, 1997; Harackiewicz & Elliot, 1998). Generally, people who benefit from flow experiences tend to experience fulfilment in their occupational life which is essential for improving wellbeing (Jonsson & Persson, 2006).

The experience of fulfilment and improved wellbeing experienced as a result of occupational flow are linked to the concept of self-actualisation. Self-actualisation refers to feeling fulfilled, or the feeling that accompanies living up to one's potential (Maslow, 1943). Self-actualised people are those who are fulfilled and satisfied and are continuously undertaking challenges, of what they are capable of (Maslow, 1997). Maslow continued by stating that, even if all physiological, safety and social needs are fulfilled, individuals may still often experience a new dissatisfaction and restlessness unless they are doing what they are suited to. Menon (2001) and Wilkinson (1998) posited that self-actualisation occurs when workers are empowered

against alienation and subjugation within the work environment. This signifies a transfer of power from the leaders or trainers to the workers or trainees. Tennant (2006) stated that encouraging self-actualisation was an integral part of the empowerment approach, especially through nurturing personal autonomy and a greater awareness of self that is independent, coherent, and rational. Hence, when workers are empowered in their workplaces, they are able to experience purpose, fulfilment and achievement, which are components of self-actualisation.

Theories that explain the self-actualisation at work acknowledge the impact of work environment and resources on achieving self-actualisation. Moneta and Siu (2002) and Trump (1991) proposed that work environments that support skill acquisitions and encourage resourcefulness frequently lead to the attainment of self-actualisation. Sturges et al. (2002) stated that resources such as on-the-job training, including career management activities, enhance workers' commitment to employment by linking logistical resources with personal development plans. Ngai et al. (2016) stated that the mastery of both hard and soft skills through training was connected to self-actualisation, and thus the possibility for more positive work motivation and engagement. Ngai et al. (2016) discovered that unemployed individuals who were more actively engaged in vocational training were more likely to find fulfilment in their training and in turn achieve a higher level of self-actualisation.

Self-actualisation enhances wellbeing by influencing quality of life, because there is a significant association between the predictions of

Maslow's theory and quality of life (Tripathi, 2018). Psychological health is impossible unless the core of the person is recognised, respected, esteemed and valued by others and by oneself. Maslow (1997) posited that when people have unfulfilled physiological and safety needs, e.g., chronic illness or an unsafe work environment, they may struggle to progress to higher order needs such as self-actualisation. It can therefore be inferred that people who experience self-actualisation have some fulfilled psychological and safety needs, thus, improving their quality of life.

2.3.6. Impact of mental illness on engagement in work

Deterioration in mental health can affect wellbeing significantly in that it can create unfulfilled physiological or safety needs. This affects the engagement in daily living activities such as work. The Adult Psychiatric Morbidity Survey (2016) estimated that one in six people of working age have common mental health problems. The survey analysed the relationship between employment and self-harm and suicide among working age adults 16–64 years. This report concluded that mental health problems were more prevalent in people of working age. The survey suggested that 19.7% of people in the United Kingdom who are aged 16 and older showed symptoms of anxiety or depression, an increase from 2013. While the prevalence of severe mental symptoms had increased from 8.5% in 2007 to 9.3% in 2014. This is an indication that a significant percentage of people in the working and productive age group in the United Kingdom are currently experiencing mental illness. The increase in the

prevalence of mental illness among the working and productive age group in the United Kingdom can be linked to an increase in awareness about mental illness through the national anti-stigma campaigns that started in 2007 (Henderson et al., 2013). This campaign analysed the impact of its awareness programmes on intended help-seeking behaviour for mental illness. It concluded that the increase in awareness about mental illness predicted an increase in help seeking and disclosure. In other words, the increase in awareness as a result of the campaign led to more individuals with mental health conditions seeking help. This has increased the reported prevalence of mental health conditions.

Mental illness is associated with the existence of a clinically recognisable set of symptoms or behaviours associated with interference with personal functions (WHO, 1992). Vona du Toit (1991) and Kielhofner (2002) established a relationship between mental illness and interference with personal functions through the concept of creative ability. Du Toit (1991) defined creative ability as the capacity to present oneself, freely, without anxiety, limitations or inhibitions. Crouch and Alers (2007) stated that mental illness can impede the growth of creative ability, or cause its regression, as a result of difficulties which fail to encourage relevant occupational behaviour. Sherwood (2010) posited that deterioration in mental health can negatively impact the initial attitude or willingness to engage in creative activities (creative response). This affects the attitude to participating in activities such as work. Mental illness also affects the active engagement in all activities of daily life (creative participation). This

includes activities that are meaningful or give pleasure but also those that may be obligatory, such as work. An important aspect of creative ability that regresses due to mental illness is the work ability. Crouch and Alers (2007) defined work ability as a person's ability to be productive, including:

> *The ability to initiate projects or tasks at the right time and see them through to conclusion, developing new ideas and methods when appropriate in both work and home setting; manage himself, his workload, and resources effectively in the work/home situation, be it in an open, sheltered, protective or educational setting, work effectively according to the norm set and be critical of his performance through realistic judgement. (p.13)*

Sherwood (2010) stated that work ability can be affected in a variety of ways depending on the severity of the mental illness. In severe cases, work ability is affected such that there is little or no evidence of routines of doing tasks, there are inadequate or poor community survival skills, and initiative is either little or not evident. In less severe cases, work endurance is affected in such a way that employment can only take the form of supported role with no significant obligations. This is because of erratic initiative, which affects the ability to choose appropriate behaviours and tasks without constant reassurance and instructions. Work effort is erratic, and support is required to sustain engagement in work tasks.

Self-neglect and poor personal care are other negative symptoms of mental illness that prevent engagement in work, since most workplaces require a good standard of self-care. This lack of motivation to uphold good personal hygiene standards is one of the characteristics of avolition.

Messinger et al. (2011) defined avolition as "both a subjective reduction in interests, desires and goals and a behavioural reduction of self-initiated and purposeful acts" (p. 164). Individuals with severe mental health difficulties can become totally dependent on support for their self-care and have a poor awareness of bodily functions (Sherwood, 2010). In less severe situations, they require supervision to have good hygiene standards.

Saavedra et al. (2015) and Boardman et al. (2013) also identified cognitive deficits as one of the many barriers to the employment of people living with serious mental illnesses. This includes a lack of concentration caused by auditory hallucinations and memory problems (Marwaha & Johnson, 2005). These symptoms of mental health conditions can increase the impact of employment barriers for people living with serious mental illness such as social dysfunction, public stigmatisation and discrimination (Ramsay et al., 2012).

The inability to engage in work as a result of mental illness or impairment is termed occupational deprivation. Whiteford (2000) defined occupational deprivation as a prolonged preclusion from engagement in occupations of meaning due to factors outside the control of an individual, such as incarceration and disability, both of which are significant features in the lives of people living with mental health conditions. As discussed above, deterioration in mental health could result in occupational disruption to engagement in work. Occupational disruption refers to a transient state in which an individual is restricted from participation in meaningful occupations caused by illness. This disruption is also a barrier to return to

work because it could lead to long-term disruption to an individual's work role and habits. This increases the difficulty of resuming work routines that would have been automatic and requires rehabilitative support to relearn these skills.

Occupational disruption results in the exclusion of people with mental health conditions from work, with the first symptoms of mental illnesses often occurring in young adulthood (Hervey et al., 2013). This period in the life of an individual is crucial for education or higher education and transition into further training or employment. Without these employment skills and education in early adulthood, people living with mental illness enter the labour market at a disadvantage (Henderson et al., 2011). Lack of employment skills and education means people living with mental illnesses are more likely to be unemployed, thus increasing their risk of recurring mental health relapse. Herbig et al. (2013) affirmed this by stating that individuals who have long-term unemployment have at least a twofold higher risk of mental illness such as depression and anxiety disorders when compared to employed persons. Unemployment also increases serious risk factors such as drug abuse and the subsequent development of drug abuse disorders, thus exacerbating symptoms of mental illness (Henkel, 2011). Henkel (2011) concluded that maladaptive alcohol consumption is more common among the unemployed, and that unemployment raises the risk of relapse after alcohol and drug addiction treatment. Vos et al. (2013) compared the prevalence of mental illness among working age adults who were employed and unemployed. Their

systematic review concluded that working-age adults who are unemployed are at a higher risk of experiencing a traumatic (38.2%) or post-traumatic stress disorder (10.5%) compared to those that were employed (29.7% and 2.7%, respectively). This report was affirmed by the APMS (2014), which stated that unemployed adults were among the groups in the general population that are more susceptible to mental illness.

Occupational disruption as a result of employment barriers in this population eventually leads to a lack of balance or disproportion in occupation (Wilcock, 2006) because daily routines become characterised by an empty routine or skewed focus on self-care and leisure. This is referred to as occupational imbalance. Lack of engagement in employment leads to a loss of productivity which could impact the other occupational participation areas of self-care and productivity. Some studies have discovered that people with mental health conditions who are unemployed sleep excessively during a 24-hour period (Bejerholm & Eklund, 2004; Krupa et al., 2003; Shmitras et al., 2003). These long periods spent sleeping are associated with lower levels of health, mastery, quality of life and social interaction (Leufstadius, 2014). This study also discovered that the daily rhythm of this population often became imbalanced. Those who turned their daily rhythm around by sleeping during the daytime and being active at night, or had a daily rhythm characterised by low levels of activity, seemed to have lower perceived levels of mastery and social interaction.

The continued experience of occupational imbalance within this population could lead to "a sense of isolation, powerlessness, frustration,

loss of control and estrangement from society or self as a result of engagement in occupation that does not satisfy inner needs (Wilcock 1998, p.343). This is likely to occur in individuals who have personal, societal or spiritual values that extol work. Within such communities, work is an occupation that enhances the human need to belong (Bromwich, 1991). An inability to engage in a valued occupation such as work could result in an absence of meaning and purpose in the occupations of daily living (Townsend & Wilcock, 2004). Since individual values bind people to actions through a sense of obligation, lack of engagement in work would negatively impact such individuals' sense of dignity and self-esteem. This could affect the individual's personal recovery from mental illness because self-esteem is a vital component of subjective wellbeing and mental health (Rosenfield, 1997; Markowitz, 2001), and thus improvement of self-esteem is central to the recovery of individuals with psychological problems (Anthony et al., 1990).

The evidence from the above discussions suggests that symptoms of mental illness in working age adults can increase the barriers to employment. This affects the recovery of mental health service-users because unemployed individuals have a higher risk of mental illness and of engaging in behaviours that exacerbate mental health symptoms. This indicates that employment has a direct impact on the recovery from mental illness and, to some extent, the management of its symptoms. Hence, there is a need for specialist employment provisions to engage mental health service-users in work.

2.4. Analysis of employment provisions within acute mental health services.

In 2015, the Conservative Party pledged to reduce the disability employment gap by half by the year 2020 (Mental Health and Employment, 2017). This was part of the continuing work based on a Government review conducted in 2011 which examined the disability employment support fit for the future. This intervention was based on data that showed that disabled people (including people living with mental health disabilities) had much lower employment rates than those without disabilities in the United Kingdom (MHE, 2017). For example, in the year 2014, 44% of disabled people aged 16-64 were in work, compared to 78% of non-disabled people. This increased to 49% of disabled people and 81% of non-disabled people in the year 2016.

The above-mentioned review of the provisions available to support disabled people to return to work also recognised the importance of employment for physical and mental health, independence and social status. It thus recommended specialist employment support for disabled people as indicated below:

- *"Employment matters. Work is positive for health, for income, for social status and for relationships. Employment is a core plank of independent living and for many people work is a key part of their identity.*
- *Public money should be used to deliver the best outcomes – for as many people as possible, on the most equitable basis possible.*

- *There should be a clear recognition of the role of the individual, the employer and the State in achieving equality for disabled people.*
- *Disabled people should have choice and control over the support we need to work. Resources and power should be allocated to individuals who, where they wish, have the right to control that resource to achieve agreed outcomes.*
- *There is a clear role for specialist disability employment expertise – as a resource not a world apart from mainstream support – available to those who demonstrably have the greatest support needs and/or labour market disadvantage, and also to those who support or employ them.*

(Department of Work and Pensions, 2011 p.17)

Vocational rehabilitation is regarded as the specialist disability employment support for individuals with mental health conditions. It is defined as a therapeutic intervention to support individuals with health conditions to stay at, return to, and remain at work (Department of Work and Pensions, 2013). Reviewing the effectiveness of vocational rehabilitation of the mentally ill, Waddel et al. (2013) concluded that while several medical and psychological treatments can improve symptoms and quality of life, there is limited evidence that they improve work outcomes. The review identified an urgent need to improve vocational rehabilitation interventions for mental health problems (Wittchen & Jacobi, 2005). It concluded that there was a rational argument, some consensus, and limited evidence, that people with mental health conditions require supplementary support beyond symptomatic treatment if they are to engage in or return to work. This is because there is evidence that work plays a significant role in the integration of mental health service-users into society. Existing qualitative evidence suggests that individuals with mental health conditions

view engagement in work as vital because they believe that it is a central goal to their personal recovery and resonates with personal accounts and definitions of recovery (Provencher et al., 2002; Killeen & O'Day, 2004; Krupa, 2004; Dunn et al. 2008; Bush et al., 2009; Lopez, 2010). Research also shows that people with mental health conditions, including those with severe and enduring mental illness such as schizophrenia and bipolar affective disorder want to engage in paid employment because they consider it to be a key marker of citizenship (Evans & Wilton, 2019). While Bevan et al. (2013) reiterated this by stating that procuring a job aids the reconstruction of social identity through the reduction of social stigma and self-stigma.

Engagement in work is not only rehabilitative but also directly impacts the health and wellbeing of mental health service-users. Walden & Burton (2006) stated that involvement in work is on balance good for the health. This view was echoed by O'Connor (2012), who stated that consistent engagement in meaningful work has positive health benefits, while being unemployed can result in a wide range of psychological problems which can in turn affect the physical health. Barack et al. (2009) conducted a meta-analysis on the effect of work on mental health. This study concluded that engagement in work led to a reduction in symptoms of anxiety and depression. Saavedra et al. (2016) discovered similar results in that work was described as a means of managing mental health and avoiding triggers. In this study, work was described as a defence against depressive episodes. This led to a reduction in the frequency of hospital

admissions due to relapse. This is because many studies have found that involvement in work has mental health benefits such as better mental health well-being, lower risk of depression and lower incidence of suicide (Boardman et al., 1999). Shuring et al. (2010) analysed the effect of re-employment on perceived health in mental health service-users. This study had similar results in that re-employed participants described an improvement in general health, physical functioning, social functioning, vitality, mental health, bodily pain and role limitations due to a reduction in emotional or physical problems. Hence, re-employment not only positively influenced mental health, it also improved physical health.

Involvement in work creates healthy routines. Modini et al. (2016) stated that work provided financial security and healthy routines for people with severe mental health difficulties. They also highlighted that involvement in work improves self-esteem and provides a consistent opportunity for social engagement for individuals with mental illnesses. Prior et al. (2013) identified similar findings in their study about mental health service-users' perceptions of their readiness for employment. Participants described the enjoyment of a safe routine of sheltered working. They believed that the recognised routine offered by sheltered work gave them a positive sense of commitment and responsibility to worker roles and other people. Saveedra et al. (2016) posited that work provided routines, and that these were highly valued, especially the normalisation of sleeping hours and eating habits. These participants also explained that the organisation of their day was more efficient in comparison to days when

they were not at work. They concluded that work supported them to be able to devote time specifically for leisure activities which hitherto, prior to their involvement in work, could not be easily differentiated. Involvement in work helped the participants to structure their time, encouraged routines for work and timetables within job roles. A combination of all of these measures supported them to devote time specifically for leisure activities.

Engagement in work has been argued to provide a sense of achievement for mental health service-users. Fossey and Harvey (2010) concluded that work gave individuals living with mental illness more independence, a sense of pride for achievement, improvement of abilities and personal development. Their study concluded that the positive relationships formed at work could improve social integration by promoting a sense of belonging. This made them feel welcome and supported. This was echoed by McQueen and Turner (2012), who reported that participants within their study identified that work justified their existence by giving them a sense of purpose. Barack et al. (2009), meanwhile, concluded that engagement in work can lead to sense of fulfilment and happiness.

In contrast, some studies identified that engagement in work has challenges for people with mental illness. Saveedra et al. (2016) identified that some service-users found their engagement in work to be stressful, tiring and responsible for a reduction in free time. Their narratives reflected how a lack of personal meanings in jobs can have a negative effect on their health. The study also described how some participants struggled to accept and react appropriately to criticism at work. Some service-users described

the anxiety and stress about decision making at work. This study concluded that the most important cause of stress was conflict management at work. Savla et al. (2013) posited that shortfalls in conflict management, such as in recognising and expressing emotions, are part of the problems associated with serious mental illness. Interestingly, however, none of the service-users saw deterioration of their health as being a direct consequence of their engagement in work.

These contrasting outcomes in respect to the engagement of mental health service-users in work is evidence of the need for specialist employment services to support them to obtain employment, return to work, gain the positive outcomes, and manage the negative outcomes of engaging in work. This statement was echoed by both Tschopp et al. (2007) and Boyce et al. (2008), who stated that while service-users can face barriers to engage in work, support from employment agencies, rehabilitation programmes and the workplace can help to overcome these barriers. As identified in the government review in 2011, there are two key elements within the specialist disability employment expertise programmes aimed at supporting mental health service-users to engage in or return to work. These are the vocational interventions, consisting mainly of Individual Placement Support (IPS) and pre-vocational training (Beck & Wernham, 2014), and the mental health interventions, which aim to improve vocational outcomes by reducing the symptoms of mental illness, such as occupational therapy and Cognitive Behavioural Therapy (CBT).

Prevocational training is based on the premise that mental health service-users require extensive preparation before entering competitive employment (Rose & Harris, 2005). Methods of vocational rehabilitation in prevocational training include job skills clubs, hospital-based work programmes, sheltered workshops, transitional employment, alternative industries and work crews.

Within vocational services, IPS is recognised as the most effective evidence-based supported employment approach for people with severe mental illness. This has been demonstrated by eleven randomised controlled trials that have proved its efficacy in successfully engaging mental health service-users in employment (Bond et al., 2008). Crowther et al. (2001b) also conducted a systematic review to compare the impact of prevocational training, supported employment and standard care on the ability of mental health service-users to obtain employment. This study concluded that individuals who engaged in supported employment programmes such as IPS were more likely to be engaged in competitive employment compared to the other approaches. Drake et al. (1996) compared the outcomes for individuals with mental health conditions who were involved in prevocational training compared to a sample who were involved in IPS. The study stated that the participants in the IPS sample reported higher employment rates, more hours worked, and more income earned at 18-month follow-up compared to the group receiving prevocational training. The study attributed the higher employment rate in

the IPS group to the integrated approach, which combined both clinical and vocational services.

Bond et al. (2004) explained that employment specialists are responsible for providing IPS support based on the following guiding principles:

- Rapid job searches.
- A principal goal of competitive employment.
- Focus on the choice and preferences of service-users.
- Incorporation of mental healthcare services with employment support.
- Indefinite support.
- Adjustments at the worksites; and provision of financial and benefits advice at an early stage in IPS.

As stated above, the mental health interventions that improve vocational outcomes by reducing the impact of mental health symptoms include occupational therapy. Within occupational therapy, engagement in work alongside leisure and self-care form the three elements of occupational participation. A balanced engagement in these elements is essential for recovery from mental illness (Crist et al., 2000). This is why the College of Occupational Therapy (2012) recommended that occupational therapists find out the aims of service-users towards employment at the earliest opportunity, including during rehabilitation. This

view was reiterated by McQueen (2011), who suggested that occupational therapists should encourage supported employment or prevocational rehabilitation as part of occupation-based interventions for service-users. Lee et al. (2018) had similar views about the importance of the involvement of occupational therapists within work placements. Their study analysed employment outcomes after vocational training for people with chronic psychiatric disorders, finding that participants who received post-training vocational counselling from occupational therapists in a mental health setting were 49% more likely to be employed than those who received vocational counselling from other specialists. Lilywhite and Haines (2010) acknowledged the importance of occupational therapists within work placements by stating that occupational therapists are strategically placed to support mentally ill service-users to get into work because of their long-established clinical practice of working with people with disabilities to support or improve function in all aspects of their daily lives. Occupational therapists have the skills to assess how service-users interact with the environment to engage in work. For example, as part of a smooth introduction to work, occupational therapists assess the emotional response of service-users before their introduction to work, especially if it is an unfamiliar activity (Sherwood, 2010). Occupational therapy models such as Vona du Toit's Model of Creative Ability (MOCA) are used to assess the emotional responses of mental health service-users, and their ability to cope with change before their introduction to work. It proposes activity requirements that could be transferred to job roles, and the presentation

of job roles as part of a successful introduction to work. An example of a person-centred assessment tool within the MOCA is the Activity Participation Outcome Measure (APOM). Crouch and Alers (2007) stated that this measure can be used accurately to assess the nature of task concepts, engagement, prevocational skills and vocational skills.

A unique aspect of the APOM is its ability to assess areas of occupational performance that are not reflected in traditional occupational therapy assessment tools. Such areas include:

- Attitude to and ability to make relational contact with materials, objects, people and events in the environment.
- Ability to plan, initiate and sustain effort until the activity is complete, or to continue at the same level of performance if the activity or task is repetitive.
- The individual's quality of performance and ability to evaluate the products against set standards.
- Ability to engage in activities with or without supervision.
- The amount of environmental structure required for adequate participation and ability to set and meet norms.
- Ability to control anxiety when faced with routine tasks and new challenges.
- Ability to act with originality to solve problems and act on decisions made.
- Response to engagement and emotional response to performance and the end product-particularly the way the individual appraises his abilities.

(Kielhofner, 1985; 2002)

Occupational therapists make use of assessment tools such as the APOM to assess service-users' emotional responses accurately and make recommendations about handling techniques during their introduction to

work. This helps work trainers and members of staff identify service-users with poor emotional responses and support them with skills to manage anxious situations. As a result of these unique skills, the COT (2007) recommended that occupational therapists should navigate vocational services within mental health services because they are ideally skilled and positioned to deliver effective support into the workplace.

Another type of specialist service that has been evidenced to support the mentally ill to return to work is Cognitive Behavioural Therapy (CBT) (Lysaker et al., 2009; Bee et al., 2010; Minjoo et al., 2014; Reme et al., 2015). Minjoo et al. (2014) conducted a systematic review to assess the effectiveness of CBT on work-related outcomes for individuals with mental illnesses. They posited that, amongst people with mental illness, cognitive behavioural therapy had a positive impact on work-related outcomes such as improved vocational functioning, job satisfaction, vocational related cognitive functioning, employment status and expectation for success. They concluded that a combination of vocational services and general CBT was the most effective in improving vocational functioning, work engagement and the expectation of success in work for people with mental health issues.

The effectiveness of the combination of CBT and vocational services in employment support for people with mental illnesses was also evidenced by Reme et al. (2015). They compared the integrated work-focused CBT with Individual Placement Support and usual care treatment (treatment from their GP and other health professionals, and encouragement to use available services, follow-up from psychologists and self-help resources).

Results indicated that an integrated approach of work-focused CBT and IPS was more effective than usual care in increasing or maintaining work participation for people with mental illnesses. The review recommended CBT approaches, with vocationally related services as the most effective approach for the vocational rehabilitation of mental health service-users.

Despite the evidence for the effectiveness of CBT in vocational rehabilitation for general mental illness, it has limited success for specific mental illnesses such as Personality Disorders (PDs) (McMahon & Enders, 2009; Zanarini et al., 2010). This is because, in PDs, vocational functioning is not directly related to an improvement in mental state. Mental health symptoms in PDs, such as emotional instability, behavioural regulation problems, identity disturbance, and difficulties with relationships create significant challenges to vocational rehabilitation, because employment settings require such individuals to demonstrate self-awareness and self-control of these symptoms (Feigenbaum, 2018). Good vocational outcomes within PDs therefore require specialised forms of CBT specifically adapted to the needs of this population.

Dialectic Behavioural Therapy is a comprehensive form of CBT that has been proven to be effective for PDs (Lineham et al., 1993; Lineham et al. 1994; Bosch, 2005; Stoffers-Winterling et al., 2012). DBT is based on the position that individuals with PDs lack interpersonal, self-regulation and distress tolerance skills. It identifies the impact of personal and environmental factors on behavioural skills through reinforcing dysfunction.

Several Randomised Control Trials have found DBT to be more effective than usual treatment for individuals with BPD (Koons et al.2001; Linehan et al., 2002; Verheul et al., 2003), especially in reducing the frequency and medical severity of suicide attempts, self-injurious behaviour, frequency and total days duration of psychiatric hospitalisations, emotional dysregulation, and in improving treatment compliance and social adjustment. Nonetheless, research evidence on the effectiveness of combining DBT with vocational services to improve employment outcomes has been limited since existing studies are based on poorer quality evidence such as pilot studies, small sample sizes and a lack of control groups (Koons et al., 2006; McMain et al., 2012; Elliot & Richard, 2014; Feigenbaum, 2018).

This section has identified the employment provisions for mainstream mental health services and concluded that engagement in work can be beneficial and challenging. It also suggested that IPS is the most effective programme for the vocational rehabilitation of mental health service-users because it integrates mental health interventions such as CBT alongside vocation-focused interventions to improve vocational functioning, work engagement and the expectation of success in work for people with mental health issues.

2.5. Analysis of the employment provisions for service-users within secure hospitals.

For mental health service-users living within secure hospitals the prospects of gaining employment are particularly challenging, especially if they have been detained for a long period of time (Samele et al., 2018). Long detention in hospital can lead to situations whereby the patients are stripped of their past roles to take on a purely institutional role (Chow & Priebe, 2013). As well as their normal social roles being taken away, patients in secure mental health hospitals tend to be subjected to restriction of freedom and suffer from the stigma of being a psychiatric patient. This is especially the case in secure services, where the stigma of mental illness and offending history produces substantial barriers to employment (Tschopp et al., 2007). Duncan (2008) identified commonplace barriers to employment for mental health, such as stigmatisation, low self-esteem, low motivation, anxiety over losing benefits and unwillingness of employers. This study also identified that service-users with forensic histories encounter uphill tasks because of the negative impact on employment opportunities of their disclosure of criminal convictions. Sahota (2010) conducted a study that reported on the social adjustment of men and women after discharge from secure hospitals. This study discovered that only 12.9% of men and 13.5% of women gained employment after a 20-year follow-up. This study highlighted that the resources to gain employment skills were particularly poor within mental health hospitals that

provide services for longer hospital admissions. Niven and Stewart (2013) concluded that employment training and education for secure mental health service-users were particularly poor when compared to released prisoners without diagnosed mental health conditions. In comparison to the latter, secure mental health service-users had inadequate resources and lacked established employment programmes. This dilemma was echoed by Samele et al. (2009), who stated that provisions and interventions to assist service-users leaving secure mental health hospitals to gain employment, training, or education, such as IPS, were limited in comparison to effective interventions for people in acute mental health services. Accessible employment support after discharge from secure hospitals was also not generally geared towards addressing needs related to forensic mental health, thereby increasing the risk of relapse and recidivism (Beck & Wernham, 2014). One of the few evidence-based employment interventions for mental health service-users within secure hospitals is prevocational training (Samele et al., 2018). This form of supported employment has proved to be significantly limited and less effective in addressing their employment needs when compared to evidenced-based approaches such as IPS. Webster et al. (2001) discovered that this traditional work-based scheme usually facilitated within secure hospitals in the United Kingdom was seldom effective in reproducing the environments of community-based workplaces. Workshop environments did not reproduce those of the workplace, such as the development of relationships with supervisors and colleagues and adhering to working hours. Webster et

al. (2001) continued by stating that institutional barriers like staff shortages resulted in limited attendance at work sessions which negatively impacted on the service-users concentration and enthusiasm. Drake and Bond (2008) argued that there was a lack of harmonisation between prevocational training services and mental health services in areas such as finances, workforces and documentation, leading to a lack of coordination in the services needed by mental health service-users to enter or return to the labour market. Hence, even though there is evidence-based research indicating the effectiveness of supported employment, more research needs to be carried out to assess the impact of evidence-based approaches such as IPS in forensic settings.

2.5.1. Current Lived experience research

Only a few studies have examined employment-focused interventions within secure mental health, with most of these containing expert opinion pieces with little emphasis on the views of service-users or lived-experience studies that reveal these views (Coffey, 2006; Smith et al., 2010). As a result, there is a dearth of lived-experience viewpoints which can be specifically helpful to explore if the vocational services have been effective or ineffective in clear and useful terms (May, 2000). By engaging directly with service-users, what is important to them can be explored and how service-users with a forensic history attribute meaning and purpose to vocational opportunities can be understood (McQueen & Turner, 2012). A

comprehensive literature search such as evidenced in Table 1 yielded a few studies that have conducted lived-experience research.

Samele et al. (2018) conducted an exploratory study to support forensic mental health service-users into work and vocational activities. The project was initiated using IPS principles of securing paid employment. Due to unspecified difficulties, however, the study adopted a different type of employment and social inclusion approach and included other vocational outcomes. The study recruited 57 participants, with data collected through semi-structured interviews and analysed using Interpretative Phenomenological Analysis (IPA). The semi-structured interviews explored how participants heard about the work programme, their hopes and ambitions about employment, the support received from members of staff, and what they thought about it, and what problems they might encounter in searching for and obtaining employment.

An analysis of this study indicated that it was limited in terms of a lack of in-depth description of the analysis process. It was unclear how the themes were derived from the data and analysed. The study did not explain how the data presented was selected from the original sample to demonstrate the analysis process. Another limitation of this study was that it did not explain if there was any contradictory data from the study. The findings in this study revealed that twelve participants were successfully able to engage in voluntary work, and another twelve able to engage in paid work. Four of the service-users achieved competitive employment and attributed this to the support that they received within the project. Two of

the participants could not retain paid employment beyond three months, however, due to breach of licence and a mental health relapse. Participants attributed their successful engagement in work to the tailored and flexible support offered within the service. Participants identified the benefits of engaging in work as building trust and confidence, teamwork, and positive relationships.

McQueen and Turner (2012) conducted a study that explored ten forensic mental health service-users' views about work, in particular in respect to how services promote their goals of employment, the development of skills for work, and the vocational rehabilitation process. A purposive sample was recruited which was appropriate for the aims of this study. The study clearly stated how data was collected through semi-structured interviews and ethical considerations were addressed and described. The data collected were analysed through Interpretative Phenomenological Analysis (IPA). The results of the study indicated that work supported participants to normalise their lives by giving them a sense of self-belief, satisfaction, confidence, achievement and usefulness. The participants identified barriers to employment as including fear of the unknown, stigma, lack of aspiration, paranoia and pressure. The participants identified the practical help and encouragement that supported them within work. These included forming coping strategies, gaining independence, returning to the person they were before becoming ill, feeling listened to and being part of a community.

One of the participants questioned the importance and value of working without being paid (in the form of voluntary work). This participant was frustrated about the limited choices of voluntary work because his values were grounded in paid work. Another participant indicated that individual needs of work were overpowered by authority figures such as doctors. Hence, they felt they were being forced to engage in voluntary work.

The first limitation identified in this study was the use of a population sample of community-based participants and hospital-based participants. This meant that the lived experiences explored cannot be used exclusively as a representation of mental health service-users in secure mental health hospitals. The study itself acknowledged some other methodological limitations to the analysis of this subjective experience. One of the limitations identified was how the analysis was moulded by the researcher's interpretative position. The researcher's vested interest in vocational rehabilitation may have affected the interview process and analysis of the results. This discussion reveals the debate between descriptive and interpretative phenomenology during the investigation of a little-known phenomenon of a peculiar population often characterised by powerlessness. It raises the question of how a researcher who has vested interests in vocational rehabilitation can interpret the lived experience of forensic mental health service-users unbiasedly without safeguards such as bracketing.

McQueen and Turner (2012) recognised this limitation and attempted to reduce such bias by employing an independent researcher without knowledge of vocational rehabilitation to analyse the results. This was done to ensure that the process of analysis was transparent and adequately distance the analysis from the researcher's bias. A further methodological limitation of this study, however, was its focus on understanding the lived experience of participants without explaining why these experiences come about. This includes exploring the circumstances that caused the experiences which are captured in past events and histories (Tuffour, 2017).

In attempting to explore the lived experience of work in service-users living in long-stay hospitals, Smith et al. (2010) conducted a study to establish a work-based learning programme within a secure learning disability setting. The aims of the work-based programme included:

> Offering a graded progression into working in the community; offering an accredited course that focused on the acquisition of work-related skills and opportunities to apply and develop literacy and numeracy skills; developing appropriate social interaction within a work-based setting; increasing self-esteem and confidence by promoting personal responsibility; and increasing awareness of health and safety within the workplace.

Interviews were carried out to gain the service-users' perspectives of the programme. Themes that emerged from this study indicated that work supported participants in being busy, improving personal literacy and numeracy skills, and work-based skills such as concentration, working towards a qualification, increased self-confidence, self-esteem and a sense of achievement. The results of this study were limited, however, because its methodology was not identified. Hence, it can be assumed that the method of data collection through interviews was not done in the context of any ontological or epistemological position. Neither did the study identify a defined methodology based on an ontological standpoint. This indicates that methodological safeguards during data collection to prevent researcher bias were not present in the study. The findings of the study, therefore, cannot be viewed as reliable. The study claimed that this work programme was helpful in securing future work because workplaces were based in the community rather than traditional long-stay work-based inhouse programmes, which do not meet the expectations of competitive employment. Data on rates of securing competitive employment or tenure of employment were absent, however, making it difficult to assess the extent to which this employment programme was more effective in comparison to traditional long-stay work-based inhouse programmes such as prevocational training.

