Surviving and Thriving in Work with Mental Health Conditions – Refocusing Counselling Psychology?

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pp 244-271: **Chapter C. Professional Case Study:** 'Developing an understanding of using integrative formulations with a complex client and the role of purpose in the importance of recovery.'

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Abstract

Background and Aim

Mental health costs UK businesses billions of pounds each year through high levels of absence and presenteeism. Despite improved interventions around enabling people with mental health conditions back into and remaining in work through Supported Employment, the figures around retention are discouraging. People with mental health conditions see employment as a sign of recovery and clinicians also support returning to work as an important step in development. Research has largely focused on trying to improve the employment rates of people with mental health conditions who have already accessed mental health services. However, there are many people in employment who are struggling with poor mental health who have chosen not to disclose to their employer about their condition, leading to issues around presenteeism. This study therefore focuses on developing psychological interventions for people struggling in work, who may not access Supported Employment services.

Method

Four participants took part in a collaborative action research process over four group sessions. Participants were co-researchers in the process, where the group worked to identify and test out interventions that might improve managing mental health conditions at work. The transcripts were then analysed using constructivist grounded theory to develop an overarching model.

Results

The model proposed highlights the role of the individual and the organisation in improving the management of mental health conditions at work, facilitated by the line management relationship. The model suggests that individuals could improve their own mental health by developing their self-awareness, work-life balance, mindfulness practice and aligning job choice with personal values. The organisation could further work on establishing a culture and physical environment centred on well-being to support individuals through line management relationships.

Discussion

Counselling Psychologists could play an important role in developing interventions around retention and also champion piloting mental health support groups in work to enable sustained change.

Chapter A: Preface

Refocusing Counselling Psychology? – Surviving and Thriving in Work with Mental Health Conditions

Preface

The pieces of work within this portfolio are linked through the concept of the importance of values-based activity in sustaining or improving mental health. All three pieces also highlight the further role that Counselling Psychologists could play in improving the management of mental health conditions in employment.

I enrolled on the Counselling DPsych training programme because I wanted to learn how to deliver therapeutic interventions, specifically within an employment context. My career as an Occupational Psychologist working in the public sector had illustrated to me the deep distress that employees were experiencing due to public sector cuts. It felt that the coaching interventions I was delivering did not provide the space that people really needed to explore their problems. I also felt my career had drifted away from the exploration of human behaviour that I had been drawn to as a Psychologist in the first place and wanted to refocus my career. Throughout my career I have been driven by finding value and meaning in my work and wanted to work with individuals directly to achieve real change.

The importance of value in work has always been central to my own career choices. Initially I left a career in Occupational Psychology behind to follow my passion for radio programming. After nearly five years in broadcasting, I found that I was increasingly more interested in understanding how the company I worked for functioned as an organisation. Wanting to improve the way editors worked as managers, I went back to training as an Occupational Psychologist. Although I still

have the odd pang of missing broadcasting, Occupational Psychology offered me a chance to meet my needs around wanting to achieve social change. I was able to join an organisation centred on achieving social results and began learning about management development. Again though, I found I was not working directly with front-line staff or individuals where real social change could happen.

When I started my training as a Counselling Psychologist I therefore knew how important seeking value and meaning in work was and my desire to achieve social change. It was around this time that I got involved with *Time to Change*, the national anti-discrimination campaign aimed at changing negative perceptions towards mental health. As an Organisational Engagement Consultant I worked with organisations to assess how mental health was managed internally. Completing this work further influenced my understanding of organisational development, but specifically in relation to mental health. During my first two years of training, I also developed a greater understanding around Acceptance and Commitment Therapy (ACT) and begun using some of the principles of the philosophy of ACT with some of my clients. The importance of values-based action as an important part of enabling and sustaining change (Hayes, 2004; Harris, 2009) made a great deal of sense to me, both personally and professionally, and I found clients responded well to spending time thinking about their internal core values and how this related to their working preferences.

Having now completed my three years of training, I am at an important point where I can see how components of Counselling and Occupational Psychology can be merged to improve the working lives of individuals. Psychologists are already using aspects

around ACT to improve stress management in the workplace (Flaxman & Bond, 2010), but I think these principles and other therapeutic models could be used more widely. Through my own personal experience and the research presented within this portfolio, I hope to demonstrate that values-based work holds an important central philosophy in enabling people to manage their mental health issues. By aligning employment decisions with values between organisation and employee, greater motivation and commitment could meditate the impact of mental health problems.

This portfolio presents three sections in which I have attempted to illustrate the importance of values-based action in therapy and managing mental health at work. I have also tried to demonstrate how Counselling Psychologists could work more widely with organisations to deliver individual and organisational interventions around mental health. Counselling Psychologists already work in vocational roles, especially around career counselling, and I would like to see more Counselling Psychologists working towards improving employment outcomes for people with mental health issues. The research thesis was conducted using action research and constructivist grounded theory to develop a model and set of interventions around managing mental health in work. The clinical case study illustrates my personal work with a client and also demonstrates my emerging integrative approach in clinical practice. The publishable paper outlines the roles of the Counselling Psychologists in improving the disclosure rates for people with mental health conditions in employment so that organisations are encouraged to improve reasonable adjustments and general well-being in work, with a focus on values in work. This paper will be submitted to the *Counselling Psychology Quarterly*. I have chosen this journal because it is an international journal with a global audience. It also focuses on

publishing research and conceptual papers that provide immediate practical relevance for Counselling Psychologists globally.

The research thesis provided me with an opportunity to further act upon my values and use an action research process to produce qualitative data. I was able to use action research as a process in which participants themselves could develop and test out interventions, therefore benefitting them also by being an active part of the development of the research. In being able to reflect upon my own therapeutic style within the clinical case study, I have been able to consider the influences on my own style and reflect upon my own development areas for the future. The publishable paper enabled me to think more about how I can champion the application of Counselling Psychology more within the workplace and where my own career might now progress.

I have recently been offered a Counselling Psychologist role within a primary care service. The service I will be joining has become one of the key pilot areas for Supported Employment, combining talking therapy with employment advice. In my thesis I discuss the importance of developing mental health groups for those people currently struggling in work. In my interview we discussed how I could potentially be part of the Supported Employment programme and run employment groups based upon the principles developed from my research thesis. I am hoping that I might be able to develop my research further, working with mental health support groups based on current employment issues. I hope I would be able to develop a more comprehensive model and also bring in further components around ACT and test how these might enable change with clients.

This portfolio is intended to illustrate my beliefs about the importance of values-based action in therapeutic work with clients and how this might enable improved motivation in order to derive the largely positive benefits of working. I also want to illustrate how psychologists as researchers can focus on improving the existing working lives of the thousands of people with mental health conditions working to improve disclosure decisions. My work with *Time to Change* has illustrated to me just how important this is for both the individuals themselves and for others within organisations. I also hope this portfolio will inspire more Counselling Psychologists to think more about their role in vocational outcomes for people with mental health problems in employment. I believe there is significant potential for organisations to engage more Counselling Psychologists to improve the working lives of their employees and positively impact the retention rates of people with long-term mental health conditions.

Chapter B: Research Thesis

Individual and Organisational Interventions for People with Long-Term Mental Health Conditions in Employment: How to Survive and Thrive at Work

Introduction

"This is the real secret of life -- to be completely engaged with what you are doing in the here and now. And instead of calling it work, realize it is play."

— Alan Wilson Watts, British Philosopher, 1915 – 1973

Since Marie Jahoda's classic 1932 study of the impact of unemployment on a small community in Austria, psychologists have developed a greater understanding about the physical and psychological importance of employment. A wealth of research literature has confirmed the largely positive psychological benefits of work (Waddell & Burton, 2006), and how unemployment can lead to poor mental health and reduced functioning (Dooley, Fielding, & Levi, 1996). Knowing that work has a largely positive psychological impact on people, it is then surprising that more is not being done to ensure people with long-term mental health conditions remain in active employment.

The Office for National Statistics (2011) report on employment and mental health identified that only one in two people with a declared disability were in employment, and the lowest employment rates were those who defined themselves as having a mental illness (ONS, Employment and Mental Health Survey, 2011). People with mental health issues are twice as likely to be made redundant compared to the normal population (Mental Health Foundation, 2007). The cost of not managing mental health issues to UK employers in the workplace is extremely high. The mental health charity Mind report that the cost to UK businesses alone is around 26 billion a year,

making this an important topic in terms of costs savings for businesses in the UK (Mind, *Employers guide to Mentally Healthy Workplaces*, 2012). The cost for employers is not just around managing sickness absence, but also the increased trend of presenteeism, where employees are physically at work, but not performing to their full capability (Centre for Mental Health, 2010).

Working environments of course can be complex and even toxic places for people. Thousands of people are signed of sick each year due to stress and being emotionally overwhelmed through work-place demands. Overall though, the evidence points to the beneficial aspects of work, especially around psychological well-being. Given the right environment, employment offers people social contact, purpose, social and economic identity and independence (Behson, Eddy & Lorenzet, 2000). It has also been shown to provide an important moderating affect towards experiencing negative symptoms of mental health conditions (Rinaldi, Perkins, Glynn, Montibeller, Clenaghan & Rutherford, 2008).

Both clinicians and mental health service users believe work is an important factor for recovery and people accessing supported employment programmes indicate a desire to work, contrary to what public opinion may be (Marwaha, Balachandra & Johnson, 2009; Bell, Choi & Lysaker, 2007). Clinicians also admit to not really knowing how to help service users sustain employment and are sometimes unaware of the existing services, which might be on offer (Marwaha et al., 2009). From the employers' perspective, managers also admit to feeling under prepared to effectively manage people with mental health conditions (Mental Health Foundation, *Fundamental Facts about Mental Health*, 2007). Clinicians and managers therefore may need further

training and greater insight into what works to increase the chances of employment and retention.

National mental health campaigns are encouraging employees to speak out about their mental health issues, in an attempt to fundamentally change the way the public and organisations perceive difficulties with mental health (Time to Change, 2014). However, employers are responding slowly to these messages, with the impact of Time to Change resulting in only a 3% reported drop in people living discrimination free lives (Henderson, Williams, Little & Thornicroft, 2013). Many people with long-term mental health conditions also choose not to disclose their condition for fear of discrimination (Thornicroft, 2008). It therefore could be a while before the fear of discrimination is no longer an issue when disclosing.

Employment and retention services in the UK do link in with mental health services, and employment advisers are embedded within mental health teams within the NHS (Centre for Mental Health, 2012). A model of Supported Employment has been developed within the UK and encompasses important aspects around individual needs and support. Recent studies have developed and evaluated Supported Employment programmes and there have been encouraging results. Individual Placement Support (IPS) services have recently been validated as an effective approach to getting people rapidly into work by an independent report by the National Development Team for Inclusion (Grieg, Chapman, Eley, Watts & Love, 2014). The report highlights how the approach results in enabling around 50% of people accessing mental health services back into employment. The report though also raises the question of what

happens to the 50% that these programmes do not work for and whether retention rates continue to support this level of employment.

Research into retention in the UK seems to be limited, and the focus has been primarily with those people who access mental health services, trying to get work (Cameron, Walker, Hart, Sadio & Haslam, 2012). Less research has been conducted with employees struggling in work with mental health issues who have not accessed supported employment. With presenteeism figures considered to contribute more to the cost of mental health for UK businesses than sickness absence (Centre for Mental Health, 2010), it seems important to consider what might be considered effective interventions for this group. There are a considerable number of employees with mental health issues who have chosen not to disclose, and it is unclear how they manage or might manage their conditions to remain in employment. This research is therefore concerned with understanding how people with long-term mental health conditions might be able to survive and thrive in work, across the working population and focus research with those people already in work.

Work therefore could be considered a positive step forward for people with mental health conditions and an important factor for clinicians to be aware of in terms of enabling recovery. There could be a wealth of ideas and knowledge in conducting research with people with mental health conditions who are already in work around how to improve retention outcomes, research that could impact problems around presenteeism. This research is therefore focused on understanding more about how individuals can manage their mental health conditions, and how clinicians can

become more aware and skilled in enabling positive outcomes for service users around employment and retention.

Literature Review

Long-term mental health conditions in employment

In a comprehensive overview of mental health and employment across Western Europe, Curran, Knapp, McDaid and Tomasson (2007) outline four important areas, which have dominated research in this field. The first two areas examine "promoting good or preventing poor working environments to protect the mental health of workers". The third area highlights "protecting the mental health of unemployed people" and the final area looks at "improving access and retention in employment for people with more severe mental health problems" (p 195).

Poor mental health as a result of unemployment is a heavily researched area. International research suggests there is a causal relationship between unemployment and poor mental health (Dooley et al., 1996) and that unemployment deprives people of many of the psychological benefits of work. Research has also focused on how to improve mental health in the workplace. O'Driscoll and Cooper (2002) have found that factors of unpredictability of workload and lack of control over own demands contribute to work-based stress to a larger extent than most other variables. To be without influence or control over our work (factors which are determined by the constraints of the job role) contributes to mental distress. Psychologists have spent a great deal of time researching stress in the workplace and developing employee assistance programmes and management training packages aimed at addressing some

of the causes of stress at work. The National Institute for Clinical Excellence (NICE, 2014) is currently in a consultation process to develop a key piece of guidance entitled, *Workplace policy and management practices to improve the health of employees*. This research aims to pull together the first three main research areas referred to, where the focus is on working conditions causing poor mental health and the role of unemployment.

Until the last decade, research into increasing employment rates for those people with severe mental health issues has received less attention from British researchers. Since 2005, more research has been conducted around supported employment programmes for mental health service users, initially developed within the United States. The main focus of Supported Employment (SE) or Individual Placement Support (IPS) is primarily concerned with enabling mental health service users back into work as soon as possible. 14 randomised clinical trials conducted in the US illustrated that IPS over any other employment method demonstrated an effective outcome for placing individuals in competitive employment. Over 50% of people receiving IPS services acquired a competitive job, whilst other vocational programmes only delivered a rate of 25% (Loveland, Driscoll & Boyle, 2007). These employment success rates for getting people into work through IPS programmes are high, but these figures significantly drop when looking at job retention. Only half of those successfully gaining employment through IPS models were able to remain in their job (Loveland et al., 2007). IPS appears to help service users acquire a job, but more than half are unable to retain and manage the pressures of the working environment.

Work is a key factor of most people's lives, providing proven psychological gains (Waddell & Burton, 2006). In the right context, work can provide increased confidence, structure and social support, vital for psychological health and well-being (Bell et al., 2007). The reasoning behind helping people with long term mental health conditions into and remaining in work, is that employment is generally seen as a rehabilitative experience both by service users and the clinical community (Marwaha et al., 2009). As will be demonstrated within this review, employment retention for mental health service users is an area, which deserves greater focus and attention from psychological researchers (Loveland et al., 2007; Cameron et al., 2012; Kukla & Bond, 2012).

Employment retention also needs greater consideration for employees who choose not to disclose and are currently in work. It has been reported that presenteeism (when employees come to work, but do not deliver at their expected capacity) costs may exceed absence sickness (Centre for Mental Health, 2010) when looking at the financial implications of mental health in the workplace. This suggests that there are many employees experiencing mental health issues who are not accessing supported employment services. Within a survey conducted by an anti-stigma and discrimination campaign, 92% of people felt disclosing their mental health condition at work would lead to damaging their career prospects (Daurka, 2010). Managing mental health conditions to ensure retention is therefore not just an issue for those people accessing employment services, but also for those struggling within work or around disclosure decisions.

Counselling Psychologists are trained to develop a pluralistic approach to treatment, helping clients to address systemic issues throughout their personal and working lives (Hemsley, 2013). As redundancy and loss of income significantly negatively effects well-being (Dooley et al., 1996), it could be argued that practitioners involved in mental health care need to know more about psychological interventions which can help people stay in their jobs. The identified gap in the psychological retention literature, also potentially reflects the need for further training around these issues within this branch of psychology. It will therefore be argued that Counselling Psychology could lead the way in developing a stronger understanding around employment impacting mental health and build this further into existing practitioner training to enhance recovery. As Cameron and colleagues (2012) from the University of Brighton highlight, "there remains limited research into such interventions and job retention needs – particularly in a UK context" (p. 462).

This research will also be focusing on people with long-term mental health conditions, as this is the group for which employment retention is such a fundamental issue. For the purposes of this research, *"long term mental health conditions"* are defined in relation to the UK Equality Act (2010). The Act highlights anyone who has a "mental impairment which has a substantial and long term adverse affect on their ability to carry out normal day-to-day activities" can be considered disabled and employers need to carry out "reasonable adjustments" to meet their needs (Mind, *Disability Discrimination Briefing*, 2014). Some research papers consider long-term to mean experiencing poor mental health over a year or more. However, the Equality Act also defines long-term to also include an impairment which is experienced for "at least 12 months or is likely to recur" (Mind, *Disability Discrimination Briefing*,

2014). If an impairment fluctuates over time, such as bipolar disorder or depression, it can also be considered long-term. The important aspect for this research is that long-term means an enduring mental health condition, which may fluctuate over time, but impairs work-based activities. This is a different focus from how work impacts mental health, although evidently the two are certainly not mutually exclusive. It will therefore be important to consider literature from the field of Occupational Psychology which understands how work impacts mental health and interventions that have resonance for people with mental health conditions and those who are experiencing poor mental health as a result of work.

This literature review aims to demonstrate that as pluralistic practitioners, Counselling Psychologists could help to further improve employment prospects for people with long-term mental health conditions. The review will identify how retention, not just competitive employment statistics, should be the key concern for researchers in this field. It will also demonstrate the need for more appropriate validated psychological interventions for individuals to be able to use within the workplace, and review the role of disclosure. Counselling Psychologists have an ethical commitment to provide the most appropriate support for their clients. This could further be achieved by developing stronger knowledge around psychological interventions to increase employment retention for improved recovery and functioning, especially for individuals who do not feel they can disclose their mental health issues.

Influences on Counselling and Occupational Psychology

Mental health at work is an area of interest for both Counselling and Occupational Psychologists in the UK, and this literature review seeks to draw research from both

disciplines into understanding more about how mental health is currently managed at work.

Occupational Psychology in the UK is broadly defined by the British Psychological Society as focusing on the psychology of work, with the aim to "increase the effectiveness of the organisation and improve the job satisfaction of individuals" (BPS website, 2015). In Britain, the roots of Occupational Psychology stem from efficiency and wellbeing studies conducted during the First World War. These studies were conducted by the Health of Munitions Workers Committee, who reviewed how fatigue and other factors impacted the health and wellbeing of munitions factory workers (Chmiel, 2000). These studies were continued by the Industrial Health Research Board set up in 1918, where the focus primarily remained upon understanding the ergonomics of an individual's working environment.

In 1921, the National Institution of Industrial Psychology (NIIP) was formed specifically to "promote and encourage the practical application of the sciences of psychology and physiology to commerce" (Shimmin & Wallace, 1994). The NIIP began to broaden research areas, with psychological studies being applied to work looking at recruitment and selection processes (Lewis & Zibarras, 2013). During the Second World War, Occupational Psychology in the UK gained further support, with psychologists being employed to develop recruitment procedures for the military. The use of psychologists during WW2 influenced the establishment of recruitment processes across the UK Civil Service, with psychologists now having a strong presence within the Department for Work and Pensions. Part of the role of practicing psychologists in the Civil Service was to also enable the return to work of people who

had become disabled because of their work. This illustrates an early involvement by Occupational Psychologists in retention for people with poor health conditions (Lewis & Zibarras, 2013).

Occupational Psychology was also heavily influenced by work conducted by members of the Tavistock Institute set up after WW2. The Institute became a focal point for psychoanalytic theory, and the development of systems thinking. The Institute also provided research contributing to understanding more about how technological change and communications impact productivity (Chmiel, 2000). Systems thinking became the basis for organisational development and action research, linking into the role of both the organisation and employee in achieving change. Following the end of the Second World War, all psychological disciplines were influenced by changing business markets, with organisations wanting to improve productivity. This included explorations in stress management, and the increasing understanding of organisation development (Lewis & Zibarras, 2013).

Within the United States (US), Counselling Psychology followed a similar development process to Occupational Psychology, with the US military requiring psychological input for training and development (Duncan, Munley, Mcdonnell & Sauer, 2004). The discipline of Counselling Psychology in the US has always had a strong emphasis on vocational aspects, linked to career counselling, development, prevention and health. Within the UK, the founders of Counselling Psychology were also influenced by developments in vocational practices and counselling within work.