Cox et al. (2014) conducted a qualitative study that described the details of establishing a vocational rehabilitation programme for a secure

learning disability service. The aims of the programme were to: offer accessible employment roles that replicate "real work"; offer an approach modified for service-users with learning disabilities that sustains an accurate replication of the employment process; support service-users to develop practical working and social skills; and increase self-esteem and confidence. The results showed that programme leaders observed improvements in the work skills of service-users, such as punctuality, interpersonal skills, managing duties, time management and working relationships with supervisors. Despite the findings, the inability of this study to explore the lived-experience views of participants about their engagement in this work programme is a limitation. May (2000) explained that lived-experience perspectives can specifically explore the effectiveness of interventions such as work in clear and useful terms. In best practice, the mental health service-user should not be a spectator, but an active participant in his own care. The findings of this study cannot be defined as reliable without an exploration of the views of the mental health service-users. Another limitation of this study was a lack of detail regarding ethical research practices.

One of the few studies that attempted to replicate community-based workplaces within a secure hospital was conducted by Beck and Wernham (2014). This study introduced social enterprises to a secure hospital based on the principles of individual placement support and the occupational therapy paradigm of occupational balance. The enterprises offered

opportunities for service-users to be involved in meaningful employment within a variety of areas so as to develop skills that future employers would value, consequently significantly increasing the likelihood of obtaining work within a competitive labour market. This enterprise taught employment-related courses that encouraged service-users to reflect on their plan for community employment. These courses educated attendees on how to disclose a mental health condition or a history of criminal conviction, permitted work, reasonable adjustments, job applications and effective interview skills. The enterprise also offered both paid and unpaid roles and delivered successful outcomes in that service-users who were engaged in the programme were able to obtain employment upon discharge from hospital. Data collection for the qualitative part of the study was done through customer feedback, service-user evaluation, and feedback from clinical teams, both directly and indirectly through clinical reports.

The lived-experience findings of this study were limited because of the lack of a defined ontological and epistemological position to guide the data collection and analysis of data. Hence, the data collection process was susceptible to research bias, especially through second-person data collected through clinical reports and feedback from clinical teams. Another limitation identified by this study was the challenges of balancing security and therapeutic risk-taking. This included maintaining a staff-to-patient ratio which could be viewed as restrictive and intrusive but was nonetheless a requirement within secure hospitals in order to meet needs and address issues of safety. The enterprises had a regular turnover of team leaders

and trainees because of progress to community employment. Additionally, it was challenging to maintain the financial sustainability of the enterprise.

Macdonald and Bertram (2018) conducted a study to evaluate a decorating project developed with secure mental health service-users. semi-structured interviews were used for data collection. The study discovered that all the service-users were driven to be employed and earn incomes. However, a combination of health problems, anxiety about approaching employers and disclosing their offences, and mental health problems, left participants feeling apprehensive about the likelihood of obtaining work. Participants doubted their capacity to work full time after long periods of unemployment and detention within a secure mental health unit. Another area that was identified was that involvement in work provided comradeship for the participants in this study. They revealed the differences of working within their work team in comparison to the arguments and conflicts they had been involved in within their mental health units. All service-users within this study identified that work provided them with structure, including giving them a focus for their week and a means of socialising with their peers. Service-users described benefiting from the social aspects connected with the work project because they were living on their own, and thus otherwise going through extreme social exclusion and isolation. Work also provided therapeutic benefits for participants in this study. They described that their involvement in work positively affected their health and wellbeing, specifically through improvements in mood, self-worth, physical fitness, and optimism for the

future. They described a reduction in their depression, anxiety and stress. The participants attributed these therapeutic benefits to the sense of fulfilment arising from engaging in work, the physicality of the work, and having responsibilities to occupy their minds. This study described how earning a wage can affect the engagement of participants in work. Participants described that they valued the wages on a practical and emotional level. The wages supported the service-users to feel that they were appreciated, and their work respected, thus making their involvement in work meaningful. The extra income also improved their quality of life. Nonetheless, some methodological limitations were identified within this study. Firstly, a methodological framework was not identified for the data collection and data analysis. Hence, the data collection process was prone to be influenced by researcher bias. How ethical issues in the research were addressed was also not described. This limitation calls into question the integrity and transparency of the study.

This analysis of studies that have described the lived experience of work in service-users living in mental health secure hospitals revealed both positive and challenging experiences. These are summarised in Table 2.

This analysis further revealed that there were strengths and limitations within the studies examined. These are described in Figure 1.

As demonstrated in Figure 1, few studies have investigated the lived experience of work among mental health service-users living in secure hospitals. None of the studies captured their lived experiences with the use

of a methodology that prevented the influence of the researcher's preconceived ideas. Only one study described the ethical process involved in the recruitment of service-users. This raised concerns about the integrity and transparency of the research process in some of these studies or the journals that published these studies.

Based on the limitations of these studies, there is a need for research that will investigate the lived experience of this population using a transparent ethical process and a methodology that produces an unbiased analysis of their experiences.

2.6. Summary

This chapter has explored the historical philosophies of work as a social norm in Western society and its importance for the societal integration of mental health service-users. It analysed studies that explored the lived experience of service-users living in secure mental health hospitals who were involved in work. This analysis highlighted the need for more robust research into the lived experience of this population.

The next chapter includes in-depth discussions about the underlying research question, ontological position, methodology, research underpinnings for the choice of the methodology and the method of analysis.

Chapter Three – Methodology

3.1. Ontological position

This chapter discusses the research paradigms that underpin the choice of the methodology. The aim of this research was to understand the lived experience of work among service-users living in secure mental health hospitals. This involved asking questions about the relationship between the knower and what is known, enquiring about how we know, what we know and what counts as knowledge (Krauss, 2005). These enquires describe the ontological standpoint. The relationship between the knower and what is known can be explored through qualitative and quantitative methods.

Punch (2014) proposed that the most effective technique to differentiate between qualitative and quantitative methods of research is based on three factors: the way the investigator approaches the social reality being studied; the methods used to collect the data and represent the phenomenon being investigated; and, the data, wherein quantitative data is often epitomised through numbers while qualitative data is mostly presented through words.

Yoshikava et al. (2013) also compared quantitative and qualitative research. They posited that quantitative methods investigate numeric illustrations of the world or the phenomena being researched, while qualitative methods investigate non-numeric illustrations such as words, texts, narratives, pictures or observations. They concluded that the world

is not inherently qualitative or quantitative, but that it is the historical challenge to describe and interpret the world through numeric or non-numeric systems that makes research either qualitative or quantitative.

Khouri (2010) proposed that qualitative research seeks to discover meaning and understanding, rather than to verify truth or predict outcomes. Since the aim of this study was to understand rather than verify the lived experience of work in mental health service-users living in secure hospitals, qualitative research was appropriate to meet the aims and objectives of this study.

It was further examined whether the lived experience of work being studied had one comprehensible reality that could be measured (positivism) or multiple realities (constructivism) which needed to be interpreted, in order to uncover the underlying meaning of events, activities and behaviours (Olson, 1995). This involved a critical consideration of the methodology that would effectively address the aim of this study. A constructivist ontology was chosen over a positivist ontology because the lived experience of work had multiple realities, including my own reality as a researcher and the realities of each of my potential participants (Kinash, 2010b). For example, one participant might view work as a necessary inconvenience to aid discharge from hospital. While another might view it as a therapeutic engagement. It was realised, therefore, that each participant in this study would have experiences from their own point of view. Consequently, each individual experiences a different reality. Investigating their lived experiences without accounting for this would have

violated the fundamental view of the participants. The multiple realities of the lived experience of work meant that knowledge could only be established through the meanings attached to the phenomenon which was intended to be studied. As a researcher, I would have to interact with the participants in the study to obtain data, acknowledge that the investigation would change both me (as the investigator) and the participant; and that the knowledge from the investigation was dependent on context and time (Cousins, 2002).

This position that there is no single reality or truth was identified as the naturalist or constructivist ontology. Lofland and Lofland (1996) explained that the naturalistic engagement in direct observation and understanding follows a specific epistemology that includes two main tenets: that one must participate in the mind of another human being in order to obtain social knowledge; and that face-to-face interaction is the most essential requirement for participating in the mind of another human being, understanding not only their words but the meanings of those words as understood and used by the individual. I therefore required a theoretical perspective that could adhere to the two epistemological tenets of the naturalistic ontology.

3.2. Phenomenology

Different forms of constructivism were examined to ensure that the methodology that best answered the research question was chosen for this

study. For example, the ethnographic methodology was considered. According to Brewer (2003), ethnography is the study of people in naturally occurring settings or 'fields' by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting (if not always the activities) in order to collect data in a systematic manner, but without meaning being imposed on them externally.

Ethnography was not considered for this study for the following reasons. Firstly, ethnographic studies require a long-term data collection process. For example, Colin M. Turnbull lived with the Mbuti people for three years in order to write the classic ethnography titled "The Forest People" (Turnbull, 1961). This method of data collection was inappropriate for this study because it had a time-limit of two years in line with the completion of a professional doctorate degree. Secondly, this research intended to understand specifically the lived experience of work among individuals living in a secure hospital rather than the culture of this group. Studying the culture of this group would have required the informed consent of all members of this group which would been impractical given the time limit on this study. Lastly, ethnography would have required the researcher to participate within this natural setting. This would have been impractical due to the level of security of the setting, level of risk and ethical issues involved in living with patients held under the Mental Health Act (1983). As a naïve researcher, being embedded in this group could have also increased researcher bias because of the difficulty of maintaining the necessary

distance for the subjective interpretation required within ethnographic studies (Hammersley, 2018).

Another constructivist methodology that was considered for this study was grounded theory. This approach, however, could not answer the research question, which was to understand how service-users within a secure mental health hospital unit experience work. Rather than understand lived experience, grounded theory intends to explain a phenomenon through building theories (Scott, 2007b).

The methodological choice of phenomenology was consistent with the aim of this study. A phenomenological approach was appropriate to determine, comprehend and explore the multiple realities of the lived experience of the participants involved in this study (Carpenter & Suto, 2008). Phenomenology "uses lived experiences as a tool for better understanding the social, cultural, political or historical context in which those experiences occur" (Polit & Beck, 2012 p. 490). It focuses on meaning and interpretation – how socially and historically conditioned individuals interpret their world within their given context. The phenomenological methodology originates principally from an attempt to form a reflective and scientific view of evidence to produce objective truths and the use of reflections to discover the appearance of subjective truths (Reeder, 2010). It utilises self-criticism to raise questions about one's views with the aim of clarifying and refining such views. During such self-critical reflections on experiences, phenomenology pursues the clarification of the lived experience of the experience itself. In other words, the phenomena which

phenomenology studies investigate are, broadly, the lived experience. Giorgi (1997) stated that phenomenology is the entirety of the lived experience of a single person in consciousness. He explained the importance of consciousness in the totality of lived experience, describing it "as the medium of access to whatever is given to awareness, since nothing can be spoken about or referred to without implicitly including consciousness" (Giorgi, 1997 p.236). He further explained that consciousness is not a neutral medium through which experiences are presented, but directly contributes to the meaning of such experiences by the fluidity of its styles, forms and modes.

3.3. Positionality of the researcher

Dombro (2007) stated that the position of a researcher is important in defining what is real and what is known. This is defined as the epistemological view or way of knowing. It was therefore essential for me to reflect critically on my position as the person conducting the research (Guber & Lincoln, 2005). As an occupational therapist, I have always believed in getting the job done despite inadequate resources. On a locked rehabilitation ward, I have worked both as a technical instructor, and as an activity coordinator. This frequently included working long hours and engaging my service-users in back-to-back daily therapeutic activities. I have combined my extended working hours with my role as a boxing mentor, a drummer in my church and as a part-time student in a professional doctorate programme. I observed my father becoming

extremely dissatisfied and unhappy when he retired because of a loss of purpose and his sense of identity. Upon reflection, I believe I am a 'workaholic' who enjoys long work hours. I believe that work in any form has a positive impact on mental health. As an occupational therapist, it has been ingrained in me that work forms an important part of a holistic treatment that is beneficial to the recovery of mental health by acting as a form of vocational rehabilitation. Over years of clinical practice, I have continued to believe that work has therapeutic value and is essential to an individual's sense of wellbeing. Hence, I use work consistently as part of treatment plans and endorse it as an important part of mental health rehabilitation.

My belief system is heavily grounded in the bias that work is beneficial to physical and mental health. I remember my parents instilling in me that "hard work does not kill, the wrong work (idleness) kills". Growing up, I watched my father combine his full-time job as a geoscientist and as a clergyman while my mum worked as a trauma nurse in an accident and emergency unit while raising children. Every weekend, there were stories from both of my parents about the benefits of work and their achievements as hard workers. As a teenager, I was given structured weekly work within the household such as washing the cars, doing the laundry and, on Sundays, ensuring that the sound system was ready for use for the service.

My belief system is therefore grounded in the perspective of a mental health occupational therapist, and an upbringing that emphasised the importance of hard work. My professional background and belief system

were identified as a potential bias. These formed preconceived ideas about work as a beneficial therapeutic engagement. Denzin and Lincoln (2003) stated that to understand a phenomenon, the researcher and participant must work together to create a shared understanding which enables the researcher to be able correctly to describe, interpret and represent the information for the neutral observer. As a researcher, my reality was created from my profession as a mental health occupational therapist and my experience as an individual who has been trained by my parents to cherish being involved in work. Dobson (2002) posited that the researcher's theoretical lens plays an important role in the choice of methodology because the underlying belief system of the researcher largely defines the choice of methodology. Hence, it was essential for me to utilise a methodology that would prevent my preconceived ideas from influencing my investigation into the lived experience of service-users living in secure mental health hospitals who were involved in work.

3.4. Descriptive phenomenology

Husserl's descriptive phenomenology enabled me to use the fundamental methodology of bracketing. This allowed me to bracket my own experiences and ensure that I did not influence the participants' understanding of the phenomenon. The choice of Husserl's phenomenological method also gave mental health service-users the opportunity to tell their own story about involvement in work whilst in hospital without any external influence. As a result of my preconceived

ideas and the fact that I have never been a mental health service-user, it is my belief that trying to interpret their experiences from my perspective would have distorted the description of their lived experiences. This would have created a bias that would potentially affect the results of this study.

Edmund Husserl (1859-1938) spent his lifetime developing the philosophy of descriptive phenomenology and is regarded as one of the founders of that method. Husserl (1913) viewed phenomenology in three ways: as a science of sciences, which strived to determine the basis of consciousness; a first philosophy; involving transcendental idealism–transcendental ego as the source of all meaning.

Husserl believed that information and insight do not come from large amounts of data but develop from a rigorous study of experiences (Husserl, 1913). He posited phenomena as the subject matter of phenomenology and defined it as "ourselves, other people, the object and events around us". Husserl further defined phenomena as a reflection of our own conscious experiences as we experience them. According to Husserl (1913), there are two spheres of consciousness that clarify the sense of the world as it actually exists: the "worldly" and the "psychological". These spheres are linked by the mind's skill to pass between them as easily as it can meander about and through them. The mind can also combine, concentrate, linger within and disperse. Husserl argued that the link between the "worldly" and "psychological" is interlinked with a third sphere—the consciousness—where experiences and intuition act out their part.

Husserl postulated that the phenomenological process is to move from the worldly and psychological spheres to the sphere of absolute consciousness. The process of phenomenological reduction ensures the movement into the sphere of absolute consciousness. This phenomenological process posited by Husserl was summed up by Morley (2017) in three steps:

> *"First, one turns toward the object whose essence must be determined and one describes it; second, one must assume the attitude of the transcendental phenomenological reduction; finally, one must describe the essence or invariant characteristic of the object with the help of the method of free fantasy variation" (p.178)*

Husserl utilised eidetic phenomenological reduction, which he explains as the process of seeking to momentarily reduce, and effectively erase, the world of speculation by returning the subject to their primordial experience of the matter (Husserl, 1913). Luft (2004) argued that an understanding of Husserl's phenomenological reduction depends on an understanding of the epistemology of phenomenology. Luft defined this as the process of attaining true knowledge. Husserl (1913) used the example of a building to demonstrate the ability of an object to yield different "views" without invalidating others. He pointed out that an observer does not have to consider the north face of a building and then a south face to get the whole picture.

This can be exemplified in the way work is viewed by observers. My view of work in secure hospitals as an occupational therapist might be

different to that of a mental health service-user. These different perspectives are defined as situational truths or standpoints. My standpoint as an occupational therapist does not contradict that of a service-user because they do not compete. Luft (2004) argues that the interest of the observer determines the truth of the situation. For situational truth to be absolute truth, therefore, it must block out other contradicting truth. My interest in work as an occupational therapist is based on its importance in mental health rehabilitation. The mental health service-user however might be interested in the use of work to occupy free time while in hospital. These interests explain the situational truths of the mental health service-user and the researcher when describing work. To make the situational truth of the service-user the absolute truth, my situational truths must be acknowledged and suspended. Despite the different perspectives of the observers, however, the fact of being involved in work remains the same. Luft (2004) concluded that Husserl believed that while an observer was in the natural attitude (everyday being in the world), an object could not be seen in its purity as this would involve stripping the world of its interest. Due to its intentional character, life always implements a certain interest. From the concept that the world consists of multiple interests, Husserl (1913) coined the term lifeworld or natural world-life. He concluded that to live in a natural life world, one must have a natural attitude: a judgement on the existence or non-existence of the natural world-life.

My natural attitude (situational truth) may be polarised when compared to that of my participants. Based on Husserl's view, this could

influence the outcome of the research process in terms of capturing their lived experience. To make their situational truths absolute, I had to bracket my preconceived ideas through phenomenological reduction. Husserl (1913) defined phenomenological reduction or "epoche" as "withholding judgment" on either the existence or nonexistence of the natural world. He explained that epoche does not trade the researcher's preconceived beliefs of the existence of the world with the opposite conviction. Rather, it proposes epoche as a means of suspending judgement of the natural world (Husserl, 1913). Using the example of my view of work as a researcher and that of a mental health service-user, I had to suspend my judgment about work to confirm their absolute truth. The time between the uncertainty and confirmation of judgement is considered as "bracketing".

Husserl explained reduction in three phases: retention, bracketing and eidetic reduction. Rodemeyer (2009) explained that the movement of objects and a counting agent was essential for the understanding of time. Time necessitates an awareness of change; a recognition of the difference between what came before and after. This requires retention. Husserl explained the importance of retention in his book titled "A Treatise of human nature" (Husserl, 1913). He posited that to avoid changing the lived experience during the process of describing an experience, description needs to be performed on an experience as it is held in retention. Husserl explained the concept of retention through the analogy of the tune of a song. When hearing the last note of a tune, an observer still retains the former notes in the living present. The former notes are not present as

heard, otherwise the observer will not hear a melody but a chord. These former notes are retained until the melody sinks into the past. Husserl differentiated between retention and memory. He explained that as the song tune sinks into the past, new experiences occur until the song tune is no longer retained as it is no longer a part of the living present. This song tune can only be remembered as a memory and, by this time, judgement about the melody would have occurred. As a result, retention is a more reliable tool of investigation than memory because it describes an event before it is influenced by the researcher's judgement.

Bracketing can only occur effectively when an observation is held in retention. Bracketing is a methodological strategy of phenomenological analysis that involves purposely putting aside one's own belief about the phenomenon being investigated, or what the investigator already knows about the subject prior to and throughout the phenomenological investigation (Carpenter, 2007). Husserl (1913) explained bracketing as a process that involves the assumption that the appearance of an object is not real, instead recording the mode in which it appears. Morley (2012) explained the importance of bracketing to qualitative research by stating that "a qualitative method alone, without an accompanying approach offered by the phenomenological epoche, is continuously vulnerable to defaulting back into naturalistic thinking" (p.165).

Heidegger (1963), who was a student of Husserl, objected to the feasibility of Husserl's principle of bracketing. He believed that bracketing prevented the provision of answers about the relationship of the object

being investigated with the outside world. This resulted in a detached, external view of the object in view, thus misrepresenting or distorting it. Ahern (1999) and Carpenter (2007), however, stated that bracketing is a means of evidencing the validity of the data collection and analysis process by intentionally putting aside one's own belief about the phenomenon under investigation. Moran (2000) reinforced the importance of bracketing by stating that: ''Explanations are not to be imposed before the phenomena have been understood from within'' (p. 4). Ray (1985) emphasised this by stating that bracketing is the process of holding in abeyance those elements that describe the limits of an experience when the researcher is investigating a phenomenon about which the researcher has considerable knowledge. As a result of my wealth of experience working within mental health settings, bracketing this knowledge was extremely important to ensure my continued curiosity during the investigation of this phenomenon. During the data collection process, I planned to bracket my preconceived ideas about mental health service-users and work through the process of retention. I was involved in inquiring directly into that which was seen, and not after conscious understanding had been applied to explain it (Crotty 1996).

In the third phase of phase of reduction (eidetic reduction), Husserl was concerned about the generalisation of the description of phenomena as they appear to gain theoretical and scientific respectability (Giorgi, 1997). According to Giorgi (1997), Husserl believed that individuals experienced the world with a natural attitude. He believed this made them

take their daily experiences for granted. He stated that this attitude was naïve because experiences may have deeper meaning than their occurrence. Husserl stated that the aim of phenomenology was to understand why things were and why events occurred. To establish this, Husserl began at a fundamental state where there is a "presence" without the attributed experience. Husserl was interested in investigating the features a 'presence' had to have before existence or realness can be attributed to it. He continued by stating that for an object to be real, it had to be given in time, space and causal regularity. When an observer experiences an event that is real, or has an existence, reduction helps that observer to step back and describe those experiences as a presence.

Husserl explained eidetic reduction with the example of a red object that can be seen either as "this red object" or as "a red object". He posited that an observer's experience in the latter is different from the former in that the observer sees this object and its redness as present to their experience. In the latter case, both the object and the universal essence are present to mind.

Theodorou (2015) reiterated this by stating that eidetic reduction deviates from the exposure of particulars to the exposure of universal essence, positing that:

> *"In order to reach the intuition of an eidos or essence of a particular, we take an actual or imaginary particular specimen, we freely vary its aspects or characteristics or parts, and through this process we acquire, in parallel, the intuition of the species, the particular, or the essence that is valid for it" (p.42).*

One of the methods of freely varying different possible instances of the phenomenon being studied is free imaginative variation (Smith et al., 2009). Free imaginative variation "imaginatively stretches the proposed transformation to the edges until it no longer describes the experience underlying the subject's naive description'' (Polkinghorne, 1989, p. 55). It asks the question "is this phenomenon still the same if we imaginatively change or delete this theme from the phenomenon?'' (van Manen, 1990, p. 107). Van Manen (1990) stressed the importance of free imaginative variation as an essential part of phenomenology descriptions and the transformation of such descriptions into phenomenological themes. He stated that free imaginative variation uncovers attributes that define a phenomenon and without which the phenomenon cannot exist. Polkinghorne (1989) stated that an adequate transformation of themes should be openly verifiable so that it can be ascertained that the transformed theme describes a process that is embodied in the original expression. In the case of this research, this involved drawing from my experiences of observing mental health service-users being involved in work to establish the essential practical and emotional features of that process.

Since the research question in this study asked participants to describe their own experiences of working while living in a mental health hospital, I had to describe this phenomenon without the bias of my belief system. The phenomenological stance best fitted for this was that of Husserl (1913).

3.5. Analysing the phenomenon

To analyse the data, Colaizzi's phenomenological method of analysis (1978) was chosen because it correlates with Husserl's first-person process (Smith et al., 2009). According to Morrow et al. (2015), Colaizzi's phenomenological analysis depends on first-person accounts of lived experience. This method provided detailed scientific steps of Husserl's phenomenology in data analysis which I was able to follow effectively as a novice researcher. It also provided a thorough analytical process that ensured that my preconceived ideas were kept from influencing the findings of this study. Rodriguez and King (2015) stated that Colaizzi believed that complete bracketing was impossible during the phenomenological process. He believed that researchers might impose their preconceived judgement on all stages of the research process without knowing it. Thus, he proposed the use of member checking.

Member checking is the process of returning data to research participants in order to validate the findings and, according to Birt et al. (2016), this can be a means of reducing researchers' bias by actively engaging participants in the research process. Girbirch (2006) argued, however, that the frequent process of reflecting, interpreting and synthesising member checking can easily distance the result from the original interview data. Morse (1994), meanwhile, stated that far from confirming the views of participants, this process may result in a lack of

clarity. Participants may have changed their mind about the phenomenon based on new experiences that may have occurred. Participants may also tell stories that they later regret and want them removed from the data. For example, the perspective of a service-user involved in work some months ago when work was stressful could be different some months after when work is no longer stressful. This can change the perception of the service-user during the member-checking process.

Arhem (2000) posited that member checking is based on the postulation that there is a fixed truth of reality that can be accounted for by a researcher and ascertained by a participant. This postulation suggests that there could be issues if the participant disagrees with the researcher's interpretation of the phenomenon, especially about whose interpretation should be accepted. The powerplay between participants and the researcher, might also result in the member-checking process being viewed as "cooperative" by participants who then agree with the researcher's findings in order to please the researcher.

When considering these discussions, it was essential that the type of member checking used would not distance itself from the original view of the participants in this study. This was achieved using the member checking of synthesised data, which is how Birt et al. (2016) characterise Colaizzi's member checking. This process explored whether the results of the research resonated with the lived experiences of the research participants. This member checking took place some time after collecting the data, and involved presenting analysed data to research participants in an accessible

way. They further stated that this type of member checking produces the reliability that enhances the transferability of results, thereby producing evidence to change practice while still enabling participants to view their lived experiences in the results. In situations where there was a disagreement about the findings during the member-checking process, there was a resolution process where the academic supervisors of this study were consulted to establish whose interpretation of the phenomenon should stand. This resolution process was employed by Sosha (2012) to settle disputes between participants and the researcher during the member checking process. Participants also need to be educated about the purpose of the member-checking process. This will reassure them about the importance of their views in confirming or disagreeing with the results during that process. It attempts to reduce the powerplay between the researcher and participants.

Figure 2 summarises the discussion about the research paradigms and underpinnings for the choice of the methodology.

3.6. Preview of the next chapter

The next chapter presents the research methods of the study. This includes the ethical considerations, interview process and data analysis process.

Chapter Four – Research Methods

4.1. Ethical considerations

The aim of the ethical process was to establish ethical excellence throughout the research process. In undertaking research on humans, the scientific excellence of a project must be matched by the ethical excellence of its processes (Benatar, 2002)

De Wet (2010) stated that it is often thought that qualitative studies do not require ethical clearance because of the assumed absence of harm during the research process. This is a flawed and dangerous postulation because research processes in qualitative studies could produce several intricate ethical problems. Psychological harm, unsatisfied hopes, dishonesty, unforeseen or inaccurate representations and different interpretations were identified as examples of possible harm that can occur during qualitative studies. De Wet (2010) continued by stating that ethical concerns are not only limited to the typical ethical rules of protecting research participants, but extend to respecting participants, minimising harm, ensuring confidentiality to the greatest degree, and engaging in meaningful and authentic informed consent. The sections below explain how research excellence was achieved.

Ethical approval was obtained from the University of Northampton Ethics Committee with the reference number ETH1718-0002. The Ethics Committee assessed the quality of the study's proposals to address relevant ethical considerations. These included: respect for the dignity of

research participants (their integrity, privacy, safety and human rights); the obligation to minimise risk; to balance risks against benefits; to make suitable remuneration for time; to provide compensation for any injury which may occur during the research; to protect confidentiality (Council for the International Organisations of Medical Sciences, 1993; Royal College of Physicians, 1996) and to avoid conflicts of interest (Emanuel & Steiner, 1995).

One of the concerns raised by the University of Northampton was that their online data storage system (OneDrive) was no longer secure. Following on from the recommendations generated as a result of ethics approval, the TUNDRA repository system was utilised for secure data storage. This research proposal was also registered in the Integrated Research Application System (IRAS) with the identification number 212165. After the study was approved by IRAS, the research proposal, participant information sheet and informed consent form were presented for approval by the East Midlands-Derby Research Ethics Committee (REC reference number 17/EM/0203). This was because service-user placements in Mental Health Hospitals are funded by the NHS Mental Health Commissioning Team and the REC ensures that all ethical considerations are met in studies involving vulnerable adults within hospitals.

The Derby REC Committee addressed issues on creating a distress protocol for participants, rewriting the participant information sheet in layman's terms, and explaining situations where confidentiality will not be kept. These were subsequently incorporated into this study.

4.2. Research site

After the study was approved by the NHS Research Ethics Committee, three potential research sites within the Midlands were considered for this study. Only one of the sites was chosen, however. This choice was arrived at on the basis that the site had vocational rehabilitation centres on site attended by a diverse population of service-users from low secure, medium secure and high secure male and female wards. This site therefore contained the population pool that matched those required for this study. The research and development department gave governance approval for the study to take place at their vocational rehabilitation centre. Recruitment was done through advertisements at the vocational rehabilitation centre (see advert in appendix 9).

Members of staff from the research site sent informed consent forms to the keyworkers of potential participants by email. This ensured that keyworkers gave their consent for participants to engage in the study before the interview took place. Although this lengthy process of involving keyworkers slowed the recruitment process, it ensured that only service-users who met the inclusion criteria and had the mental capacity to engage in the interview were recruited.

I visited the research site on a weekly basis to advertise the study to potential participants. The participant information sheet and informed consent form were given to all service-users who wanted to be involved in this study and I ensured that the content of the forms was explained to them directly.

4.2.1. Consent

After the research and development department of the hospital were satisfied that the research design had embedded processes to take account of the researcher's ethical responsibilities, permission was given to distribute the informed consent form and participant information sheet to all service-users who wanted to participate in this study. Potential participants were informed about the research based on the ethical excellence guidelines articulated by Benatar (2002). These included that: participants understood the nature and purpose of the research; had the opportunity to have their questions answered, could give truly informed consent; and could make uncoerced decisions to participate in this study.

I explained the content of the participant information forms to potential participants so as to ensure that they had all the information available to make an informed decision to participate in this study. These contained the details of the research process such as: purpose of the study, what participation would involve, participants' right to withdraw, how the results of the study would be disseminated, and potential benefits or harm involved. It included how the data would be anonymised as part of the data protection process to ensure confidentiality.

The capacity of the participants was considered to ensure that they had the ability to give their consent to participate in this study. This was done by ensuring that their keyworkers signed a consent form to attest to their ability to consent to participate in this study. Potential participants that met other inclusion criteria were presumed to have the mental capacity

to engage in this study unless there were doubts about their capacity, such as a worsening of their mental health symptoms. In such a situation, a mental capacity assessment was undertaken. This included examining the ability of participants to understand the information relevant to decision-making about participating in the study. Specifically, that they were: able to retain the information long enough to be able to make the decision about participating in the study; able to use or weigh the information about the study, including the pros and cons of the study, as part of the process of decision-making to participate; able to communicate their decision to participate in this study. In any situation where the potential participants failed to demonstrate the requirements of this assessment, they were withdrawn from the study. The keyworkers signed the consent forms of participants who met all the criteria for the capacity assessment.

Participants were encouraged to ask any questions concerning the research process. The researcher explained to the participants that in any situation where any of the participants could not give consent for the data collection process, such participants were withdrawn from the study and their data destroyed. If it was determined by the keyworkers that any of the participants lost the mental capacity to consent any time after the data collection process, such data was retained and used for the research process.

All participants were clearly informed that they would not be coerced to take part in this study. They were also informed of their rights to withdraw from this study without any consequences. This was written in

both the participant information sheet and consent forms. This was also reiterated throughout the process of data collection. The participants were informed about confidential information accessed during this study and the time commitment entailed in participating. The position of the researcher was discussed with the participants to ensure that they were aware of my motivations as the researcher. Participants were informed that this study was being conducted in the context of completing a Professional Doctorate degree.

All participants were given two weeks to sign the informed consent forms to indicate their interest in participating in this study. The two week period gave them enough time to discuss their participation in the research process with their keyworkers and carers. This gave them a cooling off period and the opportunity to withdraw if they wanted to.

4.2.2. Confidentiality

All participants were assured of the confidentiality of information at all stages of this research. Any information that was obtained in connection to this study that could identify any participant would remain confidential. Such information was disclosed only with the participant's permission or as required by law. Confidentiality during the research process was maintained by giving each participant pseudonyms. All data collected was stored in a password protected memory stick that could only be accessed by the primary researcher. This was stored in a locked cupboard at the

researcher's workplace. The information recorded on the audio recorder was transferred to an encrypted work computer that could only be accessed by the primary researcher. All these safeguards were put in place in accordance with the Data Protection Act (2018).