The formal recognition by the British Psychological Society of Counselling Psychology as a discipline begun with the development of an interest-based Section of Counselling Psychology within the Society in 1982, followed by recognised Divisional status in 1994 (Corrie & Callahan, 2000). Orlans and Van Scoyoc (2009) note that the original founders of Counselling Psychology were graduates like themselves who held a first degree in psychology and continued with their professional development either with counselling training or working in 'helping professions', but could not define themselves within the existing divisions. These founding members had experience across a range of working areas, including careers counselling, organisational development, reflective practice and action research processes (Strawbridge & Woolfe, 2003).

Contextual changes also influenced the development of Counselling Psychology in the UK. Voluntary agencies were being set up such as the Marriage Guidance Council and University counselling services and careers counselling services (Orlans & Van Scoyoc, 2009). The recognition of counselling as an important aspect within psychology was also being recognised by other professions within the BPS with Occupational Psychology courses focusing on careers counselling (Orlans & Van Scoyoc, 2009).

Both Counselling and Occupational Psychology evidently share similar influences. Both disciplines have also contributed to our understanding of work and therefore it is important to pay attention to research and interventions developed within both disciplines towards mental health at work.

In Occupational Psychology, the main focus largely appears to be around how the characteristics of work influence health and much of the literature focuses centrally on stress management and stress management interventions. In contrast, Counselling Psychology offers more of an emphasis on an individual's entire experience. Woolfe (1996) describes the Counselling Psychologist's role is to work collaboratively with their client to enhance their wellbeing through understanding how they relate to their inner reality and life experience. Within Counselling Psychology, there therefore appears to be more of emphasis on how work makes up part of the entire experience of an individual, implying a broader depth and relational aspect.

This overlap between Occupational and Counselling Psychology is evident in modern working practices. James (2013) identifies that Counselling Psychologists are currently employed in public sector mental health services, where there is a focus on improving employment prospects for people with mental health conditions. This illustrates further how Counselling Psychologists and Occupational Psychologists share similar working worlds. It seems that both disciplines have historical routes in improving the wellbeing of employees and it will be important within this review to understand the contributions from across applied psychology to understand how work interventions might be improved.

Mental Health and Employment – the financial case for change

According to the Office of National Statistics (ONS, 2013) 71.5% of the British population who are economically active are in employment. Unemployment has been falling within the last couple of years, reducing Britain's unemployed population to

around 2.5 million. These statistics point to a positive economic change in Britain, since being plunged into recession due the collapse in International markets in 2008.

The Office for National Statistics (2013) states that being employed counts if you are working for as little as one hour per week. British workers are actually experiencing *underemployment*, with more than one million people wanting more hours than they are currently employed to work. Within these figures, there are also different trends in the data, suggesting varying experiences of employment or underemployment. People over fifty or under twenty-one are experiencing a greater rise in unemployment. Over 80% of people who describe themselves as self-employed would actually prefer to be in full-time positions, but they are just not available. The cost of living has increased by 2.7% over the last year, and yet workers on average have only experienced a rise of 1.2% in their pay. This leaves the average person earning less in comparison with the rise in prices, therefore experiencing a greater pressure on every-day living expenses.

Writing for the World Health Organisation's European branch on mental health and well-being in the workplace, Baumman, Muijen, and Gaebel (WHO, 2010) urge researchers to consider how this economic loss is impacting those in the population with mental health conditions. Government agencies tend to categorise mental health under disability, so it can be difficult to gain a clear picture of what the statistics look like around mental health and unemployment. Taking this into consideration, less than one in two people with a disability were described by the ONS as being employed in their 2011 *Employment and Mental Health Survey*. Within this category of disability, people experiencing depression or an undefined 'mental illness' were rated as having

the lowest employment rates within this group. Within this survey, that equates to approximately one in four people with depression or anxiety and one in six with a mental illness actually being in employment. These figures also do not include the many people who have not declared a mental health problem, or do not consider mental health as a disability issue. Figures vary depending on which report you read, but statistics indicate that this low level of employment has not improved in recent decades irrespective of Britain's economic situation (Meltzer, Gill, Petticrew and Hinds, 1995; Singleton, Lee, Bebbington, Brugha & Jenkins, 2002).

Both the World Health Organisation and the National Institute for Clinical Excellence are cited in the Mental Health Foundation's 2007 report entitled *Fundamental Facts about Mental Health*. Their figures suggest that one in four people with long-term mental health conditions are actually counted as being employed and twice as more likely to lose their jobs compared to those without mental health conditions. Out of the managers sampled who work with staff experiencing mental health conditions, only a quarter of them felt equipped to know how best to manage their symptoms. In their annual *Absence Management Survey*, the Chartered Institute of Professional Development (CIPD, 2012) reported that almost two fifths of organisations who completed the survey noticed an increase sickness absence due to mental health issues and were noticing this as an increasing problem. In the same CIPD survey, many employers admitted to preferring to manage mental health issues through disciplinary procedures, rather than through more preventative measures in the first case.

According to Mind's *Employers Guide to Mentally Healthy Workplaces* (2012), it is estimated that mental health costs UK employers and employees on average nearly 26

billion pounds a year. These figures come from a report by the Centre for Mental Health (formerly known as the Sainsbury Centre for Mental Health, 2007) and breaking this cost down, that is 8.4 billion a year in absence due to sickness, 15.1 billion in limited productivity and 2.4 billion on recruitment practices resourcing candidates to replace employees who have left due to ill-health. The Centre for Mental Health report also suggests this approximately equates to costing every UK employee £1035. This figure varies according to which publication is referred to, but the financial implications to employers are huge. In a more recent report by the Centre for Mental Health (2010) they estimate that mental health problems cost England around £105.2 billion in 2009/10 and estimate that the cost is increasing year by year. The 2010 report from the Centre for Mental Health also suggests that the cost of presenteeism almost certainly exceeds the cost of sickness absence.

The moral case for change

Mental health therefore impacts both the individuals who struggle in and to find employment, and the managers who feel ill-equipped to help manage them. There is also another side to the business case around improving how long-term mental health conditions are managed in the workplace, highlighted by Cameron et al. (2012) in their introduction to the growth of cognitive behavioural therapy in recent years. They refer to the fact that economist Richard Layard has expressed this other important factor throughout his time as founder and Director of the Centre for Economic Performance at the London School of Economics (Layard, 2013). Layard's main argument suggests that along with the strong financial case for changing how society approaches employment and mental health, there are fundamental moral reasons for society to address these issues to enable recovery and rehabilitation.

There is a strong evidence base to suggest that enabling people with mental health difficulties to work has a rehabilitative function. In their editorial for the *British Journal of Psychiatry*, Boardman, Grove, Perkins and Shepherd (2003) note how "enabling people to retain or gain employment has a profound effect on more life domains than almost any other medical or social intervention" (p 467-468). Qualitative research backing up this statement by Lloyd, King and Moore (2010) shows a link between employment, recovery and empowerment. They reviewed the links between recovery and employment for 161 participants diagnosed with varying long-term disorders and concluded that recovery scores and feelings of empowerment were significantly higher for those people in work. van Niekerk (2009) further demonstrated that participation in work was seen as a "source of wellness for participants" (p 445), linking the idea of recovery with returning to work.

Bond (2004) highlights how returning to work can contribute to better symptom control and improved self-esteem and is seen as a goal for many around improving quality of life. This seems obvious when people who do not have existing mental health conditions find being out of work results in low levels of self-esteem, due to inactivity and experiencing a loss of being productive and useful. Marwaha and Johnson (2005) interviewed fifteen participants experiencing a diagnosis of schizophrenia or bipolar disorder. Participants described both the positives and negatives for working, but ultimately described a desire to work. Secker, Grove, and Seebohm (2001) conducted a survey as part of a vocational programme amongst 156 service users experiencing varied mental health needs. They recorded that employment was one of the most frequently identified long-term goals.

It seems that people with long-term mental health conditions have a general perception that employment equals better mental health. If work has a rehabilitative effect, then Layard argues, society has a moral duty to ensure everyone can access employment.

The psychological components of work

In their review for the Department for Work and Pensions, *Is Work Good for Your Health and Well-Being?*, Waddell and Burton (2006) summarise the majority of research around employment and improved mental health. Their comprehensive review agreed with the overall perceptions that work is good for people.

> Despite the diverse nature of the evidence and its limitations in certain areas this review has built a strong evidence base showing that work is generally good for physical and mental health and well-being. Worklessness is associated with poor physical and mental health and well-being. Work can be therapeutic and reverse the adverse health effects of unemployment. (p10).

These are bold statements by Waddell and Burton (2006), but their views are drawn from their summary of extensive research in making sense of the complex relationship between work and wellbeing. Furthermore, their review required a best evidence synthesis and a rigorous methodology for rating the strength of each research paper included in the evaluation. In terms of work meeting the needs of people with mental health issues, they generally agreed with the perception that work

could enable recovery, but that it could also minimise the harmful physical, mental and social effects of long-term sickness absence.

Social science researchers have understood these generally positive outcomes, since the explorations of Marie Jahoda (1932) into the effects of unemployment on small social communities. Occupational Psychologists have developed a number of models to help explain how work impacts mental health. The Job Characteristics Model (a helpful theory developed by Hackman and Oldham (1980) and enhanced by other theorists over the years) is just one of many work based models that aims to illustrate the components required, in order for a job to provide the right kind of work for individuals. The Job Characteristics Model (JCM) works on the premise that highly repetitive and routine tasks can lead to job dissatisfaction. In order for a job to be enriching, a job needs to provide employees with the right levels of certain components (discussed in the next paragraph). Provided these components are sufficiently supplied, employees will experience certain psychological states enabling the positive benefits of work. These psychological states encompass the opportunity for employees to feel as if their work holds meaning, that they have responsibility for the outcomes of their work and that they know how well they are performing. There are various moderators, which impact these psychological states, but empirical research demonstrates that employment should aim to facilitate these psychological states in order for work to provide positive outcomes (Behson et al., 2000).

Warr (2001), though not specifically referencing the JCM, identified the components, which would make a job more enriching as part of his 'Vitamin model'. These include personal control, skill use, externally generated goals, variety, environmental clarity,

financial remuneration, physical security, supportive supervision, opportunities for interpersonal contact and valued social positions. If people experience a sense of meaning, purpose and achievement, then this is likely to lead to increased confidence and well-being (Behson et al., 2000). Waddell and Burton conclude by stating that these positive aspects can be experienced by "healthy people of working age, for many disabled people with common health problems and for social security beneficiaries" (p 11). Employment leads to negative consequences when these components are not in place, and an individual cannot achieve these positive psychological states.

How work impacts mental health

Melchior, Caspi, Milne, Danese, Poulton and Moffitt (2007) conducted a study into work-based stress and the development of clinically significant depression and anxiety. They interviewed one thousand men and women aged 32, the age around when people are beginning to establish themselves in their careers. They illustrated that work stress appears to bring on diagnosable forms of depression and anxiety in previously healthy workers. This research has been replicated time and time again, with specific components of job control, social support and demands influencing stress levels (O'Driscoll & Cooper, 2001).

The Job Characteristics Model illustrates components involved in determining a positive experience in work and what psychological states need to be achieved in work in order for this to be maintained. Although one of the more commonly cited models within Occupational Psychology around improving well-being at work, psychologists have developed other models which are also relevant to understanding

how work impacts mental health and interventions that might be important to consider. These include structural models of work stress such as Karasek's Demand-Control Model, later adapted by Johnson and Hall (1988) to include social support, and more complex models such as Cox and MacKay's transactional model of work stress (1981). These two primary models are reviewed below and interventions founded on them provided later.

Karasek (1979) developed a widely influential model explaining job strain which has been added to by other researchers across the years. Karasek identified that people need their jobs to be sufficiently demanding in order to sustain interest, but not so demanding that they feel unable to complete their work. Employees need enough control over their work to be able to meet their demands, but also the opportunity to use their skills appropriately. Johnson and Hall (1988) added to this model to include the role of social support in enabling control and demands. Karasek's work proved to be very significant in identifying the increased risk of chronic heart disease (Karasek & Theorell, 1990). Other researchers have also suggested the importance of locus in control in terms of managing job demands (Cummins, 1989).

Karasek and the work of other researchers such as Hackman and Oldham as well as Warr view stress at work from the perspective of how the working environment and role impact health or psychological health. However, there are other models related to work-based stress that focus more on how individuals experience work. Essentially these models look more at an individual's specific relationship with work and the meaning that they derive from it. In contrast, Cox and MacKay (1981) and other transactional theorists focus primarily on an individual's attitude towards work and

their own personal coping mechanisms for managing the demands of work. These models do not offer a simple way of understanding work stress, but potentially have more validity for employees concerning the variable experience of how we each approach work and work demands. For example, one person who is more introverted may find it very difficult to work in an open plan office, yet their colleague who thrives on social interaction, may be best suited to where they can openly engage with others. Transactional models offer an opportunity for the researcher to consider these individual differences, but also the role of self-perception in managing work-based stress.

Specific interventions and evidence testing out these models will be reviewed later, but there is a body of evidence that suggests that reduced social support, control and individual confidence in ability to manage work demands impacts psychological health (Bond & Bunce, 2001; Jordan, Gurr, Tinline, Giga, Faragher and Cooper, 2003; Bond, Flaxman, Veldhoven & Biron, 2010; Randall & Lewis, 2007). This suggests there might be valuable interventions already developed from stress management literature which has important consequences for the development of interventions for managing complex mental health needs in work.

Self-esteem and Social Support

In terms of understanding specifically how work can facilitate better mental health, much of the research literature suggests that self-esteem or confidence and social support are two fundamental functions, which mental health service users identify as the benefits of work.

Many mental health disorders are accompanied by a loss of activity and purpose (Bell et al., 2007). Unemployment often provides a loss of purpose and activity, which exacerbates mental health issues, especially for people without a support network outside of work. The World Health Organisation (2000) recommends that work could be used as a way of helping people with mental health issues because it enables people to reengage in society. Rinaldi et al. (2008) expands this point by stating that employment offers a person with mental health difficulties the opportunity to develop "social identity and status; social contacts and support, a means of structuring time, activity and involvement, and a sense of personal achievement" (p. 50).

Reininghaus, Morgan, Simpson, Dazzan, Morgan, Doody and Craig (2008) in the UK compared the experiences of 546 participants (332 controls) who presented with a first episode of psychosis over a two-year period to secondary care services. Those patients who were unemployed and reported lower levels of social contacts experienced a longer duration of untreated psychosis (DUP) than those who were employed. Their conclusion was that in relation to DUP, employment and social interaction shaped how quickly a period of psychosis was treated and managed. Bond and Drake (2008) highlighted that there is a strong evidence base for employment improving symptom management and psychosocial functioning in participants diagnosed with schizophrenia. Bell et al. (2007) highlight that the benefits of work are likely to be around 'community integration through constructive social roles' (p. 11) that working provides.

Rinaldi et al. (2008) also reported a reduction in symptoms by people who gain paid employment, partially due to an improvement in self-esteem. This has been identified

on a global scale. Siu, Tsang and Bond (2010) conducting research in Hong Kong, interviewed thirteen employed participants diagnosed with a major psychiatric disorder about their experiences of being employed. They noted that just three months into employment, these participants perceived greater well-being, quality of life, time structure and increased social activities. Workplace reinforcement had also increased individual sense of competency, self-esteem and self-identity. Further studies by Wong, Chiu, Tang, Mak, Liu and Chiu (2008); Bond, Becker and Drake (2001), and Blankertz (2001), support Siu and colleagues outcomes and recognise the need to continue to promote employment to enable recovery through improved self-esteem.

Secker, Membrey, Grove and Seebohm (2003) interviewed seventeen people who were attempting to return to work following experiencing mental health difficulties. Among the problems experienced by the participants attempting to return to work was an overwhelming sense of low confidence, suggesting again the impact of unemployment on self-esteem. Schneider, Slade, Secker, Rinaldi, Boyce, Johnson and Grove (2009) reviewed the employment outcomes for 156 service-users of secondary care services, from six of the biggest providers of employment across the UK. Their sample indicated that participants experienced greater financial satisfaction in work, but also a higher level of general well-being in terms of hope and self-esteem.

These researchers illustrate that employment results in improved self-esteem and social contact and that work represents an important stage in service users' perception of their recovery process. Belief in being able to achieve something has long been established as a factor, which greatly improves the changes of success (Bandura,

1977). The belief that work represents a form of recovery therefore could further enhance the chances of recovery.

The studies cited above particularly demonstrate that work can help mental health service users because it enables them to reconnect with people socially, but also provide them with a sense of purpose and improved self-esteem, linking in some of the psychological models around work and wellbeing identified earlier. Having established that work can provide important psychological mediators around mental health and not addressing mental health issues costs organisations billions in terms of lost productivity, it is still unclear why employment retention and mental health has not been more at the forefront of psychological research.

The right kind of work

It must be noted that there exists a degree of complexity in interpreting the studies linking employment to recovery too literally. van Nierkerk's (2009) review of the literature around this area illustrates that there are often a complex set of factors for an individual as to how employment may impact their own mental health. The rehabilitative or even restorative nature of work has not always been consistently proven because of these factors. Connell, King and Crowe (2011) highlight the numerous studies, which have equally identified the limitations of being employed on an individual's mental health. Connell et al. (2011) also note that there are often differences between how measures are determined and what instruments are used, and also the level of severity of an individual's mental health issue. Comparing studies and evidence can be quite complex and it is difficult to draw generalised conclusions because of this.

Sui et al. (2010) also commentated on the negative influences of work, largely identifying them to be around physical and psychological exhaustion. They urge researchers in this area to also consider the important psychological and financial costs of re-engaging in society. Provencher, Gregg, Mead and Mueser (2002) conducted interviews with 14 participants in the United States and concluded that work is important in the role of recovery because it was perceived as a means of self-empowerment and provided a sense of self-actualization, even when considering the negatives. This suggests that the social support function and connection that work provides can outweigh the possible psychological exhaustion referred to by Sui and colleagues, but researchers need to be aware that not all work results in improved self-esteem and social support.

Secker et al. (2003) note their data also suggests returning to work is more successful when job demands are matched to ability. Work demands need to enable an increase in confidence, but not be so demanding that they make people feel overloaded and potentially bring about a rise or return in symptoms. Secker et al. (2003) also point out the financial difficulty of returning to work for people with mental health issues. They point to the fact that if an individual with declared mental health problems as a disability works over a certain number of hours, disability benefits are then cut. The position is complicated because rehabilitation experts suggest a gradual return to work for people with mental health issues, so not to take on too many hours. However, this leads to not enough hours to sustain financial independence and increased concerns over finances. It can be that some phased returns to work could present a cyclical problem as described by participants in this study.

It is therefore important to consider the nature of work itself, before suggesting that all employment offers better mental health outcomes. However, most researchers conclude that given the right kind of work, employment is a beneficial and important activity for improved mental health. There therefore seems both a financial and rehabilitative case for improving how clinicians manage and approach employment and long-term mental health conditions. Rather than suggest that all work is good for people with mental health conditions, this review recognises that this needs to be the right kind of work.

Barriers to employment

It is important to also consider what wider contextual elements influence retention and to explore perceptions around whether people with long-term mental health conditions can actually work. Marwaha et al. (2009) conducted an interesting study into clinicians' attitudes towards the employment of people with psychosis. They initially determined that little research had been conducted into this area, but that it was assumed than many clinicians believed people with long-term mental health conditions would be unable to work or it would cause a relapse of their symptoms. What their research actually demonstrated was that clinicians saw helping people get back into work as an important part of their role, but felt ill-equipped to know how to go about this. Earlier in this review, it was also demonstrated that many people with long-term health conditions wish to work and even see it as a sign of recovery (Lloyd et al., 2010). Contrary to popular belief then, potentially both clinicians and service users of mental health services believe work is an important part of recovery. In terms

of questioning whether people with long-term mental health conditions can work, leading researchers in the field believe this is not the main issue (Bell et al., 2007).