4.3. Sample

As a result of the descriptive nature of this study, a purposive sample (i.e. only mental health service-users within secure hospital units who are involved in work) was recruited for this study. This was because only a purposive sample, rather than a randomised one, could provide evocative insights into the topic being studied (Smith et al., 2009). This study aimed to continue recruitment until the point of saturation was achieved. The point of saturation is defined as the point in the study where more data does not necessarily lead to more information (Mason, 2010). Data saturation is achieved when the sample recruited has sufficient data to reproduce the study, when the ability to acquire further new data is achieved and when additional coding is no longer possible (Guest et al., 2006).

Since Guest et al. (2006) posited that there are no pragmatic guiding principles for when data saturation is achieved, the recommendations proposed by Fusch and Ness (2015) were followed: namely that the data collection process in the study had been used to achieve data saturation in previous studies (Porte, 2013); that interviews were structured to ensure that multiple participants were asked the same questions (Guest et al., 2006); that there was continued access to key informants in the research

site to ensure complete data collection and data saturation (Holloway, Brown, & Shipway, 2010).

Despite this plan to utilise data saturation to improve the quality of this study, data saturation was not achieved due to time constraints, inadequate resources, and the unavailability of participants. Based on studies such as Fusch & Ness (2015) and Landau & Drori (2008*)*, a lack of data saturation could have affected the quality and validity of this study. In the process of reflecting on that potential impact, however, it was discovered that doubts have been raised regarding its common adoption within qualitative studies.

According to O'Reilly and Parker (2013), the original meaning of saturation was founded in grounded theory, in the form of theoretical saturation and has retained its vital position in current grounded theory work. In grounded theory, the concept of saturation is not in fact the point where no new themes emerge. Instead, it refers to categories being fully accounted for, and the variability and association between them being clarified, tested and validated for a theory to emerge (Green & Thorogood, 2004). This corresponds with the underpinning epistemological position and the goals of grounded theory, which are to develop an explanatory theory of the social processes that are studied in the environments in which they have taken place (Starks & Trinidad, 2007). O'Reilly and Parker (2013) reflected that while saturation has been translated for other qualitative approaches it is not appropriate to impose it in all instances.

For example, Charmaz (2005) posited that saturation is polemically viewed as a sole criterion of the adequacy of data collection and analysis in qualitative studies, rather than being one of the many criteria that are universal markers for quality. Tracy (2010) proposed eight universal markers for assessing the quality of qualitative research: a worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethics and meaningful coherence. The universal marker of rich rigour included a position that rigorous qualitative studies should make smart choices about samples and contexts that are appropriate or well poised to study specific issues. This includes questions on how much data is enough to produce rigorous studies. O'Reilly and Parker (2013) argued that adequate sampling is often synonymous, albeit controversially, with data saturation. Within phenomenological research, the sampling adequacy has, historically, been defined largely based on depth and maximum opportunity for the transferability of findings (Spencer et al., 2003). The purpose of phenomenological research, however, is neither to count opinions nor people. Rather, it explores the variety of views and different representations of an issue (Gaskell, 2000). Phenomenology uses lived experiences as a tool for better understanding the social, cultural, political or historical context in which those experiences occur. It focuses on meaning and interpretation—how socially and historically conditioned individuals interpret their world within their given context. Consequently, sampling within qualitative research is concerned with the depth of knowledge of lived experience and, as a result, the sample required is

dependent on the nature of the topic and the resources available (Kuzel, 1992; Gaskell, 2000).

Authors such as Creswell (1998) proposed a sample of five to twenty-five for phenomenological studies. Morse (1994) proposed at least six participants, while Smith et al. (2009) recommended between four and ten participants for depth and transferability. These authors made these recommendations without emphasising the need for data saturation. Meeting these guidelines is an indication of rich rigour through appropriate sampling. This study therefore utilised these sampling recommendations to enhance its quality by focusing on the depth of the data collection process such as the use of methodologically sound procedures for the semi-structured interviews, data analysis and presentation of the findings. This study also followed the general recommendations of acceptable sample sizes in phenomenological studies by recruiting a sample size of seven participants.

Thus, the lack of data saturation in this study does not invalidate its findings. Morse (1995) posited that a lack of data saturation simply means that the phenomenon has not yet been fully explored rather than that the findings are invalid. Instead, it was proposed that any limitations of sampling adequacy are reported clearly, since transparency is one of the markers of research quality. It is in this spirit of transparency that the inability to reach saturation in this study is reported here, including a reflection on the factors that impacted data saturation such as time constraints, limited resources, and the role of gatekeepers.

4.3.1. The role of gatekeepers

Gatekeeping is the process by which researchers are given access to participants in a research site setting (Kawulich, 2011). The use of gatekeepers in this study was important because they had local influence and power which added to the credibility and validity of the study by endorsing it (Berg, 1999; Seidman, 2013). Gatekeepers also prevented harm and protected service-users by ensuring the appropriateness of the research topic and its methods, and by ensuring that only participants who met the inclusion criteria engaged in this study. Nonetheless, gatekeepers may have influenced this study negatively by preventing access to some participants through over-protectiveness, which may have denied them the opportunity to participate in research (Sixsmith et al., 2003; Heath et al., 2007). They may have also failed to provide opportunities for potential participants to exercise choice in participating in research (Miller & Bell, 2002). This may have involved excluding potential participation without consulting them because of time pressures, inconvenience, or fear of exposing the institution to investigations.

Strategies to reduce the negative impact of gatekeepers were employed as proposed by Heath et al. (2007). The first strategy was to secure access to the research site from which participants were recruited. The researcher organised meetings with the local gatekeepers at the research site, such as the heads of the vocational centre, the research and development centre and occupational therapy colleagues within the research sites (who were often keyworkers) prior to conducting the study.

This was done on a face-to-face basis to ensure that the research was discussed in an open and transparent manner. Questions related to the study were answered and clarification provided. These clarifications detailed the extent of the involvement of gatekeepers to ensure time-effective involvement in the study. These meetings allowed the gatekeepers to evaluate the researcher's professional suitability and provided the researcher with the opportunity to accentuate the value of their personal contributions (Shenton & Hayter, 2004).

The second strategy was to offer the incentive of providing the results of the study to the gatekeeper. It was proposed that the findings of this study would be published on their website as a way of raising the profile of the research site as a vocational centre that was applying evidenced-based approaches to involving service-users in work. Wanat (2008) posited that this strategy could have resulted in greater cooperation with keyworkers.

Despite the strategies taken to reduce the negative impact of gatekeepers, there were difficulties in accessing potential participants because of long waiting times to interview them. A lesson for future research would be to explore the difficulties affecting the gatekeeper roles within this site that could limit the accessibility of potential researchers to mental health service-users.

4.3.2. Inclusion and exclusion criteria

4.3.2.1. Inclusion criteria

This study included participants with the following characteristics:

- Service-users living within secure mental health hospital units and involved in work.
- Mental health service-users who had sufficient understanding of the English language to express their views and understand the interview questions.
- Mental health service-users aged 18 years and over.

4.3.2.2. Exclusion criteria

This study excluded mental health service-users with the following criteria:

- Mental health service-users who did not live within secure mental health hospital units.
- Potential participants who refused permission to inform their responsible clinician or keyworker.
- Potential participants who had insufficient understanding of English.
- Potential participants that did not have the mental capacity to give informed consent to take part in the research process.
- Mental health service-users who I was directly involved in caring for.

Keyworkers had to give their consent to ensure that the health of the research participants at the time of recruitment and during the study was appropriate to the demands made by the research. The exclusion of potential participants who did not have a sufficient understanding of English, meanwhile. was done to eliminate the cost and complication of involving an interpreter in different stages of this study, considering the limited time for the completion of this study.

The exclusion of service-users whose care the researcher was directly involved with was done to reduce the risk of power imbalance, as discussed below.

4.3.3. Potential risks to participants and provisions to minimise identified risks

The potential risks that this study may cause were identified based on a study by Richard and Schwartz (2002). One of the potential risks identified was the possibility that participation in the study might induce anxiety and distress in the participants. This study aimed to provide an in-depth understanding of an issue that could be sensitive for participants in the context of social expectations about work (as discussed in Chapter Two) and included an exploration of the reasons and context for participants' opinions and actions. The interviews were designed to be investigative in nature and, as such, potentially could provoke some anxiety or distress.

To reduce this potential risk, the interview questions (see appendix 2) were vetted by a supervisory team who are experienced researchers.

This ensured that the comfort of the participants was accounted for during the interview process. In addition, keyworkers were present during the interviews. This ensured that participants were given the opportunity of being debriefed by their keyworkers after their interview so that any welfare issues arising were identified and addressed. Sommers and Miller (2012) defined debriefing as a process that offers an early opportunity for research participants to attain appropriate information about the nature, outcomes and conclusions of the research. The debriefing process involved efforts to return the subject to a positive emotional state after a stressful interview. This served as an opportunity to correct any misconceptions that participants had of the research process.

The participants were given the opportunity to ask questions while their keyworkers provided accurate information about the nature of the study. This process was used by the keyworkers to identify and address any issues, especially in terms of any potential harm that could have been experienced by the participants.

The participants were given the contact information for their keyworkers should they wish to ask further questions about the study.

This study considered the potential risk of power imbalance to participants. Karnieli-Miller et al. (2009) stated that the developmental nature of the research process leads to changes in power relations, which pose specific ethical issues to the researcher. They proposed that there were different power dynamics within the recognised five stages of research. These are the initial stage of participant recruitment, data

collection, data analysis and production of the report, validation, and additional publications from the same source material. Since this study had not been published at the time of the writing of this thesis, only the first four stages of research were explored.

In the initial stage, the power lies in the hands of the researcher who introduces the research to the participant. Bravo-Moreno (2003) stated that the quantity and quality of the information accessible regarding the study is based on the researcher's discretion. Since the researcher's motive is to encourage participants to engage in the study, the dependence on the participant's consent to engage in the study will reduce the power imbalance between the researcher and participants. The participants will use the need for their informed consent to negotiate the power relationship by asking more questions about the study. Such questions will empower the participant to make an informed decision to participate or disengage in this study. Likewise, Richard and Schwartz (2002) identified a further risk of power imbalance during the recruitment stage of the study. They posited that the service-users may have felt compelled to take part in the study because of a feeling of responsibility, especially if the researcher had the dual roles of researcher and care-provider.

To reduce the power imbalance between the researcher and participants in my study, I met with each potential participant that met the inclusion criteria and advertised the study to them. I encouraged them to ask questions during our meetings and gave them two weeks to complete the informed consent forms. I gave the potential participants my research

contact details and encouraged them to liaise with their multidisciplinary team to weigh up their participation in the study. Likewise, I ensured that participants with whom I worked directly as a care-provider were excluded from this study. In addition, all participants were reminded of their right to withdraw from the study without any consequences throughout the research process. These actions ensured that the power dynamics within this relationship was less skewed in favour of the researcher.

In the data collection stage, the power dynamics could be tilted towards the participants and researchers from different perspectives. It could be skewed towards the participants since the study depended on their willingness to share their lived experience. This is indicative that the participants control and own the quality and quantity of the data shared. Karnieli-Miller et al. (2009) proposed that the quality and quantity of data shared depended on the relationship developed between researcher and participant. The researcher must therefore use this relationship to encourage the participants to share their stories and wealth of information about the research topic. Dickson-Swift et al. (2006) identified that some strategies used by researchers to build relationships such as self-disclosure, running errands and sharing a meal can be viewed as a form of coercion directed towards obtaining data. Krayer (2003) concluded that these actions could improve research engagement but could also heighten the vulnerability of participants.

The power dynamics could also be tilted towards the researcher because the researcher initiates the interview, determines the themes to

be discussed, controls the interview guide, and decides when to finish the interview (Brinkmann & Kvale, 2005). Likewise, while the interviews allowed participants to speak on their own terms, this could lead to possible exploitation or harm if the interview is misinterpreted by the participant to be a therapeutic encounter. The researcher could ask sensitive questions inappropriately and participants might have divulged more information than they had anticipated when consenting to the study (Small, 1998).

To build a relationship to encourage participants to share their story, I utilised ethically accepted ways of building rapport by exploring the leisure interests of participants as a way of achieving heightened empathy and familiarity before initiating the interview questions. This was identified in the pilot study as an effective way to build a relationship. I also ensured that I did not deviate from questions that were beneficial to the study. The interview questions were constructed to impose a consistent approach to information gathering within safe parameters. This meant that, even when participants spoke on their own terms, they were guided by semi-structured questions that ensured that the interview process did not deviate from its aim.

During the data collection stage, the researcher possesses absolute control over the data. The participant has no power to control the narrative and the researcher interprets the narrative into a new historical, political and cultural context. The decisions made as regards power sharing will depend on the research methodology, impact of the engagement of participants in the data analysis and the world view of the researcher. This

includes employing mechanisms to assure the accurate descriptions of the narratives and encouraging participants to engage in the final stages of writing.

To ensure power sharing, this study utilised a methodology that ensured that the cultural, political and historical ideas that could influence the interpretation of the data were bracketed. This was achieved through reflexivity and reflections. James & Platzer (1999) posited that a continuing reflective and reflexive process which scrutinises the various reasons for conducting the research and its impact on the participants might decrease the risks for the parties involved in the study and increase the benefits from the study.

In the validation stage, the researcher also possesses absolute control over the data. The participant has no power to control the presentation of the findings. Cutcliffe (2000) stated that some researchers re-engaged participants by means of follow-up interviews to establish the authenticity of the findings. This study also employed Colaizzi's method of analysis which supported participants in this study to engage in a member checking process. This ensured that synthesised data represented their views. The synthesised data was shown to each participant and they were encouraged to discuss the findings with their keyworkers.

Misinterpretation of data was also identified as a potential risk to participants in this study. Richard & Schwartz (2002) posited that misinterpretation of data could occur when a novice researcher works in isolation. As the primary researcher of this study, I did not have a lot of

field experience in qualitative research. This increased the potential risk of misinterpreting collected data. To reduce this risk, I was assigned a supervisory team of experienced researchers who were involved in the research process and monitored the analysis of data.

4.3.4. Recruitment of participants

Keyworkers identified potential participants who were interested in participating in this study and who met the inclusion criteria, and then introduced them to the researcher. The demographic data of the participants recruited is described in Table 3.

4.4. Data collection

Data collection involved face-to-face interviews that were recorded on a digital audio recorder. The choice of face-to-face interviews rather than focus groups captured the specific experiences of the individuals recruited with the expectations that such participants might be dispersed among many mental health hospitals or wards within the Midlands.

Focus groups generate a large amount of data, but their group dynamics have to be considered. Due to the nature of these participants, they could potentially be influenced by stronger personalities or a wish to seem to conform to the group. For these reasons focus groups were not considered appropriate (Breen, 2006).

To ensure the richness and depth of this study, the researcher asked semi-structured open-ended questions from an inquisitive and facilitative perspective (see appendix 2)

4.4.1. How the interview questions were developed

As a phenomenological researcher, I was interested in describing the experience of participants in the way they experienced it, and not from some theoretical standpoint (Bevan, 2014). To ensure this, I structured the interviews in a way that enabled thorough investigation to provide an accurate representation of the process (Mason, 2002). This structure for the phenomenological method used for the interviews was developed from Bevan (2014). The choice of Bevan (2014) was based on the analysis of interview methods proposed by prominent authors within the field of descriptive phenomenology. These methods were found to be generic, unstructured or too complex for a novice researcher. For example, Giorgi (1997) suggested broad and open-ended questions, while Colaizzi (1978) proposed phenomenological reduction before embarking on the interviews. Neither of these authors, however, provided a procedural guideline for a novice researcher to follow to ensure that the interview process was based on the philosophical standpoint of descriptive phenomenology. Seidman (2006) also proposed three interviews per person, which included open ended and context-building questions. This method was not considered because of the lack of guidelines to conduct the interviews and the limited timeframe of the project, which could not accommodate three interviews.

The choice of Bevan (2014) provided a structure based on the following descriptive phenomenological concepts: description, natural

attitude, lifeworld, modes of appearing, phenomenological reduction and imaginative variation. These concepts were structured into a phenomenological interviewing method consisting of three main domains: contextualisation (natural attitude and lifeworld), apprehending the phenomenon (modes of appearing, natural attitude), and clarifying the phenomenon (imaginative variation and meaning). Table four (see appendix) summarises the structure of phenomenological interviews.

4.4.1.1. Contextualisation

Husserl (1970) stated that the experiences of the lifeworld stand out against a backdrop of context, with a personal account that offers significance to that experience. Boyce (1962) posited that individuals are not always reliable informants about narrating life events of what "actually happened". Grant (2013) stated that conventional qualitative studies have the propensity to make assumptions that the voiced lived experience of individuals participating in studies authentically and directly corresponds with their narrative identities by speaking the truth of consciousness and experience. He debated that the voiced viewpoints of individuals cannot be appraised as an innocent and forthright way to account for a 'self' because power, subjectivity and yearnings form the ways in which entities express accounts of their present and their lives.

Grant starts from the position that the *"light of human meaning is always refracted through the dark glass of language, and language is*

always unstable. Any expectation of indisputable meaning is confounded by words forever constituted by myriad significatory traces of other words, thus meanings" (Grant, 2013, p. 2). This indicates that lived experience is not effectively conveyed through language because of the various meanings that words can be given. As a result, the language used when describing lived experience cannot be viewed as absolute. Mazzi and Jackson (2008) anticipated this position by arguing that the presentation of participants' voices as clear and precise accounts of their lived experiences refuses to contemplate how researchers shape these lived experiences through unequal power relationships, research objectives and timelines.

Despite these viewpoints, Grant (2013) agreed on the importance of lived experience but argued that narratives should not be given privilege as somehow separate from their contextual co-production. Instead, he called for lived experience narratives to value both the accounts of participants and their narrative, cultural, historical and material contextual bases. Thus, interviews must be initiated from a point of providing the context in which the experience is situated (Seidman, 2006).

To investigate the specific lived experience of participants, therefore, I had to consider the context and history from which the experience gains meaning (Bevan, 2014). For example, to investigate a participant's experience of work in a secure mental health hospital, I did not start directly from the experience of work. This would have isolated it from the patient's lifeworld context and rendered it meaningless. In contrast, I started with

descriptive questions about what influenced the participant to engage in work after being admitted into hospital. For example:

> **Researcher**: Tell me how you got involved in work after being admitted to hospital?
>
> **Participant**: The occupational therapist came along and did my interest checklist and identified my interest in certain things (Jamie)
>
> **Researcher**: Why did you choose work?
>
> **Participant**: When I was on the outside, I worked in a café for six years. So, it made sense to work in a food environment. I just give myself to it for a couple of days to keep busy (Jamie)

The above description of experience demonstrated how and why the participant got involved in work. In this illustration, the influence of the occupational therapist and previous history of employment provided the context for engagement in work whilst in hospital.

4.4.1.2. Apprehending the phenomenon

This directed my focus to the lived experience of work. I explored this particular experience in detail with more descriptive questions. These questions were based on the position of Husserl (1913) that an object or experience can yield different viewpoints because it has modes of appearance and is experienced in many ways. This position indicated that a single question was insufficient to present the many modes of appearance of an experience. These questions explored experiences taken for granted such as: How did you feel on the first day that you resumed work here?

What's the feeling when you're working here? Every day when you're coming to work, how do you feel? How do you feel when you finish work?

These questions provided an avenue for me to view how participants interpreted their experience through their narratives of events. In this descriptive approach I did not accept that these interpretations were already understood, although this is not to negate their existence. Rather, the approach emphasised that I needed to investigate these interpretations to produce clarity. For example:

> **Researcher**: How do you feel when you finish work?
>
> **Participant**: I just think about what I have got for the rest of the day. Of course, my mates that are not going don't feel the same sense of achievement (Jamie, no. 27)
>
> **Researcher:** Can you explain what you mean by a sense of achievement?
>
> **Participant:** The fact that I have made something that is gonna be used and I have not spent an hour doing nothing. I feel like it was a good use of time (Jamie, no. 29)

These questions demonstrated how the utilisation of structural descriptive questions allowed a thorough apprehension of the phenomenon. The word "achievement" was not accepted at face value. Accepting this without structural questioning would have meant accepting a natural attitude interpretation and would have demonstrated a lack of commitment to the phenomenological attitude.

4.4.1.3. Clarifying the phenomenon

This domain involved the use of elements of experience, or experience as a whole, while exploring the phenomenon itself. Clarification

of the phenomenon was done with the application of imaginative variation. This examined whether the phenomenon was still the same if I imaginatively changed or deleted the environmental situation of being in hospital from the phenomenon of work (van Manen, 1990).

Bevan (2014) explained that the benefit of employing imaginative variation at this point is that it remains grounded in the original context and close to the original experience. It prevents the hasty and cheap use of incomprehensible or illogical variations.

For example, participants within this study described involvement in work as an integral part of being in a long-stay hospital. Once this distinction was identified, a variation question was asked to ascertain if their engagement in work was because of their present circumstances or a lived experience with future significances. This question was asked with the aim of supporting the person to identify invariants by describing how the experience would change. For example:

Researcher: Where do you see yourself in the future in terms of work?

Participant: I would hope that I am out of hospital. I hope to actually like do some type of retail manager type or settle for some office work (Nightingale no. 77)

Researcher: Are you saying that you will continue working when you leave this place?

Participant: Yeah. (Nightingale no. 79)

Researcher: And why will you continue working?

Participant: I think it is better for your mental health to keep busy (Nightingale no.81)

The above variation was able to clarify the meaning of the experience. It identified additional areas for clarification of the meaning of a phenomenon, such as what would happen to the experience of work when the participant leaves the hospital environment.

4.4.2. Pilot of semi-structured interviews

A pilot study was conducted in order to pre-test the semi-structured interview questions for this study (Baker, 1994). This was intended to give advance warning about where the main study could fail and whether the interview questions were appropriate (Van Teijlingen & Hundley, 2002). The pilot study considered the emotional impact of the interview questions, exploring whether the questions could potentially provoke anxiety, since this has been identified as a potential risk arising from this study.

Two colleagues within the occupational therapy department in my workplace were recruited for the pilot study. This was done in order to engage professionals who were able to assess the interview questions, technique and style to provide perceptive feedback. This enabled the researcher to feel more confident with the questioning or increased awareness of participant's body language

The pilot study tested issues such as: the robustness of the questions as a data collection tool; the framing of the questions (open or leading); the relevance of the data sought; and the clarity and logic of the layout of the interviews (Mertens, 2010; Robson, 2011).

The two respondents were asked to engage in three tasks:

- Answer the interview as a respondent.
- Make any comments about the questions that were leading, unclear or confusing.
- Identify any questions that can be included in the interview.
- Identify any part of the interview that might influence the response of the participants.

The feedback about the questions was generally positive. One of the suggestions, however, was to explore the participants' interests before the main questions as a means of making them relaxed for the interview. Another suggestion was to introduce myself as a researcher and not as an occupational therapist. This was proposed to reduce the influence of social desirability bias, where participants answered questions based on their prior knowledge of contact with occupational therapists. Both suggestions were adopted within the final interview questions, as identified in appendix 6 and 7.

4.5. Data Analysis

A purposive sample of seven service-users was identified and interviews took place within their work environment. Interviews lasted from 20 to 30 minutes, and each interview was taped and transcribed. Data analysis was undertaken using the method proposed by Colaizzi (1978), which involved extracting significant statements from each interview,

formulating meanings, and identifying clusters and themes, resulting in an exhaustive description of the phenomenon. A reflexive diary was created during the initial planning phase of the research before any interviews occurred. This diary was maintained during the recruitment process, data collection and analysis of data. It also involved writing down preconceived ideas that could influence the findings of the study and bracketing them.

An example of reflexivity in the initial planning stage involved changes around my life circumstances that affected my engagement in the data collection process. Within the first three months of this process, I changed jobs, moved houses and my wife gave birth to a baby. My intention was to continue with my timeframe of the data collection process. Upon reflection, however, I realised that I was experiencing three major life events that could be major stressors. This could have impacted my mental health and affected the quality of effort put into this study. I met my supervisor and we agreed that I should extend the timeframe for recruitment by requesting for an extension for the submission of the thesis. This gave me the time to engage with these life events without the pressure of impending deadlines.

Another event took place during the recruitment stage of the project. After interviewing five participants, I was struggling to recruit more participants for the study. My method of recruitment involved email contacts with keyworkers which involved setting up a meeting to advertise the project once a participant was identified who met the inclusion criteria. I reflected on this method of contact and concluded that my relationship

with the keyworkers was impersonal. I theorised that meeting gatekeepers face-to-face would help to develop a more personal relationship. I therefore arranged face-to-face meetings to enquire what could be done to improve the recruitment of participants. I also arranged other meetings with keyworkers, especially occupational therapists on the research site who I had contact with in professional engagements. They were able to support me to expand my search for participants from their low and medium secure units. This resulted in the recruitment of two extra participants. A lesson for future research from this reflection process was to organise face-to-face meetings with gatekeepers where possible and to use professional relationships to access research sites. This will involve developing a personal relationship with gatekeepers that will support recruitment and access to the research site by providing an opportunity to discuss barriers and alternatives within the recruitment site.

A third example was the way I presented myself during the interview. I was aware that my appearance and the way that I introduced myself could play a role in the power dynamics in the interview process (Bravo-Moreno 2003). I reflected on my supervisor's reflection on her experience as a novice researcher where she dressed formally for her interviews within a mental health service. As a result of a dress code that was viewed as authoritarian, none of the potential participants engaged with her. When she returned to the research site in casual dress, she was able engage more service-users in the interviews. As a result, I dressed casually to all interviews with the intention that participants would view me as an equal

in the power dynamic. Likewise, I reflected on my physical appearance as a tall man of six feet and two inches and a muscular build. I believed that my physical appearance could be overpowering for the participants. I ensured that the chairs were positioned in such a way that I sat at a lower height than the participants. I was also aware of my body language to ensure that I displayed a relaxed demeanour throughout the interviews.

The section below describes the further use of this diary to implement Colaizzi's (1978) method of bracketing.

4.5.1. Developing bracketing skills

To develop a bracketing framework, the work of Schon (1987) and Johns (1984) were utilised to put into practice the concepts of reflecting 'on' and 'in' action, and to identify specific learning that had taken place. Three points emerged as being significant for bracketing to take place, as recommended by Wall et al. (2004):

- Bracketing 'pre'-action (prior to encountering some situations),
- Bracketing 'in'-action (bracketing during some situations) and
- Bracketing 'on'-action (bracketing to review situations after the event).

The reflexive diary helped to develop bracketing skills and to enhance methodological decision-making during the study, as demonstrated in the stages below.

4.5.1.1. Bracketing 'pre-action'

It was important to bracket both my family upbringing and my experiences as an Occupational Therapist. The diary was helpful in enabling me to bring these issues to mind, plan personal bracketing strategies, and document these in a logical manner. After reflecting on my personal experiences, some of the issues that required bracketing were as follows:

> *"I recommend work as an essential part of the mental health recovery journey. I believe that it supports reintegration by building rehabilitation skills."*
>
> *"What can be bad about work?"*
>
> *"An idle hand is the devil's workshop."*

It was vital to plan and document how these preconceived ideas were bracketed to ensure that they would not interfere with what the participants might say. I utilised visual imagery to picture the preconceived ideas within the imaginary brackets and envisioned them as being put aside or suspended psychologically. I aimed to adopt a 'neutral' nonverbal behavioural stance before the interviews took place and readied myself to use active rather than passive listening skills to facilitate the transfer of original meaning from the participant. The learning from this bracketing process at this point was that being an Occupational Therapist could prevent me from understanding the lived experiences of these service-users. Hence, I chose a purposive sample of participants in an organisation outside my own working environment where I was known as an Occupational Therapist. This reduced the power imbalance which could

prevent participants from describing views that might have differed from their perception of Occupational Therapists' views of work. I introduced myself as a student to all research participants so as to reinforce a neutral perspective of work and my intention to investigate their views. Another learning from this bracketing process was to ensure that I asked about the negative outcomes of their involvement in work as part of the interview to ensure that participants understood that these were just as important as other outcomes.

4.5.1.2. Bracketing 'in' action

Six out of seven of the participants had a chaperone present. One service-user asked to be interviewed with a chaperone because of nervousness, while the other five participants attended the interview with a member of staff because they were on escorted leave. I had not anticipated that most of the service-users would be interviewed with a chaperone. When I was faced with this situation, I believed that this could have influenced the overall methodology, as it was their unique individual experiences that were being sought. In the presence of a staff chaperone, they may have felt constrained in terms of disclosing their experiences about work, especially if these were negative. The vital aspect of learning here was that I had to expect and accept that unexpected situations will occasionally arise in research. To mitigate this situation, I ensured that my interview questions were structured in such a way that they explored the background, context, benefits and challenges of engaging in work.

Likewise, I apprehended the phenomenon being explored by clarifying particular experiences in detail with more descriptive questions. Once these safeguards were put in place, these assumptions were bracketed immediately so that they did not hinder the emerging phenomenon.

The reflexive diary was also employed to bracket my feelings when I met the participants during the semi-structured interviews. I generated a pseudonym for each participant to remind me of my bracketed feelings about their characteristics. For example, I named a participant Butterbean (after a famous aggressive boxer) due to his violent nature, inability to take responsibility for his actions and poor frustration tolerance. Butterbean reminded me of a service-user within practice that I had struggled to engage therapeutically because of violent outbursts. Meeting Butterbean for the first time brought about those feelings of frustration, negativity and hopelessness that I experienced during the interactions with the service-user within my practice. These emotions that I experienced upon meeting him could have served as a barrier to exploring his "truth" hence I gave Butterbean this name to support me to reflect on my preconceived biases about him that could have influenced the way I understood his lived experience. I named another participant Ronaldo, due to his love for sports, his frequent use of the gym, his interest in exercise and the time he spent taking care of his physical attributes. Ronaldo reminded me of service-users that I had supported over the years through physical activities such as badminton, gym exercising, cycling and football. Through engaging in these

activities with them, I grew fond of them and built a therapeutic relationship that enabled their recovery. Meeting Ronaldo brought back these pleasant memories within my practice which could have influenced my understanding of his lived experience of work. I reflected that I was more likely to view most of his lived experiences of work in a positive light based on my stereotypes. As a result, I named him Ronaldo to remind me of my stereotypes and preconceived ideas about him during my analysis of his lived experiences.

Although, these pseudonyms can be viewed as offensive or derogatory, the intention of the author was to highlight the importance of not making judgements that could influence the investigation. It served as an acknowledgement of the traits of the participants that could unconsciously influence the research process. These names served as reminders of the potential bias that I had towards the personalities and characteristics of the participants.

4.5.1.3. Bracketing 'on' action

Another way in which bracketing was used within the research study was to review its methodological progression. After completing the first interview, I reflected on how ideas from each interview could develop into preconceived ideas about the lived experience of the participants that might then interfere with the subsequent interviews. I sought to prevent this by bracketing these ideas and ensuring that all the interview questions were

asked in an open-ended format, actively avoiding leading questions. The semi-structured questioning allowed this bracketing process to occur as each interview began in the same way and addressed similar questions.

4.5.2. Colaizzi's phenomenological analysis

The descriptions below outline how Colaizzi's (1978) phenomenological analysis was applied to the data collected in this study.

4.5.2.1. Step one: General description of the data

General descriptions were developed from the data collected from interviews with participants who were mental health service-users living in hospitals and involved in work. Their dialogues were recorded on a digital recorder and then transcribed verbatim. During the process of transcribing the data collected, I became conversant with the individual descriptions of the phenomenon of work by reading and re-reading the data collected. Any thoughts and ideas that arose were added to the bracketing diary.

4.5.2.2. Step two: Statements directly linked to the phenomenon of work.

The studying of the data collected helped me to identify significant statements and phrases that were related to the lived experience of work. This was done using NVivo software (version 10). The transcripts were uploaded into the NVivo program. Significant statements were copied from each transcript and placed in a pool of significant statements. For example:

"*When I was on the outside, I worked in a café for six years. So, it made sense to work in a food environment. I just give myself to it to a couple of days to keep busy"* (Jamie, no.5)

"*Eh you could be doing other things but, em eemm you might not have time for other things as much time for other things. That's all I could think of really*" (Rooney, no.35)

*"Em yeah, It's good. I come down and I have to sign myself in or ****my escort signs me in. And then you go to, there are quite a few staff, so I don't really know who you go to, usually the first one I see. And you go to them and say what do you want me to do today, and they say an activity, so it could be weeding, eh sweeping the polythene or potting or working on the till in the shop, eh potting flowers, things like that, moving compost. Yeah, you just ask them, and they go, you can do this if you want. They give you loads of options instead of saying right, you are doing this for an hour. So, this is good." (*Ronaldo, no.33)

I was happy because it was a different experience for me (Calzaghe, no.8)

From the pool of significant statements, similar statements were grouped together in nodes. An example of similar statements is displayed below: -

"It teaches you skills. Skills that could be useful outside. It's a productive use of time. I guess in some situations, you socialise as well".

"I wasn't in a good mood one day, but when I came back it felt better. I felt better".

"It helps me get experience of what work would be like in the community, it prepares me for that, and it is something positive to focus on".

"I think it helps to do good work. It might not always be that enjoyable, so that can feel a little bit negative sometimes. But it is getting me somewhere, so I am happy to do it".

"In terms of advantages, when you go down there, you have a fresh mind, you have to keep the body active. It keeps your focus and lets you get up in the morning".

"It keeps my mental health stable, keeps my mind fresh. When you don't go to work, arguments will happen, if people do more sessions, there is less aggro and frustration".

4.5.2.3. Step 3: Creating formulated meanings and aggregating such meanings into clusters

Formulated meanings for each of the significant statements were extracted from the narrative of each participant. The formulated meanings were grouped into clustered themes. This is described in Table 5.

4.5.2.4. Step 4: Developing emergent themes

This step involved the gathering of the identified meanings into clusters of themes that were recurrent across all the accounts of lived experience. During this process, it was essential for me to continue to bracket preconceived ideas so as to prevent them from exerting any influence on the theory. The formulated meanings were grouped into categories that reflect a unique structure of clusters of themes. Each theme cluster was coded to include all formulated meanings related to that group of meanings. These theme clusters formed eight emergent themes. An example of this is shown in the Table 6. The final thematic map developed for this study is illustrated in Figure 3.

4.5.2.5. Step 5: Exhaustive description of emergent themes

At this stage of analysis, all the themes were defined into an exhaustive description by merging all the study themes. The exhaustive description is as follows:

> *Occupational therapists support involvement in work and introduction to work evokes emotions. Involvement of service-user in choice of work is beneficial. Involvement in work is therapeutic. Work provides structure, gives a sense of purpose and achievement and increases the possibility of exploring future employment. Involvement in work has potential drawbacks, such as being unsuited to a service-user's abilities and provoking boredom because of a lack of interest.*

4.5.2.6. Step 6: Fundamental structure

In this step, the exhaustive description was summarised to emphasise the fundamental structure. This denser statement captured only aspects of the exhaustive description deemed to be essential to the structure of the phenomenon. The fundamental structure is as follows:

> *Occupational therapists support the involvement of service-users in work. The lived experience of work can be therapeutic in nature, increasing the possibility of future employment, but also has some negative outcomes such as work being unsuited to a service-user's abilities and provoking boredom because of a lack of interest.*

4.5.2.7. Step 7: Member checking

The member-checking process involved returning the fundamental statements to the participants to verify if they captured their experiences. This could lead to the incorporation of any changes based on the participant's feedback. I met each of the participants to explain how the data collected through the interviews was analysed into synthesised data. We discussed each of the emergent themes to identify if they represented their lived experience of work. I explained the exhaustive description of the fundamental structure, especially how it combined all the themes of this study. Participants were able to identify their statements within the themes that were presented. All participants agreed that the synthesised data represented their lived experience of work as mental health service-users. The participants did not add any new knowledge. This process of member checking ensured that the synthesised data represented their lived experience of work.

4.6. Summary

This chapter outlined the methods followed during the research process. This included the semi-structured interviews which were utilised as the data collection instrument in the study. Ethical considerations were presented in conjunction with the bracketing process and a brief outline into the use of Colaizzi's (1978) as a method of analysis. The next chapter will present the findings arising from the analysis of the data.

Chapter Five – Findings

5.1. Findings: participants' views about their involvement in work

This chapter presents the findings from the analysis of seven interview transcripts of mental health service-users involved in work. As discussed in chapter four, Colaizzi's phenomenological analysis (1978) was utilised for an in-depth investigation into their lived experience of work. In this chapter, these findings are illustrated by interview extracts to demonstrate the generated themes and how these are grounded in the participants' own thought-driven data.

5.2. Introduction of the themes

In the analysis, three emergent themes were identified that were concerned with the "lived experience of mental health service-users" involved in work. These were:

1. Work is therapeutic.
2. Occupational Therapists support involvement in work.
3. Involvement in work has some challenges.

These themes are not given a hierarchical status and are narrated in a complementary manner since their influences are seen as interrelated rather than being mutually exclusive. It is important to emphasise that these subthemes should not be considered in a strictly classified manner. Numbers were allocated to each narrative extracted from an interview, both

to identify the extract and to locate the statements within the participant's transcript (see appendix 2). For the sake of confidentiality, asterisk signs were used to anonymise the names of members of staff mentioned in the extracts of the interviews. The following sections work through the data in respect to each of the above themes.

5.3. Involvement in work is therapeutic

Participants described their involvement in work with five subthemes: work improves health; improves rehabilitation skills; provides purpose, fulfilment and achievement; involvement in choices around work is beneficial; and increased possibility of exploring future employment. Their narratives focused on the therapeutic impact of work on their mental health

5.3.1. Introduction to work evokes positive emotions

When the participants were asked about their lived experiences of work within hospital, they described their introduction to work as evoking positive emotions.

5.3.1.1. Feelings of anticipation

One participant (Rooney) described his emotions as comprising a sense of anticipation. In this narrative, the participant described this anticipation as a motivation to ensure that his introduction to work went well. He described this positive impact of his anticipation for a new start involving work, specifically in terms of driving him to make sure his first day at work went well. He said:

It was just a new start for me doing stuff that I was not used to doing and getting back to the working environment. I just wanted it to go well really. (no.17)

In this narrative, Rooney acknowledged that his introduction to work involved unfamiliar elements. While this unfamiliarity made other participants nervous, he identified that this gave him the determination and eagerness to devote his energy to ensure that this new start went well.

5.3.2. Involvement in work improves health

For the first subtheme, five participants explained that involvement in work had a therapeutic effect on their health. Their narratives described the benefits of work to their mental health. For some of the participants, work was described as a positive coping mechanism and a way of avoiding triggers that could result in a relapse. These descriptions indicated that the participants were able to identify their involvement in work as a vital part of their wellness and recovery. Some participants also described work, and the associated opportunity to focus on being productive, as acting as a distraction from mental health symptoms. They experienced an altered sense of time, and a sense that their involvement in work was rewarding. This theme was best represented by narratives from Nightingale and Butterbean. Nightingale explained this phenomenon in the description of how work distracts her from mental health issues:

I like keeping busy because I just forget all my problems like, yes, really good really. (no.56)

She described a loss of self-awareness about her mental illness which involved concentrating on the moment, saying:

> *There is a difference yeah. It is like when I am down here, I am happy and cheerful. I am like forgetting all my problems and when I am back on the ward, your mood starts to drop slightly and just yeah. (no.33)*

Nightingale continued by explaining that work diverts her attention from stressful events, saying that:

> *I think that if I come down a little bit stressed. But since I get into the work that I need to do, I can take my focus off that and put it into the work that I am doing. (no.62)*

She concluded by explaining that being busy was beneficial to her mental health. She said:

> *I think it is better for your mental health to keep busy. (no.81)*

From Nightingale's statement, it is evident that she experienced therapeutic rewards of work in respect to her mental health. She described how the reality of her situation as a mental health service-user dawned on her when she had to return to her ward after work. This indicated that she was able to explain that there was a therapeutic difference between being at work and being on the hospital ward.

Butterbean described how his involvement in work supported him to manage his mental health and avoid triggers that could cause a relapse, saying:

It keeps my mental health stable, keeps my mind fresh. When you don't go to work, arguments will happen, if people do more sessions, there is less aggro and frustration. (no.21)

Butterbean viewed work as a way of avoiding negative coping skills such as aggression. He explained that work prevented him from having negative thoughts by keeping his mind engaged. He described periods when he did not engage in work as being triggers, leading to a deterioration in his mental state. Butterbean's lived experience of work was that it provided him with a positive coping strategy for managing his mental health symptoms.

5.3.3. Involvement in work improve rehabilitation skills

For the second subtheme, five participants explained how involvement in work supported their rehabilitation by developing skills that support community integration. These narratives emphasised the importance of work for their reintegration into society. They described their work environment as a place where they could develop life skills that could support their rehabilitation. These skills included: the simulation of work in the community, the discipline of keeping a job, and the development of social skills. This phenomenon was best described by the narratives of Rooney and Ronaldo. Rooney described his lived experience by stating that work gave him the opportunity to experience and prepare for how work would be in the community:

It helps me get experience of what work would be like in the community. Eh, it prepares me for that, and it is something positive to focus on. (no.31)

He continued by saying that:

I think it helps erm to do good work. It might not always be that enjoyable, so that can feel a little bit negative sometimes. But it is getting me somewhere, so I am happy to do it. (no.43)

Rooney described how his involvement in work encouraged him to set rehabilitation goals related to working in the community. Being at work gave him the opportunity to hone his employment skills within a simulated environment. One of the skills that he identified was the discipline of being consistent with work, even when it was not enjoyable.

Ronaldo believed that involvement in work gave him the experience of being in the community. He said:

I enjoy it, it em gets me out of that environment into like a community environment for an hour, an hour a week and it just yeah feels like I am doing something I enjoy. (no.55)

This narrative corresponds with Ronaldo's perspective of his involvement in work as a means of developing his social skills. Being in the work environment gave him the opportunity to get out of his mental health hospital to be exposed to what he considered normal society. This indicated that he viewed his involvement in work as an opportunity to develop and practise his social skills.

5.3.4. Work provides structure within mental health hospitals.

When the participants were asked about their lived experiences of work within hospital, they described their involvement in work as a form of structure. This emergent theme was described by three subthemes, namely: routine, productivity and occupying time.

5.3.4.1. "Work as a routine"

Three participants described involvement in work as a routine. These routines were described by participants as developing the ability to engage consistently in familiar environments or situations. These actions of involvement in work and the consistent environmental conditions of a workplace formed a steady culture of work. This experience was described by Duran below:

> *When you get up in the morning, you have something to do during the day and you come back, and it's em it's a routine that gets to be your way of life. (no.38)*

Duran emphasised the importance of work as a way of life. He described the routine of work as a pattern of behaviour that determined who he could be. This was an indication that he viewed his involvement in work as an opportunity to form a new lifestyle. Duran's lifestyle during his stay in hospital was that of a mental health patient who was undergoing rehabilitation. He viewed his routine of work as an opportunity to change his lifestyle to that of a worker.

A similar narrative about the routine of work in hospital described it as a way of replicating a pre-morbid work identity. The routine of work gave the participant the opportunity to define his stay in hospital by work tasks that he could excel at rather than the disability of his mental health condition. Jamie explained:

> *When I was on the outside, I worked in a café for six years. So, it made sense to work in a food environment. I just give myself to a couple of days to keep busy. (no.5)*

Jamie, who had been a chef before his relapse, was working in the same capacity during his mental health hospital admission. To him, his routine of work was a way of holding onto normality and preserving his identity as a chef, something he did when he was well.

5.3.4.2. Work as a means of occupying time

Four participants identified their involvement in work as a means of occupying time. They described work as being one of the desired activities that occupied their time and that were necessary for their wellbeing. Their narratives focused on how work kept them busy and filled their time during their stay in hospital. They attributed being busy with a sense of satisfaction about their daily structure. This was best described by Rooney, who explained:

> *Eh, I am pleased that I have got the sessions because it keeps me busy and makes me feel good, yeah. (no.23)*

Rooney had been in hospital on a long-term basis as part of his slow-stream rehabilitation. Because he had to spend long periods of time within the hospital environment, his involvement in work was a means of engaging in an activity that had the personal meaning of satisfying him.

5.3.4.3. Work as a means of productivity.

One participant described involvement in work as an opportunity to be productive:

> *Definitely, Em I'll just say, it keeps you busy, it gives you something to do instead of just being sat there and its fun once you build up the, what's the word confidence, you'll love it. You meet loads of nice people. Em Yeah, you are doing something. Then you can choose kind of choose where you wanna go to start. Em yeah, its petty cool (no.47).*

> *Em, if I woke up and I didn't come down here on a Monday morning, it will be like, it will be more like I am just sitting around and yeah not really good. It makes me happy, it's good. (no.57).*

This participant, Ronaldo, described productivity in the form of actions that yielded services to others. He described the reality that, without the structure of work, his stay in hospital was unproductive. This was an indication that without work, there were limited opportunities to be productive on a daily basis. He explained that being productive at work gave him personal fulfilment (fun) because it built up his confidence to interact with nice people. It is worth mentioning that, throughout the study, it was evident that Ronaldo valued the social skills that working enabled him to develop.

5.3.5. Involvement of service-users in choices around work is beneficial

Participants described the importance of involving them in the choice of work. They explained this within two subthemes: choice of work enabled engagement, and giving them choice within work empowered them.

5.3.5.1. Choice of work enables engagement

In the first subtheme, two participants described how their choice of work enabled their engagement. They focused on how their choice of work fitted their current abilities, ensuring that they were capable of succeeding in their chosen working environment. Their narrative described how they knew their abilities best and that the choice of work should be person-centred. They also reflected on how the right job supported their engagement. They described this process of choosing work as giving them control and supporting them to achieve the outcomes important to them. This subtheme was represented by statements from Jamie and Duran. Jamie was certain that his current work role fitted his abilities. He described that his chosen job role had less pressure compared to his premorbid job. He attributed the pressure that he faced in his premorbid job to his mental health relapse. He explained that his choice of job within hospital reduced the work-related pressure while giving him the experience of engaging in work. Jamie stated:

> *It's sort of like work but it's not as much pressure, like it's not all down to you. So, it eases it over. (no.11)*

I am not great with pressure. I get flustered easily. So, it's nice not being pressured. It's because I was high up in the café. So, it was quite a bit of pressure and I didn't end up coping very well. (no.13)

Duran was more exploratory in his choice of work, trying out different roles within his work placement. His narrative focused on his ability to deal with the demands that his work role placed on him:

I've not enjoyed it too much because it seems that I don't get on, I don't enjoy the social erm, the social setting. Any sort of social sessions on my timetable I don't tend to enjoy as much as one to ones. Ahh (sighs) but, I have you know, I have always been green fingered, you know, out of any occupation, as someone who hasn't got a qualification or anything, ah you know, gardening work seems to suit me, so that's why I went for that but I have since ah come off that and I'm volunteering ah with the grounds team, the groundsmen within the hospital. You know, I do an hour a fortnight volunteering work alongside them and I can be working anywhere in the hospital grounds on me own and ah I enjoy that better. (no.4)

Duran did not enjoy the social aspect of work and preferred to work alone. He believed that volunteering with the groundsmen gave him the opportunity to work alone. Duran further explained how he had enjoyed working alone by saying:

Ah well the last couple of weeks, the last few weeks, I've been ah I've been counting the petty cash. Ah you know, I tend to get into that. I don't tend to… I don't tend to ah clock watch so much. You know, I do it by myself, there is a goal there, you know, it's quite ah systematic. You know there is something else involved that

working with people, you know ah developing me arithmetic skills and you know... ah I can get into that. (no.12).

Duran described his preference for working alone and was critical of job roles that involved social interaction. He believed that there were more benefits of being involved in work than just interacting with people. He believed that he chose his work role based on an assessment of his level of education and social abilities.

5.3.5.2. Giving service-users choices within work empowers them

Within the second subtheme, five participants explained that giving them choices within work empowers them. Their description of choice within work was about being in control of when to engage in work and being given options at work. Their narratives revealed the importance that the participants placed on control over the choice to engage in work. They described that they wanted to be motivated rather than being forced to engage in work. Their descriptions focused on the powerplay between the participants and their employers at work. This was an indication that participants viewed work as a partnership with their employers rather than an authoritarian relationship. They wanted to be consulted on any issues related to their involvement in work. These descriptions were best represented by the narratives of Jamie and Ronaldo.

Jamie spoke about the importance of being given the choice to participate in work. He said:

It will be that if I don't want to go, that I won't be forced. (no.37)

He placed emphasis on being given the choice to participate by saying that:

It is important if you are given free choice to participate. (no.39)

For Jamie, the control of these elements gave him the agency to engage in work. He had previously identified that his inability to control the pressure within his premorbid job was the main reason behind his relapse. Regaining control over the process of establishing his involvement in work, even with the risk of disengagement, was a significant part of his recovery.

Ronaldo, meanwhile, said that giving him an option of choices at work made him settle into his placement. He said:

> *First to start off, they brought me down to here and loads of other places around here to see what I wanted to do and I em had to have an interview, they asked loads of questions and then basically, you go on the waiting list to get accepted. So, I have been down here for over three years now (laughs). (no.18)*

> *They gave me like you can do this or this or this, that made me relaxed (laughs). And they said, oh just be relaxed. And then from the first week nervous and the second week, happy, so relaxed. (no.29)*

Ronaldo continued to accentuate the importance of choice within work by saying:

> *And you go to them and say what do you want me to do today, and they say an activity, so it could be weeding, eh sweeping the polythene or potting or working on the till in the shop, eh potting flowers, things like that, moving compost. Yeah, you just ask*

them, and they go, you can do this if you want. They give you loads of options instead of saying right, you are doing this for an hour. So, this is good. (no.33)

Through these narratives, Ronaldo revealed that being able to choose from a variety of tasks supported him to settle into work. This statement stressed the importance of his working relationship as a partnership with his employer where he was consulted to establish his job role.

5.3.6. Work gives a sense of purpose, fulfilment and achievement

All seven participants in this study explained that work gave them a sense of purpose, fulfilment and achievement. Their views reflected that work gave the experience of belonging to something meaningful as part of a greater goal. They described involvement in work as giving them a reason to exist. From these narratives, it can be inferred that participants described work as an opportunity to achieve their full potential. This experience of purpose and achievement came from discontentment with an ordinary existence during their stay in hospital. Coupled with the opportunity to achieve their full potential, work gave participants feelings of gratification and confidence in their abilities. These experiences were described in the narratives of Duran and Calzaghe. Duran viewed work as giving a purpose and meaning in life. He said:

I mean really, one has to view work as ah you know something ah not just to gain something. It has to be viewed as having a purpose, having a purpose just being involved in something, having a purpose and ah having something to get up for each day,

you know to be involved, to have some kind of meaning in life. (no.38)

Duran described his work as the motivation and definition of his daily existence beyond being a mental health service-user; an opportunity to explore and partake in a reality beyond his current existence.

Calzaghe referred to the mood-enhancing effects and increase in self-esteem of his achievements at work. He said:

I feel joyful and excited to go back to the ward. Feel pride and excitement that I managed to do something new. (no.12)

He described the satisfaction and pleasure of engaging in a new experience beyond his existence in a mental health hospital. This resulted in a positive transformation of his emotions after his daily involvement in work.

5.3.7. Involvement in work increases the possibility of exploring future employment

All seven participants described their involvement in work as a route to enable them to engage in future employment. They believed that the end-product of their work within the hospital environment was community-based future employment. The willingness of the participants to continue to engage in this work as part of plans for the future is an indication of the phenomenon of habituation. Participants wanted to continue to engage in

work because they identified with its habits and internalised roles as part of their aspirational targets for the future.

This was best described by the accounts of Duran and Nightingale. Duran said:

> *Ah, it might eh help eh for when I become, when I actually leave. You know, there will be more of an idea about what I am suitable for; either employment or volunteer work in the future. (no.24)*

Duran was certain of his intention to be involved in work when discharged from hospital. He viewed his involvement in work during his stay in hospital as an opportunity to determine if his skills matched paid or voluntary work.

Nightingale explained that her current work role was part of her work towards getting a qualification. She said:

> *Actually, you get like AQAs out of there. So, you actually get a qualification doing what I am doing. It is really handy so that when I get out of hospital, some certificates too… I can get a job on the outside and show them what I have been doing. (no.44)*

She explained that her work role and qualifications would support her to get into work:

> *I would hope that I am out of hospital. I hope to actually like to do some type of retail manager type or settle for some office work. (no.77)*

Nightingale believed that her efforts at work were not only designed to keep her occupied within hospital; she was being skilled to acquire qualifications which prepared her for gainful employment in the community.

She believed that the certificates she acquired would provide future employers with evidence of her employability.

5.3.8. Occupational Therapists support involvement in work

All seven participants identified the role of Occupational Therapists in their involvement in work. This involved introducing them to work and supporting them in work. This is an indication that participants viewed Occupational Therapists as vital to their engagement in work. Their narratives described the strategic role of Occupational Therapists in identifying their employment needs through skilled assessments, supporting them to explore different work roles, and enabling them to engage consistently in their job roles. This theme was best described by narratives from Jamie and Rooney.

Jamie described how an Occupational Therapist supported him to actualise his interest in work. He said:

> *The occupational therapist came along and did my interest checklist and identified my interest in certain things so... (no.3).*

Jamie acknowledged the significance of how the Occupational Therapist assessed his needs to ensure that his involvement in work was person-centred. It is important to know that Jamie had previously expressed how important it was for him to be involved in the choice of work roles. Due to this, he viewed the Occupational Therapist's assessment of his work interests as a way of validating his involvement. Jamie continued

by explaining how the Occupational Therapist supported him to adapt to a new work environment with his mental health diagnosis. He said:

> *Very nervous. I am not good with new situations. I think it is part of the autism, the Asperger's. I am not good meeting new people, doing new things in a new environment but I had my Occupational Therapist with me that came for the first session, well, came for the first few ones to get me to settle. (no.19)*

Jamie attributed settling into work to the presence and the skill of his Occupational Therapist. He identified that his anxiety about new situations was significant enough to disable his engagement in work. His Occupational Therapist was able to use an understanding of this to support him within work.

Rooney also stated that his Occupational Therapist introduced him and supported him to settle into work. He said:

> *Ah, I think **** my OT introduced me to ah **** and ****, another OT technician has helped me ah come down here and supervised me during sessions. (no.7)*

From his statement, he acknowledged the need to be supported to engage in work and guided to master the tasks of his job role by members of the Occupational Therapy Department. Rooney had spoken during his interview about the success of his gradual progression from ward-based sessions to vocational roles. He spoke of the challenges in respect to his plans to increase his working hours. This was an indication that Rooney needed support with any changes to his task routines. Due to this, the

Occupational Therapy team played a significant role in his lived experience of work by supporting him to make gradual progress in his work role.

5.4. Involvement in work has some challenges.

Participants identified some negatives related to their involvement in work. Their narratives focused on the challenges that they faced during their engagement in work.

5.4.1. Work can prevent engagement in leisure activities

One participant identified a lack of opportunities to engage in leisure activities as a negative outcome of his involvement in work. This participant placed a significant value on his engagement in leisure activities alongside his engagement in work. Rooney said:

> *You could be doing other things; you might not have time for other things. That's all I could think of. Like shopping, listening to music or exercising, playing on the computer or watching TV. (no.35&37)*

From this narrative, it appeared that Rooney was struggling with balancing his work and leisure activities. He believed that his involvement in work prevented him from engaging in valued leisure activities. This is an indication that he was experiencing occupational imbalance.

5.4.2. Tiredness

One participant identified tiredness as a negative outcome of his involvement in work. Ronaldo described how tiredness reduced his motivation to be at work. He said:

> *I do a lot of exercise on Monday, Tuesday, Wednesday, Thursday and Saturday. I do gym work. And it's like, sometimes, you wake up the day after something and you just feel so huh, so achy. You just don't want to move. You want to stay in bed, play games and stuff like that. But then you just gonna get up. Em that's all of it. (no.53)*

Despite stating in the interview that he enjoyed his engagement in work, Ronaldo admitted that there were times that he felt too tired to engage in work. He still had to wake up in the morning to go work but indicated that he would have preferred to rest and relax on occasions. Ronaldo was volunteering in multiple placements and engaging in several activities based on his interests within and outside his hospital placement, thus expending his energy across multiple roles could have explained his occasional fatigue.

5.4.3. Work unsuited to abilities

Two participants explained that a negative outcome of their involvement in work involved situations where their job roles did not match their abilities**.** This could be an indication that their job roles were neither person-centred nor based on their strengths**.** This was best described by Duran who said:

I've not enjoyed it too much because it seems that I get on, I don't enjoy the social erm, the social setting. Any sort of social sessions on my timetable I don't tend to enjoy as much as one to ones. (no.4).

He described his experience as:

Ah up and down really. You know sometimes, I find it a little bit hard to settle ah….ah. You know not all jobs ah have appealed to me, but you know I've… I've got by. (no.10)

Duran explained that he has not derived pleasure from his work role because of the social interaction aspect of this role. He had managed to continue his involvement in work despite this but reiterated that he was not satisfied with work roles that involved social interaction.

5.4.4. Boredom

One participant attributed boredom as a downside to his involvement in work. He described the experience of being demoralised in work roles where he did not have the ability to fulfil his role demands. This experience was categorised by his emotional fatigue and distancing himself from his work role through pessimism. Rooney explained that he experienced this pessimism because of a lack of interest in his job role:

Ah It can get a bit much, like if you are not really interested in what you are doing. Sometimes, I look at my watch and am like, I think, I hope, I hope that it does not go on for too much longer; am going back soon which is good. But even though sometimes I feel like that, I am still able to work well. (no.5).

In this statement, Rooney described the situations where his work roles did not have the quality to evoke his curiosity. It was evident throughout his interview that he became bored when there was a mismatch between the demands of the work role and his abilities.

5.4.5. Impact of mistakes at work on mental health service-users

Another negative outcome of the participants' involvement in work that was identified in this study was the impact of mistakes on teamwork and mood. One participant described how his poor tolerance of his mistakes at work affected his mental state. This frustration originated from the emotional imbalance of the participant arising from failure to achieve success at work. In this narrative, it was deduced that the participant derived great satisfaction and value from team productivity. When this could not be achieved because of his mistakes, he became frustrated and this affected his mood negatively. Butterbean explained this through his narrative by saying:

> *If you make a mistake in your measurement, the person sanding will have to correct it and the next person who works in the team will have nothing to do. If you make a mistake it can spoil a day's work. Then you feel bad and take it out on people on the ward. It sets a day's job back. (no.19)*

Butterbean's narrative also provided insights about his emotional regulation and associated risks. At the time of this interview, he was detained within a medium secure hospital, possibly because of a propensity

to be violent because of his frustration about unfulfilled needs. His narrative revealed that mistakes at work can trigger such risks.

5.4.6. Work can be demanding

Another negative outcome of involvement in work identified by this study was work-related pressure. One participant described this as the pressure of devoting his energy to please his customers. He explained that this could lead to increased stress levels. This experience of stress was described by Rooney as being a result of a continual use of his process skills to ensure that the quality of his work products was satisfactory to his customers. He said:

> *I think it is nice to be in a work environment but sometimes, it gets a bit much, but I know the work that I do helps people and it is something to be proud of. So yeah! (no.3)*

Rooney acknowledged the importance of his engagement in work. He worked in the woodwork section, which was involved in the production of household appliances sold to customers at market prices. There was an expectation that the products would meet market standards. Rooney believed that these expectations increased pressure and that this occasionally led to increased stress levels. He explained that the reward for these increased demands at work was the pride of people benefitting from his hard work.

5.4.7. Unfriendly work environment

This study identified how an unfriendly environment could be a downside to involvement in work. One participant indicated how his engagement in work was affected by social acceptance. This participant had previously identified that his involvement in work improved his social skills because of contact with his work colleagues and customers in the community. Due to this, the mood of his colleagues at work affected his lived experience of work. Ronaldo said:

> *Em, Em Someone might be grumpy (laughs). Sometimes you come down here and say hey ***, how are you? Like the lady was this morning. Sometimes they could be like hello (in a low voice), speak differently, em that is the only disadvantage, I think. Everything is good just the same, everything is good. Maybe getting out of bed in the morning. That's a disadvantage of. I can't think of anything, I think it's all good. (no.60)*

5.4.8. Introduction to work evokes difficult emotions

When the participants were asked about their lived experiences of work within hospital, they described their introduction to work as evoking some emotions.

5.4.8.1. *Feelings of nervousness*

Four participants described their feelings of nervousness when initially introduced to work. These emotions occurred because the participants felt anxious when introduced to a new phenomenon. The participants became anxious about how their involvement in work for the

first time would turn out. Uncertainties such as expectations at work and team dynamics were regarded as potential threats to their involvement in work. This experience was best described by the narratives of Butterbean and Nightingale. Butterbean described the feeling of nervousness when introduced to work. He associated this with trying to understand the team dynamics and his role within the team. He said:

> *I was surprised to see what I was going to be doing. Nervous to see how to get on with the team, the team dynamics and how the team works. (no.8).*

Nightingale described the feeling of nervousness in the form of what to expect when she was first introduced to work. She explained:

> *I was really nervous because I didn't know what to expect. I was quite like, I was excited but nervous, but I have got to know staff down here. (no.19)*

5.4.8.2. Feelings of social isolation

One participant described experiencing loneliness on his first day at work due to working within an unfamiliar community. This narrative revealed the significant value of social acceptance and building relationships within the work environment for this participant. Ronaldo, who regarded his involvement in work as a means of developing his social skills, described experiencing the need for social acceptance during his first week at work. He said:

> *Em, for the first week, probably, I didn't know anyone, I was just put in the midst of whoever was working, or random people who I have never met (no.31)*

5.5. Summary of chapter five

The scrutiny of the statements of participants within this study indicated that they described work based on their experience of introduction to work, their present experience during work, and future plans for work. Figure 4 summarises the findings about the lived experience of work.

5.6. Preview of chapter six

The next chapter discusses the implications of the findings of this study for the understanding of the lived experiences of mental health service-users involved in work within secure mental health hospitals.

Chapter Six – Discussion

6.1. Introduction

The aim of this study was to understand how service-users within mental health hospitals experience work. This was done through face-to-face interviews to explore their lived experiences and analysed using descriptive phenomenological analysis. The discussions of the results were categorised to reflect how participants described their lived experience during their stay in hospital. There were three themes that contributed to the lived experience of work for a mental health service-user living within hospitals. These themes are represented in Figure 5.

To contextualise this discussion, it is important to revisit the aim that forms the foundation of this study and to reference the degree to which this study has adhered to these. The aim outlined in Chapter One was as follows: To understand how service-users within secure mental health hospital units experience work.

The aim of this research has remained consistent throughout the course of the study. All stages of the literature review, data collection, data analysis and literature review were designed according to the aim of this study. This section will compare the findings from chapter five to the current literature.

6.2. Involvement in work is therapeutic

Participants in this study described the therapeutic impact of work on their mental health. This discussion will focus on its four subthemes: introduction to work evokes positive emotions, involvement in work supports rehabilitation, work provides structure and involvement in work improves health.

6.2.1. Introduction to work evokes positive emotions

This study revealed that a participant experienced anxiety in the form anticipation and a resultant drive to ensure that the introduction to work went well. Tallis (1990) stated that anxiety is an individualistic phenomenon and thus the response of individuals varies. Hence, one participant experienced a positive response of anticipation while other participants were nervous.

This positive response was explained by Mortensen (2014), who stated that a certain baseline of normal anxiety supports individuals by increasing their edginess, alertness and unsettled feelings, which in turn provides the impetus to perform. Hence, this participant utilised the anxiety that he experienced to ensure that his introduction to work was a success. The positive experience is linked to the participant's sense of capacity and of the effectiveness of his abilities in anticipation of his introduction to work. This is termed personal causation (Parkinson et al., 2004). The participant whose narratives about work showed that he was capable of engaging in work and achieving success experienced a positive response to anxiety. As

discussed in the literature review, personal causations constitute one of the three elements that drive the motivation to engage in work. Therefore, individuals who believe in their capacity and effectiveness to engage in work roles are likely to experience positive emotions about work. This encourages them to be more motivated to engage in work.

6.2.2. Involvement in work improves rehabilitation skills

This theme indicated that involvement in work supported rehabilitation. Participants' statements about work portrayed it as offering development of skills relevant to community integration, replication of the experience of being in the community, learning skills, an end-product of rehabilitation and a means of learning from mistakes. As discussed in the literature review, these skills are essential to occupational participation at work but can be applied to other areas of community integration. Shuring et al. (2010) described similar rehabilitation outcomes of improved social functioning and reduced role limitations among re-employed mental health service-users. Likewise, Bond (2004) stated that supported employment encouraged the integration of service-users in the competitive job market. McDonald and Bertram (2018) also identified teamwork and comradeship as part of the community integration skills that service-users experienced at work.

Kielhofner (2008) proposed that these rehabilitative skills that aid work performance include communication and interaction skills such as appropriate body language, ability to initiate, disclose and sustain

conversations, and ability to be cooperative and respectful at work. Other skills include the ability to initiate projects or tasks at the right time and see them through to conclusion; developing new ideas and methods when appropriate; and the ability to manage workload and resources effectively. In the literature review, these skills were identified as the third element of a person (alongside volition and habituation) that interacts with the environment to allow occupational participation in work. When these skills combine with volition, habituation and the work environment, occupational flow can be achieved at work as result of a challenge-skill balance. This can lead to fulfilment and purpose, which are elements of self-actualisation. The experience of self-actualisation at work is directly linked to job tenure. This is an indication that service-users are likely to explore and retain future employment if they are supported to develop the skills to match their work roles.

6.2.3. Involvement of service-users in choices around work is beneficial

Participants in this study identified the importance of being an integral part of the choices around their involvement in work. The participants chose roles that they were interested in based on their perception of their abilities. Jamie chose a role that he was interested in based on his previous work history as a chef. He also indicated a preference for his current role because it had less pressure in comparison to his premorbid work role. Likewise, Duran chose a role of interest that involved

being green fingered (adept at growing plants) and his preference for working alone. He enjoyed it better than previous roles that were not based on his interests. From the lived experiences of both participants, it can be observed that their work history played a vital part in the roles that they chose during their work placement in hospital.

As recognised in the literature review, the choices of individuals around engagement in work are driven by their interests. Parkinson et al. (2004) identified interests as the third component that drives volition (motivation), which is in turn one of the three elements that interact with the environment to make engagement in work possible. Kielhofner (2008) posited that "interests reveal themselves both as the enjoyment of doing something and as a preference for doing certain things over others" (p. 42). He continued by stating that enjoyment can be derived from a combination of factors including bodily pleasure, fulfilment from intellectual and creative pleasures, the handling of materials and production of something pleasing, and social interaction. Kielhofner associated the attraction people might have to specific occupations with the concept of occupational flow (Csikszentmihalyi, 1990). He indicated that enjoyment (and, therefore, interest) typically increases when individual capacities match activity demands. This statement indicates that the interest of the participants in their chosen work roles is linked to the enjoyment that they experienced as a result of a challenge-skill balance.