The UK Government have been improving the way in which clinicians interact with other services, in order to develop a more connected service offer to patients. Employment advisers specialising in Supported Employment are currently embedded in many Community Mental Health Teams, aimed at getting people back into work having experienced a mental health crisis. Improving Access to Psychological Therapy (IAPT) services have also embraced the importance of employment and utilise behavioural activation developed from cognitive behavioural therapy, to encourage people to engage in work-based activities to improve mood. According to the Centre for Mental Health (2013) though, more needs to be done to focus on employment and connect services around mental health and employment further, as there are too few vocational experts.

The UK Government has also been trying to improve mental health issues in the workplace, through developing better understanding and behaviours around how mental health is managed. National campaigns such as *Time to Change* are currently being evaluated and the outcomes suggest some increased public awareness around mental health disorders at work. Henderson et al. (2013) conducted a telephone survey with major employers as part of a follow-up assessment around changing public attitudes towards mental health. It was concluded that there continues to be an improved understanding of mental health issues in the work place, but employers still do not know their legal obligations when it comes to managing employees with declared mental health issues.

Seymour (2010) writing for the Centre for Mental Health on an update on common successful work interventions, highlighted how the role of the line manager has often been overlooked by previous researchers. Since Seymour's observation, Mind, working in collaboration with the CIPD (2011), have produced guidance for employers on how to manage and support employees with poor mental health at work. The guidance outlines the employer's role and how managers can enable more facilitative conversations, yet there is still a lack of research around understanding more about the line management and employee relationship. One study by Fleten and Johnsen (2006) suggested that employers could use statistics around sick leave more effectively to build better strategies around managing mental health at work.

Butterworth, Costello, Looker and Cuming (2011), working for [redacted] have developed the *Job Retention Practitioner's Handbook* (2011), providing advice for Case Managers and employers around what can be done to practically enable support. One important element includes the '*Healthy Working Plan'*, a contract between employer and employee on what adjustments may be possible. The guidance outlines the employer's role and how to enable conversations in order to encourage disclosure and subsequent reasonable adjustments. This guide provides a lot of practical interventions, but also recognises the limits of caseworkers and that many will not have specialist psychological skills. Mind (2013) have recently published a guide entitled *How to be Mentally Healthy at Work.* This guide is a helpful starting point for considering individual interventions, with tips around managing stress and emotions at work, but it is unclear how widely known about these resources are.

An assumption made within these interventions mentioned so far, is that people with mental health issues willingly disclose to their employer or access mental health services. However, according to Deverill and King (2009) only 39% of people with mental health problems in England access mental health services and many people believe that disclosure would affect their career progression (CIPD, 2011). MacDonald-Wilson (2005) found that colleagues and managers go to great lengths to disguise their mental health issues, not taking time off or seeking help, and even demonstrate a reluctance to take medication because of side effects. There is therefore a further gap in the research literature around understanding both what those people do to stay in work and manage their mental health, or around interventions, which they might be able to access without disclosing.

Under the Equality Act (2010) employees do not have to disclose their mental health status, but if they do not, then employers are not required to make necessary reasonable adjustments. 'Reasonable adjustments' vary depending upon the needs of the individual and also depend on whether the employee is labelled as having an impairment, which qualifies as a disability. These adjustments may be as simple as offering flexible hours or more complex interventions such as systematic reviews of work.

Brohan, Henderson, Wheat, Malcolm, Clement, Barley and Thornicroft (2012) carried out a systematic review of the literature around the decision making of disclosure. There was some evidence to suggest that disclosure led to hypothetical candidates receiving lower employment scores, but this was in anecdotal evidence. They could

not conclusively state outcomes around employer behaviour towards employees with mental health issues. Their review did suggest that many factors appear to influence the way in which subsequent disclosures were managed, including gender, type of supported approach, familiarity with legislation, primary diagnosis or severity of symptoms and work setting. One important factor which stemmed from this research and the *Time to Change* review was the need to ensure organisations understood their legal obligations more fully and what employees could expect to receive upon disclosure.

A report by the WHO (2000) found that barriers to working did include actual discrimination, and disclosure issues. The *Time to Change* review also identified that 32% of respondents felt that "organisations take a significant risk when employing people with mental health problems in a public/ client-facing role" (p. 72). The fact that the Equality Act has made it illegal for employers to insist that employees declare their mental health needs also suggests there is some degree of perceived discrimination occurring upon disclosure at a Government level. Professor Bevan, Gulliford, Steadman, Taskila, Thomas and Moise (2013) from the Work Foundation provided a comprehensive review of why people with schizophrenia are one of the lowest groups engaged in employment. Along with a number of other factors, stigma and simple lack of knowledge around managing symptoms was a high contributory factor for many employers. Whether there exists a perceived or real discrimination, studies by researchers globally indicate people are still not disclosing because of mental health problems being used as a reason to dismiss them or not progress their careers (Corrigan, 2004; Petersen et al., 2011). Retention work therefore may also need to consider interventions, which do not rely on disclosure.

For those who do disclose and seek clinical support, the picture is beginning to change. Over the last five years, mental health teams have been working more closely with employment specialists on a core approach to helping those with long-term mental health conditions back into work, developing Individual Placement Support Services (IPS).

Individual Placement Support Services – a model for change

The central model of IPS has been developed widely within Europe and the US and the UK has made significant progress towards adopting some of its central principles. Developed by Becker and Drake (1993), the overall philosophy behind supported employment is that anyone can work, provided the right sort of support, role and environment can be found. Currently employment support workers are embedded within NHS mental health services, recognising the need to improve links between clinicians and employment opportunities.

Studies into supported employment have offered some impressive results, both across the UK and more globally. In a follow up review looking at additional interventions, Boycott, Schneider and McMurran (2012) indicated that IPS works when clear principles are followed. These include a focus on competitive employment, acknowledgement of personal interests, a rapid job search, integration of mental health and employment services, programme entry based on client choice, time unlimited support and benefits counselling. IPS reviews conducted by Bond, Drake and Becker (2008) indicated that 61% of participants enrolled on IPS programmes were employed, compared to only 23% with other interventions, yet retention rates

drop away. The retention rate of mental health services users attending supported employment programmes is estimated to be anywhere around 20-40%, although most researchers estimate towards the lower end of this range (Kukla and Bond, 2012; 2013).

Rinaldi et al. (2008) outlined what is involved in IPS and also identified the need for these principles to be adopted further within clinical practice. IPS involves a specialised centred approach where an employment specialist uses their skills and networks to enable a client to find work. The focus is on the individual needs and not waiting until the individual is deemed to be more psychologically well, the practitioner acts quickly to work with the client to attain employment. This can be through helping to fill in job applications, developing strategies around managing conditions, or working directly with the employer to set up structures to accommodate any adjustments. Rinaldi, Miller and Perkins (2010) demonstrated that when NHS mental health services adopted the IPS approach there was an increase in employment rates. These strategies appear to work well, but largely in terms of gaining a job in the first instance.

Kukla and Bond (2012) have conducted extensive research into IPS and Supported Employment programmes nationally. Their research has helped to define the principles of IPS and increase the success rate around employment using this model. However, they also acknowledge difficulty with employment retention, stating "people with severe mental illness (SMI) get jobs, but often have difficulty keeping them" (p 11). Surely this is a fundamental point for consideration in relation to determining success within this area.

A recent research paper by them concluded that Job Match was important in determining Job Tenure, and perhaps could explain why retention figures are relatively low. Boycott et al. (2012) and Cameron et al. (2012) also highlight the poor outcomes for job tenure within the SMI group, with all researchers pointing to the need to develop better research in this area.

None of the above studies appear to consider the population who do not access these services because they have chosen not to disclose. Neither do they discuss the critical point of the impact of dropping out of a job, once attained through an IPS programme. If the founders of IPS services note that retention is a real issue for service users, then this seems a fundamental problem which needs addressing quickly. As noted previously, Occupational Psychology has offered central research findings around characteristics at work, which improve general wellbeing. It could be important for IPS programmes to pay greater attention to the characteristics of work in order to improve retentions outcomes.

This literature review has shown how beneficial work can be, and equally how being unemployed can lead to increased mental health issues. It therefore seems inappropriate to judge the success of an intervention on obtaining a job in the first place, rather than retaining that role. Although gaining a role may be empowering in the first instance, the psychological benefits of work are surely only obtained by staying in that role. It is therefore confusing as to why so many researchers have spent time reviewing competitive employment rates, rather than retention figures. This may

be due to the fact that retention is an ongoing measure, which needs long-term studies to identify these figures.

Job Retention Interventions – additional to IPS

Much of the research literature around psychological interventions stems from additional elements added to the IPS framework. These studies were predominantly conducted in the United States, where IPS has been adopted and developed more comprehensively. Boycott and colleagues (2012) reviewed 11 papers in total around interventions to enhance the effectiveness of IPS and covered 6 distinct studies. Those interventions that were highlighted were described under two categories, skills training and cognitive rehabilitation, classed as 'additional interventions' to IPS. There is some difficulty here in defining what 'interventions' belong to the IPS framework and what is meant by additional interventions. It is also difficult to identify always exactly what additional interventions were offered in the research literature. It may therefore be unhelpful to distinguish between interventions, but simply to understand currently what has been trialled in relation to enabling people with long-term mental illness to remain in work, irrespective of the IPS role.

Boycott and colleagues identified two types of skills training interventions, one around social skills group training and the other around problem solving and managing symptoms. Tsang (2003) provided social skills training in a study conducted in Hong Kong, demonstrating encouraging results compared to the other interventions. Cognitive rehabilitation interventions conducted by Grieg, Zito, Wexler, Fiszdon and Bell (2007); Kern, Liberman, Kopelowicz, Mintz and Green (2002) and McGurk, Mueser and Pascaris (2005) involved neuro-cognitive

enhancement (NET) therapy, errorless learning and the thinking skills work programme. Participants were seen to achieve higher rates of employment when engaged in the NET programme, focusing on enhancing cognitive skills often impaired by severe mental illness. The authors go on to conclude that skills training and cognitive enhancement training showed improved employment rates compared to just utilising the IPS model.

Although these trials suggest work-related skills training may enable improved outcomes for IPS, they are only preliminary findings. It could be questioned whether the results can be compared considering the different applications of IPS mentioned by the researchers. None of these studies were conducted within a UK context, where there are likely to be variations on social and economic influences. The other difficulty with this review was that only two of the six studies included looked at the outcomes for job tenure. Out of these two, inconsistent results were derived. As mentioned above, it is unclear what function using competitive employment rates achieves as the definitive measure of success. If service users do not actually stay in the attained jobs in the first place, it could be questioned whether, they would benefit from the psychological outcomes of work described by some of the previous literature.

Psychological Interventions Studies

It appears that psychological interventions used within retention work cover a broad range of aspects, from practical to more conceptual aspects working towards improving cognitive and emotional functioning in work. The review referred to earlier conducted by Cameron and colleagues (2012) looked at the impact of job retention

projects for mental health service users, using a broad range of interventions. Along with CBT initiatives, mental health charities are now working alongside mental health Trusts and employment organisations to run pilot job retention projects. Cameron and colleagues interviewed fourteen service users attending the '*Retain*' project run by the Richmond Fellowship in East Sussex. The project involved developing cognitive strategies in a group, based upon a work context. In conjunction with this, clients were provided with confidence boosting sessions, employment law briefings, and advice on how to negotiate adjustments. Advisers were also provided to go work directly with each participant and facilitate negotiations with employers around workplace issues.

Results from the qualitative interviews demonstrated than ten of the fourteen remained in employment. The rest were encouraged to retain their worker identity and continue to engage in work-based activities through volunteering or group interaction. An important outcome from this research also identified that any intervention around retention needs to impact change at the individual, job and workplace level. Whilst behavioural changes are likely to be important, ensuring that the job role enables change and adjustment and that the workplace supports those changes were also identified as important. Self-confidence and emotional regulation also appeared to be strong factors in retaining work for this sample group.

Cameron at al.'s (2012) review only looked at the qualitative comments of 14 service users, in one location, which makes it difficult to draw conclusions around retention interventions. Throughout the article it was also unclear when the interviews had taken place and how far along participants were in participating in the programme.

Throughout these studies, little attention is paid to the fact that these retention services are only open to mental health service users and people who have already disclosed their mental health condition. For example, this study was conducted with people who were willing to be interviewed and engaged with the retention programme. Retention also seems to focus on people who have used IPS programmes to gain work, and there is little focus around retention of workers from a preventative perspective, rather than just following assisted competitive employment. What is encouraging though, is that given the right support, retention rates can improve.

Following the extension of Cognitive Behavioural Services as part of the NHS's Improving Access to Psychological Therapies, many Trusts within the UK have been piloting CBT as a way of improving the employment outcomes of service users. Within the previous section, it was mentioned that application of some CBT interventions had proven to be successful as part of a wider programme of activities. However, Cameron et al. (2012) refer to the fact that there have been a limited number of studies conducted into this area. CBT services also often use a quantitative measure of a reduction in symptoms around mood as their benchmark for success. A decrease in psychological complaints might not be the most appropriate factor in considering work resumption or success in work (Blonk, Brenninkmeijer, Lagerveld & Houtman, 2006). Whilst CBT has been shown to work effectively with a number of mental health issues, including psychosis and even schizophrenia, according to Cameron et al. (2012) CBT alone 'may be insufficient to produce positive work outcomes' (p. 2). Computer based CBT has also been introduced to try to manage mental health at work, but Schneider (2012) found no significant improved impacts of cCBT on psychological outcomes alone.

Bell et al. (2007) collaborated on a less recent paper, but specifically around psychological interventions to improve work outcomes for people with SMI. It could be assumed that service users who experience more complex SMI are likely to present with different and more challenging issues at work. Bell and colleagues (2007) actually indicate that this is not the case and often very similar issues come up for mental health services users at this chronic level. Four programmes of interventions are presented by Bell et al. (2007), some already mentioned previously by Boycott et al. (2012).

The first intervention involves Work Behaviour Feedback Groups, where clients are informed about their performance and social interactions at work weekly, with the ability to problem solve and set further weekly goals. The second involves addressing clients' negative beliefs about themselves, utilising existing cognitive behavioural therapy techniques. The third intervention uses the social skills training mentioned earlier to assess and identify common ways of managing work-based problems (Tsang, 2003). The fourth and final intervention centres on the computer based training interventions around improving cognitive functioning, such as in NET also referred to earlier. Unlike previously cited papers, the researchers have taken time to explain the rationale behind each intervention by outlining what initial difficulties participants face in the workplace.

Looking at the evidence for feedback in work, it appears that Work Behaviour Feedback Groups do play an important role in helping service users in understanding their achievements, and potentially enable them to achieve the psychological states

referred to earlier as part of the Job Characteristics Model. However, Bell et al.'s (2007) own study highlighted that measures were obtained over a six month 'transitionary work programme'. It was unclear whether this measured job retention rates or would be an accurate predictor of improving job retention rates. The Cognitive Behavioural programmes were also results obtained from a six month work placement (Lysaker, Bond & Davis, 2005), and whilst outcomes for self esteem and hours worked increased following the programme, it was unclear whether this could be enough support to identify psychological interventions in a longer-term work based setting.

Bell et al., (2007) did not have the benefits of the results of Tsang et al's (2010) three-year follow-up study, looking at the longer impact of social skills training. As mentioned earlier, the results were encouraging, with 189 participants recruited to understand the long-term impact of this training. The research support for the interventions around social skills training indicated increased job tenure at a significant level. However, this work has been conducted solely in Hong-Kong and it will be important to understand if UK service users experienced similar benefits. According to Boycott et al. (2012), these results were also seen in one of Tsang and colleagues follow-ups and not the other. The results for NET interventions have also been encouraging, with McGurk et al. (2005) particularly illustrating long-term job retention outcomes.

Based upon a clear rationale around common problems that mental health service users experience at work, these psychological interventions were shown to have varying, but largely positive effects. The researchers note that these interventions

cannot yet be used in a prescriptive way with clients, but offer the foundations of enhancing retention outcomes for individuals with long-term mental health issues. It appears that interventions, which enhance social and cognitive skills within a work context, may enable better employment prospects.

However, these studies were all largely done outside of the UK and with those service users already known to mental health teams. The focus of previous research also seems to also have been with people who are out of work, seeking employment, or those in assisted work placement programmes. There is also a general assumption that people experience similar difficulties in the workplace. Although this may be true, it appears that retention research has not looked at people with long-term mental health conditions who have chosen not to disclose to their employer and remain in an existing role. By focusing further research on this group, it could be identified what this group manage to do to stay in work, and utilise this for mental health service users or develop more preventative interventions, irrespective of disclosure.

The studies that have been presented in this literature review offer insights into maintaining mental health at work, but no comprehensive model. There are clearly important aspects around job characteristics, which are part of improving general wellbeing. However, these studies do not go far enough to consider the impact of the characteristics already identified by Occupational Psychologists. Whilst improved competitive employment supported by IPS programmes is encouraging for existing mental health service users, the research literature is sparse around retention. There exist only a few interventions studies around improving retention already reviewed outlining the importance of improving social and cognitive skills and support from an

external agency providing training and increased confidence. There also appears to be inadequate outcomes defined for existing employees, drawing little from stress intervention literature.

Learning from Work-Stress Interventions and Participatory Action Research (PAR)

It might be that the existing body of literature around interventions to help manage work stress could provide insight into how to improve the situation for those people with mental health conditions. Occupational Psychologists have worked towards developing interventions that tackle both organisational factors (primary interventions) and those, which focus specifically on individual job stress prevention (secondary interventions) or individual stress reduction (tertiary interventions). All these interventions derive from the structural and transactional models of stress referred to earlier. These levels also echo the recommendation of Cameron et al. (2012) that retention interventions need to focus on the work of an individual and the organisation in which they work.

Change to the working environment can involve anything from changing the job tasks associated with a role through to changing the entire culture of an organisation. At a primary intervention level many studies have focused on redesigning the working environment through job redesign and policy change. At this level, change is often achieved with the involvement of employees through a process known as participative action research or PAR. The role of engaging employees in job redesign is not new and has a long history within Occupational Psychology.

A comprehensive review of stress management literature conducted for the Health and Safety Executive by Jordan et al., (2003) identified the importance of using a PAR approach within health interventions to achieve success. Most organisations in their review ran focus groups, staff appraisals or surveys in order to gain and understand employee opinion. One example from Bond and Bunce (2001) used a PAR approach to identify that stress related outcomes can be reduced by increasing people's job control. Employees were given discretion and choice over their work and they found that overall work stress reduced. Primary interventions using a PAR approach may enable change through employing Karasek's demand – control – support model, and according to Jordan et al. (2003) produce successful outcomes.

A further exploration of PAR will be reviewed later in relation to understanding more about the approach taken in this research and the benefits of engaging participants in this way, but it is already noted how important involving participants in their own solutions might be within any intervention process.

Despite not dealing with any organisational cause of stress, secondary and tertiary interventions are often the options chosen by organisations. Most employees are probably familiar with stress management training programmes, where the individual is held more accountable for their own input into managing their health. Many stress intervention programmes are based on elements of cognitive behavioural therapy or relaxation training, recognising the link between Counselling and Occupational Psychology. More recently stress management studies have begun to focus on developments in counselling practices and workplaces are beginning to see the benefits of acceptance and commitment therapy and enabling psychological flexibility

on employee wellbeing (Bond et al., 2010). Stress management training is likely to be helpful when there is more of an individual cause of work-based stress.

Most researchers would associate tertiary interventions linked to Employee Assistance Programmes or EAPs. EAPs primarily offer individuals counselling or other health interventions, which offer bespoke individual interventions. EAPs do result in successful outcomes providing management engagement and training is provided, along with agreed policy, purpose and evaluation (Randall & Lewis, 2007). Although this may benefit individuals, if there are more systemic origins of stress then a stand-alone EAP programme may not be the most appropriate solution.

What is evident from the work-stress literature is that developing interventions for improving health and well-being is complex and unlikely to involve one stand-alone intervention. Selecting interventions will depend much on the working environment of the organisation and the specific challenges each employee is facing. Practitioners draw on all models of stress to develop interventions and the research literature provided above suggests that both individual and organisational factors need to be considered. Primary interventions may be more helpful when stress is experienced at an organisational level. Secondary and tertiary interventions may be more appropriate when an individual is experiencing stress, which is not completely linked to organisational factors such as culture or workload.