Likewise, Kielhofner proposed that people develop a special pattern of interests, which is accrued through experience. People make choices

about occupation over time, according to their preferences, and these frequently develop into a pattern of choices. He suggested that the patterns of interests that people develop are "usually paralleled by a routine in which their interests are at least partially indulged" (p. 44). This is an indication that the choice of interests is a vital part of individuals' processes of habituation because they are likely to build their routines and roles around their interests. A service-user's previous work history can therefore reveal the kind of roles that they are attracted to and their preferences within work roles. This measure can also reveal habits and roles developed based on their work roles. The concept of a pattern of interests forms a link to the next theme which stated that work provides structure (habituation).

The literature review in this study also acknowledged that the individual placement and support model (IPS), which is the most extensively researched model of supported employment, enshrined the consideration of service-user choices and preferences within its core principles (Bond et al., 2013). Two of the core principles of this model are a focus on attention to consumer preference in job searches and provisions for employment specialist to develop relationships with employers based on a person's work preference (Bond, 2004). This is an indication that choices and preferences are part of the key therapeutic factors for the successful engagement of service-users in work.

6.2.4. Work provides structure within mental health hospitals.

The exploration of the lived experience of work among service-users within secure mental health hospital units produced a theme of work as a form of structuring within mental health units. This description of work as an opportunity for structure has correlations with current research findings, especially in the exploration of the subthemes of routine and occupying time. As identified in the literature review, Modini et al. (2016) discovered that work provided healthy routines for people with severe mental health difficulties. Prior et al. (2013) also stated that the recognised routine offered by sheltered work gave service-users a positive sense of commitment and responsibility to worker roles and other people.

These narratives of structure focused on being able to follow an organised and consistent schedule of work, and this aligns with the characterisation of habituation described in the literature review. The narratives about the combination of these worker roles and routines described by participants in this study are vital characteristics of habituation: an identity, a means of productivity and a way of keeping busy.

Structure in the form of habituation is therapeutic because roles are the functions assumed by individuals, and the internalisation of roles is a process that provides individuals with an identity (Park et al., 2019). As a result of habituation, service-users have the unique opportunity to identify themselves within the empowering roles based on their interests and routines around work. This forms their identities rather than the often-disempowering identity as a mental health service-user. Parkinson (2004)

also stated that habituation forms one of the three elements that interact with the environment to make occupational flow possible. Csikszentmihalyi (1990) stated that when an individual's internal capacities (volition, habituation and skills) match the demands of the working environment, occupational flow is likely to occur. This is an indication that habituation in combination with other elements of a person and the environment directly affects the experience of occupational flow and, as such, directly affects self-actualisation (fulfilment, achievement and purpose). This verifies the theme within this study which stated that work gives fulfilment, achievement and purpose.

6.2.5. Involvement in work improves health

The literature surrounding the therapeutic use of work has identified similar improvements in the health of mental health service-users to those described in this study. This included statements that involvement in work supported participants with feeling accepted, as well as helping them to cope with illness. Work also helped them to manage their mental health and avoid triggers, and had an overall positive impact on mental health by providing a distraction from mental health issues and stressful events. As identified in the literature review, Saavedra et al. (2016) discovered that involvement in work improved the mental health of service-users by acting as a defence against depressive episodes. Engagement in work led to a reduction in the frequency of hospital admissions because of mental health relapse. Dunn et al. (2008) also described the use of work to overcome

troubling mental health symptoms. These findings resonate with the accounts of service-users within this study.

An important finding in this study that can contribute to new knowledge is the account of the therapeutic use of work as a distraction from mental health issues and stressful events. A participant described being less aware about her mental health symptoms. Specifically, she said:

> *It is like when I am down here, I am happy and cheerful. I am like forgetting all my problems and when I am back on the ward, your mood starts to drop slightly. (no.33)*

The participant continued by saying:

> *I think that if I come down a little bit stressed. But since I get into the work that I need to do, I can take my focus off that and put it into the work that I am doing. (no.62)*

These statements depict the participant's experience of occupational flow through a description of the therapeutic benefits of involvement in work. Reed (2011) described occupational flow as situations where individuals are so fully involved in an activity that they appear to forget their personified being-in-the-world altogether. The participant above described forgetting all her problems, taking her focus off stressful situations, and devoting this to work. This indicated a loss of self-consciousness about her existing situation as a mental health service-user through the process of concentrating on the clear goal of work. She described engagement in work as "really good" and "better" for her mental health. This narrative demonstrated that she felt a sense that her engagement in work was rewarding. Lastly, the participant described a

return to her personified being-in-the-world when she returned to the mental health ward. This was in the form of the realisation that she had returned to her role as a mental health service-user.

Csikszentmihalyi (1990) explained the phenomenon of flow through the concept of the challenge-skill balance (see Figure 6). This concept describes the balance between engaging in an activity and the individual's abilities. It specifies that such activities epitomise a challenge for the individual, but only to the extent that s/he is able to realise it. As identified in the literature review, flow is experienced during the process of engagement in the activity, when both the situational demand and the abilities are high (Csikszentmihalyi, 1990). This theme is connected to other themes within this study such as: work provides structure; involvement of service-users in choices around work is beneficial; and, work gives a sense of purpose, fulfilment and achievement. When an individual's internal capacities (volition, habituation and skills) match the demands of the working environment, occupational flow is likely to occur. The experience of flow would have occurred because the participant's roles and routines (structure) were adequate for successful engagement in work. Likewise, for flow to have occurred, this participant would have been given choices to engage in work roles of interest.

As recognised in the literature review, people who benefit from occupational flow experiences tend to experience fulfilment and purpose in their occupational life, which is essential for improving wellbeing (Jonsson & Persson, 2006). The theme of the experience of occupational flow at work

is therefore directly linked to the theme which stated that work gives a sense of purpose, fulfilment and achievement, in that it is that consistent experience of flow that leads to fulfilment, purpose and achievement.

6.2.6. Work gives a sense of purpose, fulfilment and achievement

This theme was characterised by statements such as: involvement in work gives purpose and meaning in life; a feeling of achievement; producing something that can be used; positive feeling from achievement; sense of achievement; fulfilment; increase in self-esteem from achievement; feeling of happiness from achievement; and sense of achievement from doing something independently. These statements correspond with self-fulfilment, a characteristic of self-actualisation within work roles, as recognised in the literature review. Maslow (1943) defined self-actualisation as "the desire to become more and more what one is, to become everything that one is capable of becoming" (p. 382). Maslow continued by stating that, even if all physiological, safety and social needs are fulfilled, individuals may still often experience a new dissatisfaction and restlessness unless they are doing what they are suited. Participants described work as suitable for their stay in hospital since it gave them a sense of purpose, fulfilment and achievement, which are all characteristics of self-actualisation. Coupled with the possibility of attainment of self-actualisation, the participants experienced the feeling of gratification and confidence in their abilities.

As identified in the literature review, McQueen and Turner (2012) identified similar lived experiences of achievement and sense of purpose in forensic mental health service-users. This experience during their engagement in work resulted in hope and empowerment. Similarly, Fossey and Harvey (2010) concluded that the engagement of mental health service-users in work gave them more independence, a sense of pride in their achievement, and in the improvement of their abilities and personal development.

Authors within the literature study established that self-actualisation experiences among the participants can be attributed to several factors within the workplace. So, for example, empowering service-users by encouraging work choices and interests was identified in the theme that recognised that involvement of service-users in the choice of work is beneficial. The work environment and resources also affected the achievement of fulfilment, and hence self-actualisation. All the service-users within this study were undergoing vocational rehabilitation within their work placements. As researched in the literature review, work environments that support skill acquisitions and encourage resourcefulness frequently lead to the attainment of self-actualisation.

The literature review in this study identified the link between the themes of occupational flow, fulfilment achievement and purpose (self-actualisation), and the increased possibility of the service-user experiencing future employment. Kielhofner (2008) explained that flow experiences occur when the demands of an activity optimally match the

capacities of the individual. The implication is that enjoyment, and therefore interest, typically increases when individual capacities match activity demands. The enjoyable experience of work as a result of occupational flow leads to self-fulfilment, which is linked to the concept of self-actualisation. Work environments where occupational flow and self-actualisation are experienced, therefore, are associated with an increased interest in work, and accordingly an increased motivation to engage continually in work. Intrinsically motivated employees are continuously interested in the work they are involved in and would continually engage in their employment and are fascinated by the tasks they perform (Csikszentmihalyi, 1997; Harackiewicz & Elliot, 1998). Hence, service-users who experience occupational flow and self-actualisation at work are likely to explore future employment.

6.2.7. Involvement in work increases the possibility of exploring future employment

Participants in this study described that their involvement in work provided them with the means of exploring future employment when discharged. The only subtheme described was that involvement in work during hospital admission supports their plans for future work when discharged from hospital. Participants described that their work placements in hospital: simulate a paid job; give them the discipline to keep a job; help them to proceed to a paid job; provide them with qualifications for future

employment; help them to reflect about work in the community; and give them the opportunities to further their education.

The narrative that involvement in work supported participants' plans for future employment was consistent with Hamilton et al. (2013), who conducted a study about the implementation of evidenced-based employment services in speciality mental health. More than half of the 801 service-users recruited in that study were interested in returning to competitive employment. This study revealed that there was a significant increase in the employment rate between service-users who were in supported employment compared to those who were not. Studies by Honey (2003) and Secker et al. (2003) also concluded that previous employment history was the greatest predictor of the likelihood of mental health service-users' involvement in paid work.

It is important to note that all the participants within this study had a positive perception of their ability to be involved in paid or voluntary work in the future. They viewed the experience and skills gained at work as transferable to future employment. This can be linked to the fact that all the service-users within this study identified with the theme that work provided them fulfilment, purpose and achievement (self-actualisation). As discussed in this theme, when self-actualisation is experienced within a work environment, there is an increased motivation to continue to engage in work. This study highlights the importance of involving service-users in work at the earliest possible stage after admission to secure mental health hospitals. Introducing service-users to work can shape their work history

positively by creating the routines, skills and motivation necessary for engagement in work and by delivering the work experience needed for paid employment. This can increase the chances of obtaining paid employment when discharged into the community (Honey, 2003; Secker et al., 2003).

6.3. Occupational therapists support involvement in work

This finding revealed that occupational therapists play an important role in the involvement of mental health service-users in work. All the participants in this study indicated that occupational therapists supported their involvement in work in various ways, such as by supporting their interest in work; supporting their involvement in work; empowerment to make decisions about work; settling down in work; support to choose a more suitable job; collaborative efforts to progress to consistent work; and support to adapt to the work environment.

The themes "supporting their interest in work" and "introduction to work" indicated that occupational therapists were in a unique position to identify occupational deprivation and imbalance among the participants. Occupational therapists were in the forefront of restoring occupational justice by supporting the participants to actualise their involvement in work. As discussed in the literature review, occurrences of occupational deprivation and imbalance are significant features in the lives of mental health service-users living in secure hospitals due to factors outside their

control such as incarceration and disability. Based on these themes, occupational therapists play a vital role in correcting occupational imbalance and deprivation.

The theme "empowerment to make decisions about work" is indicative that occupational therapists ensured that participants' interests and choices about work roles and within the work environment were encouraged. Based on the literature review, interests play an important role in motivation to engage in work and fulfilment within work roles. This leads to tenure within employment roles. It can be inferred that by encouraging the interest and choices of service-users within work roles, occupational therapists support motivation, fulfilment and future engagement in work. This theme is indicative of the vital role of occupational therapists in empowering service-users to make decisions around work.

The theme "support to choose a more suitable job" indicated that occupational therapist supported the participants to find work roles that matched their expectations but also performance skills. Likewise, the themes "settling down in work" and "support to adapt to the work environment" indicated that occupational therapists supported them to develop the internal capacities to match the challenges of the working environment. This ensured that participants were able to continue to engage in work.

As identified in the literature review, COT (2007) recommended that occupational therapists should navigate vocational services within mental

health services because they are ideally skilled and positioned to deliver effective support into the workplace due to their long-established clinical practice of working with people with disabilities to support or improve function in all aspects of their daily lives (Lilywhite & Haines, 2010).

6.4. Involvement in work has some negative outcomes

Participants in this study described that their involvement in work had some negative outcomes, specifically preventing engagement in leisure, the impact of mistakes at work on service-users, work roles not being suited to service-users' abilities, boredom, and the demanding nature of work. These are discussed in turn below.

6.4.1. Introduction to work evokes difficult emotions

This study revealed that participants experienced anxiety in the form of nervousness during their introduction to work. May (1977) explained why this might be the case, highlighting that anxiety arises when individuals feel a strong sense of threat to a value that they cherish. Participants in this study experienced anxiety because they felt that their introduction to work had the potential to be unsuccessful, and hence a threat to their involvement in work. Eysenck et al. (2017) explained the negative responses experienced by the participants through Processing Efficiency Theory (PET) and Attentional Control Theory (ACT). These theories proposed that, during anxiety, when a goal is being threatened, an

individual devotes attention, through internal (thoughts) or external (distractors), to discover the origin of the threat to the goal, which in turn reduces performance. This statement was reiterated by Ansari and Derakshan (2010) and Schwabe et al. (2009), who posited that anxiety results in poor performance through deficits in the cognition process as a result of a reduction in the storage and processing capacity of total working memory. These explanations analyse the negative impact of anxiety, such as nervousness, on the engagement of service-users with work, especially their performance during their introduction to work.

The negative experiences are linked to the participants' sense of incapacity in anticipation of their introduction to work. For example, Nightingale said,

"*I was really nervous because I didn't know what to expect*"

Her narrative about work showed nervous about her ability to meet work expectations. Her sense of incapacity led to her experiencing the negative effects of anxiety. Kielhofner (2008) explained that individuals encounter incapacity, which "is experienced as difficulty doing the things that matter in one's life" (p. 37). A sense of incapacity affects an individual's ability to engage in work because it influences motivation. According to the Model of Human Occupation (Kielhofner 2002, 2008), motivation is one of the three elements of a person that interacts with the environment for occupational participation. When individuals doubt their capacity to match the expectations of work roles, they are likely to be less motivated to engage in work.

6.4.2. Work can prevent engagement in leisure

This subtheme described how work prevented a participant's engagement in leisure activities. As acknowledged in the literature review, Saavedra et al. (2016) reported a reduction in free time to do personal things among mental health service-users who were engaged in work.

The participant within this study perceived that his work roles prevented him from participating in leisure activities. His account of a work-life imbalance is a description of occupational imbalance as discussed in the literature review. Hakansson and Ahlborg (2018) defined occupational imbalance as a disproportion of occupational engagement such as work, play and rest. The implication of this is that individuals with mental illness who structured their time in a combination of activity categories such as work, self-care and leisure, had better perceived health, mastery, quality of life and social interaction than service-users in work roles who dedicated shorter times to these activities (Eklund et al., 2010). Similarly, Ahlborg and Hakansson (2015) stated that occupational imbalance predicted stress-related disorders among both women and men workers, which resulted in sickness.

This is an indication that occupationally balanced service-users are more likely to continue their engagement in work and are less likely to experience negative outcomes such as burnouts and stress because of perceived improved quality of life.

6.4.3. Tiredness

The theme that engagement in work resulted in tiredness can be linked to occupational imbalance, as discussed in the theme "work prevents enjoyment in leisure activities". One participant explained that the cause of his tiredness was due to his daily engagement in multiple work roles and daily exercise, which limited his time to explore other leisure activities. His statement indicated tiredness and a yearning to engage in leisure activities. He said:

"*I do a lot of exercise on Tuesday, Wednesday and Saturday. I do gym work. Sometimes, you wake up the day after and you just feel so achy. You just don't want to move. You want to stay in bed, play games and stuff like that. But then you gonna get up*"

Engagement in work without the balance of leisure and rest results in occupational imbalance which causes tiredness and stress-related disorders among workers (Ahlborg & Hakansson, 2015). This finding echoed experiences in Marwa and Johnson's (2005) exploration of the views and experiences of work in people with psychosis. It is important to note that the repeated experience of tiredness by mental health service-users who are engaged in work may result in a persistent reduction in work motivation (Daniels, 2000). This indicates that tiredness can adversely affect the service-user's willingness to exert and maintain efforts to achieve their work goals. Indeed, Björklund et al. (2013) demonstrated that there is a negative relationship between tiredness at work and the development of work motivation. They concluded that the continuous experience of

tiredness at work over a period of time can lead to fatigue. This can reduce levels of motivation and exacerbate depressive symptoms among mental health service-users. Demerouti and Bakker (2008) also linked repeated tiredness at work to emotional exhaustion which is characteristic of a burnout at work.

6.4.4. Impact of mistakes at work on service-users

Another negative outcome of work was identified by a participant who described how his poor frustration tolerance within work roles affected his mental state. This frustration occurred because of the lack of fulfilment of the service-user's need for success at work. Such situations included when his mistakes at work were responsible for a reduction in team productivity at his workplace. These mistakes occurred because of the participant's engagement in work roles that did not match his internal capacities of volition, skills and habituation. This resulted in a challenge-skill imbalance, evidenced by mistakes within work roles and frustration as a consequence of these mistakes.

This frustration was described by Neveanu (1978) in the literature review as an intricate act of emotional imbalance fostered at the level of personality because of a failure to fulfil needs, and emotional and material deprivation. Laplanche and Pontalis (1994) explained that the kind of frustration described in this narrative arises when an individual is denied the satisfaction produced by the fulfilment of a certain need at work.

In the narrative within this study, the participant placed great importance and satisfaction on team productivity. When these expectations could not be met because of his mistakes, he became frustrated and this affected his mood negatively. This indicated that the service-user had poor coping skills to manage his frustration.

Based on the transactional model of stress (Lazarus & Folkman, 1984) discussed in the literature review, the participant did not have the right coping skills to cope with the frustration experienced because of his mistakes, and as a result became aggressive when he returned to the ward. In individuals such as this participant, who may have negative emotional states due to their mental illnesses, their ability to regulate emotions is likely to be degraded (Baumeister et al., 2007). Raio et al. (2013) proposed that this continuous exposure to stress can hinder effective emotional regulation abilities and increase emotional dysregulation over time. This resulted in emotionally dysregulated behaviour such as verbal and physical aggression.

This theme describes how a lack of challenge-skill balance within work roles linked to frustration and over time, results in emotional dysregulation.

6.4.5. Boredom

Participants in this study described boredom as "not interested in the work" and "not liking what you are doing". The lack of interest and engagement within work roles in this study led to the occurrence of

symptoms characteristic of a burnout. Saveedra et al. (2016) described similar findings in which community-based mental health service-users identified how a lack of personal meanings invested in jobs can affect their health.

As discussed in the literature review, burnout occurs within work roles when the internal capacities of workers do not match the demands of the work environment. Demerouti and Bakker (2008) defined this burnout syndrome as a mental state categorised by emotional exhaustion and distancing oneself from one's work role through pessimism. One of the key characteristics of burnout within this study was that it occurred in response to varying interpersonal stressors within work roles. The source of stress was the lack of interest in the work role. Interest plays a vital role in achieving self-fulfilment because it constitutes one of the three elements that encourage motivation to engage in work. When workers are interested in employment roles, they would derive increased enjoyment and satisfaction during their engagement in such roles. This would increase their motivation to continue to engage in such roles.

The lack of interest led to reduced motivation to engage in work, as indicated in one of the participant's statement; "sometimes, I look at my watch and think, I hope that it does not go on for too much longer, am going back soon which is good". This narrative corresponds with that Maslach et al. (2001), who posited that burnout characterised by exhaustion, cynicism and lack of efficacy is a direct opposite to work engagement, which is characterised by energy, involvement and efficacy.

The finding explains how a lack of interest in work roles can lead to is boredom. Prolonged experiences of boredom within job roles can result in a burnout. Such burnouts affect the work motivation and engagement of mental health service-users. According to Maslach et al. (2001), burnout is linked with various forms of job withdrawal–absenteeism, intention to leave the job, and actual turnover. It leads to lower productivity and engagement for individuals who remain in the work role.

6.4.6. Work not suited to service-user's abilities

This subtheme described the service-users' perception of work being a negative experience in situations where their work roles did not match their abilities. These lived experiences indicated an imbalance between the participants' appraisal of their abilities and the perception of the task demand at work. The description of a mismatch between service-users' skill and their work role is a portrayal of the concept of challenge-skill balance (Csikszentmihalyi, 1990), as illustrated in Figure 6. In this study, one participant perceived a challenge-skill imbalance in his work role. He said:

> *I've been going there ah for a while. I've not enjoyed it too much because it seems that I get on, I don't enjoy the social erm, the social setting. (no.4).*

In this scenario, the participant believed that his performance capacity in terms of interaction skills was inadequate for the social requirements of this work role. This is indicative that the work role did not match his appraisal of his social abilities. As identified in the literature review, a person's belief about their effectiveness, referred to as personal causation, has an impact

on the motivation to engage in work because it constitutes one of the three elements of motivation (Kielhofner, 2008). The implication is that mental health service-users must have a sense of effectiveness to match work roles in order engage consistently in work. Without a sense of effectiveness, engagement in work would be difficult because of a lack of motivation.

6.4.7. Unfriendly work environment

This theme identified how an unfriendly environment could be a downside to involvement in work. One participant had previously identified that he enjoyed the social environment because the contact with his work colleagues and customers from the community helped to develop his social skills. This is indicative of how his social environment affected his engagement in work. He said:

> *Someone might be grumpy. Sometimes you come down here and say hey, how are you? Like the lady was this morning. Sometimes they could be like hello (in a low voice), speak differently, that is the only disadvantage. (no.60).*

In this scenario, he identified the impact of the negative mood of his supervisor as a disadvantage to his engagement in work. He perceived his supervisor's response to his greetings as unwelcoming. As discussed in the literature review, the social environment plays an important role in engagement in work. A good work environment and conditions can increase job satisfaction in that the employees will give their best thus increasing the employee work performance (Jung & Kim, 2012; Sekhar, 2013).

6.5. Summary

This chapter discussed the findings of the research, focusing on the data gathered in the semi-structured interviews and the analysis of emergent themes. This was conducted in light of research evidence and highlighted issues that were not evidenced extensively, if at all, in the existing literature. These issues will be addressed further in Chapter Seven, which will elucidate the implications of this research, propose practical applications of this study, and provide some recommendations for further research in this area.

Chapter Seven – Conclusions

The findings of this research were outlined in chapter five, and these were then discussed in chapter six, while chapters two, three and four present the literature review, methodology and methods for this research, respectively. This final chapter offers a summary of the overall findings of the research and its contributions to knowledge. It will discuss the strengths and limitations of the study and, importantly, provides recommendations for future practice

7.1. Practical application of this study

In this study, the three emergent themes were viewed as central to the lived experience of work because they were represented in the views of all the participants. These views were that work is therapeutic, has negative outcomes, and that occupational therapists support involvement in work.

As identified in the discussion, occupational therapists are the link to determine the difference between therapeutic outcomes and negative outcomes of work. This is because they are strategically placed due to their long-established clinical practice of working with people with disabilities to support or improve function in all aspects of their daily lives (Lilywhite & Haines, 2010). Occupational therapists can alleviate occupational deprivation by introducing mental health service-users to work and ensuring work adaptation by supporting them to understand the

requirements of their work environment. This includes the utilisation of person-centred assessments and approaches such as the Activity Participation Outcome Measure (APOM) to assess and gauge their emotional response to work challenges and frustration tolerance. Such information can aid referral for work-based interventions such as CBT and DBT, which can help to improve vocational outcomes.

Occupational therapists can ensure that work requirements match service users' performance skills, volition and habituations (structure). This can be done through Occupational Performance History Interviews (OPHI), which enquire about the service-user's history in work, play and self-care performance. This will provide insights into the service-users' volition (interests, personal causations and values related to work) and habituation (roles and routines related to work). Assessments such as the Assessment of Work Performance (AWP) can be used to assess work-related skills such as motor, performance and communication and interaction skills.

Likewise, occupational therapists are strategically placed to correct occupational imbalance at work, which featured among participants in this study. This can involve planning leisure and self-care activities alongside engagement in work. These measures will ensure a challenge-skill balance resulting in occupational flow at work. Consistent experience of occupational flow leads to self-fulfilment at work thus increasing the possibility of service-users exploring future employment, as in the discussion. Figure 7 summarises the practical measures that can improve the lived experience of service-users as identified in discussion chapter.

Based on the evidence gathered in this study, the following recommendations have been developed:

Recommendation 1: Occupational therapists should be at the forefront of supporting mental health service-users in secure hospitals to engage in work because it is therapeutic and aids their recovery. Engagement in work in hospital can also support service-users to develop rehabilitative skills for community integration and future engagement in work.

Recommendation 2: Occupational therapists should empower service-users to be involved in their choice around work. This ensures that engagement in work is meaningful and directed towards their specific interests. This will improve their motivation to engage in work and future exploration of work.

Recommendation 3: Occupational therapists should support mental health service-users to achieve occupational balance alongside their work roles. Involving occupational therapists will ensure that accurate work abilities are assessed alongside their leisure and self-care. Such measures will encourage a balanced routine that reduces occurrences of negative outcomes of work such as burnout and tiredness.

Recommendation 4: Occupational therapists should assess service-users' response to change, frustration tolerance and response to new challenges before and during their engagement in work. These assessments will support the construction of therapeutic interventions such as referral

to CBT and DBT. These interventions will help them to manage their emotions during challenging situations at work.

Recommendation 5: Occupational therapists should continually assess the impact of the work environment on mental health service-users who are involved in work. This ensures that the work environment matches with their internal capacities to continue to engage in work.

7.2. Reflections on the research process

The findings, contributions to theory and practical recommendations of this study are considered to be reflexive and reliable. This section reflects on the strengths and limitations of this study.

7.2.1. Generalisability

The findings of this study were developed from the lived experience of those interviewed. Consequently, they are not transferable but may resonate as true to the participants.

I recognise, therefore, that this study will mainly contribute to the development of theories, knowledge formation and the identification of further research avenues.

7.2.2. Purposive method of sampling

The purposive sampling technique used in this study helped in the gathering of relevant data from participants with a common set of characteristics (Mason, 2002). Despite these benefits, this method of sampling had some limitations. Purposive sampling could have created a

sample of participants who are highly motivated to be involved in the study, producing an uncharacteristic representation of service-users within mental health services. This study only captured the voices of individuals who were interested and had the capacity to speak to a researcher about their lived experiences of work. This was evidenced through the process of obtaining their informed consent and that of their keyworkers during the recruitment process. Fluctuations in mental state and the time of day for which the interviews were planned may have prevented other individuals from engaging in the study.

The service-users who engaged in this study may have felt distressed discussing their lived experiences about their hospital stay and employment services, especially if they misinterpreted the purpose of the interviews as therapeutic intervention. This could have led to the social desirability effect where participants would just say what they thought the researcher would want to hear. This effect was mitigated by the choice of a population sample who did not have a therapeutic relationship with the researcher. The researcher was carefully introduced during the advertisements and interviews as an academic rather than as an occupational therapist so as to reduce the social desirability effect.

7.2.3. Reflexivity

My understanding of the reflexivity in this study was based on research by Probst (2015) that considered the benefits and challenges of reflexivity in qualitative social work research.

One of the challenges I encountered within this study was the use of reflexivity to question my beliefs and assumptions. This was uncomfortable and overwhelming for me as a novice researcher because I had to lay bare my innermost and deep-rooted beliefs which included exploring my history from childhood to adulthood. This was done to identify my preconceived beliefs about engagement in work. My reservations and inexperience during the process of reflexivity revealed to me that I had not become skilled in this process. The lack of formal training on reflexivity in qualitative research was identified as a limitation because it raised doubts as to the adequacy of the reflexive actions taken within this study.

Despite my inexperience, my reflexivity was vital in improving the rigour of this study. It made the positionality, subjectivity and reactivity of this study more transparent. It made me aware of my own viewpoints in relation to the study, with the awareness that there is no neutral position in research. It supported me to establish my viewpoints, recognise how they could influence this study and bracket these preconceived ideas. This served as a baseline of honesty and served as a check against naive claims of purity or objectivity (Probst, 2015). My reflexivity also enhanced the epistemological rigour of this study through recursive self-enquiry. This prevented my assumptions and preconceived ideas based on my professional and family background from undermining the "truth" of this study.

My reflexivity was also crucial to establishing a thorough and transparent ethical process. This included establishing my research agenda,

reducing the power imbalance, and acknowledging to participants my personal gains of completing a doctoral degree. This was done to improve the confidence, impartiality, honesty and respect for the participants. My reflexivity safeguarded me against the self-deception and further bias that could occur when power imbalance was not recognised. An example of this was my decision to recruit service-users from a hospital different from where I worked. This reduced the possibility that participants would feel compelled to take part in my study out of a feeling of responsibility or fear of repercussions.

Another benefit was that it guided my reaction to surprising situations within this study. For example, six out of my seven participants were chaperoned by a member of staff during the semi-structured interviews. I assumed that this could have influenced the overall methodology, as it was their unique individual experiences that were being sought. In the presence of a staff chaperone, they may have been constrained to disclose their experiences about work, especially if these were negative. My reflexivity normalised my reaction both by putting it into context and by distancing this context from my reactions. The context was that they were service users who were on escorted leave. Hence, a member of staff always had to be with them during the interview.

7.2.4. Quality and rigour of this study

To demonstrate the strengths of this study further, I utilised Yardley's (2000) evaluation criteria for qualitative research to critically appraise its quality and rigour. The following criteria were used to appraise this study:

7.2.4.1. Commitment and rigour

As an inexperienced researcher, I was extensively guided by Colaizzi's (1978) approach to phenomenological analysis. I attended a lecture delivered by experienced researchers on the utilisation of descriptive phenomenology to investigate phenomena. Through rigorous research and my continuous referral to descriptive phenomenological authors, I ensured that this the study was conducted with a systematic commitment to the philosophical underpinnings of Husserl (1913) and Colaizzi (1978). These actions ensured that my inexperience did not influence the research process, through the application of reflexivity and bracketing, as described in chapter four. The continued utilisation of rigorous ethical processes, such as obtaining keyworker consent alongside the consent of participants demonstrated, the regard for the welfare of the participants. The member checking of the synthesised data displayed a commitment to ensuring that the narratives of the participants were established, and that the findings of the study matched these narratives.

7.3.5.2 Sensitivity to context

The justification for choosing Husserl's (1913) descriptive phenomenology was that it was suitable for exploring the lived experience of mental health service-users living in secure hospitals and involved in work. The choice of this methodology was appropriate for a phenomenon that is not yet fully researched or understood. This methodology also supported me to bracket preconceived ideas based on my historical and employment background that could influence the narratives of the participants, as described in chapter three. The sensitivity to context was also demonstrated by the choice of semi-structured interviews, the steps taken to prevent researcher bias, and the safeguards to prevent potential risks to participants, as described in chapter four. The descriptions of the narratives of participants were done verbatim to ensure that their voices were heard, while the use of Colaizzi's phenomenological analysis (1978) ensured that the narratives were analysed using a process that complements Husserl's (1913) descriptive phenomenology.

7.2.4.3. Impact and importance

Since there are limited studies that have explored the lived experience of mental health service-users in secure hospitals, this study will give a much-needed voice to this population, as described in chapters six and seven. The findings of this study can be used to build up the evidence base in respect to the lived experience of work in secure hospitals.

7.2.4.4. Transparency and coherence

A further strength of this study lies in the demonstration of a comprehensive explanation for the choices and decisions that influenced the research process. This was demonstrated through the writings in chapter 3 (methodology) and chapter 4 (methods). This included an explanation about the inability to achieve data saturation. The transparency of this study was also evidenced through the utilisation of the inclusion and exclusion criteria to select appropriate participants for this study, and by the discussion of the problems encountered during the recruitment of participants (chapter 7). This study also offered a rigorous description of how difficulties encountered during the interview process were overcome through reflexivity and the step-by-step analysis of data (chapter 4).

7.3. Summary of this study

The background of the study described the need for studies that explore the lived experience of work among mental health service-users living in secure hospitals. From this, the aim of this study was developed, i.e. to understand how service-users within secure mental health hospital units experience work. The literature review explored the historical philosophies of work as a social norm in Western societies. It analysed the impact of mental illness on engagement in work, and explored employment provisions for service-users in secure hospitals. This was because of a dearth of studies that explored this topic, resulting in a lack of knowledge about their lived experience in work.

A descriptive phenomenological approach inspired by Husserl (1913) was used as the methodological framework of this study. Through this framework, bracketing was used to evidence the validity of the data collection and analysis process. This involved intentionally putting aside my beliefs about the phenomenon under investigation.

Ethical clearance was sought from the NHS East Midlands- Derby Research Ethics Committee (REC) and the University of Northampton Ethics committee. After ethical clearance was granted, further ethical clearance was sought from the research and development departments of the research sites. The participant information sheet and informed consent form were given to all service-users who wanted to be involved in this study and it was ensured that the content was explained to them. Consent from their keyworkers was also sought before the data collection process could begin.

A pilot study was conducted to test issues such as the robustness of the questions as a data collection tool, the framing of the questions, the relevance of the data sought and the clarity and logic of the layout of the questionnaire. One of the suggestions raised was to explore the participants' leisure interests before the main questions so as to help relax participants for the rest of the interview. This was adopted as part of the interview questions. Seven mental health service-users were recruited for this study. Data was collected through semi-structured interviews based on the phenomenological interview guidelines of Bevan (2014) and recorded by means of an audio recorder. The analysis of the interviews was inspired

Colaizzi's (1978) phenomenological analysis. This analysis revealed three emergent themes illustrating the lived experience of work within a secure hospital. The themes were: work is therapeutic; occupational therapists support involvement in work; and involvement in work has some negative outcomes.

The discussion highlighted an important discovery that could contribute to new knowledge. A participant described the therapeutic use of work as a distraction from mental health issues and stressful situations. This narrative described the lived experience of occupational flow. The practical application of this study explored the relationship between the three emergent themes that were central to the lived experience of work. It detailed how occupational therapists can influence the therapeutic outcomes and reduce negative experiences of work.

This study proposed recommendations to improve the lived experience of work for mental health service-users in secure hospitals. This included the role of occupational therapists in the successful engagement of service-users in work with the aim of achieving self-actualisation.

Appendix 1

PARTICIPANT INFORMATION SHEET

An exploration of how mental health service-users experience work

1. **Introduction**

You have been asked to participate in a research study conducted by Joshua Ige, a student at the University of Northampton. This study is being conducted as part of a graduate student project at the University of Northampton. Your participation in this study is entirely voluntary.

Please read the information below and feel free to ask questions about anything you do not understand. The researcher will go through this information sheet and answer any questions you have. This will take approximately 10-15 minutes of your time.

2. **Purpose of the study**

To understand what it is to be a mental health service-user working and living in a hospital.

3. **Why have I been invited?**

As a mental health service-user, information about your involvement in work will be needed to complete this study.

4. **Do I have to take part?**

It is up to you to decide whether or not to join the study. We will describe the study and go through this information sheet. If you agree to take part, you will be asked to sign a consent form. **You are asked to participate in this study; however, you are free to withdraw at any time, without giving a reason**. This would not affect the standard of care you receive or affect you negatively in any way.

5. **What will happen to me if I take part?**

You will be asked questions about your involvement in work in an interview. This interview will use audio recording equipment and notes will be taken by the interviewer. Direct quotes from your interview will be used when writing up the study. These direct quotes will not include your name or any information that will identify you.

6. **Duration**

This interview will take approximately 45 minutes to 1hour. The research will take 2 years to complete.

7. **What will I have to do?**

If you participate in this study, you will be asked to sign the informed consent form. Your keyworker or responsible clinician will be informed about your plan to be included in this study.

8. Potential risks and discomforts

The following are potential risks of this study.

a) Anxiety or distress when discussing your views about the interview questions.

b) Power imbalance as a result of the researcher being a healthcare professional.

9. Potential benefits to participants

To understand and explain what it is to be a mental health service-user working and living in a hospital.

10. Confidentiality

Any information that is obtained in this study will not be revealed to any unauthorised person except with your permission or if there is evidence of a risk to yourself or others. If such situation arose, your keyworker would be informed immediately.

It is anticipated that findings from this study will be published in a reputable journal so its findings can be used to provide evidence on how mental health service-users experience work.

11. Participation and withdrawal

Should you choose to volunteer to be in this study, you may withdraw at any time. There is no penalty if you withdraw from the study and you will not lose any benefits to which you are otherwise entitled.

12. Identification of investigators

If you have any questions or concerns about this research, please contact Joshua Ige (Chief) Investigator at Joshua.ige@northampton.ac.uk.

For further clarification, you can contact Professor Jackie Parkes of the School of Health, University of Northampton at Jackie.Parkes@northampton.ac.uk.

13. Who has reviewed this study?

This research has been looked at by an independent group of people, East Midlands - Derby Research Ethics Committee, to protect your interests. This study has also been reviewed and given favourable opinion by the University of Northampton School of Health Research Ethics Committee.

Appendix 2: Example of the semi-structured interview

Introduction

Researcher: I will read through the information sheet. I am trying to find out how you experience work from your own perspective. I am doing this for my doctorate, as a doctoral student at the university of Northampton. I have asked for permission to interview service-users in **** to see what their perspective of work is. Please, feel free to answer me. Whatever you say will help the body of knowledge in terms of people's experience of work. If you are interested, I have some forms for you to sign. You can withdraw at any time during this interview without giving any reason. However, after the data has been collected, such data will not be returned. I will remind you that this recording is confidential. My supervisors at the University of Northampton and I will listen to it, but you will not be identifiable through these interviews.

1. **Researcher:** Just to start with, I want to know a little bit about you. Tell me anything about you. You can talk about yourself. One of the things I will like to know is, what are the things you do during your free time? So, when there is nothing, no activity going on? what are the things you do, like your hobbies?
2. **NIGHTINGALE:** I do like, I like swimming, I do a lot of reading, listening to music and I do a lot of work in ******** and ********. It takes up quite a lot of my time as well which I really enjoy.
3. **Researcher:** That's quite good and how has it been? When you are doing these things during your free time, is it something you enjoy?
4. **NIGHTINGALE:** I enjoy reading biographies. I am reading it at the moment, I really enjoy reading them. My favourite music is little mix.
5. **Researcher**: That's brilliant. I also like reading when I have the time. It is actually quite good. I don't swim anyway. It is something that I hope that I will learn one of these days. I am a little bit scared to do it at the moment. One of these days, I will be able to do it. It is quite brilliant to know that you keep yourself quite busy.
6. **Researcher**: Now, let me ask you, how did you get involved in work when you were admitted to hospital?
7. **NIGHTINGALE:** , I was just like doing things on the ward, textiles and I was helping and doing some stuff on the ward like and this got me inspired to do some textile work, contracting work and everything like that
8. **Researcher**: And who got you into work like, who introduced you to work like you went to meet somebody or somebody gave you the direction like you know what, you might want to try this. How did you get involved in work like in ******** here?
9. **NIGHTINGALE :** I spoke to the OT (occupational therapist) and because she thinks that I was ready to be moved on, like being able to do challenging things

like ******** which I started off doing 2 days a week, I just gradually progressed and moved to ******** o do more textile work

10. Researcher That's brilliant, thank you for that. So, let me ask you, how long have you been doing this work, how long have you been working?
11. **NIGHTINGALE:** Oooh, for a very long time.
12. Researcher: If you could give me an estimate on how long?
13. **NIGHTINGALE:** Since 2015
14. Researcher: That is a good amount of time and if you don't mind me asking, what do you do say work, how does your day go. If you start a 9 o'clock, what are the things that you do?
15. **NIGHTINGALE:** I do like sewing, I am making moss bags at the moment. I am using the sowing machine to make like fabrics and sew them together
16. Researcher: Thank you for that. So, what you are telling me is that when you get in, you sew from the beginning till the end, is that it?
17. NIGHTINGALE: Yes, sometimes, I have to cut out material for to actually sew the bags together.
18. **Researcher**: So, I want you to think back a little bit, the first day you resumed at work, like when you started work in Worbridge, how did you feel on that first day?
19. NIGHTINGALE: I was really nervous because I didn't know what to expect. I was quite like, I was excited but nervous, but I have got to know staff down here. Everyone is so good and very friendly (pause)
20. **Researcher:** You can continue, feel free to talk, am listening. So, at present, how is like at your workplace? You said that you were nervous at first, and you said that you got to know the members of staff. What is it like now when you compare your experience then and now? How do u feel about it?
21. **NIGHTINGALE :** Very good, I enjoy like doing all the office skills, textiles, I am doing, I do quite a lot of it by myself now, I still require a little guidance but I do quite a lot on my own.
22. **Researcher:** You said that you do things on your own, how do you feel when you do things on your own?
23. **NIGHTINGALE:** I feel really positive that I have actually achieved something by myself, So I am really…...
24. **Researcher**: So, the sense of achievement, so you are saying that when you do things on your own. That's good to know.
25. **Researcher:** Now, when you go to work every day in the morning and you are like I am going to work, what is the feeling, how do you feel when you go to work?
26. **NIGHTINGALE:** Mondays, I am downhill, so when I get up, I am like yes, I am going, I feel really good and I know that I can come down here and achieve something good
27. **Researcher:** OK, so let's assume that that day, you were not going to work, how would you feel if you were not going to work that day?
28. **NIGHTINGALE:** Ok but not like great, but yeah, I just like to enjoy and keep myself busy.
29. **Researcher:** Good to know that
30. **Researcher:** What about after work? Like today, you have gone to work, and you have…When you get back, how do you feel?
31. **NIGHTINGALE:** I feel okay but, I know that I have got other stuff to do., I know that I have to go back to do lots of staff on the ward. Yeah
32. **Researcher:** Is there a difference between your feelings when you are at work and when you get back on the ward? Is there a difference?

33. **NIGHTINGALE:** There is a difference yeah. It is like when I am down here, I am happy and cheerful. I am like forgetting all my problems and when I am back on the ward, your mood starts to drop slightly and just yeah. (Nightingale observed looking sad and emotional).
34. **Researcher:** If you want to take a little bit of a break. I have got some water for you. Have some water if you want to. Are you happy for me to continue?
35. **NIGHTINGALE:** Yeah.
36. **Researcher:** So, what you are saying is that there is a difference. When you come here there is the excitement
37. **NIGHTINGALE:** Yeah
38. **Researcher:** But when you go back to the ward it reminds you of your problems, reminds you of everything.
39. **NIGHTINGALE:** Yeah
40. **Researcher:** Thanks for sharing that with me, it is much appreciated.
41. **Researcher:** From your own viewpoint, are there any benefits to being in work, you come to ********, is there any benefit to being involved in this kind of work? You volunteer at this place
42. **NIGHTINGALE:** Yeah
43. **Researcher:** Is there any benefit to that?
44. **NIGHTINGALE:** Actually, you get like AQAs out of there. So, you actually get a qualification doing what I am doing. It is really handy so that when I get out of hospital, some certificates to… I can get a job on the outside and show them what I have been doing.
45. **Researcher:** So, these certificates, you are saying that you can use them on the outside, when you want to get a job in the community, can you use it there?
46. **NIGHTINGALE:** Yeah
47. **Researcher:** So, you feel that what you are doing here is not wasted, you can still use it to get a job
48. **NIGHTINGALE:** Yeah
49. **Researcher:** Is there any other benefit to being involved in work apart from the certificates?
50. **NIGHTINGALE:** (pauses) I don't think so.
51. **Researcher:** So, if you were not going to get certificates out of work, would you still go to work?
52. **NIGHTINGALE:** Yeah, I would go to work
53. **Researcher:** Why?
54. **NIGHTINGALE:** I just like filling my time and if I have not got much to do then I will be like keep myself busy and try to help people really
55. **Researcher:** So, you said that you like keeping yourself busy, how does it help you, why do you like keeping yourself busy?
56. Nightingale: Because I just forget all my problems like, yes, really good really.
57. **Researcher:** Are there any disadvantages to being at work? You know, coming to this place, volunteering, is there any disadvantage to that?
58. **NIGHTINGALE:** No, I don't think so, I like all the staff here, like we all mix in together doing stuff like what Sarah is doing (laughs).
59. **Researcher:** So, since you have been working for some time now, you have not seen any disadvantages?
60. **NIGHTINGALE:** No, I love coming down here
61. **Researcher:** Brilliant, so, in terms of your mental health, this might be a sensitive question, do you think that work, is there any impact that work has on your mental health?

62. **NIGHTINGALE :** I don't think it does, I think that if I come down a little bit stressed but since I get into the work that I need to do I can take my focus off that and put it into the work that I am doing.
63. **Researcher:** Is it a positive or negative impact?
64. **NIGHTINGALE:** I think it is like positive not to dwell on the past and that so……
65. **Researcher:** Is there any negative impact? Like you feel that work has a negative impact on my mental health, any negative impact?
66. **Nightingale:** No
67. **Researcher:** Thank you for being honest with me, like I said, the research is about you and your answers are absolute.
68. **Researcher:** Now, you have been talking about work, would you recommend work to your friends or people on the ward? Would recommend that they come to work also?
69. **NIGHTINGALE:** Yeah
70. **Researcher:** Why would you recommend it?
71. **NIGHTINGALE:** It is a friendly atmosphere, everybody can help you, like some people have got problems like learning needs so they all like work with you and so I think it is really good.
72. **Researcher**: From what you are saying, you are saying that the staff support is very vital and help you whatever the need may be.
73. **NIGHTINGALE:** Yeah
74. **Researcher:** What type of help have you received that you have seen them give you?
75. **NIGHTINGALE :** (Pauses for a few seconds) some people have got learning difficulties, they find it hard to read and answer questions but for me, I don't need that much help, like yesterday I was on my own but they left me to do it because I was capable of doing that but a lot of people would need staff support
76. **Researcher:** Brilliant, one more question. Where do you see yourself in the future in terms of work? You have been doing lots of work and getting certificates, where do you see yourself in the future?
77. **NIGHTINGALE: I** would hope that I am out of hospital. I hope to actually like do some type of retail manager type or settle for some office work
78. **Researcher:** Are you saying that you will continue working when you leave this place?
79. **NIGHTINGALE:** Yeah
80. **Researcher:** And why will you continue working? if you don't mind me asking?
81. **NIGHTINGALE:** I think it is better for your mental health to keep busy

Appendix 3: Consent Form

CONSENT FORM

Title of Project: An exploration of how mental health service-users experience work

Name of Researcher: Joshua Ige

	Please, tick the box
1. I confirm that I have read and understand the information sheet dated ..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
3. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the University of Northampton, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records	
4. I give permission for my interviews to be audio recorded	
5. I agree to my Responsible Clinician being informed of my participation in the study	
6. I agree to take part in the above study	

Printed Name of Subject: _____

Signature of Participant Date:

_____

_____

Signature of Witness Date:

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.

Appendix 4: Keyworker consent letter

Dear responsible clinician/ keyworker,

Responsible clinician/ Keyworker Consent Letter

Your patient has been identified as a potential participant to engage in a study titled "How mental health service-users experience work". In view of his/her medical or psychiatric condition, I will appreciate your confirmation that you have no objections to my involvement in this respect, and there are no medical or psychiatric reasons that will prevent their engagement in this study.

For your information I have included an explanatory note on the research process. I have also included the research proposal, the participant information sheet and patient's informed consent form.

Yours sincerely,

Joshua Ige

Chief investigator.

Appendix 5: Keyworker consent form

Responsible clinician/ Keyworker Consent form

Please ✓ the box for consent or non-consent

I **Keyworker / responsible Clinician,** after consideration of the patients' medical history and mental state,

☐ I consent for my patient to participate in this study.

☐ I do not consent for my patient to participate in this study.

At this time with Joshua Ige (Chief investigator) Signed..... Date .....

Appendix 6: Interview questions before the pilot study

Introduction

I will read through the information sheet. I am trying to find out how you experience work from your own perspective. I am an occupational therapist at ****** and conducting this study doing this for my doctorate at the university of Northampton. I have asked for permission to interview service-users in **** to see what their perspective of work is. Please, feel free to answer me. Whatever you say will help the body of knowledge in terms of people's experience of work. If you are interested, I have some forms for you to sign. You can withdraw at any time during this interview without giving any reason. However, after the data has been collected, such data will not be returned. I will remind you that this recording is confidential. My supervisors at the University of Northampton and I will listen to it, but you will not be identifiable through these interviews.

1. Tell me how you got involved in work after being admitted to hospital.
2. The first day you came into work, how did you feel
3. How do you feel every day before going to work?
4. Every day after work, how do you feel?
5. From your own perspective, are there any benefits to be involved in work?
6. So, would you recommend work your peers on the ward?
7. Are there any disadvantages to work?
8. Do you think work has an impact on your mental health?
9. Where do you see yourself in the future in terms of work?

Appendix 7: Interview questions after the pilot study

Introduction

I will read through the information sheet. I am trying to find out how you experience work from your own perspective. I am doing this for my doctorate, as a doctoral student at the university of Northampton. I have asked for permission to interview service-users in **** to see what their perspective of work is. Please, feel free to answer me. Whatever you say will help the body of knowledge in terms of people's experience of work. If you are interested, I have some forms for you to sign. You can withdraw at any time during this interview without giving any reason. However, after the data has been collected, such data will not be returned. I will remind you that this recording is confidential. My supervisors at the University of Northampton and I will listen to it, but you will not be identifiable through these interviews.

Introductory chat: Let me know a little bit about you. What are your interests? What do you do to enjoy yourself? want to know a little bit about you. Tell me anything about you. You can talk about yourself. One of the things I would like to know is, what are the things you do during your free time? what are the things you do, like your hobbies?

1. Tell me how you got involved in work after being admitted to hospital.
2. The first day you came into work, how did you feel
3. How do you feel every day before going to work?
4. Every day after work, how do you feel?
5. From your own perspective, are there any benefits to be involved in work?
6. So, would you recommend work your peers on the ward?
7. Are there any disadvantages to work?
8. Do you think work has an impact on your mental health?
9. Where do you see yourself in the future in terms of work?

Appendix 8: Emergent themes of participants within this study

<table>
<tr><th colspan="2">Theme1: Involvement in work is therapeutic</th></tr>
<tr><td>

Emotions of anticipation

- Anticipation about a new start

Improves health

- Feeling refreshed.
- improvement in mood
- Happiness
- Feeling good.
- Enjoyment
- Expression of love
- Feeling accepted and support to cope with illness
- Means of managing mental health and avoiding triggers.
- Distraction from mental health issues.
- Diverts attention from stressful events
- Positive impact on mental health.
- Improves physical health by providing exercise

Supports Rehabilitation

- Skill development for community integration
- Replicates being in the community
- Channelling energy into something
- learning skills
- Something positive to focus
- End-product of rehabilitation
- learning from mistakes.

Purpose, Fulfilment, and achievement

- Purpose and meaning in life.
- feeling of achievement
- producing something that can be used.
- positive feeling from achievement.
- Sense of achievement
- Fulfilment
- Increase in self-esteem from achievement
- Feeling of happiness from achievement
- Sense of achievement from doing something independently

Involvement of service-user in choices around work is beneficial

- Less pressure
- Enjoyment of work
- Encourage Individual choices.
- Not being forced to work.
- Choice to engage in work
- Choice to engage in type of work
- Being given options of work
- Being options in work.

Work provides structure within mental health hospitals.

- Replicates previous work routine
- Part of a routine
- Reason to get up in the morning.
- sense of responsibility
- Being busy.
- occupies time
- Filling time
- concerns about being unproductive without work.
- something to him to do.

Plans for future employment

- Supports plans for future work
- Simulates a paid job
- Discipline of keeping a job.
- Proceeding to a paid job
- Qualifications for future employment
- Reflecting about work in the community
- Furthering education

</td></tr>
<tr><td>Theme 2: Involvement in work has challenges</td><td>Theme 3: Occupational therapist support involvement in work</td></tr>
</table>

• Work not suited to service-user's abilities • Awareness of how mistakes at work can impact service-users. • Work can be demanding • Work can be boring • Work can prevent engagement in leisure • Tiredness • Difficulty in waking up • Tiredness reducing motivation. • Unfriendly environment • Lack of interest in job **Emotions of nervousness** • when introduced to work • About role and how to fit into team dynamics. • What to expect **Feeling of social isolation** • Feeling alone	• Support interest in work • Support involvement in work • Empowerment to make decision about work. • Introduction to work • settling down in work. • Support to choose more suitable job • collaborative work to progress to consistent work. • Support to adapt to work environment.

Appendix 9 : Research advert

We want to learn more about how mental health service-users experience work

We're hoping you can help.

A researcher from the University of Northampton School of Health wants to find out how mental health service-users experience work. This research study is for mental health service-users who live within secure hospital units.

Research is always voluntary!

Would the study be a good fit for me?

This study might be a good fit for you if:

You are a mental health service-user involved in work

What would happen if I took part in the study?

If you decide to take part:

You will be required to attend an interview that will ask questions about your involvement in work. This interview will be recorded through the use of an audio recorder and notes will also be taken by the interviewer.

The principal researcher for this study is Joshua Ige, a professional doctorate student at the University of Northampton School of Health.

Contact information

To participate in this study, please, contact your keyworker for further details.

A researcher from the University of Northampton School of Health wants to find out how mental health service-users experience work. This research study is for mental health service-users who live within secure hospital units.

Research is always voluntary!

Appendix 10: Tables

Table 1: Example of search terms

Keywords	Data base	Results
Work engagement + mental health service-users + secure + forensic hospitals.	NELSON	0
Employment + mental health service-users + secure + Forensic hospitals	Google scholar, Research gate	McQueen & Turner (2012), Samele et al, (2018), Beck & Wernham, (2014)
Employment + mental health service-users + secure + Forensic hospitals	NELSON, PubMed	McDonald & Bertram (2018)
work and employment in secure forensic mental health hospitals	NELSON	Smith et al, (2010)

Table 2: Published lived experience narratives of work in mental health service-users living in secure hospitals.

Author	Positive lived experience of work	Challenges within the lived experience of work
Samele (2018)	Participants attributed their successful engagement in work to the tailored and flexible support offered within the service.	Two participants could not retain paid employment beyond three months due to a breach of license and a mental health relapse.
	Participants identified the benefits of engaging in work as including building trust and confidence, teamwork and positive relationships.	
McQueen & Turner (2012)	Work normalised their lives by giving them self-belief, satisfaction, confidence, achievement and a feeling of usefulness.	Participants identified barriers to employment as fear of unknown, stigma, lack of aspiration, paranoia and pressure.
	Participants identified practical help that supported them within work. These included: forming coping strategies; gaining independence, returning to the person they were before becoming ill, feeling listened to and being part of community.	Concerns raised about the value of working without being paid. Concerns that individual needs of work were overpowered by authority figures such as doctors.
Smith et al. (2010)	Being busy, improvement of personal skills, improvement in ward-based skills such as concentration, improvement in literacy and numeracy skills, working towards a qualification, increased self-confidence, self-esteem and a sense of achievement.	None identified.
Macdonald & Bertram (2018)	Fulfilment from engaging in work. Socialising with their peers. Structure. Comradeship.	Combination of health problems, anxiety about approaching employers and disclosing their offences and mental health problems left participants feeling apprehensive about the likelihood of obtaining work.
	The physicality of the work. Responsibilities to occupy their minds. Value of the wages on a practical and emotional level.	Participants doubted their capacity to work full time after long periods of unemployment and detention within a secure mental health unit.
Cox et al. (2014)	Programme leaders observed improvements in the work skills of service-users such as punctuality, interpersonal skills, managing duties, time management and working relationships with supervisors.	None identified.

Table 3: Demographic data of participants recruited.

Age	**Number of Participants**
18-29	5
30-40	1
40-50	1
Gender	**Number of Participants**
Male	6
Female	1
Type of secure Hospital	**Number of Participants**
Low secure hospital	5
Medium secure hospital	2

Table 4: Summary of the interview method used in this study.

Phenomenological Attitude	**Researcher Approach**	**Interview Structure**	**Method**	**Example Question**
Phenomenological Reduction (Epoché)	Acceptance of the natural attitude of participants	Contextualisation (eliciting the lifeworld in natural attitude)	Descriptive/narrative context questions	How did you get involved in work? What got you interested in work? Why work?
	Reflexive, critical dialogue with self	Apprehending the phenomenon (modes of appearing in natural attitude)	Descriptive and structural questions of modes of appearing	So, you said that the occupational therapist contacted you and asked if you were interested? So, you talk about pressure, is there something about pressure (at work) that you appreciate that doesn't happen here?
	Active listening	Clarifying the phenomenon (meaning through imaginative variation)	Imaginative variation: varying of structure questions	Are you saying that you will continue working when you leave this place? And why will you continue working?

Table 5: Examples of the Process of Creating Formulated Meanings from Significant Statements

Significant statements	**Formulated meanings**
It teaches you skills. Skills that could be useful outside. It's a productive use of time. I guess in some situations, you socialise as well.	Service-user views work as therapeutic including, skill development for community integration, productive use of time and as a means of socialisation.
I enjoy it, I find the walk down here invigorating.	Service-user reflected that walking down to work is refreshing.
I was happy because it was a different experience for me.	Service-user reflected on an improvement in mood because of being involved in work, which was a different experience compared to his usual lifestyle.
I still feel happy now being involved in work.	Happiness because of being involved in work.
I wasn't in a good mood one day, but when I came back it felt better. I felt better.	Service-user reflected that involvement in work had a therapeutic effect on improving his mood.
It helps me get experience of what work would be like in the community, it prepares me for that, and it is something positive to focus on.	Service-user views work as a therapeutic means of preparing for community integration and something positive to focus on during stay in hospital.

Table 6: Theme clusters of emergent themes

Formulated meanings	**Theme clusters**	**Emergent themes**
Service-user appreciates the altruistic effect of being involved in work. He feels acceptance and support in respect to his needs and coping with illness.	Improves health	Involvement in work is therapeutic
Service-user sees work as a means of managing his mental health and avoiding triggers that will worsen his mental health, like arguments. He also sees involvement in work as a means of managing aggression and frustration.		
Service-user believes being on the ward affects her mood negatively but going to work has a therapeutic effect of helping her not to concentrate on mental health issues by making her happy.		
Service-user describes the bad experience of being on the hospital ward, and the therapeutic effect of being involved in work, such as having something to channel his energy into.		
Service-user believes that being involved in work improves his mood because of leaving a stressful environment on the ward to be involved in work. He also mentions the altruistic benefits of using the happiness derived from being involved in work to support his peers.		
Service-user believes that being busy with work moves her focus from her mental health to something positive.		
Service-user believes that his involvement in work supports him to take his energy from stressful events and devote it to duties at work.		
Service-user views work as therapeutic, including development of skills for community integration, productive use of time and as a means of socialisation	Supports rehabilitation	
Service-user reflects that being involved in work replicates being in the community (feeling of normalcy) when compared to the ward environment. It produces the feeling of enjoyment.		
Service-user believes that work has the therapeutic effect of providing exercise, channelling his energy into something, and occupying him. He also views work as a means to learn skills and get qualifications for future work.		

Appendix 11: Figures

Figure 1: Strengths and limitations of lived experience studies that analysed the lived experience of work in service-users living in hospitals.

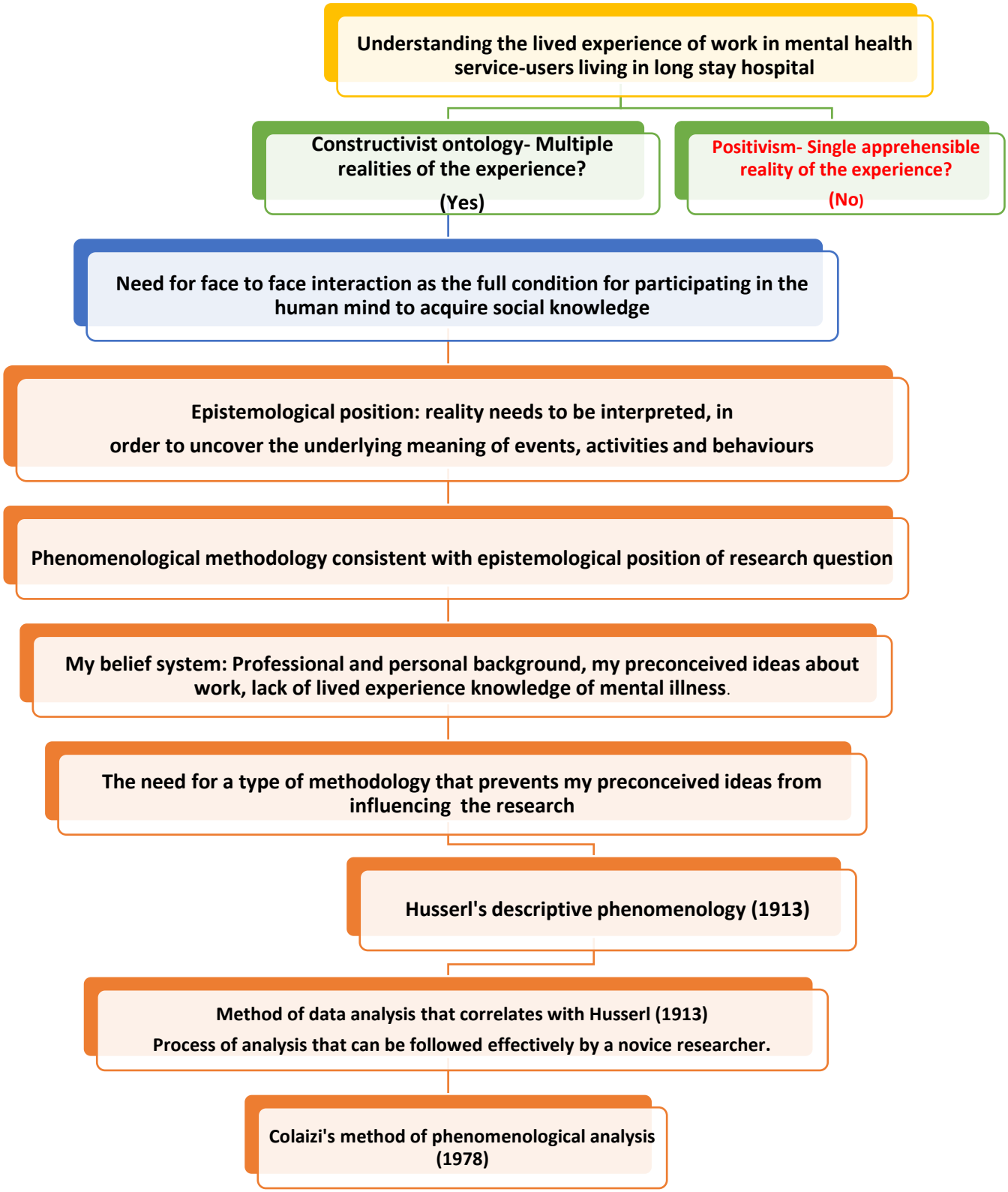

Figure 2: Research paradigms and underpinnings for the choice of the methodology.