In regards to contributing towards the future direction of this research though, several important aspects are relevant. Firstly, a research process, which engages and works with participants from the beginning to develop solutions is likely to be an effective

and contributory factor for success. Secondly, it will be difficult to separate negative symptoms arising from poor working practices and symptoms associated with a primary mental health condition. It is therefore likely that understanding organisational work factors will be important to consider within this research process. Lastly it could be suggested that a multi-level approach is important to consider in developing an appropriate theory.

Future direction of research

This literature review has set out an evidenced based case for changing how people with long-term mental health conditions access and sustain employment. It has been illustrated that employment improves well-being more generally within the population, and with mental health services users and clinicians is seen as a sign of recovery. There are fundamental connections between improved self-confidence and social support that the right kind of work can provide, which can be seen as an important aspect for maintaining better mental health. Given the right kind of work, people can work. However, the retention rates in employment for mental health service users are still fundamentally low.

Individual Placement Support Services are pioneering the way in which employers interact with potential employees with mental health issues, and helping them to gain employment. More recent research has begun to focus on how to improve these programmes with psychological interventions aimed at addressing poor retention rates. Some of these studies have used more than just competitive employment outcomes for their measures of success and show impact around improved social

skills training and cognitive enhancement, improving retention rates. It has been argued though that these programmes only target a fraction of the people who experience long-term mental health conditions. Despite improvements in public policy and campaigning, many people with mental health issues choose to not disclose or ever come into contact with employment programmes designed to impact these employment and retention rates.

The majority of the research into employment interventions for people with long-term mental health conditions has been conducted outside of the UK, with unemployed people who have accessed mental health services. This research also seems to have been conducted through employment support programmes. These programmes are likely to be working with employers who understand and respond to making reasonable adjustments for workers. The interventions proposed previously also indicated that the role of the employment adviser or trainer was vital in their outcome (Cameron et al., 2012). With an estimated 2 out of 3 people with common mental health problems (Deverill and King, 2009) not accessing mental health services, let alone employment support services, there is a question around what realistic interventions they can put in place. With a real fear of discrimination, it may be that some of these interventions could be adapted for people who choose not to disclose, but it is unclear what this might look like. It would also be helpful to understand what people do to positively improve their working experience and build upon Occupational Psychology knowledge from work stress interventions. Research also indicated that clinicians still feel deskilled when it comes to thinking about psychological interventions for people in work.

As a pluralistic discipline it seems vitally important that Counselling Psychologists could be thinking more about the role work plays in an individual's life and build upon existing individual adaptations which may help someone mediate the demands of the modern working environment. This research therefore aims to broaden the understanding and development of psychological interventions within work for people with severe mental health conditions.

Research Aim

To summarise, there are three main justifications why research into improving retention for people with long-term mental health conditions is important. Firstly, every person has the right to economic freedom, and an ability to develop a sense of purpose and achievement. Employment is a means of achieving this and both clinicians and service users alike regard this as a part of their recovery and connection back into society. Secondly, managing mental health more effectively could save employers billons of pounds, and may result in greater productivity. It may also enable employers to be viewed in a more favourable light by their consumers and potential employees. Finally there is a need to change perceptions towards mental health at a society level. There is evidently still an issue around perceived discrimination and this needs addressing as much as attitudes towards physical disability have changed and become more progressive (Equality Act, 2010). This research therefore intends to explore how people with long-term mental health conditions can retain work and will look at understanding more about the role of the individual and employer in doing so.

This research therefore aims to determine a set of psychological interventions for people with long-term mental health conditions to employ in the workplace, to enable them to survive and even thrive within the workplace. It is recognised that changing attitudes at a society level or encouraging employers commitment to change is likely to be a longer-term objective of a larger research project. Therefore this research will primarily focus on what individuals can do and also consider what might be possible without disclosing. This study also will discuss the potential role of mental health professionals and what knowledge might be useful to them to enable change with clients struggling in work. There are likely to be overlaps with supported employment initiatives and stress management interventions, but it is the intention of this study to add to this understanding by working with a different group of research participants who are actively engaged in work. This study will aim to be the foundation of a longer-term piece of work into understanding what specific therapeutic interventions might be employed by employers and practitioners to enable people to gain a positive and supportive experience within the workplace or enhance understanding.

Relevance to Counselling Psychology

As a Counselling Psychologist in Training, I have noticed that a number of my clients across the three years have presented with issues specifically associated with employment. I believe this will be an further important component of the work of Counselling Psychologists in future years as the Government focuses more on improving mental health in the workplace (Organisation for Economic Co-operation and Development, 2014). There could be an exciting further role for Counselling Psychologists in the UK to develop more comprehensive therapeutic interventions concerning managing mental health at work for the purposes of retention. With

specific therapeutic and mental health knowledge, Counselling Psychologists could be well placed to also lead changes around organisational cultures towards mental health.

Proposed Process and Reflexivity

The objective of this research is to work collaboratively with a group of people suffering from long-term mental health conditions, to understand how they thrive and survive in work. The aim is to develop and test out interventions, which have a psychological and therapeutic basis. It is the intention of this project to use action research as the process by which this collaborative data is collected, in order to enable an open and experimental approach to defining and testing out these interventions and draw on stress management literature.

Importantly, I want this research project to have a direct positive impact on the participants involved with it. I think Counselling Psychology research has become too consumed with the idea of exploring experience, rather than thinking more specifically around how we can use research to enable positive change. Action research provides the blueprint for how to achieve this collaboratively and will benefit participants involved in the process (Brydon-Miller, Greenwood & Maguire, 2003). As a research process, action research also will keep me engaged and links into my own values around wanting to achieve social change around the way employers think about mental health issues.

I recognise the importance of reflecting within this process about my professional influence on this research, but also my personal thinking and understanding of this subject matter. As Counselling Psychologists in Training we have been asked

throughout our clinical work to consider how our own thoughts and reflections about the world, knowledge and meaning, impact the outcomes of research.

Firstly I have facilitated a number of groups and training workshops to be able to facilitate an action research group. My training enables me to understand more about the world of work and an appreciation of certain factors that enable employment to be a beneficial experience to enhance well-being. Although I believe these aspects to be an advantage, it might also significantly influence the research process and I need to be mindful about the assumptions I might make about the knowledge generated. I am also intending to use constructivist grounded theory as a way of analysing the data produced by the action research process. It is likely than any subsequent theory or model developed will be influenced by my previous knowledge and experience. However, as previously noted, both Occupational and Counselling Psychology have developed under the influence of similar contextual and philosophical influences, which suggests similar conclusions might be drawn by psychologists without an occupational background.

Research Thesis and The Research Question

It is the intention of this research thesis to tell a story about both the evolution of this project but also about the subsequent model developed from the analysis. This thesis has already outlined more explicitly the literature around retention in work and subsequent psychological interventions, where the argument for this research has been produced. The method will outline important research considerations and how the process of action research and constructivist grounded theory were conducted. The results section then reflects upon the action research process and the theory derived

from constructivist grounded theory analysis. The discussion links the model to the original literature review and I have tried to reflect and provide arguments for the way in which I conducted this process.

The research question for this project is therefore '*How can people with long-term mental health conditions remain and even thrive in their workplace?'*

The next section will outline the research process that was used to try and answer this research question. I will also review the importance of holding certain philosophical positions in relation to conducting research and how Counselling Psychologists might be more creative in their approach to research.

Method

Willig (2008) draws attention to the fact that research methods are not recipes for how to proceed in qualitative research, but ways of "approaching questions, and the value of our research depends on the skill with which we manage to match our methods to our questions in the pursuit of knowledge and understanding" (p161). The choice of one methodological approach over another illustrates to a researcher something about their own philosophical approach to knowledge. The researcher therefore needs to be aware of what type of knowledge they wish to obtain and consider how the research question and aims influence what form of data collection and analysis is selected.

Willig (2008) also points to the fact that active research is not driven by the research methodology, but by the need to communicate something important about the human experience. In other words, a researcher may find that the initial research process they have selected does not give them the answers to the question they are considering and should not be restricted to continuing with that chosen method. Although this can be achieved through a quantitative research process, a qualitative process provides a greater opportunity for the researcher to explore meaning and theory generation (Willig, 2008). A starting point for any researcher embarking on a qualitative research process is to first question what epistemological and ontological positions they themselves hold, to understand how this might impact methodological selection. As qualitative research can be time consuming, Willig (2008) also reflects that the researcher needs to adopt an approach, which ensures they stay engaged in the process.

Epistemological and Ontological Positioning

Epistemology and ontology stem from the philosophical sciences and ask the researcher to consider what they believe knowledge is and how we know what it is. Put simply, ontology asks, what there is to know and epistemology asks how we know what we know. I will outline how I hold two central positions in relation to these considerations and how this has influenced my choice around the research process and analytical method applied within the project.

Qualitative research processes grew in popularity during the mid-20th century, largely in an attempt to challenge the majority positivist approach popular at that time. A positivist approach assumes that there exists a single, objective reality, uninfluenced

by the views and perspectives of the person (Kirk & Miller, 1986). Positivist researchers would want to collect quantifiable data, believing that an objective truth can be measured and compared. Most modern researchers would label themselves within the post-positivism movement. Post-positivism does not reject the idea of an objective reality as a relativist might do, but rather recognises that the person researching it always influences this reality (Popper, 1963). A post-positivist would therefore be attempting to find an objective reality, but recognise this is almost impossible, due to historical, cultural and social influences that the researcher and all those involved in the process may put on interpretation.

Under the umbrella of post-positivism, lie a number of other fractions and distillations of opinion. As Willig (2008) states, the difference between philosophies is in how we choose to approach the world of objective knowledge, not whether there is one or not. Two of the most common forms of post-positivism are critical realism and social constructionism. For Forrester (2010) critical realism adopts the post-positivist stance that suggests there is an objective reality, but recognises this is almost impossible to fully define or know. It is a position, which lies closer to the realist perspective than other post-positivist viewpoints, and answers the ontological question around what is there to know i.e. there is a proposed objective reality.

Social constructionism has gained increasing influence within the last twenty years, with a range of sociological and interpretivists thinkers accredited with its origins (Burr, 2003). Social constructionism focuses more clearly on answering how do we know what we know. Berger and Luckmann (1991) concern themselves less with the question of an objective reality, but more with the perception that reality is

constructed rather than created. They do not go as far as to say that there is no such thing as shared knowledge or reality, but that society is constructed through the influence of history, society and culture. An example of social constructionism might be around how two nations define their role in war or conflict. Social constructionism therefore does not reject the idea of an objective reality, but is more concerned with how this knowledge is constructed and understood, a question of epistemology rather than ontology. The social constructionist would therefore have an epistemological stance that knowledge is derived through constructed means.

Thinking about how I approach the theory of knowledge, I have come to the conclusion that I hold both positions. It has been helpful for me to consider myself as a critical realist to answer the question of ontology and as a social constructionist as a way to answer the question of epistemology. My ontological position is therefore defined through the lens of a critical realist. I believe that knowledge does exist as an objective reality, but it is almost impossible to ever get close to this. Research that attempts to define this reality is important, as it helps to build a shared understanding of the world, enabling greater change. My understanding is also that our society, culture and language all influence our understanding of this reality. Therefore any research process should attempt to understand and define this shared reality, but also interpret findings through considering socially constructed influences. Therefore my epistemological position is that of a social constructionist, allowing the researcher to consider how we have constructed meaning to produce data. Knowledge derived from any research process therefore should attempt to explore an objective reality, but consider how this reality has been in part socially constructed.

The research question for this thesis is, '*how can people with long term mental health conditions remain and even thrive in their workplace?*' which also proposes a collaborative process, focused on positive change. I mentioned in my preface how important I believe the idea of social change is for me and engaging in actions, which are based on core values. Keeping in mind Willig's (2008) important point of the researcher remaining engaged in the research process, I recognise that embarking on a research process which facilitates change to happen, resulting in possible social change, would ensure I am more committed and motivated to the research process which can often be lengthy and time consuming.

As an Occupational Psychologist, I have worked, and continue to work, for a number of organisations whose mission statement is based on social change. I am extremely passionate about training and development that results in change, not just for those attending training, but the service users they often work with. My values around providing interventions that improve outcomes are central to what I do. I would therefore want to use a research process that focuses on social change and enabled positive change for participants, rather than just an exploration into meaning. Brydon-Miller et al. (2003) points to the fact that researchers need to consider how they shape the research. With this in mind, I also need a process that allows me to reflect on how I have shaped the research and that this is not a negative influence. Looking at my values around social change, I recognise that I would only be able to facilitate change, if participants were collaboratively involved in some way with the research process itself.

In summary, the choice of research process applied to answer the research question, needed to include:

- a collaborative data gathering method in which participants are actively involved in the research process, resulting in social change
- a focus on attempting to define an objective reality in order to benefit the majority of people within this process
- an interpretative approach that enables a shared perspective to be developed, whilst ensuring outcomes are interpreted through the influence of socially constructed meanings

To answer the research question, I therefore chose action research as the process by which to collect data and constructivist grounded theory as the way in which to analyse the data. I shall now outline both processes, how they complement one another and then how this was conducted.

A Brief Introduction to Action Research

Reason and Bradbury (2001) define action research as a framework, which guides a researcher's methodology approach and aims to produce practical knowledge that is useful to people in the everyday conduct of their lives, contribute through this knowledge to increased well-being of individuals and communities and combine practical outcomes with new understanding. Kagan, Burton and Siddiquee (2008) describe action research as a process, which provides the conceptual framework for the method by which a researcher moves beyond just exploring psychological phenomena, and actually begins a dynamic process of research where participants become 'co-researchers' engaged in change.

Action research is used across scientific disciplines and has roots across different fields and developed as one of many alternative qualitative research processes aimed at challenging a largely positivist stance. Brydon-Miller et al. (2003) argue that knowledge is actually largely socially constructed and that this is embedded within a system of values where scientific objectivity is largely a myth. Action research is therefore not just a socially constructed qualitative process, but also founded upon strong social values, where the focus is on social change. As Brydon-Miller and colleagues (2003) describe, the researcher becomes committed to a form of research, which "challenges unjust and undemocratic economic, social and political systems and practices" (p. 11). In fact, action research has led to bringing about positive change in disputes around labour oppression and civil rights movements (Reason & Bradbury, 2001).

As a collaborative process, action research often starts with a theory or idea, which is both collaboratively devised, and then tested out in the real world. There are four key elements of action research, which are demonstrated by Figure 1a) below. It is an on-going process of discussing the original issue and planning what action to take, taking action, evaluating that action and then reflection. Based upon subsequent reflection, further action is taken if required, until the process reaches an appropriate ending. Or at least this is how it is defined in action research literature. However, Kagan et al. (2008) also point out that an action research project can start at any stage, one stage rarely proceeds another and may only involve part of or go through many iterations of the original cycle. Importantly, action research therefore enables a researcher to not

only understand and explore experiences within context, but also to develop practical outcomes and interventions, developed and devised in collaboration.

Figure 1. Action Research Process

Commonality amongst action researchers is therefore around the philosophical approach of enabling change at a social level, but also through the recognition that people learn through doing. Any outcomes of an action research process therefore need to be interpreted with both an understanding of the influence of socially constructed meanings, but also the values and principles of the researcher themselves. Action research does not imply that a shared reality cannot exist, but that it needs to be considered with respect of the views and values of those engaged in the research process.

One critique of using action research on its own, is that although it offers researchers a framework for collecting collaborative data through a change process, it does not always offer the concise way in which emerging data might be understood and

analysed (Dick, 2003). Therefore, if the researcher wanted to develop a theory or set of interventions based upon the findings of an action research process, there is not a clear method outlined within the current literature as to how to do this. However, constructivist grounded theory provides a complimentary way in which data might be interpreted from an action theory process, although what type of action research also needs reviewing.

Practical vs. Participatory Action Research

In the literature review, I discussed participatory action research, but practical action research is also another type of process which is important to consider. Practical action research has less of a focus on engaging with stakeholders and empowerment. It is likely to be used to address a single problem and could almost be considered as a problem-solving process. Kagan et al. (2008) refer to the fact that practical action research could be considered as a means for developing reflective practice and link far more to learning outcomes for an individual. An example of a practical action research group could be a reflective supervision group used in clinical services to improve individual practice. These sort of groups are used widely across NHS services in the UK to support development (Knight, 2015)

Participatory action research is a process often used by researchers looking to develop stress interventions at an organisational level, where the focus is on a system change (Jordan et al., 2003). As referred to in the literature review, these are known as primary interventions and seek to change the pressures creating stress at an organisational level. Participatory action research has a long history in being used as a

method to enable management and employees to work collaboratively together to achieve change (Whyte, 1991).

Heaney, Israel, Schurman, Baker, House and Hugentobler (1993) conducted an evaluation of a participatory action research (PAR) approach to reducing work-based stress in a manufacturing plant with a union representing 1,100 people. They found that those people who had been highly involved with the PAR process were more involved in the decision-making processes within the manufacturing plants and felt that joint problem solving could be a constructive process. This suggests that PAR strategies enable participants to feel more engaged in problem-solving activities, and offers a process whereby meaningful outcomes can be achieved.

Interestingly, one of the PAR groups also illustrated an increase in co-worker support and a reduction in depressive symptoms. This result has been replicated by other researchers looking at the impact of PAR interventions, including a reduction in sickness absence (Bond and Bunce, 2001). This has implications therefore for any research process using action research. If PAR leads to more engagement and even a reduction in mental health symptoms, using this type of action research process is likely to have had important implications for my own research study. I would be able to both engage participants in their own problem solving, but also potentially help reduce mental health symptoms as the group progresses.

In summary, practical action research focuses more on problem solving and reflection, where individual development and learning are important outcomes. Participatory action research includes a wider set of criteria, looking to result in some

form of social change or development, where the outcomes can be seen across an organisational or systems level. Both types of action research are relevant for my study and I will reflect upon these aspects later.

A Brief Introduction to Constructivist Grounded Theory

Constructivist grounded theory is an offshoot of the original grounded theory method, more recently enhanced by Charmaz (2006). Constructivist grounded theory provides a method by which to analyse data, providing categories of meaning from data, but also a final product or theory around what is being researched. Grounded theory takes the philosophical stance that we can come to some universal understanding or theory about the world in which we live. Charmaz (2006) extends this idea to suggest that to some extent humans construct our own grounded theories, always influenced by our own experience, interactions and our research practices. I agree with Charmaz to some extent and recognise how my own view of the world shapes my daily life. Charmaz's (2006) summarises that constructivist ground theory offers the researcher an "interpretive portrayal of the studied world" (p. 10). Constructivist grounded theory therefore is based upon the same social constructed philosophical principles that action researcher holds. This sentiment I believe reflects accurately what the qualitative researcher is always struggling with, where their interpretation can be argued to be one of many possible socially constructed meanings.

Through a process of coding and memoing, the researcher is looking to achieve theoretical saturation, where however much more data was gathered, nothing further could be added to theory development. (For a worked example of the coding process, please see results section). After collecting appropriate data, Charmaz (2006) states

that the researcher begins to make analytical sense of any meaning or actions through coding. There are different options within coding, and the researcher needs to consider what will work most effectively for them. The researcher simultaneously makes memos, which helps to further code the data and pursue further lines of enquiry. Further coding is conducted until overall conceptual concepts emerge. These concepts can be linked using diagramming methods until an overall conceptual theory emerges through theoretical saturation. The important difference concerning constructivist grounded theory methodology, compared to other types of grounded theory, is that the researcher consistently reflects upon their own influence on the research process. The researcher also needs to consider final theory or category development in relation to the socially constructed influences and recognise how this may be one example of the portrayed world.

Criticisms of Constructivist Grounded Theory

Constructivist grounded theory could initially seem to conflict with the core principles of the original method. After all, grounded theorists look to develop a theory, which holds universal truth and objectivity. Charmaz's version identifies that the individual and society fundamentally influence theory development. Andrews (2012) argues that Charmaz is focusing more on the epistemological position of knowledge construction, rather than the ontological and this is where the seeming conflict comes from. Andrews suggests that Charmaz is not arguing that there cannot be an objective truth, or a universal theory, but more that researchers are naïve if they do not identify socially constructed influences.

Andrews (2012) also notes that Charmaz uses the words constructivist and constructionist interchangeably to describe constructivist grounded theory. This is potentially confusing, as both terms have slightly different meanings. Whilst both enable the researcher to understand objective reality through the lens of subjective influences, constructivism relates specifically to how the individual understands the world from their perspective, and constructionism focuses more on how society influences theory development. Throughout Charmaz's book she refers to both the individual influence on research and that of society's influence. When illustrating a theoretical framework on identity and disability, she mentions both the varying individual experience of the subject matter and their underlying social contexts. I have therefore incorporated Charmaz's version using a constructivist lens and have chosen to reflect upon how my own worldview and society have influenced the outcomes of this research.

Traditional grounded theorists view the world from a pure realist perspective, where there is an objective reality. In adopting this position, an emergent theory can arise which represents true meaning and can be applied to an entire population. The main criticism of Charmaz's approach is that if social constructivist grounded theorists take a relativist approach where many realities exist, how can the findings of any research be judged as essentially useful (Bury, 1986). To address this argument, Andrews (2012) points to the importance of how researchers using this form of analysis present their findings. Social constructivist grounded theorists essentially need to consider their findings in relation to individual and society influences and present a "convincing argument rather than arguing their results are definitive" (p 5). I interpret this to mean that a researcher using constructivist grounded theory is always open to

change, critique and enhancement of any theory presented, but still need to consider whether the resulting theory is plausible, focusing on constructivist and constructionist influences.

Epistemology of Action Research and Constructivist Grounded Theory

Both action research and constructivist grounded theory stem from the epistemological stance of the social constructionist (Dick, 2003). Here, as quoted earlier by Charmaz (2006), the researcher understands that the knowledge derived from these research processes offers one interpretation of the studied world. This interpretation is a form of objective reality, but never directly illustrates all the influences and insights occurring to form a fully objective picture (Willig, 2008). Both action research and constructivist grounded theory also offer the researcher the opportunity to develop an overall theory that relates to the group under consideration. Both processes involve going back and consulting with participants or gathering more data, with the aim of getting as close to objective reality as possible, finding out what there is to know, fulfilling the ontological stance. The action research process allows the researcher to gain knowledge that is also collaboratively derived. Constructivist grounded theory provides the researcher with a means of producing an overall theory, but which is interpreted through exploring constructed aspects around historical, cultural and linguistic influences.

Action research also identifies the researcher as something of an activist, committing themselves to research which challenges existing social practices (Brydon-Miller et al., 2003). Although I do not consider myself to be an activist in the purest sense of the word, I do recognise my need to enable change. This is reflected in my current

involvement with mental health campaigns such as *Time to Change*, directly involved with challenging how mental health issues are perceived at work. I also recognise the values I hold around research not being an inactive process. Ideally research should enable change for the participants themselves. Action research therefore offers the chance for me to engage my values within the research process and ensure I am more committed to the process itself.

Brydon-Miller et al. (2003) also explore the commonality between action researchers around a respect for all participants engaged in the process, a belief that change can be achieved through group consensus and an undeniable commitment to 'do' something. There is a sense here that action research seeks knowledge through the involvement of others and actually validating outcomes through trail and exploration. Throughout my psychological training I have always described myself as an activist in terms of Kolb's (1984) learning cycle, focused on the importance of action to achieve change and learn new processes. I have a strong belief that researchers have a duty to think more conclusively about the impact they have on participants and how research can actually result in change, rather than just a further exploration of knowledge. Action research therefore offers an approach which fits in with my world view around action-orientated behaviour achieving change and that qualitative research does not have to be a static and purely reflective process.

Using constructivist grounded theory in an action research process

Dick (2003) provides a helpful response to how taking a constructivist grounded theory approach to analysis can actually complement an action research process. Action research offers a framework for how to conduct research in a collaborative and

emergent way. However, it does not offer a clear process around how to define and analyse what has been found. Action research lacks instruction on how exactly a theory is developed. Dick (2003) suggests that constructivist grounded theory provides or at least improves the theory in action research. When used as a theory development process, constructivist grounded theory offers the researcher a clearer way of analysing data that can be fed back into action research processes, or used to analyse the resulting emergent data. Both action research and constructivist grounded theory are 'emergent', the research process is shaped through an iterative process, data is collected, reflected upon and changed or added until there is repetition or nothing more can be added. Constructivist grounded theory therefore complements an action research process and Dick (2003) considers that researchers could make more use of mixing the two processes.

In summary, action research was selected as the process by which data was collected to answer the question around '*how can people with long term mental health conditions remain and even thrive in their workplace?*' As action research does not offer a concise enough method for how the resulting data can be interpreted, constructivist grounded theory was used as the method for analysis. It is worth noting that although the action research process is likely to result in definable interventions which aim to answer the research question, a possible theoretical framework can also be derived by using constructivist grounded theory. Before describing the research design, it is helpful to understand how participants were recruited for this process and what inclusion criteria was considered to be important, given the nature of a more experimental research process.

Research Procedure

Participant Recruitment Strategy

Participants were recruited through [redacted], a partner willing to provide participants in a study looking more closely at how to improve working conditions for people with mental health issues. A sample email was drawn up and sent to interested participants who had approached Mind whilst waiting for their counselling services. If an individual was interested, a Mind administrator would contact me and I would conduct a short telephone interview to assess their suitability. Upon agreement, they would be included as part of the group and sent forms around consent and more about the study.

Having completed an initial short telephone recruitment interview and selected participants who met the criteria (outlined below), I was able to exclude people in a sensitive way. I initially started a first group with six participants who met the criteria with five people attending the first session. By the second session, only three people attended. Discussing this with Mind, I decided to re-run the group and ensure that participants were only passed on to me for interview if they were able to commit to identified dates. This pilot group was a useful process to engage in as it meant that I had a stricter inclusion policy.

Sample Size

The discussion around sample size is often a difficult topic for qualitative researchers. For quantitative researchers an adequate sample size determines whether a result can be considered statistically significant or not. Qualitative research usually takes a long time to complete and therefore often involves a small number of people. However, it

then throws into question whether these results can then be used to generalise about a population (Willig, 2008). Within the context of this research though, this issue may not be a problem. Constructivist grounded theory suggests that we make sense of the world as we see it. We derive theories to explain that world, which are always influenced by many different factors (Charmaz, 2006). What is important is that the data we gather represents some perception of the world as it is now, but we must take into account both the influences in and on the research process, including that role of the researcher.

With this in mind, Glaser (2002) points to the fact that 'all is data', and that we can make some generalisations about the data we collect because it represents a view of the world. Within this thesis, it is recognised that the time and resources available for the project were limited. Therefore it is important to state that it is expected that more could be found beyond what this research project identifies, but that what it identifies is helpful because it will illustrate an interpretive portrayal of the studied world as stated so succinctly by Charmaz (2006). The number of participants is not such an issue then within qualitative research founded upon socially constructed ideas. It was however recognised that enough people would need to be recruited to enable a rich discussion. I therefore aimed to recruit between 4 – 8 participants. I ended up running a pilot with six participants to start with, but this group has to be reformed due to a number of issues around attendance. The second group I ran included 4 participants who were fully committed to the process.

Inclusion criteria

Action research is a highly participative process and does involve a degree of exploration and managing uncertainty (Demarco & Willig, 2011). Therefore the participants needed to be comfortable with attending such a group in the first place. Participants needed to be in full or part-time employment and ideally working in a range of different environments. Experience of having a range of mental health issues was also important, along with being willing to be recorded and talk about their experiences within a confidential setting. They also needed to be able to test out interventions within their workplace and be aware of what might be possible under their employee contracts. For example, if the group recommended changing working hours, would this really be feasible for many to implement. Participants would also need to be able to keep confidential ground rules and ensure they were able to support one another. The experimental nature of the group was also highlighted and participants needed to bring along issues that they were genuinely struggling with.

Participants

Four female participants were recruited for the action research group as only women applied to take part, after the pilot recruitment process led to a stricter inclusion criteria around being able to attend specified dates (Appendices A – E outline documentation concerning recruitment). All participants were employed in different occupational settings at the time that this research was conducted and reported experiencing a range of long-term mental health conditions. The women who applied to take part in the group represented a broad age range and occupational backgrounds. Not all participants were from the UK, but all had worked in UK organisations for more than five years.

Research Documentation

A number of key documents were developed that were used within the action research process. These included an initial consent form and more information about the project, a debrief form and diary sheets used for reflection. The consent form outlined how the transcripts would be used and what to expect from the study. The debriefing information provided follow-up support numbers and ways of contacting myself and my supervisor. The diary sheets were based upon open, reflective questions to enable participants to reflect on interventions. These materials are included in the appendices A - E.

Research Design

The active research process took place over a period of three months. After the primary group of four people were selected, four dates were confirmed for group sessions, spread two weeks apart. The first session involved agreeing group ground rules and introducing one another. The conversation then moved into sharing experiences of mental health conditions at work and participants raised primary concerns around what they were struggling with at work. Having identified a number of issues, the group then spent time reflecting on what might help to manage those difficulties. This explorative and reflective process occurred across four group sessions.

Towards the end of the first session, participants were asked to reflect on and think of anything they could put into practice as a result of the discussion. At the beginning of the next session, the group reflected on any actions or reflections from the previous

session and considered any areas for change. In between group sessions, the participants were asked to keep a reflective diary and where possible put discussion points into action. In the final session, the overall process was reflected upon and learning considered. The group were then contacted six months later with the final outcomes and asked to consider if there was anything they might include.

As mentioned earlier, active research follows a loose structure around a learning cycle of analysing, planning, taking action and reviewing. This structure is applied within the group processes, but the literature does not always clearly define how this is implemented. Kagan et al. (2008) set out a set of criteria to consider which helped to make the process less vague and provide me with some further structure as the facilitator. This was used as the main template for how action research and constructivist grounded theory were assimilated into the research design and is considered below. The results sections outlines exactly what action was taken and further explores what is meant by taking action.

A focus on practical issues – the focus of this research is to find out what interventions work to manage long-term mental health conditions in the workplace. After recruiting an appropriate group of participants, I facilitated four ninety-minute sessions in which the focus was on developing practical interventions on issues that any member of the group could raise. Using a cycle of planning, taking action, evaluating and reflecting, interventions were discussed and developed within a group process, using Socratic questioning.

Reflection on ones own practices – this cycle was used across four group sessions, in which participants had an opportunity to test out interventions in between sessions. They were also asked to reflect upon their experiences. At the same time, I also kept a diary note of what was happening, to further inform the later stages of analysis.

Collaboration between researcher and participants – in order to develop a cohesive working group, we collaboratively set ground rules within the first session about how the group would function. We also agreed to share email addresses so support could be gained across the process. The sessions themselves involved participants raising lines of inquiry and the group and myself facilitating and discussing possible interventions and ideas. The group then agreed to test out what they wanted to and reflect upon the outcomes within the next group.

A dynamic process of spiralling back and forth among reflection – this was critical in terms of challenging one another on what might be effective within working situations; I bought in time for the group to reflect at the beginning and end of session, but also encouraged participants to keep reflective diaries, which might provide further analysis

Data collection and action – after each group session, I fed the main discussion topics back into the group through emails, the group then had an opportunity to test out any discussed interventions between sessions; the structure of subsequent sessions then involved discussing interventions or reflections and adjusting appropriate interventions; each session provided the opportunity to bring in new thinking; apart from ensuring time for reflection and summing up, the sessions were largely

unstructured, with myself playing a questioning and facilitative role around the main research question

A development of a plan of action to respond to a practical issue – this research followed a two stage process of developing proposed key interventions and then asking participants to test them out; I worked with participants in a collaborative way to identify, discuss and refine proposed interventions; the four sessions were structured so that the initial session set ground rules and discussed what people might be struggling with, the middle sessions involved discussing and testing out interventions and the final session involved summarising and reflecting on those interventions and any further thoughts

Sharing of findings with all relevant stakeholders – the final stage involved asking the participants to individually reflect upon the final analysis. The final analysis was conducted using constructivist grounded theory and produced into an overall theory and set of interventions, made useful to both employers and employees. The participants were asked to reflect upon the final product and suggest any amendments or inclusions. It is my intention to further develop this into a useful guide that employers and employees will be able to use.

The whole process was explorative and centred around change. Action research therefore offered a process by which I could collect relevant data, providing four transcripts for analysis. As mentioned, this process itself produced interventions that partially answered the research question. However, the process alone did not provide the means for explicitly analysing the transcripts and ultimately producing an

overarching 'theory' which answers the research question *how can people with long term mental health conditions remain and even thrive in their workplace?* I therefore analysed the transcripts using constructivist grounded theory to provide a possible theoretical framework for understanding how people with long-term mental health conditions can improve their working lives, along with practical interventions relating to that theory.

Analytical Strategy

After each session I pulled out the main themes from the group discussion and then reintroduced any topics in the next session for reflection and changes if required. I was aiming for theoretical saturation, and action research enabled me to develop the beginnings of an emerging theory. After each session I emailed the group what I reflected to be the main conclusions from the group, shared these and asked participants to reflect or test out interventions. By the final session, I had the beginning of an emergent theory (or actually a model, this will be discussed later) around appropriate interventions or ideas. In order to achieve full saturation, I then used constructivist grounded theory to analyse the transcripts to 'flesh out' this emerging theory.

Within action research literature it has been difficult to outline exactly how a theory emerges. Constructivst grounded theory on the other hand, gives a defined way of developing theory, and was therefore used in the research project 'as a theory development process, within an action research cycle' (p 6) (Dick, 2003). It is also unclear in the action research literature when group processes should cease.

Constructivist grounded theory provides the researcher with a natural stopping point, when they feel they have reached theoretical saturation.

After collecting appropriate data, Charmaz (2006) states that the researcher begins to make analytical sense of any meaning or actions. The real process of analysing the data then began after the final session, with coding. There are different options within coding, but I started by using the first transcript and sorted my data into certain codes. I then made notes called memos around this data, which helped to code the data and pursue further lines of analysis. These became more analytical until overall conceptual categories emerged. This involved me using two of the session transcripts. I then used the last two transcripts to obtain further information to saturate my categories as far as possible or consider new ones. Using the memos, I explored relationships between the categories. Using diagramming, I then went back to the original research question and aimed to develop an overall conceptual model with practical interventions, which attempted to answer this and can be seen in the results section. The difficulties with the process around considering what to include in the final analysis will be discussed in the next section, along with further detail about the process itself (and a worked example can be seen as in the results section). My final stage to ensure theoretical saturation was to return to the original participants and ask whether anything further could be added. I will reflect further upon all these processes within the results section, as reflection is such a key part of this process.

The Literature Review in Constructivist Grounded Theory

Having discussed the process I used to identify a model around how to manage long-term mental health conditions more effectively in work, there are a few points about

using any type of grounded theory process that need to be mentioned. Firstly, consideration needs to be given to when to conduct the literature review in a grounded theory process. The original proponents of grounded theory suggest that the literature review be conducted after the analysis and subsequent theory generation so that the new theory remains fresh and original (Glaser & Strauss, 19867). It is then that the researcher should look into previous research, in order to compare the theory generated and consider how it compliments or contests other theory development. There are several difficulties with adopting this position in the reality of writing a research thesis. Firstly, this position assumes that the researcher will not have any prior knowledge related to the research topic of their choice. Secondly, it infers that the researcher has not had to put in a previous research proposal, reviewing literature to understand and argue the importance of taking their research forward.

As an Occupational Psychologist, I have pre-conceived knowledge about the area of mental health in work. I also had to submit a comprehensive research proposal, making a case for why this research would be important and what theoretical gap in psychological knowledge it maybe trying to influence. I therefore could not claim that the proposal literature review and my previous knowledge would not influence the research process. Charmaz (2006) is realistic about the demands of research processes, but suggests leaving deeper explorations of the research literature "fallow, until you have developed your categories and the analytical relationship between them" (p. 166).

Given the timescale of this project though, I needed to begin to write my thesis and could only really start with the literature review. I therefore started this more

comprehensive review towards the end of the action research process. The literature review for this thesis is more comprehensive than the one conducted for the proposal, but did not offer any greater insights that I had not already established from my training in Occupational Psychology or from the previous proposal literature review. I would say that it made me more aware around the issue of disclosure though and pushed me towards exploring what interventions might be possible for those who do not disclose. I do not consider this to be a negative within this research project, but actually helped to structure the research question towards a group previously largely unconsidered by researchers interested in retention.

I see the literature review as a means of setting the scene for the subsequent research and beginning to tell the story of why this research is important and what it might be aiming to find. I also think the literature review ensures that the researcher is not ignorantly embarking on a line of discovery that has already been heavily considered and commented on. Although I view knowledge as partially being socially constructed and therefore any study adds to different perceptions of the studied world, it would seem unhelpful to pursue another research project into a well-researched topic. The literature review therefore did influence how the subsequent constructivist grounded theory was developed, in the sense that I think it helped to confirm the gap in the research literature and an identified area for theory development.

Trustworthiness in Qualitative Data

Shenton (2004) describes the importance of a qualitative researcher paying attention to the trustworthiness of their data and refers to four criteria, which need to be considered within a qualitative research process to respond to criticisms of post-

positivist approaches. The first construct is credibility, likened to internal validity within quantitative research. Credibility is viewed as the researcher attempting to demonstrate that a true picture of what is being researched is actually being presented. The second construct is transferability, likened to external validity. This largely refers to whether the findings can be replicated to other situations similar to the one in which the researcher is investigating. The final two refer to dependability (or reliability) and conformability (or objectivity). This refers to whether results can be replicated by another researcher and equally not informed from their own predispositions.

The first two criteria are more easily explored and accounted for within the action research process. I deliberately tried to select participants from different working environments, with different mental health issues to gain as much of a broad picture as possible. This provides credibility to the research process, as does the continual reflection within the group. If a topic was unclear, or not fully explored, I ensured that I would keep the conversation open until the participants felt they had fully explored the topic. Credibility also comes from attempting to try interventions within the work-place to see if they worked. I tried to focus on interventions and reflections where participants struggled with similar difficulties at work, seeking to meet transferability. Although I cannot confirm that all participants would experience similar difficulties, there was consensus from participants around what shared issues were and what appropriate interventions might have been obtained, suggesting transferability. I also recognise though that a larger sample group would give more credibility to this process and be able to generalise the results to a wider population, even in a socially constructed research project.

The last two criteria pose questions related back to philosophical debates. As both processes stem from a social constructionist position, the question of replication and the researcher influencing the outcomes of the process may not be an issue. Social constructionism recognises that the researcher automatically influences the research process. Whilst the process should be able to be replicated by any other researcher, there might be differences in outcomes due to socially constructed influences. In order to try to ensure greater dependability and conformability though, Charmaz (2006) provides a helpful checklist of what entails rich and sufficient data. These questions include:

- Have I collected enough background data about the persons, processes and settings to have ready recall and to understand and portray the full range of contexts of the study?
- Have I gained detailed descriptions of a range of participants' views and actions?
- Does the data reveal what lies beneath the surface?
- Are the data sufficient to reveal changes over time?
- Have I gained multiple views of the participants range of actions?
- Have I gathered data that enable me to develop analytical categories?
- What kinds of comparisons can I make between data? How do these comparisons generate and inform my ideas?

I ensured that I considered these questions before each group session and afterwards, so I could adjust my focus for the next session if these questions were not sufficiently

answered, although obviously I only had a limited influence on this. I will reflect about the limits of this process further in the following sections.

The role of the Action Researcher and reflection

I will reflect about action research as a process and constructivist grounded theory more within the results section. However, it might be important here to think more about the role of participants and the facilitator in the action research process, as it is different from many other research processes. From the beginning, I tried to think of myself as part of the research process and be in part a participatory role, which action researchers suggest is so important (Reason & Bradbury, 2001). I therefore was almost one of the participants myself to some extent, but recognise that I also had a role in facilitating the group and do not suffer from a serious mental health problem. The action researcher may find these two roles conflicting and I think it is important to highlight your own role as participant and facilitator to groups. I also recognise the experimental nature of this research and how I had to manage my own and others anxiety. Demarco and Willig (2011) mention this as managing uncertainty, even a sense of 'vagueness', and yet coming to some form of group clarity and emerging outcomes. It is clear that this type of research also involves facilitating strong relationships throughout the process. By applying the skills I have developed as a Counselling Psychologist, such as empathy and active listening skills, I was able to achieve this. I think we built strong rapport within the group, which helped to reinforce the collaborative nature of this research process.