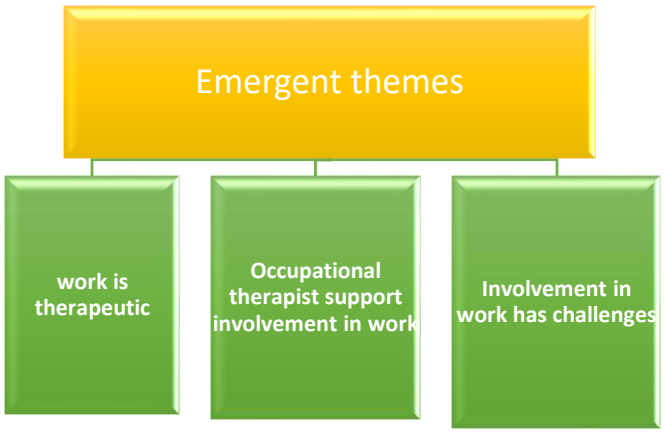

Figure 3: Final thematic map

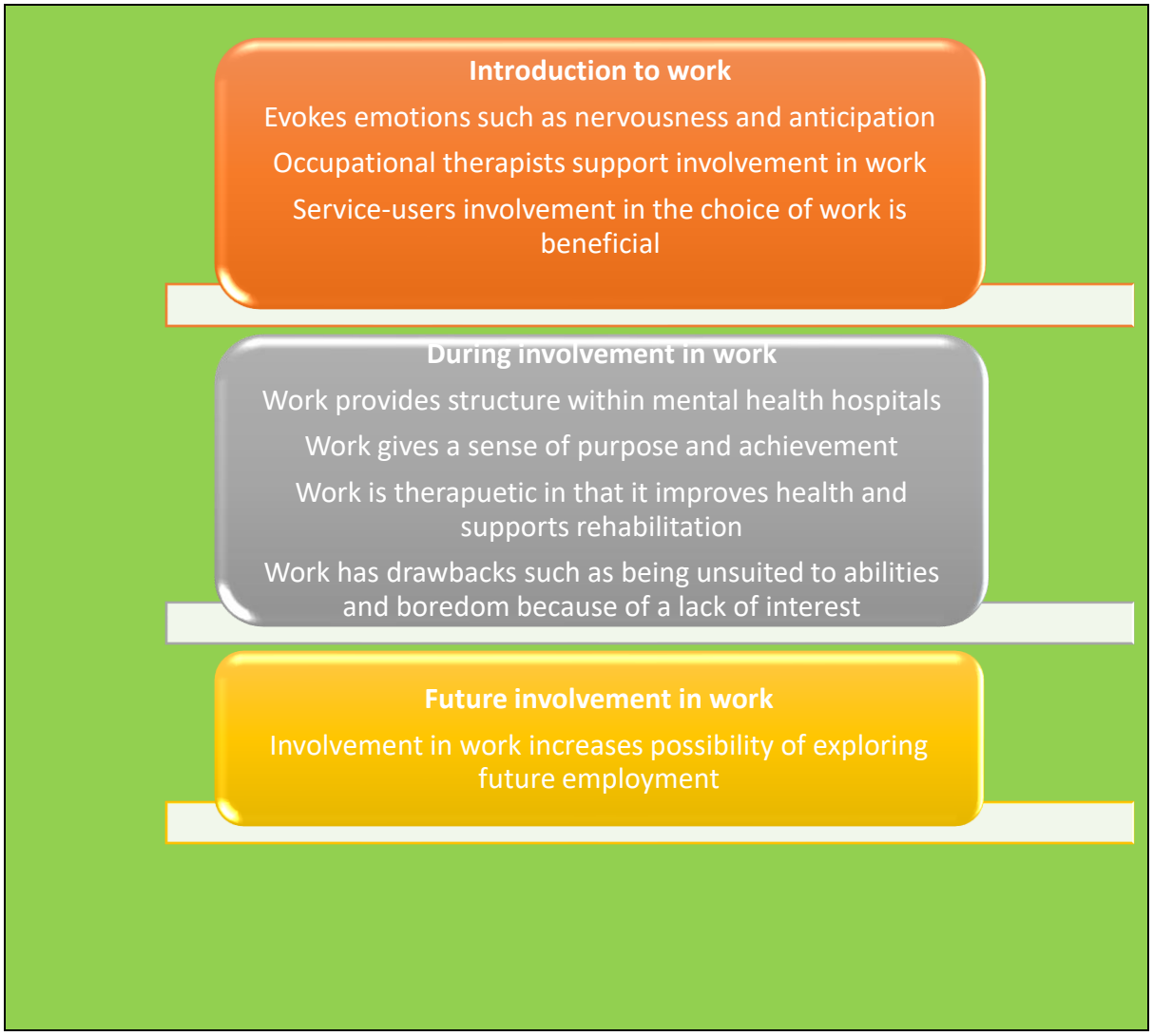

Figure 4: Summary of the findings

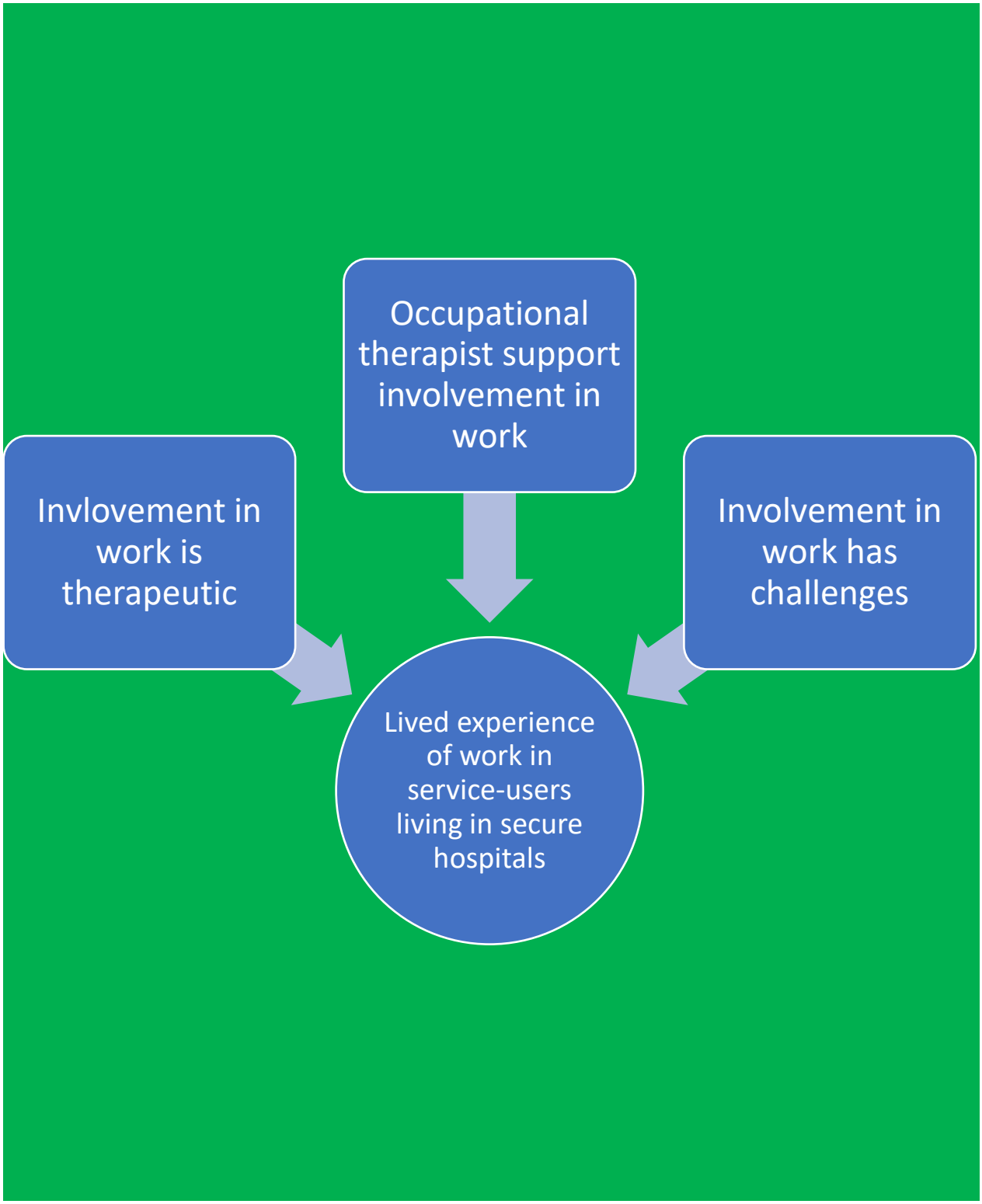

Figure 5: Themes of the research findings

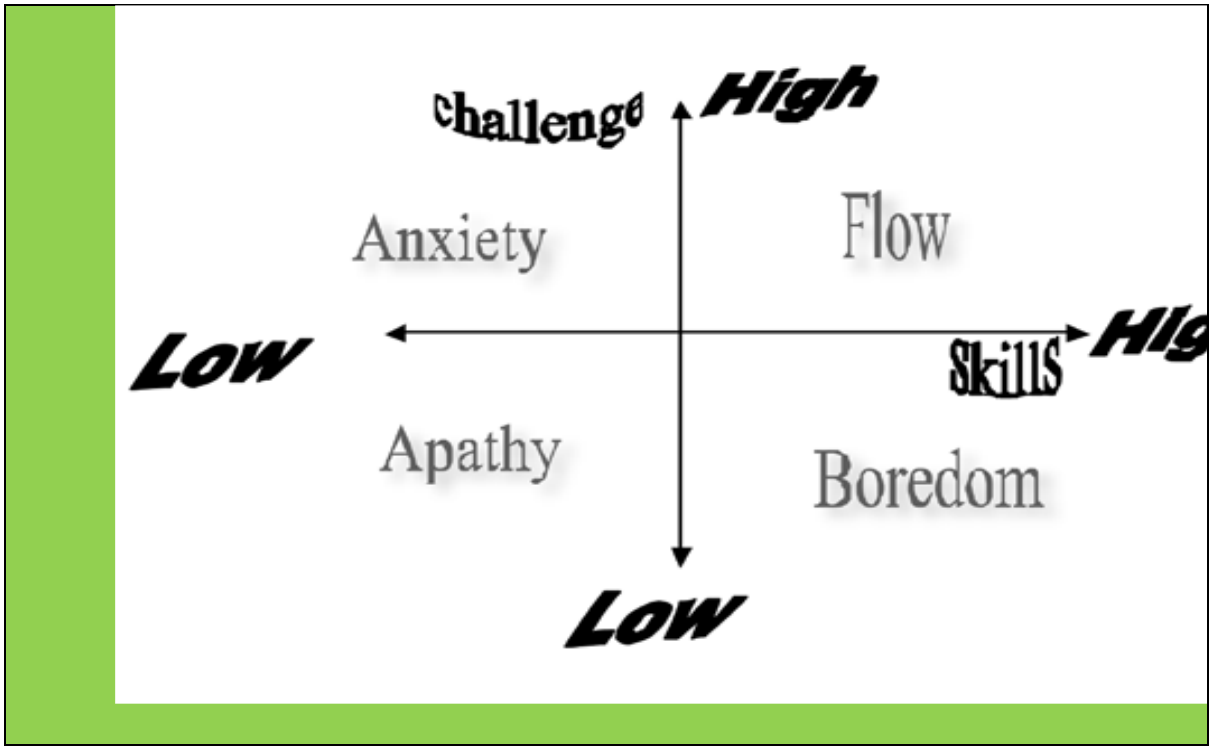

Figure 6: Challenge-skill balance (Csikszentmihalyi, 1990)

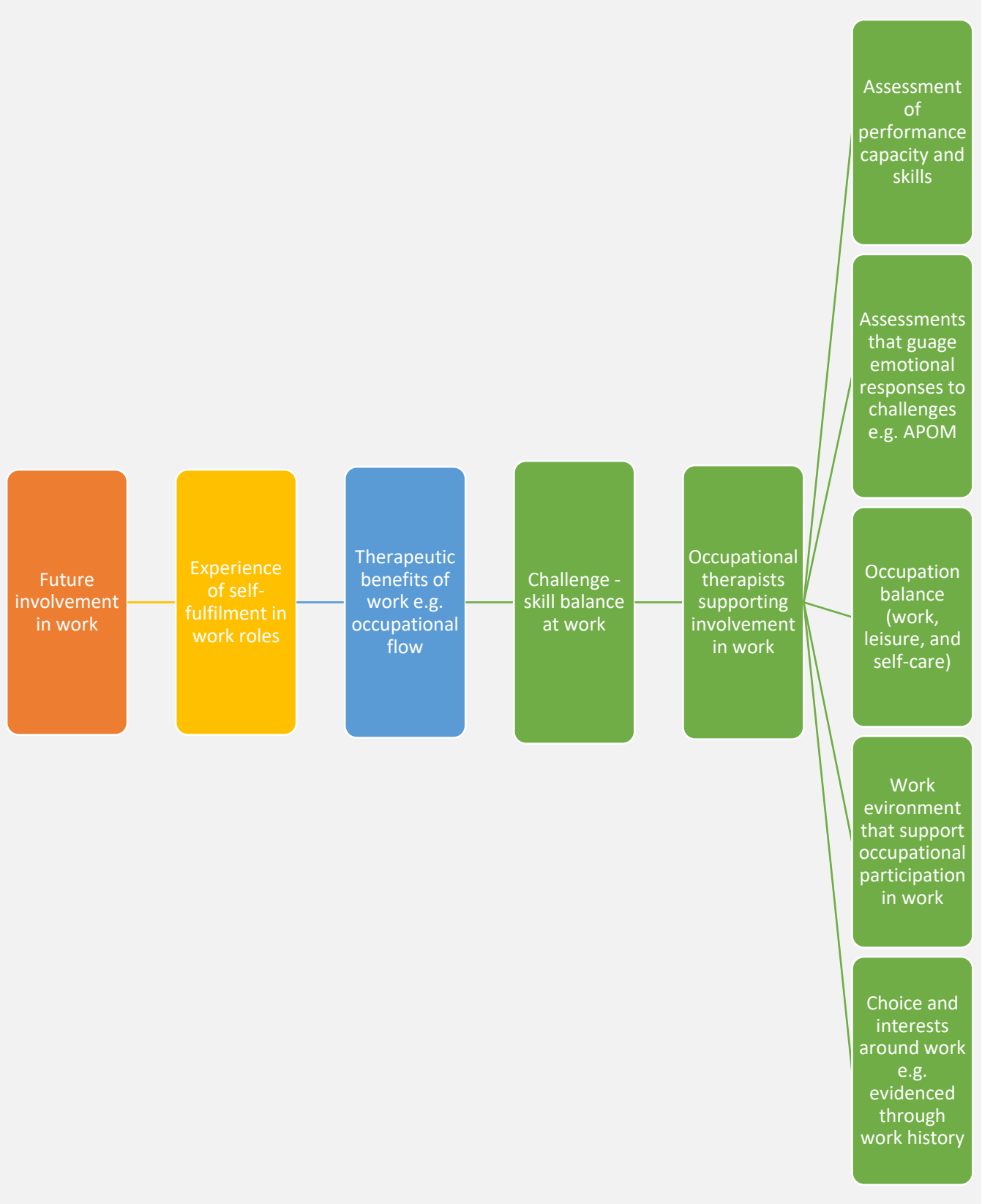

Figure 8: Theoretical model that can improve the lived experiences of mental health service-user involved in work.

References

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research, 9*, pp.407-411.

Al-Ghareeb, A., McKenna, L. and Cooper, S. (2019) 'The influence of anxiety on student nurse performance in a simulated clinical setting: A mixed methods design', *International Journal of Nursing Studies*. Elsevier Ltd, 98, pp. 57–66.

Anthony, W. A., Rogers, E. S., & Farkas, M. D. (2003). Research on evidence-based practices:

Future directions in an era of recovery. Community Mental Health Journal, 39, 101–114.

Angen, M. J. (2000) 'Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue', *Qualitative Health Research*, 10(3), pp. 378–395.

Ansari L. & Derakshan, N. (2010) Anxiety impairs inhibitory control but not volitional action control, Cognition and Emotion, 24 (2), pp.241-254

Areberg, C., Björkman, T. and Bejerholm, U. (2013) 'Experiences of the individual placement and support approach in persons with severe mental illness', *Scandinavian Journal of Caring Sciences*, 27(3), pp. 589–596.

Baker T (1994) Doing social research. 2nd edition. New York: McGraw-Hill

Barak M, Travis J, Pyun H, & Xie B (2009), "The Impact of Supervision on Worker Outcomes: A Meta-analysis," *Social Service* 83(1), pp. 3-32.

Beck, A. (1991). Cognitive therapy and emotional disorders. United States of America: Penguin

Beck, C. and Wernham, C. (2014) 'Improving access to competitive employment for service users in forensic psychiatric units', *BMJ Quality Improvement Reports*, 3(1), pp.1-4

Becker R, Mueser T, & Wolfe R. (2001) Supported employment, job preferences, job tenure and satisfaction. *Journal of Mental Health*, 10(4), pp.411-417

Becker, D.R., Drake, R.E., Farabaugh, A. & Bond, G. (1996). Job preferences of clients with severe psychiatric disorders participating in supported employment programs. *Psychiatric Services*, 47, pp.1223–1226.

Bee, P., Bower, P., Gilbody, S., & Lovell, K. (2010). Improving health and productivity of depressed workers: A pilot randomized controlled trial of telephone cognitive behavioral therapy delivery in workplace settings. *General Hospital Psychiatry*, *32*, 337–340.

Bejerholm U & Eklund M (2004). Time use and occupational performance among persons with schizophrenia. *Mental health Occupational Therapy*. 20, pp. 27-47.

Beijaard, D., Verloop, N. and Vermunt, J. D. (2000) 'Teachers' perceptions of professional identity: An exploratory study from a personal knowledge perspective', *Teaching and Teacher Education*, 16(7), pp. 749–764.

Berg, J. A. (1999). Gaining access to under-researched populations in women's health research. *Health Care for Women International*. 20, pp. 237–243.

Belousov, M. (2016) On the Problem of the World in Husserl's Phenomenology. *Russian Studies in Philosophy,* 54(1) pp.20-34

Benatar, S. R. (2002). Reflections and recommendations on research ethics in developing countries. Social Science and Medicine, 54, p.1131–1141.

Ben-Porath D. (2002) Stigmatization of individuals who receive psychotherapy: an interaction between help-seeking behavior and the presence of depression. *Journal of Sociology and Clinical Psychology*, 21, pp.400–413

Bernstein, P. (1988). The work ethic: Economics, not religion. Business Horizons, 31(3), 8-11.

Bevan, Stephen, Jenny Gulliford, Karen Steadman, Tyna Taskila, Rosemary Thomas, and Andreea Moise (2013) Working with Schizophrenia: Pathways to Employment, Recovery & Inclusion. The Work Foundation: Lancaster.

Birt L, Scott S, Cavers D, Campbell C & Walter, F (2016) Member checking: a tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, 26(13) 1802–1811

Blustein, D. L. (2008) 'The Role of Work in Psychological Health and Well-Being: A Conceptual, Historical, and Public Policy Perspective', *American Psychologist*, 63(4), pp. 228–240.

Bloor, M. (1997). Techniques of validation in qualitative research: A critical commentary. In G. Miller & R. Dingwall (Eds.), *Context & method in qualitative inquiry* (pp. 37–50). Thousand Oaks, CA: Sage.

Boardman AP, Grimbaldeston AH, Handley C, Jones PW, Willmott S. (1999). The North Staffordshire Suicide Study: a case control study of suicide in one health district. *Psychological Medicine*, 29 pp.27-33.

Boardman, J, Grove B, Perkins, R and Shepherd G. (2003) Work and Employment for People with Psychiatric Disabilities. *The British Journal of Psychiatry,* 182: 467–468.

Boardman, J. and Shepherd, G. (2012) 'RECOVERY: Implementing recovery in mental health services.', *International psychiatry: bulletin of the Board of International Affairs of the Royal College of Psychiatrists*, 9(1), pp. 6–8.

Bond, G. R., Drake, R. E. and Becker, D. R. (2008) 'An update on randomized controlled trials of evidence-based supported employment.', *Psychiatric Rehabilitation Journal*, 31(4), pp. 280–290.

Bond, G, Salyers, M, Rollins, A, Rapp, C, & Zipple, A (2004) 'How evidence-based practices contribute to community integration', *Community Mental Health Journal*, 40(6), pp. 569–588.

Bond, G. R., Resnick, S. R., Drake, R. E., Xie, H., McHugo, G. J., & Bebout, R. R. (2001). Does competitive employment improve non-vocational outcomes for people with severe mental illness? Journal of Consulting and Clinical Psychology, 69, 489–501.

Bond, G & Drake, R. (2013), Introduction to the special issue on individual placement and support, Psychiatric Rehabilitation Journal, Vol. 37 No. 2, pp. 76-8.

Boslaugh, S. and Boslaugh, S. (2009) 'An Introduction to Secondary Data Analysis', *Secondary Data Sources for Public Health*, pp. 1–11.

Boyce Gibson (1962) 'Husserl Ideas: General Introduction to Pure Phenomenology', (1913), pp. 1–5.

Boyce, M., Secker, J., Johnson, R., Floyd, M., Grove, B., Schneider, J. and Slade, J. (2008), ''Mental health service users' experiences of returning to paid employment'', Disability and Society, Vol. 23 No. 1, pp. 77-88.

Braude, L. (1975). Work and workers. New York: Praeger.

Bravo-Moreno, A. (2003). Power games between the researcher and the participant in the social inquiry. *The Qualitative Report*, *8*(4), 624-639.

Breen, R. (2006) A Practical Guide to Focus-Group Research, Journal of Geography in Higher Education, 30 (3), pp.463-475.

Brewer, J. (2003). "Ethnography," In The A–Z of Social Research, 2nd ed. London: Sage

Brinkmann, S., & Kvale, S. (2005). Confronting the ethics of qualitative research, *Journal of Constructivist Psychology*, *18*(2), 157-181.

Brocki, J. M. and Wearden, A. J. (2006) 'A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology', *Psychology and Health*, 21(1), pp. 87–108.

Bromwich, D. (1991). Alienation and belonging to humanity. *Social Research. 58,* pp.139-157.

Brooke A., (2015) Selected Psychometric Properties of The Activity Participation Outcome Measure to Describe Trends In A Forensic Population Of Mental Health Care Users. University of the Witwatersrand: Johannesburg.

Burns, T. *et al.* (2007) 'The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial', *Lancet*, 370(9593), pp. 1146–1152.

Bush, P. *et al.* (2009) 'The Long-Term Impact of Employment on Mental Health Service Use and Costs for Persons with Severe Mental Illness', *Psychiatric Services*, 60(8), pp. 1024–1031.

Business, H. S. of and Hall, S. E. (no date) 'International journal of value-based management'. Available at: http://ezproxy.viu.ca/login?url=http://cufts2.lib.sfu.ca/CJDB/BNM/journal/142501.Central, P. E. (2019) 'Attitudes to Work and Workers in Ancient Greece1 '', pp. 33–53.

Carpenter, D. (2007) Phenomenology as method. In Streubert H &Carpenter D. (Eds.) *Qualitative research in nursing: Advancing the humanistic imperative* (pp.75-99). Philadelphia, PA: Lippincott.

Carpenter C & Suto M (2008) Qualitative research for occupational and physical therapists: a practical guide. Wiley-Blackwell, Edinburgh.

Centre for Mental Health (2011), Pathways to Unlocking Secure Mental Healthcare, Centre for Mental Health, London.

Chan, Z. C. Y., Fung, Y. L. and Chien, W. T. (2013) 'Bracketing in phenomenology: Only undertaken in the data collection and analysis process?', *Qualitative Report*, 18(30), pp. 1–9.

Chandley & Rouski (2014) Recovery, turning points and forensics: views from the ward in an English high secure facility. ", *Mental Health and Social Inclusion*, 18 (2) pp. 83-91.

Chandler, D & Munday, R. (2020) Oxford Dictionary of Media and Communication (3rd ed.) Oxford University Press. Available at: https://www.oxfordreference.com/view/10.1093/acref/9780198841838.001.0001/acref-9780198841838

Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. K. Denzin & Y.S. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 507-535). Thousand Oaks, CA: Sage.

Chow, W & Priebe, S (2013). Understanding psychiatric institutionalization: a conceptual review. *BMC Psychiatry.* 13, 169.

Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. Kings (Eds.), *Existential phenomenological alternative for psychology* (pp. 48-71). New York: Oxford University Press.

College of Occupational Therapists (2012). Occupational Therapists' Use of Occupation Focused Practice in Secure Hospitals. Practice guideline, 1st ed. London: COT

Colman, M. (2015) Oxford Dictionary psychology (4th ed.) Oxford University Press. Available at: https://www.oxfordreference.com/view/10.1093/acref/9780199657681.001.0001/acref-9780199657681-e-3249?rskey=xF3YLf&result=1

Corrigan P. & Rao D (2012) On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change. *Canadian Journal of Psychiatry* ,57(8), pp. 464–469

Council of Europe (2017), "Report to the government of the United Kingdom on the visit to the United Kingdom carried out by the European committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT)", Council of Europe, Strasbourg.

Council for International Organisations of Medical Research (1993). Ethics and research on human subjects: International guidelines. Geneva

Cousins, C. (2002). Getting to the "truth": Issues in contemporary qualitative research. *Australian Journal of Adult Learning*, 42, p.192-204.

Cox A, Simmons H, Painter G, Philipson P, Hill R & Chester V (2014) Real Work Opportunities: Establishing an accessible vocational rehabilitation programme within a forensic intellectual disability service. *Journal of Intellectual Disabilities and Offending Behaviour.* 5(4) pp.160-166.

Craig, T. K. J. *et al.* (2014) 'Vocational rehabilitation in early psychosis: Cluster randomised trial', *British Journal of Psychiatry*, 205(2), pp. 145–150.

Creswell, John (1998). Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, CA: Sage.

Crotty, M (1996). Phenomenology and nursing research. Melbourne: Churchill Livingston.

Crouch R. & Alers V. (2007) Occupational therapy in psychiatry and mental health. 4th ed. London: Whurr Publishers.

Crowther, R. *et al.* (2001) 'Vocational rehabilitation for people with severe mental illness', *Cochrane Database of Systematic Reviews*.

Crocker, J., Major, B., Steele, C., (1998). Social stigma. In: Gilbert, D., Fiske, S., Lindzey, G. (Eds.), The Handbook of Social Psychology, 4th ed. NewYork, NY: McGraw-Hill, pp.504–553.

Csikszentmihalyi M (1990). Flow: The Psychology of Optimal Experience. New York, NY: Harper & Row.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing,* 31(6), 1476-1484.

Daniel, K. (2000) Measures of five aspects of affective well-being at work. *Human Relations***.** 53(2): 275–294

Data Protection Act (2018). Available at: **http://www.legislation.gov.uk/ukpga/2018/12/enacted#:~:text=206%20Index%20of%20defined%20expressions%20%20%20the,%20section%203%20%2051%20more%20rows%20**

(Accessed:13.07.2020)

Davidson, L., O'Connell, M. J., Tondora, J., *et al* (2005b) Recovery in serious mental illness: a new wine or just a new bottle? *Professional Psychology: Research and Practice*, 36, 480–487.

Davis, M. and Rinaldi, M. (2004) 'Using an evidence-based approach to enable people with mental health problems to gain and retain employment, education and voluntary work', *British Journal of Occupational Therapy*, 67(7), pp. 319–322.

Dein S, Cook, C, Powell A, & Eagger, S (2010). Religion, spirituality, and mental health. *The Psychiatrist*. 34, pp.63-64.

Democratic Republic of Congo: their feelings and experiences. *Tropical Medicine International Health*, 3, pp 883–885.

Denzin, NK & Lincoln, YS 2003, *Strategies of qualitative inquiry*, Sage, Thousand Oaks, California.

Department for Work and Pensions (2011) *Disability employment support fit for the future*.

Department for Work and Pensions (2013), "Universal Credit guidelines", GOV.UK Publications.

Department of Health (2011), The High Security Psychiatric Services (Arrangements for Safety and Security at Ashworth, Broadmoor and Rampton Hospitals) Directions 2011, Department of Health, London.

Department of Health (2003) 'Confidentiality: NHS code of practice', *Published following a major public consultation*, (September), pp. 1–45. Available at: http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/codes/confcode.pdf.

De Roo A, Ado B, Rose B, et al (1998). Survey among survivors of the 1995 Ebola epidemic in Kikwit.

De Wet K. (2010) The Importance of Ethical Appraisal in Social Science Research: Reviewing a Faculty of Humanities' Research Ethics Committee. *Journal of Academic Ethics*, 8, pp301–314

Drake, R. E., McHugo, G. J., Becker, D. R., Anthony, W. A., & Clark, R. E. (1996). The New Hampshire study of supported employment for people with severe mental illness: Vocational outcomes. *Journal of Consulting and Clinical Psychology*, 64, 391–399.

Drake, R. E, Becker, D. R., & Bond G. (2003). Recent research on Persons with severe mental illness. *Current opinions in psychiatry*, 16, 451-457

Dombro, M (2007), *Historical and philosophical foundations of qualitative research*, in PL Munhall (ed.), *Nursing research: a qualitative perspective,* Jones and Bartlett Publishers, Sudbury, Massachusetts.

Duignan, J. (2016) Oxford Dictionary of Business Research Methods. 1st ed. Oxford University Press. Available at: https://www.oxfordreference.com/view/10.1093/acref/9780191792236.001.0001/acref-9780191792236

Dunn, E. C., Wewiorski, N. J. and Rogers, E. S. (2008) 'The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study.', *Psychiatric Rehabilitation Journal*, 32(1), pp. 59–62.

Duncan, E. (2008), ''Forensic occupational therapy'', in Creek, J. and Lougher, L. (Eds), Occupational Therapy and Mental Health, Churchill Livingstone Elsevier, Edinburgh, pp. 513-34.

Du Toit V (1991) Patient Volition and Action in Occupational Therapy. 2nd ed. Pretoria: Vona & Marie du Toit foundation.

Eklund, M., Erlandsson L, & Leufstadius, C. (2010) Time use in relation to valued and satisfying occupations among people with persistent mental illness: Exploring occupational balance. *Journal of Occupational Science*, 17(4), pp.231-238.

Edward, K. (2016) 'The extension of Colaizzi's method of phenomenological enquiry', *Contemporary Nurse*, 39(January), pp. 163–171.

Edvardsson D., Mahoney A.-M., Hardy J., McGillion T., McLean A., Pearce F. & Watt E. (2015) Psychometric performance of the English language six-item Caring Behaviours Inventory in an acute care context. *Journal of Clinical Nursing,* 24, pp.2538–2544.

Emanuel, J. & Steiner, D. (1995). Institutional conflict of interest. *New England Journal of Medicine*, 332 pp.262–267.

Emerson H (1998). Flow and occupation: A review of the literature. Canadian Journal of Occupational Therapy 65: 37–44

Eysenck, M. W., Derakshan, N., Santos, R., & Calvo, M. G. (2007). Anxiety and cognitive performance: Attentional control theory. *Emotion*, 7, 336–353.

Evans J. & Wilton R. (2019) Well Enough to Work? Social Enterprise Employment and the Geographies of Mental Health Recovery, *Annals of the American Association of Geographers*, 109:1, pp.87-103.

Fossey, E, Harvey C & Williams A (2010) Sustaining employment in a social firm: Use of the Work Environment Impact Scale v2.0 to explore views of employees with psychiatric disabilities. *British Journal of Occupational Therapy,* 73(11) pp. 531-539

Frede, D. (2006) The Question of Being: Heidegger's Project. The Cambridge Companion to Heidegger. Cambridge: Cambridge University Press.

Fusch I & Ness L (2015) Are We There Yet? Data Saturation in Qualitative Research. *Qualitative Report*, 20(9) pp.1408-1416

Gaskell, G. (2000). Individual and group interviewing. In Bauer, M, & Gaskell, G. (Eds). *Qualitative Researching with Text, Image and Sound.* (pp: 38-56). London: SAGE

Giorgi A. (1997). The theory, practice and evaluation of the phenomenological method as a qualitative research procedure. *Journal of phenomenological psychology,* 28, pp.235-260

GBD 2017 Disease and Injury Incidence and Prevalence Collaborators. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet. Available at: DOI:https://doi.org/10.1016/S0140-6736(18)32279-7

Gnambs, T., Stiglbauer, B. and Selenko, E. (2015) 'Psychological effects of (non)employment: A cross-national comparison of the United States and Japan', *Scandinavian Journal of Psychology*. Springer Netherlands, 56(6), pp. 659–669.

Goh, Y. W., Sawang, S. and Oei, T. P. S. (2010) 'The Revised Transactional Model (RTM) of Occupational Stress and Coping: An Improved Process Approach', *The Australian and New Zealand Journal of Organisational Psychology*, 3, pp. 13–20.

Grant (2013) Troubling 'lived experience': a post-structural critique of mental health nursing qualitative research assumption. *Journal of Psychiatry and Mental Health Nursing*. 21 (6), pp.544-549

Green, J. & Thorogood, N. (2004). *Qualitative Methods for Health Research.* London: SAGE Publications.

Guba, E & Lincoln, Y (2005). *Paradigmatic controversies, contradictions and emerging confluences*, in NK Denzin & YS Lincoln (eds), *Handbook of qualitative research,* Sage Publications, Thousand Oaks, California.

Guest, Greg; Bunce, Arwen & Johnson, Laura (2006). "How many interviews are enough? An experiment with data saturation and variability". *Field Methods*, 18(1), 59-82.

Guidance for commissioners of perinatal mental health services', p. 23. Available at: www.jcpmh.info

Hakanen, J. J. and Schaufeli, W. B. (2012) 'Do burnout and work engagement predict depressive symptoms and life satisfaction? A three-wave seven-year prospective study', *Journal of Affective Disorders*. Elsevier B.V., 141(2–3), pp. 415–424.

Håkansson, C. and Ahlborg, G. (2018) 'Occupational imbalance and the role of perceived stress in predicting stress-related disorders', *Scandinavian Journal of Occupational Therapy*. Informa UK Limited, trading as Taylor & Francis Group, 25(4), pp. 278–287.

Hamilton A, Cohen A, Glover D, et al (2013). Implementation of evidence-based employment services in specialty mental health. *Health Service Research,*48(6), pp.2224-2244.

Hammersley M (2018) What is ethnography? Can it survive? Should it? *Ethnography and Education*, 13:1, pp1-17.

Harackiewicz, J. M., & Elliot, A. J. (1998). The joint effects of target and purpose goals on intrinsic motivation: A mediational analysis. *Personality and Social Psychology Bulletin.* 24 pp.657–689.

Harper, D. and Thompson, A. R. (2011) 'Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners', *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*.

Harper, M. and Cole, P. (2012) 'Member checking: Can benefits be gained similar to group therapy?', *Qualitative Report*, 17(2), pp. 1–8. Available at: http://www.nova.edu/ssss/QR/QR17-2/harper.pdf.

Harris J, Leskela, J& Hoffman-Konn L. (2016) *Provider Lived Experience and Stigma American Journal of Orthopsychiatry*, 86(6) pp. 604–609

Harvey SB, Modini M, Christensen H, Glozier N (2013). Severe mental illness and work: what can we do to maximise the employment opportunities for individuals with psychosis? *Australian & New Zealand Journal of Psychiatry* 47, pp.421–424.

Haugeland, John. 2013. *Dasein disclosed: John Haugeland's Heidegger,* ed. Joseph Rouse. Harvard: Harvard University Press.

Haynes N, Richard S. & Kubany S. (1995) Content Validity in Psychological Assessment: A Functional Approach to Concepts and Methods Psychological Assessment. *American Psychological Association*. 7(3), pp.238-247.

Heath, S., Charles, V., Crow, G., & Wiles, R. (2007). Informed consent, gatekeepers, and go-betweens: Negotiating consent in child and youth-orientated institutions. British Educational Research Journal, 33, pp.403–417.

Henderson M, Harvey S, Overland S, Mykletun A, & Hotopf M (2011). Work and common psychiatric disorders. *Journal of the Royal Society of Medicine* 104, pp.198–207.