Before embarking on action research, a careful reflection upon skills relating to facilitating, acceptance around uncertainty and existing between two roles might be

important to consider. I have spent the past few years of my career facilitating groups and action learning sets and therefore felt I have developed skills required for this role. Learning how to run action-learning sets has also enabled me to facilitate dialogues, and be more aware about not leading them, which was important in this type of research. I have also had to manage great anxiety and uncertainty working with public sector clients, who often had to operate without knowing whether they had a job or not. My own tolerance for uncertainty is reasonably high, especially working as a freelancer. My ability to manage relationships is also relatively strong and has been highlighted as a core strength for me in work appraisals. I therefore felt I had the necessary skill set to embark upon a more emergent research process.

Ethics

I used the Division of Counselling Psychology's own professional guidelines to inform my research, which helped to ensure that both the participants and myself were protected in terms of this research process. These guidelines were used to inform the consent and debriefing documents that are included in the appendices.

The DoCP's Professional Practice Guidelines (p. 6) outline the role of a practitioner as researcher, stating that:

- It is expected that there will be congruence between the model of research chosen and the values expressed in counselling psychology. Research will be designed and conducted in the spirit of the ways of working emphasised in counselling psychology.

- The individual's right to full information about the nature and value of research will be respected. Participants must be able to give free, informed consent and to withdraw or withhold data without prejudice to their care.

- When personally sensitive information is disclosed, the practitioner has a responsibility to ensure that the support and aftercare be made available to the participants. Similarly, debriefing and support should be provided for all participants when the research topic is of a potentially distressing nature.

- Practitioners have a responsibility to make their research available to other professionals and the wider world.

When discussing congruence, the guidelines discuss the importance of clear contracting, confidentiality, personal and professional strength and fitness to practice, continuing to use appropriate supervision and training where appropriate. By using an action research model and providing clear contracts with participants around what was involved with the process, I was able to ensure these elements and able to use a collaborative model of research, in line with my own ways of conducting therapeutic work. The guidelines also helped determine which interventions could be explored, ensuring the well-being of participants was my main priority, as defined by the ethical guidelines working as a Counselling Psychologist.

To ensure the elements around confidentiality, the results and report from any stage of the process were kept confidentially (as described by the BPS) and participants informed throughout the process about how their data was used. Participants also had to fully consent to the process and be willing and able to try out appropriate interventions. Any interventions therefore had to be reasonable in terms of application and not provide any conflict within participants' work places. I also ensured that we tried not to use surnames or organisations and if these were named, remove them from the transcripts.

The guidelines also influenced the way I recruited participants, ensuring they did not work for the same organisation in the first informal recruitment interview. I also felt it important to exclude participants who were suffering from too severe mental illness where working was just not a viable option at present. Severity of mental illness is difficult to define, but ultimately where there is not enough psychological flexibility to be able to carry out basic psychological interventions and report back on them. I ensured that any participants deemed not suitable were offered alternative help through Mind and made sure this was a priority before ending contact with them.

When recruiting, I tried to ensure that participants understood it was a research process, which they needed to commit to. Following the failure in attendance of the first group, I ensured I selected participants who would definitely commit to the process and be able to attend all four sessions. I also had to manage a few of the participants left from the first group who had attended. I ensured they were invited to join the next group or could talk to me in between to discuss options, whilst also ensuring they had access to other courses or groups through Mind where possible.

With both groups, I tried to ensure participants were also made aware that it was foremost a research group, and not there to replace individual therapy.

Group confidentiality and ground rules were important to establish from the beginning of the sessions, so that each individual felt they were listened to and had equal chances for input. A group contract also protected myself and established the role I played in the research. As this was a less directive research process than others, it was helpful to establish what influence and expectations the group had of myself, and each other and recognise the time limitations involved in the process. Our last session and reflective log were there for debriefing purposes and the group provided a support network for each other in between sessions. Participants have also been able to access employment or mindfulness training with Mind, which ensures there is some continuation of support beyond the group ending.

In this section I have discussed how I conducted the action research process and used constructivist grounded theory to analyse the results. I have discussed the importance of reflecting upon my own view of the world and the importance of ethics in conducting research according to the professional standards of the researcher. The next section not only outlines the findings from the analysis, but also considers my reflections on actually conducting the action research process and any possible areas for change and the actual outcome of the grounded theory process.

Results

In this section I have outlined the interventions derived collaboratively within the research group and then presented the main findings from the constructivist grounded theory analysis. The analysis is presented as an overarching model with core categories developed which connect with one another. Included in the presentation of categories are also examples of conceptual memos to present the categories in a richer context. A worked example is provided shortly of using constructivist grounded theory. The overarching model is also presented in later in this section and will be referred to throughout.

I firstly though want to reflect upon my experience and use of action research as a process. In the method section, I referred to the fact that I believe research should not be an inactive process. Action research offers practitioners a framework for conducting research in which "transformation can take place…for the achievement of positive social change to put our psychology to work in support of our values" (Brydon-Miller, 1997, p. 657). Hefferon and Gil-Rodriguez (2011) review how the use of interpretative phenomenological analysis (IPA) has become the default analysis option for many students of psychology. They suggest that this is because focusing on lived experience naturally appeals to Counselling Psychologists and that IPA is perceived as a way of conducting a thematic analysis where the focus is on interpretation.

The wide spread use of IPA therefore offers the researcher a way of contributing to our outstanding of the world, but not how to actively change it. Demarco and Willig (2011) highlight this exact same point, where Demarco herself started an action

research process due to feeling she had not directly contributed to enhancing participants situations from a previous project. As Counselling Psychologists we are trained to work with clients to enable positive change in their lives. Action research therefore offers an exciting alternative for Counselling Psychologists as researchers and could enhance furthering social change and results.

I also wanted to reflect upon the process as Kagan et al. (2008) highlight how the action researcher needs to engage in a continuous process of reflection. Reflexivity also plays a significant role in the use of constructivist grounded theory and Charmaz (2006) suggests that the researcher needs to actively review how they conducted their research and how they related to and represented their participants during the research process and write-up, which I have considered in the discussion. I have chosen to reflect upon the process of action research under headings identified by Kagan et al.'s (2008) model of action research used for this research project and Demarco's (2011) reflection of significant processes. It is also worth noting how I have commentated on what I experienced within this section, not yet about the implications for future researchers. I shall comment on implications about all these points within the discussion.

Overview of the Action Research Process

What action research process was I following?

The research aim of this study is to look at what interventions could be developed for people with long-term mental health conditions in work in order to improve retention and work experience. Reason and Bradbury (2001) identify that the purpose of action

research is to ultimately produce practical knowledge and outcomes that are useful to people in their everyday lives and therefore action research seemed an appropriated process in which to gather data and achieve results for participants themselves. Upon deciding that this was the correct process, I then had to determine how to do it.

As mentioned in the methodology, Kagan et al. (2008) identify two types of action research: practical and participatory. Practical action research appears to be more focused on solving immediate issues identified by a group and working collaboratively to solve those issues. Participatory action research is more focused on changing practices at a society level and collaborative action resulting in social change and has been used widely in stress management interventions as referred to earlier.

Kagan et al. (2008) note that there are many examples of participatory and practical action research merging, but both are based upon a clear number of principles. Both processes are values based, follow cyclical processes, context bound, combine theory and action and are concerned with change. When I reflect back on the type of action research I conducted, I think that I was unclear as to what type I was actually using. By aiming to develop practical interventions for the participants involved, but also wanting to develop an overaching theory for application at a society level, I feel that I was in constant contention between discussing wider social issues with the group and individual interventions around personal concerns, rather than predominantly focusing on one.

Having said this though, there were benefits to merging these two approaches, by both enabling problem solving and participants having an equal stake in developing interventions. The group were engaged and offered up advice and support to one another. As explored later in this section, several participants were encouraged to seek change at an organisational level. Participants also commentated on the positive psychological support the group provided and with one another. As previous research has indicated, an increase in social support and a reduction in mental health symptoms is likely when participants are considered as key stakeholders and driving their own outcomes. This study therefore further advocates participants suggesting and sharing interventions as the implications are that there will be additional benefits to the process.

How do you conduct action research?

When reviewing how to conduct action research, I discovered that researchers were often vague about how to conduct it. Demarco (2011) in her reflective account about conducting action research both highlights how this uncertainty about the process is both challenging, but important to the process. The role of the action researcher is not to be the 'expert', but rather be part of the process themselves and the group together will form clarity and direction in where to take action. Demarco (2011) sees this is the "shifting of the locus of control" (p34) and in many ways compares the role of the action researcher to role in which the Counselling Psychologist inhabits during therapy.

As Kagan et al. (2008) point out, action research is cyclical, the end point is never known and projects may include one part of the cycle, a part cycle or any number of

full cycles. I used their version of action research in which I took the headings of planning, taking action, evaluating and reflecting as the key stages involved in the process. It was my intention to progress through these key stages within each session, but I found myself often getting stuck at analysing or planning with participants. I think this reflected the tension I experienced between balancing the sessions around practical outcomes for individuals within the group and openly discussing societal issues around changing the context for people with mental health issues. Reassuringly though, many action researchers comment on how emergent action research is and "it can be difficult to approach action research in a conventional way" (Kagan et al., 2008, p11)

Stages of the Action Research Process

Planning

Within the planning phase is the idea of developing a plan of action or an agreement around what to test out. Although this discussion produced rich data in the transcripts for analysis, as a group we spent a lot of time across sessions exploring topics, without always coming to some identifiable interventions. I was constantly aware of my own need to come to solid interventions quickly and I underestimated the time that the group needed to get to know one another, trust one another and share experiences. Kagan et al. (2008) mention that it cannot be predicted how long each stage will take and reflects that participants and the facilitator as 'co-researchers' come with different stories and backgrounds and therefore it will take time to explore these aspects.

Demarco (2011) reflects upon experiencing a similar process occurring within her study around *collaboration and ownership*. She remarks how she had to continually wait for co-researchers to take action and questioned whether ownership became forced ownership. This question occurred to me to when I sent a follow up email after sessions identifying what I thought the main discussion points and interventions were that we had considered. However, Demarco mentions how she was "resourceful when they needed ideas and knowledge…being almost invisible but highly supportive when they decided to take action" (p. 36). Providing a summary of the sessions from my perspective did not force any of them to act or try out interventions, but acted as a further resource for knowledge they could turn to.

Taking Action

A question for me throughout this process was what constituted *taking action?* When the group visibly supported one another during a difficult discussion living with mental health conditions, did that count as taking action? When I sent an email after each session directly to the group with helpful resources, was that taking action? When the group became more aware about psychological conditions through sharing, did that count as taking action? I struggled with this question throughout the entire process, especially when considering what to identify as an intervention. Entering this process, I conceived a psychological intervention or taking action as a practical application of either a theoretical concept such as building social support or a practical application of more concrete conditions such as working hours. I also conceived the idea that individuals could implement interventions irrespective of the workplace or disclosing.

As the sessions progressed though, I saw that taking action could include more theoretical or abstract change, and that disclosing and including others might be more important to achieving positive change than I first realised. When reading more about participatory action research it seemed that theory development which can influence change processes is a type of action. Kagan et al. (2008) discuss how learning is a central process to action research and I began to consider that our conversations around what could be changed at a society level and what had previously made a difference to the group could also be considered as taking action.

Earlier I referred to the fact that I see myself as an activist in terms of Kolb's learning cycle (1984). I think it is also important to reflect here upon Kolb's influence on my own study and consider whether action learning was taking place over taking action. Kolb's action learning cycle is different to action research, although they share similar principles. The main difference is that the primary aim of the process is to undertake learning through the process of reflection in a group setting (McGill & Beaty, 2002). It could be that more action learning was taking place within the group, rather than taking action to promote change. However, some participants did initiate more concrete changes within their workplace so it is my understanding that action and learning were taking place in the same process.

I also recognised that by attending the group and supporting one another, participants were taking action. I think this was an important concept for me to fully recognise as I had underestimated how important group support and cohesion was in the action research process. I also recognised that I was trying to find actions, which had resulted in a concrete and definable result. By doing this, I was potentially excluding

important theoretical or more abstract concepts that the group discussed which could result in change for individuals working lives. I agree with Demarco's (2011) idea that taking action should signify 'a movement towards change' (p. 37), but I know recognise that this can be theory development and learning within a group, and I will reflect more later around how this concept may influence future researchers.

Evaluating

Within each session, I ensured we spent time evaluating both interventions that had been tested out and previous interventions that had worked for other participants. Participants considered an intervention to have worked either by a practical outcome or by how they now saw the issue. For example, several participants had direct conversations with their line managers and saw a shift in how they were being helped and managed. Others reflected upon the nature of their work and whether it was something they wanted to do with their lives. This reflection was not a direct practical outcome like the first, but participants could begin the process of assessing what might be meaningful and important for them. Demarco (2011) talks about how when the action research process is over, participants are still fuelled by change and thought. One participant contacted me after the group finished and asked for advice about changing jobs vocationally, so there maybe delayed interventions beyond the action research process.

As mentioned in the method section, I felt I had the necessary skills and experience to manage the uncertainty of the situation, but also to facilitate the group. Reflecting back, I used all my key counselling skills in facilitating the group and the group

responded well by developing a cohesive and supportive team. When I listened back to the recorded sessions though, I found myself providing what sometimes sounded like the role of the expert and occasionally directing reflecting and evaluating towards key concepts that I had been thinking about or inhabiting the role of therapist. Despite Demarco's (2011) reflection around having to adopt many different roles in the process providing me with some reassurance, I found a lack of guidance around how to balance the emotional needs of participants with the research question I was trying to answer.

Reflection

Participants were strong at reflecting in session about what made the difference to them in terms of managing their mental health. I saw my role as engaging all my therapeutic skills to enable a space in which open exploration could be achieved. I think this was one of my particular strengths and Demarco notes how using open questioning and listening with true empathy enabled participants to openly question one another and come up with original ideas. I too was able to achieve this and participants asked open questions of one another and reflected without feeling reserved or unable to question each other.

I think the difficulty that presented itself for me in these sessions was ensuring participants continued to reflect between sessions. As the sessions progressed participants had not completed their logs despite their commitment to the group and the process. Also, when I asked for final comments on the proposed theory presented as a diagram, most commentated that they thought it really looked good but had nothing to add. I increasingly found it difficult to keep asking for their reflective

diaries and in my experience, unless participants capture reflections straight away, their thoughts are not retained. Reflection being such a key part of the action research process, I felt as if this was an area which may have contributed to interventions remaining more theoretical and a rich source of further data not being included in the final theoretical framework. I will further reflect on all these implications in the discussion section.

Interventions discussed within the Action Research Process

As mentioned, psychological interventions can cover a broad range of areas for consideration. Interventions that have been included here cover both theoretical and more practical aspects. I do recognise that some of these concepts need validating and testing out in the real world to understand their full impact.

Within the first group session, participants raised the problems of managing emotions at work and negotiating the line-management relationship. These two concepts were common, fundamental themes for all participants. Participants also raised the idea of gaining and wanting clear feedback in work, the importance of understanding your own mental health problem and understanding your own warning signs. There was a consensus within the group around the poor knowledge that they had around rights at work and how complex the issue is around disclosure. They also discussed the role of the organisation in educating individuals about mental health. Participants shared how their mental health problems impact them, and there were common themes around issues of focus, emotional fatigue, poor concentration and low energy levels. In my follow-up email to the group, I alerted them to WRAP (wellbeing recovery actions

plans) plans, a Mind guide on employee rights, a document on effective conversations with line managers and what effective feedback should look like.

Meeting for the second session, participants commentated on how they had found the first session useful and had implemented some ideas. Some participants had put into practice being more assertive with colleagues and line managers and also trying to establish clearer feedback mechanisms. The group had also become a clear source of support for one another and evidently acted as a functional intervention in itself. The group independently contacted each other before the next session and suggested doing something creative together and also shared some important employment resources. A rich conversation continued around values in work, but also about managing absences from work and how communication mechanisms needed to be agreed on when off sick. In my follow up email I mentioned using colleagues as a further source of feedback, finding value in the work you do and reminded the group about helpful coping mechanisms that we had discussed such as taking regular breaks at work, spending time with others, developing a coping card, having something to look forward to, developing a routine, building a more compassionate mind and further resources on mindfulness.

Session three continued to provide a supportive environment for the group reflecting on interventions. Some participants reflected how they continued to benefit from being more assertive with their line managers and has gone on to educate their workplaces about their rights. The conversation around values at work continued and several participants explored their options around developing more creativity in their lives. I found myself providing a lot of psycho-education around anxiety and panic in

this session and considered this to further the intervention around improving their psychological knowledge. The main topics explored within this session also included how line managers need better training and general access to resources and more around developing mindfulness. I directed participants to further self-help websites and information on resources around panic and anxiety.

For the last group session participants reflected how much the group had supported them and been a place for understanding more about their conditions. Participants had been more assertive at work asking for the support they needed and wanted to establish similar groups in their place of work. Within this last session, participants also reflected largely on issues around disclosure, and agreed it seemed that this was the best way to get needs met and ask for reasonable adjustments. Many of them recognised the importance of creativity and value in work for them and agreed to continue to support each other beyond the end of the group. Several participants also continued to consider if they needed to change their current roles for a career that offered them more motivation and opportunities for creativity.

These interventions have been expanded upon and related to key categories later within this section, which can be viewed diagrammatically further below and in the appendices.

Constructivist Grounded Theory Analysis

I briefly touched upon how the analysis was conducted within the method section, but now want to reflect upon conducting grounded theory in practice. The process of

developing a constructivist grounded theory had begun after the first session. I was able to start developing the beginnings of an emerging theory, writing memos to myself around emerging codes. Using my initial reflections from these sessions and the first two transcripts, I was then able to begin the process of analysis. Charmaz (2006) outlines the first stage of coding in which the researcher begins to make analytical sense of the data. Various options are presented to the researcher in how this coding process occurs and Sbaraini and colleagues (2011) provide a clear example of how I decided to code the data for this thesis.

Charmaz (2006) states that coding is where the researcher attempts to look at the data and make sense of the actions within the data. Reviewing the transcripts I considered what the data was suggesting and noted the main active messages from the data. Initial coding can be conducted word-by-word, line-by-line or incident-by-incident. As there were many lines of transcription to go through, I decided to use incident-by-incident and considered an incident as a new contribution from a different member of the group. This process also helped me to quickly identify emerging categories and concepts.

During this process of initial coding, I continued to write the memos that I had started during the action research process. Memos help to make sense of the data and are an important part of the research process, helping to capture thoughts and crystallise connections between data. Sbaraini et al (2011) describes this process as developing conceptual memos. I noted what I considered to be the meaning of codes and mentioned connections and considered further lines of inquiry. Completing this process for the first two transcripts, I then began to develop focused codes. Focused

coding is the second major step in the coding process and defines codes that are more selective and conceptual. Charmaz (2006) states that focused coding involves using the most frequent earlier codes to sift through large amounts of data. Here a choice was made around which initial codes I considered to make the most sense of the data presented. I have included an example below of this coding process.

Table 1. Example of coding and using memos

Raw Data – Transcript Session 1 (October 2013)	Initial Coding	Memos	**Focused Coding**
R4: No, they were very supportive but I thought they were being intrusive because they wanted me to sort of phone up every week and check in with them and that would just cause more anxiety and I wouldn't want to call in, and my manager would ask, I felt just a bit intrusive questions. You know, 'What have you been doing?' You know, it's just like, 'Go away. Stop asking me these questions.' You know, it got to the point where I just answered 'Yes,' and she'd start talking about work and I'd just hold the phone away and I was like, 'I'm not listening to this. I'm not doing it.' And yeah, when I went back into work, it was kind of, "Okay, we want you to settle in slowly" but it wasn't managed like that. It was kind of, "Okay, off you go." So yeah. **I: I think I'm just going to shut the door actually, because I think somebody... but I think you're not alone in that at all.** R4: "Hey, welcome back! Off you go" *[laughter]* R1: Mine was quite different though because my boss has had two periods of being off with depression and both were three	Managing working relationships when taking time off work for poor mental health; feeling that managers are being intrusive; saying would settle in slowly, but actually expected to carry on as before; talking about pressures at work Different experience between manager who had depression themselves, encouraged to take time off	<u>Managing returning to work/Line management relationship</u> It appears there is an important point for employers around being explicit around how people should be contacted when they are off sick and also about people returning to work and ensuring this is phased in slowly	**Line management relationship** – clear processes in place for when people are off sick; speaking to individual around contracting what person can do; phased return; agreed method of communication when off

months off, and I wasn't planning to go off with depression at all and she really shoved me out of the door.			

Developing focused codes from the first two transcripts, I was then able to use the third and fourth transcripts to compare the data further and develop and enhance the focused codes. As Charmaz (2006) reminds the researcher, coding is an emergent process and codes are shaped and developed by how the researcher interprets the data. I was able to quickly code the last two transcripts and obtained enhanced focused codes, which accounted for more of the data presented, using the constant comparative method. I also continued to add to existing memos throughout to further enhance and develop my understanding of how codes might relate to one another. Sbaraini et al. (2011) suggests focusing on gerunds, which emphasise actions and process to initially code data. A code became a 'focused code' when it became central to improving mental health conditions in the workplace and contributed to making sense of the data.

The final phase of coding involved theoretical coding. Charmaz (2006) describes this process as specifying possible relationships between categories developed from focused codes. In understanding more how theoretical codes differentiate from focused codes, Sbaraini et al. (2011) describes the process as refining the final categories (derived from focused codes) and relating them to one another. In their study, they produced focused codes and then conducted theoretical coding after they had conducted theoretical sampling. Charmaz (2006) describes this process as wanting to further enhance categories, which seem theoretically slim. Due to the time

constraints of this project, I used the final two transcripts to flesh out my focused codes leading to emerging categories.

I took the focused codes that had emerged from the data and considered relationships between them and how they might merge or define themselves as separate categories. Using my memos to inform this process, clear categories emerged, relating to one another, explaining nearly all of the data in the transcripts. I went back to the initial codes and checked that the categories accounted for the all the data emerging relevant to the research area. In order to fully develop my categories and emerging theory, I used a visual diagram to help sort my data. Clarke (2003) considers this a vital part of developing emerging theories in grounded theory and helped to identify related categories more clearly. This visual representation of categories within related concepts can be seen in Figure 2. and I have made this into an on-line interactive display, which can be easily added to or altered. Using a diagram also meant I could also include specific interventions, which had been tested or proposed across the action research process.

Charmaz (2006) considers that the analysis process is complete when theoretical saturation has occurred. This seems to be when all the categories account for the data presented and when no further theoretical 'sparks' are triggered gathering new data. Categories remain robust when they appear as abstract concepts, but still clearly can be identified from the data (Charmaz, 2006). I would argue that theoretical saturation is difficult to achieve both theoretically and in practice. Charmaz (2006) recognises that the researcher is always constructing their own specific grounded theory. It is therefore possible that one researcher's definition of theoretical saturation may differ

to another's interpretation. I stopped when I felt I had achieved theoretical saturation in terms of the data I had gathered for this project, but also want to mention the time restraints of this process. In order to achieve further theoretical saturation, I presented the emergent model in diagram form to the original participants for their input and reflected their responses back into the final emergent model. Participants thought that it was comprehensive and had nothing further to add.

Linking Theoretical Categories

The original research aim and question of this thesis was to understand how can people with long-term mental health conditions remain and even thrive in their workplace. I also wanted to understand and collaborate with those people experiencing mental health problems in work around what psychological interventions individuals and Counselling Psychologists could use to help achieve this, either within therapy or through self-help resources. Action research enabled participants to consider a number of key concepts and subsequent interventions, which they thought would help manage their conditions in the workplace. These interventions were discussed either in what had worked retrospectively, were tested in between sessions or discussed in a more theoretical way. The results are presented under emergent categories with an exploration around how these translate to interventions that could be employed.

Willig (2008) defines categories as the grouping together of instances that share central features or characteristics with one another. Categories emerge as analytic and interpret the data rather than just describe it. Ten categories emerged from the action research process and it became apparent that interventions were linked through a

close relationship between the individual and the organisation. In the diagram presented shortly, which illustrates the overall conceptual model, there are three areas of categories, which overlap with one another to illustrate this close relationship. A more detailed presentation of the model can be viewed in the appendices.

Visual Representation of Model

The large circle in the model presented as Figure 2. represents the person and the area outside of this, the organisation. Outside of the large circle are two small circles, which represent categories that are specific to the organisation, the *Working Environment* and *Wellbeing Culture*. These categories are considered to be areas for which an organisation is primarily responsible. Categories that overlap between the inner and outer circle represent interventions and form part of the model that both the organisation and individual need to work together to implement and include *Disclosure, Being Informed, Mental Health Support Group and the Line Management Relationship.*

The inner circle represents part of the model that individuals are primarily responsible for, *Self-awareness, Values in Work, Observable Mind and Active Body and Work-life Balance*. Under the categories I have also attempted to add key interventions discussed within the groups, although some of these interventions would need further evaluation, as some remain theoretical and not acted upon. I have chosen to overlap the categories to illustrate that there is a connection between all of them. There is no specific reason as to why categories have been placed where they are in relation to one another, other than to signify their place in relation to the categories of the person and the organisation. A detailed version of this can be viewed in the appendices.

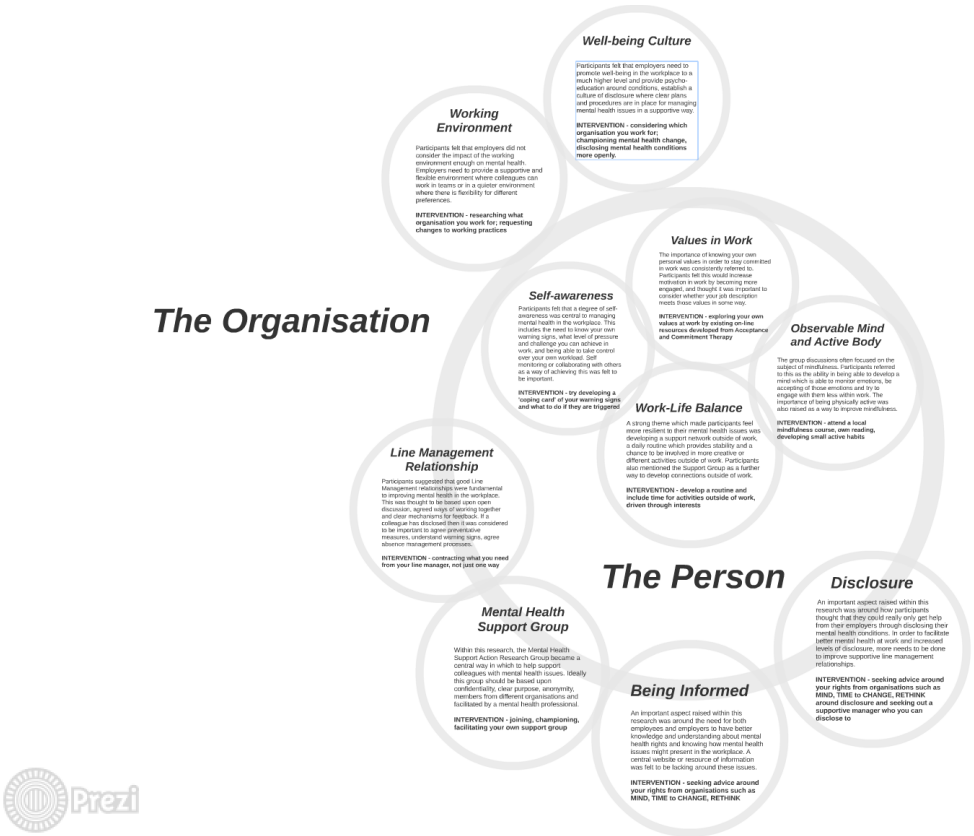


Figure 2) Visual Presentation of a Model of Individual and Organisational Interventions in Managing Mental Health at Work

Throughout the action research process it became clear to me that implementing any interventions were difficult without the collaborative relationship between the individual and the organisation. It is proposed that this collaborative relationship is facilitated through the line management relationship and therefore of central importance to managing mental health issues at work. At the beginning of the action research process, I was mindful to understand how the employee who chooses not to disclose might manage their mental health issue. I argued that many people still choose not to disclose and therefore may need to access interventions that do not rely on this disclosure. However, I found that the categories formed from my analysis indicated that successful retention in work maybe difficult to achieve, without a

collaborative relationship between employer and employee. Categories are therefore linked into an overarching model through the relationship between employer and employee, likely to mediated through the line management relationship. Conceptual memos also helped to make sense of the data and the links between categories. I have included some conceptual memos in order to further illustrate how these categories link together.

Construct - The Organisation and the Individual

Category 1 – the Line Management Relationship

Throughout the sessions participants commentated on the impact of the relationship with their line manager as to how well their mental health was managed in the workplace. Some participants had disclosed about their mental health conditions, whilst others had not. Successful management of mental health issues upon disclosure appeared to be in part down to how well the organisation understood and managed mental health and the line manager's own experience of mental health.

Three participants talked about their different experiences in returning to work, depending upon the approach of their line manager.

Initially they were like 'Okay, we want you to settle in slowly" but it wasn't managed like that. It was kind of, "Okay, off you go." So yeah. (Participant 1)

Mine was quite different though because my boss has had two periods of being off with depression and both were three months off, and I wasn't planning to go off with depression at all and she really shoved me out of the door. (Participant 2)

I had a HR manager say to me, "At least it's nice weather for it" over the summer when I was off sick. (Participant 4)

Participants mentioned that they felt interrogated by their line managers when signed off sick and a poor understanding of how to help them return to work. Some participants felt that their line managers were treating them differently compared to other colleagues because of their disclosure, and inconsistencies in communication when off sick.

Yeah, and then. but actually, when I was off, she kept wanting to phone me and I was just like, "Can't you email me instead?" (Participant 1)
Yeah, email is just less sort of invasive. (Participant 4)
Yeah, and you can still respond. (Participant 1)
You can respond when you want to respond. (Participant 4)

Two participants decided to have open conversations with their line managers around changing how issues were managed in the workplace. Participants realised that their line managers also needed their help in understanding more about their conditions and how best they could help them. Participants also recognised they had some responsibility in asking for what they needed from their employer to manage their conditions.

My line manager had a conversation that we hadn't really had, which is about… she's worried about putting pressure on me, that giving me too much work is going to be too much for me. And I was like no, you have to give me more, 'cause

I feel better when I'm doing more work. Now she understands that, my HR actually got in touch with Mind and the two of them I think they're going on a course. (Participant 4)

Participants also shared information around Wellness Recovery Action Plans (WRAPS) and how managers could discuss emotions and mental health issues more openly at work. One participant mentioned how she was able to use humour with her line manager and this made it easier for them to be open about how they were feeling.

We made jokes about how many tissues I was going to have to take into the meeting and it was like, "Oh, it's two tissues in this meeting," (Participant 2)

A brief conceptual memo taken during coding of Transcript 1 helped to pull this category together.

Conceptual Memo Box 1 - Line Management Relationship – this seems one of the interventions which is crucial to deciding how adaptations are made within work to enable better mental health; it maybe that this can be done without disclosure, although this made it easier to convince Line Managers to gain training; it appears an open conversation where predictions and assumptions are discussed is really helpful.

Category 1: The Line Management Relationship

Participants suggested that good Line Management relationships were fundamental to improving mental health in the workplace. This was thought to be based upon open discussion, agreed ways of working together and clear mechanisms for feedback. If a colleague has disclosed then it was considered to be important to agree preventative

measures, understand warning signs and agree absence management processes.
Intervention 1: The Line Management Relationship - contracting what you need from your line manager, not just one way. In order to seek reasonable adjustments and support from an organisation, having an open conversation with a line manager and requesting what you need is an important step in being able to achieve this. It might be helpful to use existing resources such as WRAPS and employer guidance to educate line managers about their area of responsibility. As a two-way relationship, the line manager will also need support in understanding their role and being open about their own limits in how they can help and there is a role here for the organisation to support managers in achieving this.

Category 2 – the Mental Health Support Action Research Group

Mentioned in the participant recruitment form to join the group (see Appendices A – E), potential candidates were offered an experience that would be "a therapeutic, supportive group experience…but ultimately a practical research group." Throughout the process itself, participants commentated on how helpful and supportive the group was and had set up a network of support outside the group sessions.

Was there anything anybody wants to just end with or say? **(Facilitator)**

Why aren't there groups like this in workplaces? (Participant 4)

This led to a wider conversation about groups and action learning sets and several participants identified how useful this approach had been in the past too in order to openly discuss difficulties in work.

(Talking about a previous action learning group)…I wasn't a part of it, one of our staff was volunteering there, but that was happening, and there's been talks about bringing it back because that was really helpful. The managers weren't allowed to attend, it was just four people, the development workers and lower levels. (Participant 2)

Conceptual Memo Box 2 - Group as a Intervention - Importance of clear ground rules for facilitator and group to ensure openness; group will work better by people being able to contact each other between sessions; could the group itself be a model adopted by organisations to support mental health issues? Participants were very open from the beginning about mental health issues and used humour to be part of the group and ease other people; seems to help to have someone informed about psychological interventions running the group in order to be able to discuss diagnosed conditions; was important for some members that people should work in different industries to enable confidentiality and be open about experiencing mental health issues.

Before this group had been formed, a pilot group had been run, where six different individuals had been recruited and five started in the initial session. Over the first few months, their commitment dropped and people started not attending, although did provide explanations. Reflecting upon the differences between this group and the group participants selected for this research, the process of screening participants more thoroughly and formalising group processes were important considerations in developing an effective action research group. I was much more focused the second time around, on recruiting people who were struggling in work, but really committed

to attending a group. There were clear group ground rules and people were able to attend specific dates. Selecting people from different organisations with varying mental health conditions was also important. From the beginning, the group were also supportive of one another and open about their issues.

Following an appropriate selection criteria, it also seemed important that the facilitator have some psychological and employment knowledge. In terms of knowledge around employment issues, I believe that this basic knowledge should be known to all Psychologists, whatever their particular discipline. It helped being able to point people to existing resources, but also to be able to explain different conditions and therefore psycho-education became an important aspect to the group.

I don't know what is the sign of a panic attack? (Participant 3)

So usually panic attacks are the misinterpretation of anxiety feelings. So it tends to be that you, you know you've nearly all experienced anxiety, but what happens in a panic attack is you tend to have a thought about I'm going to collapse, I'm going to die. I'm going to have a heart attack. And it of course makes the anxiety feelings worse. And then that exacerbates the whole thing and you literally panic.

(Facilitator)

Within the group, participants supported one another to be open and have assertive conversations with their line managers. They also mentioned contacting each other between sessions and referred to doing something creative together beyond the end of the sessions.

That might be another thing to do. I might be art classes so if either of you want to come and do something in the evening? (Participant 2)

Yeah. (Participant 1)

Well make each to go….each other kind of thing… (Participant 4)

Yeah, yeah. (Participant 1)

It could be that the group provided a space to increase confidence, but also a form of unique social support where participants could be open about their conditions and support one another. The group itself therefore offered a form of intervention and may have the foundations of an important blueprint for how to further support colleagues in work. It could even be an anonymous support system where colleagues would not have to disclose, or test out disclosure decisions and therefore remove fearing discrimination at work.

(Discussing decision about openly discussing mental health with manager) *Cause I wouldn't have spoken to her about it, and I don't think I would have said it unless we'd had that chat. But I felt really supported by everybody. And you text me 'yeah, come on girl.' But it's like, yeah I'm okay. So it was quite …It was really good actually. It was a really positive outcome from running this group* (Participant 4)

Category 2: Mental Health Support Group

Within this research, the Mental Health Support Action Research Group became a central way in which to help support colleagues with mental health issues. Ideally this group should be based upon confidentiality, clear purpose, anonymity, members from different organisations and facilitated by a mental health professional**.**

Intervention 2: Mental Health Support Group - joining, championing, facilitating your own support group. Developing Mental Health Support Action Research Groups could be an important step to improving mental health within organisations. Whether they are open groups set up in organisations, or confidential groups developed between a number of organisations, facilitators need to consider carefully the purpose of the group and who it is facilitated by.

Category 3 - Being informed

Throughout the group sessions participants commentated on both their lack of knowledge around their own employment rights when it comes to mental health at work, but also within the organisation they work for.

I was so overwhelmed by how much I didn't know about my rights, I didn't know about my diagnosis, meaning that I would be given more rights…. HR's job is to protect the company and as much as they said it's there to support the staff, it's not… I mean I was fortunate enough in that I've been well enough to go out and get that advice and get that help. There's so many people that are not well enough to do that and they would have just been out the door. (Participant 4)

One participant found herself taking employment information from Mind about working polices and practices to her own line manager to inform her. This then enabled them to have an open conversation around both of their needs. Her line manager and a colleague from HR then signed themselves up to attend training around mental health issues in the workplace.

Participants felt that the degree to which their line managers were informed about mental health issues varied, but many of them did not know about helpful documentation such as Wellbeing Recovery Action Plans. Along with employers needing to know more about their legal responsibilities around mental health issues, participants also discussed the importance of colleagues and line managers knowing more about mental health signs and symptoms.

I think even just generally, people aren't aware to kind of know the difference between being a bit hectic, you look a bit anxious and actually, what's going on? It's a bit, especially at work because you kind of put on a bit of a face, don't you? It's just being able to pick up on little signs and things. I went to an employee benefits seminar thing last week and there was a woman who was speaking about mental health in the workplace and speaking on what managers should try and do and they should notice when they've got a colleague or someone who they're managing starts to act a bit differently or is being forgetful, or looking a bit more stressed, or reacting differently. And just to pick up on those small signs and to sort of sit down and ask, "How are you? We're a bit concerned about these areas. This isn't like you," and just what ways to approach it…I think just something like that, if that could be implemented in every workplace, so anyone who does suffer with mental health problems, they know managers are kind of trained or taught just to look out for those sorts of signs that the colleague might not even know themselves that they're doing. (Participant 1)

Participants also did not know about the range of self-help materials and resources available for them, or about the employment support services specifically designed

for mental health service users. There was consensus within the group that both individuals and organisations need to be more aware around their own rights and responsibilities. The mental health support group could be a way in which to provide resources and information. Emailing the group afterwards with materials around topics raised was an example of how this might work and participants found signposting to different self-help resources to be invaluable.

Participants within this group agreed how useful it would have been to know more about their own rights before accessing sick leave. This might be an important intervention for both organisations and individuals to ensure they know their own rights and a space to discuss reasonable adjustments.

There's one thing that I think is a really simple thing, is that the moment you're diagnosed or the moment you're taking time off work, it should just be a formality that your GP gives you something that somebody gets that goes, "These are your rights." That is not a difficult thing. That's just a bit of government pamphlet bumf that somebody gets that goes, "These are your rights, this is what you're allowed to do, and this is how it works for you." (Participant 4)

Category 3: Being informed An important aspect raised within this research was around the need for both employees and employers to have better knowledge and understanding about mental health rights and knowing how mental health issues might present in the workplace. A central website or resource of information was felt to be lacking around these issues.
Intervention 3: Being Informed - seeking advice around your rights from

organisations such as MIND, TIME to CHANGE, RETHINK. It could be that both individuals and organisations just need to be more aware about existing resources out there, or that training around mental health issues becomes a compulsory part of management training.

Category 4 – Disclosure

When discussing reasons for not disclosing, participants felt that it was because their line manager would not understand and have little knowledge around how to manage their conditions and also perceptions amongst colleagues about their condition.

I suppose it's difficult but I think as much as you disclose, I don't know if anyone else feels like this, but I don't ever want to be seen as my work being second rate or be seen as not achieving, I'm very, very focused on my job…. I disclosed to make sure I could get my hours off and that's the only reason I disclosed. (Participant 4)

I do quite a bit of work for a team in xxxx and they can be quite bolshie and I quite like that, actually, but they're quite, I don't know, they can be awkward sometimes. And since I've been back, they've all been nice and I think my boss had told them. It's just completely different now. It's like, 'Ooh, I don't know...' So I think she was trying to do the right thing because actually, everyone knows there can be difficult characters but I like difficult characters so I feel a bit like...(Participant 2)

You don't want to be treated any differently? **(Facilitator)**

Yeah, and really awkward managers are being nice to me and I don't know how to cope with that…And I've told them now that I was off with depression because I think they knew already and I wouldn't have told them otherwise because I just wanted to get on with my job. (Participant 2)

Participant 3 also spoke about the impact of line managers' perceptions on mental health issues influencing the whole organisation and other colleagues being reluctant to disclose and leave rather than manage issues there. When participants did disclose they felt any adjustments or phased returns to work were handled poorly. When asked, most of the participants knew little around their rights under the Disability Discrimination Act or around aspects about disclosure and felt that it was evidently a difficult decision to make.