Henderson, C., Evans-Lacko, S., & Thornicroft, G., (2013). Mental Illness Stigma, Help Seeking, and Public Health Programs. *American Journal of Public Health*. 103, pp.777-780,

Henkel D (2010) Unemployment and Substance Use: A Review of the Literature (1990-2010). Current Drug Abuse Reviews, 4, pp.4-27

Heidegger, M. (1962). *Being and time*. New York: Harper. (Original work published 1927)

Heinrich, S. *et al.* (2011) 'Accuracy of self-reports of mental health care utilization and calculated costs compared to hospital records', *Psychiatry Research*. Elsevier Ltd, 185(1–2), pp. 261–268.

Herbig B, Dragano N, Angerer P (2013) Health in the long-term unemployed. *Dtsch Arztebl International*. 110(23–24)

Hewlett L & Hewlett S (2005) Providing care and facing death: nursing during Ebola outbreaks in central Africa. Journal of Transcultural Nursing, 16: p. 289–297.

Hill R (1996) History of work ethics. Available at: http://rhill.coe.uga.edu/workethic/hist.htm

Ho C, Chee C & Ho R (2020) Mental Health Strategies to Combat the Psychological Impact of COVID-19 Beyond Paranoia and Panic. Article in Press.

Available at: http://www.anmm.org.mx/descargas/Ann-Acad-Med-Singapore.pdf

Holloway, I., Brown, L., & Shipway, R. (2010). Meaning not measurement: Using ethnography to bring a deeper understanding to the participant experience of festivals and events. *International Journal of Event and Festival Management.* Vol 1(1), p.74-85.

Honey A (2003) Benefits and drawbacks of employment: perspectives of people with mental illness. *Qualitative Health Research, 14(3),* 381-95.

Hudson Jones, A. (1997) 'Literature and medicine: Narratives of mental illness', *Lancet*, 350(9074), pp. 359–361.

Husserl, E. (1913) *Ideas: General Introduction to Pure Phenomenology*, Translated by W. R. Boyce Gibson (1962). London, New York: Collier, Macmillan.

Jacobson, N. & Greenley, D. (2001) What is recovery? A conceptual model and explication. *Psychiatric Services*, 52, pp.482–485.

James, T., & Platzer, H. (1999). Ethical considerations in qualitative research with vulnerable groups: Exploring lesbians' and gay men's experiences of health care—A personal perspective. *Nursing Ethics*, *6*, 73-81.

Joint Commissioning Panel for Mental Health (2013) Guidance for commissioners for forensic mental health services. London: JCP-MH.

Jonsson, H & Persson D, (2006) Towards an Experiential Model of Occupational Balance: An Alternative Perspective on Flow Theory Analysis *Journal of Occupational Science*. 13 (1) pp. 62-73.

Johns C (1994) Nuances of reflection. *Journal of Clinical Nursing*. 3(2) pp.71-75.

Kaite, C. P. *et al.* (2015) '"An Ongoing Struggle With the Self and Illness": A Meta-Synthesis of the Studies of the Lived Experience of Severe Mental Illness', *Archives of Psychiatric Nursing*. Elsevier Inc., 29(6), pp. 458–473.

Kawulich, B. (2011). Gatekeeping: An ongoing adventure in research. *Field Methods*. 23, 57–76.

Keller, P. (1999) Husserl & Heidegger on Human Experience: Cambridge University Press. Cambridge: United Kingdom.

Kelloway K., Gallagher G. & Barling J. (2004) Theoretical Perspectives on Work and the Employment Relationship, in Kaufman B. (1st ed.) *Theoretical Perspectives on Work and the Employment Relationship.* Industrial Relations Research Association: University of Illinois.

Kielhofner G (1985) *A Model of Human Occupation: Theory and Application. ed*. Baltimore: Williams & Wilkins

Kielhofner G, (2002) A Model of Human Occupation: Theory and Application. 3rd ed. Baltimore: Lippincott and Wilkins

Koelsch, E. (2013) Reconceptualizing the Member Check Interview. *International Journal of Qualitative Methods.* 12 pp.168-179

Koletsi, M. *et al.* (2009) 'Working with mental health problems: Clients' experiences of IPS, vocational rehabilitation and employment', *Social Psychiatry and Psychiatric Epidemiology*, 44(11), pp. 961–970.

Krayer, A. (2003). Fieldwork, participation, and practice: Ethics and dilemmas in qualitative research. *Sociology of Health and Illness*, *25*(1), 134-136.

Krebs, M. (2006) 'Service-Learning: Motivations for K-12 Teachers.', *Online Submission*, 8(27), pp. 31–43. Available at: http://eujournal.org/index.php/esj/article/view/588.

Krupa T, Mc Lean H, Eastbrook S, Bonham A, Baksh L (2003). Daily time use as a measure of community adjustment for persons served by assertive community treatment teams. *American Journal of Occupational Therapy;* 57: pp558-64.

Kuzel, A. (1992). Sampling in qualitative inquiry. In B. Crabtree, & W. Miller, (Eds). *Doing Qualitative Research. (pp: 31-44).* California: SAGE.

Lee, H. L. *et al.* (2018) 'Employment outcomes after vocational training for people with chronic psychiatric disorders: A multicenter study', *American Journal of Occupational Therapy*, 72(5), pp. 1–10.

Laplanche, J. & Pontalis, J. (1994). The vocabulary of psychoanalysis. Humanitas Publishing House: Bucharest.

Lee, T., Cheung, C., & Kwong, W. (2012) Resilience as a Positive Youth Development Construct: A Conceptual Review. *The Scientific World Journal*, pp.1-9.

Leufstadius, C. and Eklund, M. (2008) 'Time use among individuals with persistent mental illness: Identifying risk factors for imbalance in daily activities', *Scandinavian Journal of Occupational Therapy*, 15(1), pp. 23–33.

Leufstadius C, Erlandsson K, & Eklund M (2014). Time use and daily rhythm among people with persistent mental illness. *Occupational Therapy International.*

Liersch-Sumskis, S (2013). A phenomenological examination of the meaning of resilience as described by people who experience schizophrenia, Doctor of Philosophy thesis, School of Nursing, Midwifery and Indigenous Health, University of Wollongong.

Lilywhite, A. & Haines D. (2010) Occupational therapists and people with learning disabilities: Findings from a research study. College of Occupational Therapy: London

Lis, C, & Soly, H. (2012) Worthy Efforts : Attitudes to Work and Workers in Pre-Industrial Europe. Available at: http://ebookcentral.proquest.com/lib/northampton/detail.action?docID=999475

Lo´pez, Marcelino, Margarita Laviana, and Sergio Gonza´lez (2010) Rehabilitacio´n laboral y programas de empleo. In Pastor, A., A. Blanco, D. Navarro (Eds.) Manual de rehabilitacio´n del trastorno mental grave, pp. 511–537. Madrid: Sı´ntesis

Lofland, J., & Lofland, L. (1996). *Analyzing social settings* (3rd ed.). Belmont, CA:
Wadsworth.

Lubian, K., Weich, S., Stansfeld, S., Bebbington, P., Brugha, T., Spiers, N., McManus, S. and Cooper, C. (2016) 'Chapter 3 Mental health treatment and services' *In* McManus, S., Bebbington, P., Jenkins, R.

and Brugha, T. (eds.) *Mental Health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014.* Leeds: NHS Digital, pp. 69-105.

Luft, S. (2004b). Husserl's theory of the phenomenological reduction: Between lifeworld and Cartesianism. *Research in Phenomenology* 34: 198–234.

Lysaker, P, Davis, L., Bryson, G., & Bell, M. (2009). Effects of cognitive behavioral therapy on work outcomes in vocational rehabilitation for participants with schizophrenia spectrum disorders. *Schizophrenia Research*, *107*(2), pp.186–191.

Maccoby, M. (1988). Why work? New York: Simon and Schuster

Maggs-Rapport, F. (2000) 'Combining methodological approaches in research: Ethnography and interpretive phenomenology', *Journal of Advanced Nursing*, 31(1), pp. 219–225.

Marwaha, S. and Johnson, S. (2005) 'Views and experiences of employment among people with psychosis: A qualitative descriptive study', *International Journal of Social Psychiatry*, 51(4), pp. 302–316.

Mason, J. (2002). *Qualitative researching*, 2nd ed. London: Sage.

Mauritz, M., & van Meijel, B. (2009). Loss and grief in patients with schizophrenia: On living in another world. Archives of Psychiatric Nursing, 23, 251–260.

May, R. (1977). The meaning of anxiety. New York: Norton.

May, R (2000) Routes to Recovery from Psychosis: The Roots of A Clinical Psychologist. *Clinical Psychology Forum*, 146, 6-10.

Mayou, R. (1989) 'The history of General hospital psychiatry', *British Journal of Psychiatry*, 155(DEC.), pp. 764–776.

Markowitz (2001) Modelling processes in recovery from mental illness: Relationships between symptoms, life satisfaction, and self-concept. *Journal of Health and Social Behaviour,* **42**, pp.64–79.

Miller, T., & Bell, L. (2002). Consenting to what? Issues of access, gatekeeping, and 'informed' consent. In M. Mauthner, M. Birch, J. Jessop, & T. Miller (Eds.), Ethics in qualitative research. London: Sage.

McCrum, B, Burnside, L, & Duffy, T (1997) Organising for work: A job clinic for people with mental health needs. Journal of Mental Health, 6(5), pp.503–13McDonald, R., Furtado, V. and Völlm, B. (2016), "Managing madness, madness, murderers and paedophiles: creating new dimensions of professional work in an institutionally complex healthcare field", Social Science & Medicine, Vol. 164, pp. 12-8.

McDonald S & Bertram M. (2018) Job creation through income generation: an evaluation of Re-Cover, a decorating project developed with forensic mental health service users. The Journal Of Mental Health Training, Education And Practice. 13(3) Pp. 148-156,

McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: results of a household survey. The NHS Information Centre for health and social care.

McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014. Leeds: NHS digital.

McPherran L (2010) The Religion of Socrates. Pennsylvania: Penn state press

McQueen, J. M. and Turner, J. (2012) 'Exploring forensic mental health service users' views on work: An interpretative phenomenological analysis', *British Journal of Forensic Practice*, 14(3), pp. 168–179.

Mental Health Act (1983). Available at: https://www.legislation.gov.uk/ukpga/1983/20/contents (Accessed 22nd of February, 2020)

Mental Health and Employment (2017). Available at: https://www.tuc.org.uk/sites/default/files/Mental_Health_and_Employment.pdf (Accessed 2nd of January 2020)

Mertens, D. M. (2010). *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative, and Mixed Methods* (3rd ed.). Thousand Oaks: Sage.

Mf, D. *et al.* (2013) 'Users' guides to the medical literature. II. Questions to help you make sense of a descriptive study.', *Public Health*, 270(21), pp. 1–7.

Michon, H. W. C. *et al.* (2005) 'Person-related predictors of employment outcomes after participation in psychiatric vocational rehabilitation programmes', *Social Psychiatry and Psychiatric Epidemiology*, 40(5), pp. 408–416.

Minjoo, K., Mpofu, E., Brock, K., Millington, M. & Athanasou J. (2014). Cognitive-behavioural therapy effects on employment-related outcomes for individuals with mental illness: A scoping systematic review. South African Journal of Industrial Psychology, 40(2).

Miller, W. F. (1986). Emerging technologies and their implications for America. USA Today, 115, pp.60-65.

Mircica, N. (2018) 'TWO The Forgotten Question', *Analysis and Metaphysics*, 10(I), pp. 15–30.

Moran D. (2000) Introduction to Phenomenology. London: Routledge

Morley, J. (2012). Phenomenological psychology. In S. Luft & S. Overgaard (Eds.), The Routledge companion to phenomenology. London: Routledge.

Modini M., Joyce S., Christensen H., Mykletun A., Bryant R., Mitchell P. B. and Harvey S. B. (2016) Workplace interventions for common mental disorders: a systematic meta-review. Psychological Medicine, 46, 683–697.

Morrow, R., Rodriguez, A. and King, N. (2014) 'Camping: A tool for relationship maintenance?', *Therapeutic Communities*, 35(2), pp. 48–55.

Morrow, R., Rodriguez, A. and King, N. (2015) Colaizzi's descriptive phenomenological method. *The Psychologist.* 28(8) pp.643-644

Morse JM (1994) *Designing funded qualitative research*, *Handbook of qualitative research*. Edited by D. and Y. Lincoln. Thousand Oaks: Sage Publications.

Morse, J. (1995). The significance of Saturation. *Qualitative Health Research, 5 (2),* 147-149.

Morley J., Giorgi, A. & Giorgi B. (2017). The Descriptive Phenomenological Psychological Method. Available at: https://easewellbeing.co.uk/wp-content/uploads/PDF_Downloads/Giorgi-2017-the-descriptive-phenomenological-psychological-method.pdf (Accessed: 11th of January, 2019)

Mortensen, R., (2014). Anxiety, work, and coping. *The Psychologist-Manager Journal. 17*(3), pp.178-181.

Nathan, A. J. and Scobell, A. (2012) 'How China sees America', *Foreign Affairs*, 91(5), pp. 1689–1699.

Nestoros, I., & Vallianatou, N. (1996). Syntheitiki psyxotherapeiame stoixeia psyxopathologias (transl. from Greek). Athens: Ellinika Grammata

National Centre for Social Research and Department of Health Sciences; University of Leicester (2009) *Adult psychiatric morbidity in England, 2007: Results of a household study*, *The NHS Information Centre for health and social care.*

National Health Service Act (2006) Available at: http://www.legislation.gov.uk/ukpga/2006/41/contents (Accessed 22nd of February, 2020)

National Voices (2017). Person-centered care in 2017. Available at: https://www.nationalvoices.org.uk/publications/our-publications/person-centred-care-2017

Neveanu, P., (1978) *Dictionary of Psychology.* Albatros Publishing House: Bucharest.

Newbutt, N. *et al.* (2016) 'Brief Report: A Pilot Study of the Use of a Virtual Reality Headset in Autism Populations', *Journal of Autism and Developmental Disorders*. Springer US, 46(9), pp. 3166–3176.

Ngai, S. S. yum, Cheung, C. kiu and Yuan, R. (2016) 'Effects of vocational training on unemployed youths' work motivation and work engagement: Mediating roles of training adequacy and self-actualization', *Children and Youth Services Review*. Elsevier Ltd, 63, pp. 93–100.

Niven, S. and Stewart, D. (2005) *Resettlement Outcomes on Release from Prison.* London: Home Office.

O'Connor RC, O'Carroll RE, Ryan C, Smyth R. (2012) Self-regulation of unattainable goals in suicide attempters: a two-year prospective study. *Journal of Affective Disorders;* **142:** 248–55.

Oosterhuis, H. (2012). Mental health as civic virtue. Psychological definitions of citizenship in The Netherlands (1900–1985). In K. Brückweh (Ed.), Engineering society. The scientization of the social in comparative perspective, 1880–1990 (pp. 1880–1990). Basingstoke: Palgrave Macmillan.

Oosterhuis, H. and Loughnan, A. (2014) 'Madness and crime: Historical perspectives on forensic psychiatry', *International Journal of Law and Psychiatry*, 37(1), pp. 1–16.

O'Reilly, M., & Parker, N. (2013). 'Unsatisfactory Saturation': A critical exploration of the notion of saturated sample sizes in qualitative research. Qualitative Research, 13(2), 190-197.

Parkinson, S, Forsyth,K & Kielhofner, G (2004) A user's manual for Model of Human Occupation

Screening Tool (MOHOST). The Model of Human Occupation Clearinghouse. Department of Occupational Therapy: University of Illinois at Chicago

Patricia H, Christine G, & Patricia S. (2000) The Effects of Employment and Mental Health Status on the Balance of Work, Play/Leisure, Self-Care, and Rest. *Occupational Therapy in Mental Health* 15 (1), p.27-42.

Perlman D., Patterson C., Moxham, L, Taylor K. Brighton, R, Sumskis, S., & Heffernan T (2017) Understanding the influence of resilience for people with a lived experience of mental illness: A self-determination theory perspective. Journal of Community *Psychology*, 45, pp.1026–1032.

Peterson D (1982), ed. A mad people's history of madness. Pittsburgh, PA: University of Pittsburgh Press.

Polit, D & Beck C (2010) Essentials of Nursing research: Appraisal evidence for nursing practice. 7th ed. Philadelphia, PA: Wolters Kluwer Health/ Lippincott Williams & Wilkins

Polkinghorne, D. E. (1989). Phenomenological research methods. In R.S. Valle & S. Halling (Eds.) *Existential-phenomenological perspectives in psychology* (pp. 41-60). New York: Plenum.

Porte, G. (2013). Who needs replication? *Computer Assisted Language Instruction Consortium Journal*. Vol 30, p.10-15.

Porter, R. (1987) Mind Forg'd Manacles. London: Athlone Press

Prior, S. Maciver, D, Forsyth, K, Walsh M, Meiklejohn A, Irvine, L. (2013) Readiness for Employment: Perceptions of Mental Health Service Users. *Community Mental Health Journal,* 49: pp.658–667

Probst B. (2015) The Eye Regards Itself: Benefits and Challenges of Reflexivity in Qualitative Social Work Research. *Social Work Research*.39(1) pp.37-47

Ramsay, CE, T Stewart, and MT Compton (2012) Unemployment Among Patients with Newly Diagnosed First-Episode Psychosis: Prevalence and Clinical Correlates in a US Sample. *Social Psychiatry and Psychiatric Epidemiology* 47: 797– 803.

Ray, M. A. (1985). A philosophical method to study nursing phenomena. In M. M. Leininger (Ed.), Qualitative research methods in nursing (pp. 81-92). Orlando, FL: Grune & Stratton.

Reid, K., Flowers, P. & Larkin, M. (2005) Exploring lived experience: An introduction to Interpretative Phenomenological Analysis. *The Psychologist.* Vol18:1, p.20-23.

Reed, D. (2011) 'Mindfulness and Flow in Occupational Engagement: Presence in Doing', *Canadian Journal of Occupational Therapy*, 78(1), pp. 50–56.

Reeder P. (2010) The Theory and Practice of Husserl's Phenomenology: Pathways in Phenomenology: Zeta Books

Reme S, Grasdal A, & Løvvik C (2015). Occupational Environmental Medicine. 72: pp.745–752

Richard &Schwartz (2002) Ethics of quality research: are there special issues for health services research? *Family Practice.* Vol 19 p.135-139

Richards, H. M. (2002) 'Ethics of qualitative research: are there special issues for health services research?', *Family Practice*, 19(2), pp. 135–139.

Richardson, C. R. *et al.* (2005) 'Integrating physical activity into mental health services for persons with serious mental illness', *Psychiatric Services*, 56(3), pp. 324–331.

Robson, C. (2011). *Real world research: A resource for social-scientists and practitioner- researchers.* 3rd ed. Oxford: Blackwell Publishing

Rodemeyer, M. (2009) How do we Imagine the Past? Reconsidering Retention and Recollection in Husserl's Phenomenology of Inner Time-Consciousness, Journal of the British Society for Phenomenology, 40 (2), pp171-187.

Rodriguez, C. M. *et al.* (2017) 'Predicting Parent-Child Aggression Risk in Mothers and Fathers: Role of Emotion Regulation and Frustration Tolerance', *Journal of Child and Family Studies*. Springer US, 26(9), pp. 2529–2538.

Rose, V. K. and Harris, E. (2005) 'What employment programs should health services invest in for people with a psychiatric disability?', *Australian health review: a publication of the Australian Hospital Association*, 29(2), pp. 185–188.

Rosenfield, S. (1997) Labelling mental illness: the effects of received services and perceived stigma on life satisfaction. *American Sociological Review*, **62**, 660–672.

Roth, W. 2005. *Ethics in the Workplace: A Systems Perspective*. Upper Saddle River: Pearson Prentice Hall.

Roth, W. (2014) 'Has the Work Ethic Run Out of Steam?', *World Futures Review*, 6(2), pp. 172–177.

Royal College of Occupational Therapists (2017) Occupational Therapists' Use of Occupation Focused Practice in Secure Hospitals, Practice guideline, Second edition. London: COT

Royal College of Physicians (1996). Guidelines on the practice of ethics committees in medical research involving human subjects, 3rd ed. London.

Rusch N, Corrigan PW, Wassel A, Michaels P, Olschewski M, & Wilkniss S (2009). A stress-coping model of mental illness stigma: Predictors of cognitive stress appraisal. *Schizophrenia Research,* 110, pp. 59–64.

Rüsch, N., Abbruzzese, E., Hagedorn, E., Hartenhauer, D., Kaufmann, I., Curschellas, J., Corrigan, P. W. (2014). Efficacy of coming out proud to reduce stigma's impact among people with mental illness: Pilot randomised controlled trial. *The British Journal of Psychiatry,* (204), pp.391-397.

Rutherford, R and Duggan, S (2007). Forensic Mental Health Services: facts and figures on current provision. London. The Sainsbury Centre for Mental Health.

Rudestam, K. E. and Newton, R. R. (2007) 'The method chapter: describing your research plan', *Surviving your dissertation: a comprehensive guide to content and process*, pp. 87–116.

Rudnick, A. *et al.* (2011) 'Supported reporting of first-person accounts: Assisting people who have mental health challenges in writing and publishing reports about their lived experience', *Schizophrenia Bulletin*, 37(5), pp. 879–881.

Saavedra, J. *et al.* (2016) 'Does Employment Promote Recovery? Meanings from Work Experience in People Diagnosed with Serious Mental Illness', *Culture, Medicine and Psychiatry*, 40(3), pp. 507–532.

Sahota S, Davies S, Duggan C, et al. (2010). Women admitted to medium secure care: Their admission characteristics and outcome as compared with men. *International Journal of Forensic Mental Health,* 9, pp. 110–17.

Salize H, Rossler W, Becker T (2007) Mental health care in Germany. European Archives of Psychiatry Clinical Neuroscience 257, pp. 92–103.

Samele C, Keil J, Thomas S. (2009). Securing employment for offenders with mental health problems. London: Sainsbury Centre for Mental Health.

Samele, C., Forrester, A. and Bertram, M. (2018) 'An evaluation of an employment pilot to support forensic mental health service users into work and vocational activities. *Journal of Mental Health*. Taylor & Francis, 27(1), pp. 45–51.

Sartorius N. (2007). Stigma and mental health. *Lancet* 370, pp. 810-811.

Savla, N, Lea V, Casey C, Penn D, & Twamley, E. (2013) Deficits in Domains of Social Cognition in Schizophrenia: A Meta-analysis of the Empirical Evidence. *Schizophrenia Bulletin,* 39: 979–992.

Schuring, M. *et al.* (2010) 'The effect of re-employment on perceived health', *Journal of Epidemiology and Community Health*, 65(7), pp. 639–644.

Schwabe L, Wolf T & Oitzl, M (2009) Memory formation under stress: quantity and quality *Neuroscience Biobehavioral Review*, 34, pp. 584-591.

Schön, D. (1987). *Educating the reflective practitioner*. San Francisco, CA: Jossey- Bass Higher Education Series.

Scott, H. (2007b). The Temporal Integration of Connected Study into a Structured Life: A Grounded Theory. University of Portsmouth: Portsmouth.

Secker J, Grove B, & Seebohm P (2001) Challenging barriers to employment, training, and education for mental health service users: the service user's perspective. *Journal of Mental Health, 10(4), p* 395.

Selye, H. (1950). Stress*.* Acta Medical Publisher: Montreal.

Shanley E. & Jubb-Shanley M. (2007) The recovery alliance theory of mental health nursing. *Journal of Psychiatric and Mental Health Nursing,* 14, 734–743

Sheehy, J. W. (1990). New work ethic is frightening. *Personnel Journal*. 69(6), 28-36.

Sherwood W, White B, Wilson S (2015) *The Vona du Toit Model of Creative Ability: a practical guide for acute mental health occupational therapy practice*. Northampton: Vona du Toit Model of Creative Ability Foundation (UK).

Slade, M. (2009) *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*. Cambridge University Press.

Slade, M., Amering, M., Farka, M., Hamilton, B., O' Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, M., & Whitley, R. (2014) Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*,13: pp.12–20.

Small N (1998) The story as gift: researching AIDS in the Welfare marketplace. In Barbour R & Huby G (1998) (eds) *Meddling with mythology: Aids & the social construction of knowledge*. London: Routledge

Smith, J, Flowers P & Larkin, M (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. 2nd ed. SAGE Publications Ltd: London

Smith, A., Petty, M., Oughton, I. and Alexander, R. (2010), ''Establishing a work-based learning programme: vocational rehabilitation in a forensic learning disability setting'', British Journal of Occupational Therapy, Vol. 73 No. 9, pp. 431-6.

Sommers, R. and Miller, F. G. (2013) 'Forgoing Debriefing in Deceptive Research: Is It Ever Ethical?', *Ethics and Behavior*, 23(2), pp. 98–116.

Sosha, G (2012) Employment of Colaizzi's Strategy in Descriptive Phenomenology: The Reflections of a Researcher. *European Scientific journal,* 8(27) pp31-43

Stansfeld, S. *et al.* (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*, *Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digitals.

Starks, H. and Trinidad, S. B. (2007) 'Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory', *Qualitative Health Research*, 17(10), pp. 1372–1380.

Seidman, I. E. (2006). *Interviewing as qualitative research: A guide to researchers in education and the social sciences* (3rd ed.). New York: Teachers College Press.

Seidman, I. (2013). Interviewing as qualitative research: A guide for researchers in education and the social sciences (3rd ed.). New York: Teachers' College Press.

Shenton, A. & Hayter, S. (2004). Strategies for gaining access to organisations and informants in qualitative studies. *Education for Information*, 22, pp. 223–231.

Shimitras L, Fossey E, Harvey C (2003). Time use of people living with schizophrenia in a north London catchment area. *British Journal of Occupational Therapy*; 66: pp. 46-54.

Sixsmith, J., Boneham, M., & Goldring, J. E. (2003). Accessing the community: Gaining insider perspectives from the outside. *Qualitative Health Research*, 13, pp.578–589.

Spencer, L., Ritchie, J & Lewis, J. et al (2003). *Quality in Qualitative Evaluation: A Framework for Assessing Research Evidence,* Government Chief Social Researcher's Office, Prime Minister's strategy Unit, London. www.strategy.gov.uk.

Svendsen, L. and Svendsen, L. (2013) 'From curse to vocation: a brief history of the philosophy of work', *Work*, pp. 13–28.

Tallis, F. (1990). How to stop worrying. London: Sheldon.

Tepper, L.; Rogers, S, Coleman, E & Malony, H, (2001) The prevalence of religious coping among persons with persistent mental illness. *Psychiatric Service*. 52, pp.660–665.

The Holy Bible: King James Version (2001). Iowa Falls, IA: World Bible Publishers.

Thornicroft, G. and Tansella, M. (2004) 'Components of a modern mental health service: A pragmatic balance of community and hospital care. Overview of systematic evidence', *British Journal of Psychiatry*, 185(OCT.), pp. 283–290.

Theodoru, P. (2015) Husserl and Heidegger on Reduction, Primordiality, and the Categorial Phenomenology: Beyond its Original Divide. New York: Springer

The ICD-10 Classification of Mental and Behavioural Disorders (1992). Clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

Tilgher, A. (1930). Homo faber: Work through the ages. Translated by D. C. Fisher. New York: Harcourt Brace.

Torrey, W. C. *et al.* (2001) 'Implementing evidence-based practices for persons with severe mental illnesses', *Psychiatric Services*, 52(1), pp. 45–50.

Torrey, W. C. *et al.* (2000) 'Self-esteem as an outcome measure in studies of vocational rehabilitation for adults with severe mental illness', *Psychiatric Services*, 51(2), pp. 229–233.

Tracy, S. (2010). Qualitative quality: eight "Big-Tent" criteria for excellent qualitative research. *Qualitative Inquiry,* 16 (10), pp.837-851.

Tripathi N (2018). A valuation of Abraham Maslow's theory of self-actualization for the enhancement of quality of life. *Indian Journal of Health and Wellbeing.* 9 (3), p. 499-504.

Tschopp, M.K., Perkins, D.V., Hart-Katuin, C., Born, D.L. and Holt, S.L. (2007), ''Employment barriers and strategies for individuals with psychiatric disabilities and criminal histories'', Journal of Vocational Rehabilitation, Vol. 26 No. 3, pp. 175-87.

Tse, S., Siu, B. W. M., & Kan, A. (2013). Can recovery-oriented mental health services be created in Hong Kong? Struggles and strategies. *Administration and Policy in Mental Health and Mental Health Services Research*, 40(3), pp.155–158.

Tsiopela, D. and Jimoyiannis, A. (2017) 'Pre-vocational skills laboratory: designing interventions to improve employment skills for students with autism spectrum disorders', *Universal Access in the Information Society*. Springer Berlin Heidelberg, 16(3), pp. 609–627.

Tuffour, I. (2017) 'A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach', *Journal of Healthcare Communications*, 2(4), pp. 1–5.

Turnbull, C (1961), The Forest People: A study of the Pygmies of Congo (1st ed.) Simon & Schuster: New York.

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Suny Press.

Van Teijlingen E, Hundley V (2002) The importance of pilot studies. Nursing Standard. 16 (40), pp. 33-36

Van Voren, R. (2010) 'Political abuse of psychiatry - An historical overview', *Schizophrenia Bulletin*, 36(1), pp. 33–35.

Völlm, B., Majid, S. and Edworthy, R. (2018) 'English vs Dutch high secure hospitals: service user perspectives', *Journal of Forensic Practice*, 20(2), pp. 112–121.

Vos, T., et al. (2013) Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study. *The Lancet*. 386 (9995). pp. 743-800.

Waddell, G. and Burton, A. (2006), Is Work Good for Your Health and Wellbeing? Department for Work and Pensions, Birmingham.

Waddell G, Burton A, Kendall K (2013) Vocational Rehabilitation What Works, For Whom, And When? Vocational Rehabilitation Task Group: Department of Works & Pension

Wall, C, Glenn, S, Mitchinson s, & Poole H (2004) 'Using a reflective diary to develop bracketing skills during a phenomenological investigation.', *Nurse researcher*, 11(4), pp. 20–29.

Walsh, D., Daly, A. and Moran, R. (2016) 'The institutional response to mental disorder in Ireland: censuses of Irish asylums, psychiatric hospitals and units 1844–2014', *Irish Journal of Medical Science*. Springer London, 185(3), pp. 761–768.

Wanat, C. (2008). Getting past the gatekeepers: Differences between access and cooperation in public school research. *Field Methods*, 20, 191–208.

Watzke, S., Galvao, A. and Brieger, P. (2009) 'Vocational rehabilitation for subjects with severe mental illnesses in Germany: A controlled study', *Social Psychiatry and Psychiatric Epidemiology*, 44(7), pp. 523–531.

Waugh, C. E., & Koster, E. H. W. (2015). A resilience framework for promoting stable remission from depression. *Clinical Psychological Review*, 41, pp.49–60

Webster, R., Hedderman, C., Turnbull, P.J. and May, T. (2001), "Building bridges to employment for prisoners", Home Office Research Study 226, The Criminal Policy Research Unit, South Bank University, Home Office Research, Development and Statistics Directorate, London

Weissman, M. M. (2005) 'What Works for Whom? *Psychological Medicine*, 35(9), pp. 1379–1380.

Whiteford, G. (2000). Occupational deprivation: Global challenge in the new millennium. British Journal of Occupational Therapy, 63(5), 200-204

Wexler, B. E. and Bell, M. D. (2005) 'Cognitive remediation and vocational rehabilitation for schizophrenia', *Schizophrenia Bulletin*, 31(4), pp. 931–941.

World Health Organisation (2020) Factsheet on depression. Available at: https://www.who.int/news-room/factsheets/detail/depression#:~:text=Depression%20is%20one%20of%20the%20priority%20conditions%20covered,workers%20who%20are%20not%20specialists%20in%20mental%20health. (Accessed: 15th of July, 2020)

Wilcock A. (2006) An Occupational Perspective of Health. Thorofare (NJ): Slack

Wilcock, A. & Townsend, A. (2009). Occupational justice. In E.B. Crepeau, E.S. Cohn & B.A. Boyt Schell (Eds.), Willard & Spackman's occupational therapy (11th ed., pp. 192-199). Baltimore: Lippincott Williams & Wilkins

Wimpenny, P. and Gass, J. (2000) 'Interviewing in phenomenology and grounded theory: Is there a difference?', *Journal of Advanced Nursing*, 31(6), pp. 1485–1492.

Winship, G. (2016) A meta-recovery framework: positioning the 'New Recovery' movement and other recovery approaches. Journal of Psychiatric and Mental Health Nursing, 23 (1). pp. 66-73

Wisnewski, J. (2012) Heidegger: An Introduction. Rowman & Littlefield Publishers.

Wissow, L., Rutkow, L. and Mental, A. C. (2012) 'Frequently Asked Questions on Ethical Issues Related to Mental Health Care in Emergencies', pp. 1–5. Available at: http://www.jhsph.edu/research/centers-and-institutes/center-for-law-and-the-publics-health/research/CDC_PERRC_Tool6.pdf.

Wittchen H-U, Jacobi F (2005) Size and burden of mental disorders in Europe -a critical review and appraisal of 27 studies. *European Neuropsychopharmacology* 15: 357-376.

Wolfe J (2015) The Industrial Revolution: Steam & Steel. 1st ed. New York: Rosen Publishing group.

Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology & Health*, 15 (2), pp.215-228,

Zuckerman, N. (2015) 'Heidegger and the Essence of Dasein', *Southern Journal of Philosophy*, 53(4), pp. 493–516.