Overall though, it appeared that without disclosing, participants found it difficult to understand how mental health issues could be managed without the help of their line manager. This crucial relationship appeared to be central in helping participants manage difficult times and also facilitating sustained better mental health, but there was often a perceived complexity around discrimination. If employees choose not to disclose then participants agreed that having an assertive and close relationship with a line manager was important, where feedback and agreed ways of working were even more important to establish. Most participants felt that disclosure decisions were still based largely upon the discrimination associated with disclosing.

All of the problem with all of it is the stigma about mental health. Because we should all be quite happy to disclose to our work what is going on with us, as we would if we

had a wooden leg. We should be happy to do that because there's law in place to protect us, we shouldn't feel that anybody in the workplace is going to judge us for that, and that is the only way that it's ever really going to work (Participant 1)

Category 4: Disclosure An important aspect raised within this research was around how participants thought they could really only get help from their employers through disclosing their mental health conditions to their line managers. It was suggested that disclosing is a difficult decision as it left some participants feeling as if they were being treated differently by their line managers. In order to facilitate better mental health at work and increased levels of disclosure, potentially more needs to be considered into how to develop more supportive line management relationships.
Intervention 4: Disclosure - seeking advice around your rights from organisations such as MIND, TIME to CHANGE, RETHINK around disclosure and seeking out a supportive manager who you can disclose to. Organisations need a clear policy around disclosure and train managers on how to manage confidential decisions.

Construct - The Individual

Category 5 - Self-awareness

Most of the participants within the group had experienced sickness absence due to their mental health condition. Participants commentated that they had felt unable to cope with the demands of work and needed time to seek help and consider their options. Each participant experienced a different set of triggers and considered the role of work to provide a different function in relation to their mental health compared

to others. Some participants found elements of work to be very challenging, whilst others considered the same aspect to have restorative functions.

When I was off, I put on so much weight…But I just ate – and drank, actually – all day. And when I'm at work, I don't do that. If I was, I'd be the size of a whale. So work is a structure for me, and a bit of a routine, and I know that, okay, it's a school night, I can't drink. It's that sort of thing, that really does help me. (Participant 2)

Okay, so work gives you structure and routine, and a little bit more of a focus, I think that's interesting. ***(Facilitator)***

For me as well, it makes me think. If I was at home, I'd just be watching TV, stupid daytime TV, and go shopping. It makes you think, it makes your brain a bit more stimulated. *(Participant 3)*

Are you saying no? ***(Facilitator referring to Participant 4)***

Well, I don't know, it's half and half. The place I work is so different I think to the place that you guys work. *(Participant 4)*

Participants commentated that they had not known the warning signs around the triggers for an episode and felt that they had to accept and consider what their own capacity and capability was. Upon returning to work, participants had varying experiences, but there was a sense that line managers made assumptions around what participants could manage.

I sort of said what I would find easy work and what I wouldn't, because I do training for part of my job, and my boss was like, "Oh well, you won't want to stand up in front of a group," and I was like, "I love that bit. That's playtime," whereas writing

the strategy, I just couldn't focus enough to sit and write a big document or anything. (Participant 2)

In terms of managing their own mental health conditions, participants commentated that they needed to know what worked for them around managing their own mental health, both in terms of workload and potential stressors or triggers and were not seeing therapists.

I'm not working at that level the same as my boss but actually, she's superhuman and I just have to accept that, I think. Do you know what I mean? I think there's a limit to what's possible. So I am still working at a lower level than I was before but I think it's probably healthier for me (Participant 2)

This concept was conceived as self-awareness and included having an understanding of your own mental health condition, but specifically your own limitations and warning signs. The group itself provided a space for reflection and participants were able to capture personal differences in how they approached work and their own coping mechanisms and were encouraged to reflect on this outside the group. Although not tested within the group, participants could have captured these insights in a 'coping card' outlining warning signs and coping mechanisms for managing workload.

Linking in with self-awareness, the group reflected how they needed other people in their lives to help keep them more grounded and aware. Participants discussed how they had opened up to friends at work and asked for their feedback. Feedback had led

to helpful ways of joint working such as one participant developing a shared 'to do' spreadsheet that they could both refer to.

…that's been a really good thing for me with her being able to know that I'm doing it without me feeling like she's breathing down my neck because it's not a conversation, it's just a document that we don't have to talk about. (Participant 4)

The importance of feedback from work colleagues and managers was discussed in depth within the group. Participants considered that feedback on their performance was helpful as it enabled them to consider achievements as well as considering warning signs. Poor feedback was also discussed and how some line managers need training in how to deliver behaviour based feedback in an empathetic way. Participants again felt that it would be difficult to ask for more considered feedback, if colleagues and line managers were not aware of their mental health condition.

In terms of monitoring own mental health symptoms and needs, participants discussed keeping a diary, along with discussing openly with colleagues about their conditions. They also mentioned the need to record positive outcomes as these can be easily forgotten and to use performance processes to raise issues around symptoms and achievements, which one participant chose to do to try and negotiate a better job description and salary increase.

Like it's so hard to go through everything that you take responsibility for in a year. It's actually a really good thing to do as well, I think in general (referring to writing down achievements) (Participant 4)

Participants mentioned that some colleagues at work had enabled a smoother return to work because of their support and understanding. Participants considered how colleagues had provided them with support by finding joint ways of working together or normalising experiences within the workplace. There was consideration of how colleagues had also been supportive through encouraging open conversation around mental health issues.

So I've kind of told them what the signs are so they have got them written down and so they can actually, I mean, my colleagues are really good friends anyway so they would probably start to know. (Participant 4)

They're amazing but a lot of that's come from me having the confidence to be able (to disclose)…and being supported by my colleagues (Participant 2)

It appeared that finding colleagues who could be confided in was also important in sustaining better mental health, but also focusing on collaborative ways of working together. Participants also noted how the group had become a space for social support, outside of the working environment and a further intervention in itself. It appears that developing ways to ensure improved self-awareness was considered important in managing mental health at work.

Category 5: Self awareness

Participants felt that a degree of self-awareness was central to managing mental health in the workplace. This includes the need to know your own warning signs, what level

of pressure and challenge you can achieve in work, and being able to take control over your own workload. Participants felt that this could be done through self-monitoring methods such diary keeping, or involving others. They also discussed how important collaborating with colleagues was in managing mental health in terms of them helping to recognise warning signs or developing helpful ways of working together.
Intervention 5: Self awareness - try developing a 'coping card' of your warning signs and what to do if they are triggered in order to improve self awareness and establish preferred ways of working with colleagues and developing relationships with trusted colleagues to help them monitor your mental health

Category 6 - Values in Work

Within current third wave cognitive behavioural approaches to therapy, the concept of valued-driven action is often referred to as an important means of sustaining change (Hayes, 2004). Values driven action refers to engaging in activities, which inspire and maintain motivation because they link with intrinsic values in an individual. Within the sessions, participants discussed the type of professions they were in and discussed what they enjoyed about work. Those who felt that work enabled them to manage their mental health difficulties to some degree considered how they were actually motivated by the type of work they were in.

I work in sales…I love my job… I just decided to work through it (talking about panic attacks). That's my best way of dealing with this, just I think if I stayed at home, I would get worse. I do a lot of work, I work a lot online and with people who start

being at home, and it's harder, the longer…but the longer you stay at home, the harder it is to get out. (Participant 3)

Those participants who did not feel engaged in their work considered how they actually were bored with what they had to do and how this contributed to their poor mental health.

I think I kind of realise what I need to keep me thinking and keep me interested. And if I'm in a job where I'm like, "Uhhhh," I'm going to get frustrated, I'm going to get pissed off, I'm going to get irritable and bored…So I think I need something that's a bit more challenging, but enjoyable as well. (Participant 1).

Both participants in the pilot group and the one used for this research process decided to look for and even change direction based upon considering their core values and what they considered to be important to them. One participant recognised when they were engaged in a creative process, they forgot time and were fully immersed in what they were doing.

I could do it all day. I'm so, just losing myself in it…(Participant 2)

Participants felt that if they were engaged in activities that enabled them to experience the state of psychological flow, then this would help them to navigate their way through work. It might be that aligning working options for people with mental health needs to core values needs even greater attention than merely just matching people to a role that they feel able to manage and cope with. Participants also recognised that

all work presented with tedious and mundane tasks, but felt more able to cope if in a role that offered them the opportunity to complete tasks they felt motivated by and one participant sought advice from Mind's employment team around a career change.

Category 6: Values in Work The importance of knowing your own personal values in order to stay committed in work was consistently referred to. Participants felt this would increase motivation in work by becoming more engaged, and thought it was important to consider whether your job description meets those values in some way.
Intervention 6: Values in Work - exploring your own values at work by existing on-line resources developed from Acceptance and Commitment Therapy. Taking time out to consider what is important to you and what might keep you motivated because elements of your work match with your values as a person may help to ensure difficult times are easier to sustain.

Category 7 - Observable Mind, Active Body

Throughout the group discussion, participants commentated on how mindfulness was an important concept they had been learning more about and felt was an important part of managing their own mental health. Mindfulness has fallen into the category of positive psychology, but has actually been part of mediation practices for thousands of years. Harris (2009) describes mindfulness as a way of paying attention, a process of awareness in the moment and not getting caught up in negative ways of thinking. Although linked to the category of self-awareness, participants discussed mindfulness

as a way of monitoring and understanding emotions and thoughts on a daily basis, a state of mind where they were more aware of thoughts and feelings in the moment.

it's about recognising when my mind's just gone boooarh! And I'm worrying or stressing or anticipating or pre-empting crap stuff and always catastrophising with whatever thoughts are coming up. And so it's recognising when my mind's gone booarh! And you're going now stop it, bring it back. It's okay, having like a few breaths and a few pauses, and then the smaller stuff helps. (Participant 1)

Participants had been attending a mindfulness course throughout the longevity of the group and remarked how it was an important intervention. They felt it enabled them to be more in tune with their emotions, the origins of them, but try not to engage in them, especially at work. One participant commentated how they had developed time during the day to practice mindfulness and were now able to not get caught up in negative thoughts they had previously held.

My boss was really grumpy the other day, and … I said are you all right? And she said 'oh I've got a really bad cold and a cough and I've got to do training'…but normally I would be thinking oh my God she hates me, in a mood because of me. (Participant 2)

Linked in with developing an observable mind, participants reviewed how being more active enabled them to manage their moods and engage less in reacting to negative moods. Participants commentated that simple activities such as going for a run or walk at lunchtime just allowed them to reconnect with more balanced feelings.

Like we'd all have a bit of a lunch on our desks and stuff and I started saying "I'm going to take half an hour out and I'm going to go for a walk." And occasionally someone will join me but other people have started going out more at lunch time now and I think that's healthy to do (Participant 2).

Participants commentated that it was difficult to develop and had to find their own set of exercises (both physical and mental), which worked for them, but saw a shift in how they were able to manage their emotions.

Category 7: Observable Mind, Active Body The group discussions often focused on the subject of mindfulness. Participants referred to this as the ability in being able to develop a mind, which is able to monitor emotions, be accepting of those emotions and try to engage with them less within work. The importance of being physically active was also raised as a way to improve mindfulness.
Intervention 7: Observable Mind, Active Body - attend a local mindfulness course to develop greater self-awareness and be able to monitor emotions, or develop own mindfulness practice through reading; also engage in small behavioural activities to keep physically active

Category 8 - Work-Life Balance

During the sessions, participants often raised the idea that they believed work was not all that life should be about. One participant commentated that since being diagnosed

with a mental health issue they had thought more carefully about how they spent their time outside of work.

I enjoy drawing, painting, photography, writing, whatever else is creative – I do it. I've never done that for a career or been involved in that kind of creative work. I'm like 'alright now is the time to start venturing into that for myself' but…(Participant 1)

You might find that's the thing that keeps you going…When the depression comes back, it might be the thing that you enjoy and that…**(Facilitator)**

Yeah…It's expression isn't it, it's a way it's kind of voice yourself without having to talk to anyone, without having to explain yourself…(Participant 1)

When taking time off work to manage mental health issues, one participant recognised the importance of other tasks to help occupy their mind and provide them with activity. Participants also discussed the importance of routine in providing stability and encouraging time within that routine to be creative. Participants found that by engaging in more creative pastimes and having a routine, they noticed their general level of well-being were maintained. Participants also commentated that the group provided a place outside of work to resolve issues and meet with friends, another link to the group itself being an intervention.

One participant referred to the fact that when they were at their lowest with their mental health condition, they took everything *day by day*. The group echoed the importance of this philosophy and shared tips around the small things which got them through each day when experiencing a difficult episode. Participants discussed a range of small interventions, which enabled them to individually navigate their day

and were related to knowing themselves and their own conditions and what they could manage. Some of these have been mentioned previously, but participants commentated that using headphones and listening to music helped them to concentrate, taking mindful breaks and also keeping a 'positive log' about their achievements. These interventions link in with self-awareness and having a sense of what you need to keep on going through the day.

So if I feel really crap I just put my headphones in and get on with it and just be 'I'm going to be unsociable for the next few hours' (Participant 1)

I'm just going to get a coffee and I'm going to see how the first half an hour goes and… you know…one thing at a time (Participant 4)

Like we'd all have a bit of a lunch on our desks and stuff and I started saying "I'm going to take half an hour out and I'm going to go for a walk." (Participant 2)

Category 8: Work-Life Balance A strong theme which made participants feel more resilient to their mental health issues was developing a support network outside of work, a daily routine which provides stability and a chance to be involved in more creative or different activities outside of work. Participants also mentioned the Support Group as a further way to develop connections outside of work and each had many small ways of helping with the everyday stressors of life.
Intervention: Work-Life Balance - develop a routine and include time for activities outside of work, driven through interests and engaging in small activities throughout the working day to provide a break from everyday stressors

Construct – The Organisation

Category 9 - Well-being culture

Whilst discussing what participants could do for themselves throughout the sessions, there was recognition that to some extent the type of organisation that people worked in contributed significantly to the management of their own mental health.

I think it does just depend I guess on the work environment you're in. Sometimes you do just have to feel like you're going to throw yourself back in and get on with it. A previous employer that I was with, if I had taken time off with them, they probably would have found some way to just boot me out anyway, which was just horrible....(Participant 1)

Raising the issue of organisational culture, participants reflected on how well their own organisation discussed and managed mental health issues. As mentioned, some of the participants felt they had to educate their own organisations on mental health issues, whilst others felt it was pointless raising such issues.

Participants felt that if they had received some education around mental health and there were clear plans for how to manage mental health difficulties already established, they may not have had to take time off work as a result. Whilst considering values in work, participants reflected on the way in which mental health was talked about and where well-being was on the agenda for their organisations. All participants agreed that a lot more could be done, including running mental health support groups like the one they attended.

You start a job and you train up on this, that, and the other, and you're at school, why is there not more CBT-based stuff in there? But yeah, there should be some responsibility that falls on the workplace, the workplace has to offer some kind of proper support…(Participant 4)

Participants felt that consideration around what sort of organisation they joined was important. One participant who now worked for a charity reflected upon the unhelpful working environment of a previous organisation.

I literally would have had to just go in and just be like, "Oh yeah, I'm fine," and get on with it and throw yourself into 10, 12 hour working days. And I was like, 'This is not what my life is supposed to be'…(Participant 1)

Whilst difficult to change, guides for managing mental health aimed specifically at organisations have been developed such as MIND's Guide to Mentally Healthy Workplaces. Participants were emailed these guides and even alerted them to their employers. Considering further about organisational culture, a few of the participants began to consider if a change in career would benefit them upon completing the action research group.

Along with promoting a culture of well-being, participants felt that if the organisation as a whole was more aware of providing a generally more supportive working culture, then their would be benefits for all people, not jus those with mental health issues.

Obviously workplaces should be looking after people better, people shouldn't be bullied, people should be made to feel happy and comfortable and supported. But I think that helps everybody, rather than just people with mental health problems. (Participant 1)

I think what's healthy for healthy people is healthy for unhealthy – I don't really see 'unhealthy' is us, but I think it's a continuum and we're all of that continuum, and therefore there are some things which are good for everyone. It's feeling valued, feeling like you can take a break when you need to, feeling like you can ask for help when you need to. But they sound like basic human rights, rather than anything to do with a condition. (Participant 4)

As mentioned previously, participants considered how their line managers cared, but were sometimes ignorant of what really experiencing a mental health issue was like. Participants did not propose interventions about how to influence this, but presenting an open and honest policy around disclosure was thought to be helpful. During the final session, participants reflected on how they could become champions themselves and develop support groups or at least propose the idea. It was considered that organisational awareness would develop when organisations recognised more around their legal responsibilities in managing mental health issues for employees and there needed to be greater education around mental health from as early as school age.

Category 9: Well-being Culture

Participants felt that employers need to promote well-being in the workplace to a much higher level and provide psycho-education around conditions, establish a culture of disclosure where clear plans and procedures are in place for managing

mental health issues in a supportive way. One of the topics raised consistently by participants was that just like individuals, organisations need to be more aware about how mental issues present in the workplace and provide an open forum for discussing those issues or more supportive mechanisms such as Mental Health Action Research Groups.
Intervention 9: Well-being Culture - considering which organisation you work for; championing mental health change, disclosing mental health conditions more openly. Organisations have a role to champion positive mental health and ensure employees are educated about mental health in the workplace and their rights.

Category 10 - Working environment

Increasingly linked with a well-being culture, but greatly underestimated by employers seemed to be the physical environment in which participants worked in. Participants commentated that their mental health affected them in very different ways. Some participants found they needed more space and quiet than their open plan office allowed, whilst others needed to be engaged within a busy working environment.

I've only worked in open-plan once, and I didn't particularly like it, because there's so much going on, and you can hear everything. (Participant 1)

Yeah, I know, I will be distracted, I know that. When there's somebody on the phone, I'll get distracted. And there'll be about 40 of us in one room. (Participant 3)

I like open-plan more than being in a closed room with three other people all quite close, it's all a bit sort of [unclear 10:53], really. So I much prefer knowing that I'm

*in an open-plan…I mean, I used to have an office, I used to hate it, I just used to come out and just talk to people. Then they look at you thinking [unclear 11:11] and I was like, "No, I'm just lonely." (*Participant 2)

Participants felt they benefitted from an environment where they could ask for flexibility in their workspace, but this was either something they had to push for or not possible. Participants reflected that their office environment was important in contributing to their mental health and needed more consideration from organisations in the first instance.

Category 10: Working Environment Participants felt that employers did not consider the impact of the working environment enough on mental health. Employers need to provide a supportive and flexible environment where colleagues can work in teams or in a quieter environment where there is flexibility for different preferences.
Intervention 10: Working Environment - researching what organisation you work for; requesting changes to working practices and considering ways to improve working environments

A model of Individual and Organisational Interventions in Managing Mental Health at Work

Returning to my research question I wanted to explore how people with mental health conditions might thrive at work. My understanding of a theory is that it should attempt to explain something, answer the question as to why something is occurring.

A theory seeks to generate systemic assumptions that can be evidenced through observations. It not only explains something, but it can predict future outcomes and be applied practically. Charmaz (2006) might describe this as holding a positivist stance, where the emphasis is on explaining a phenomenon, ignoring the interpretative influence of both the researcher and participants. In Charmaz's (2006) own examples, she offers up exerts which manage to both explain a phenomenon, yet recognises the influence of her own interpretation on participants statements and actions.

Whether a theory is derived from a positivist or more interpretative perspective, I consider that my own end product from this research process is not a theory. My constructivist grounded theory analysis has produced a set of interventions and categories that indicate how people with mental health problems might improve their experiences of work, which might be best explained as a practitioner's model. This model illustrates how interventions could be if people wanted to improve mental health at work. However, it does not explain how mental health impacts work, nor does it predict outcomes or provide an evidenced set of assumptions based upon observed practices.

To turn this model into a theory I would need to be able to answer more explicitly how people with mental health conditions might survive in work and look more closely at related components such as social support or self-belief to explain why. A theory would need to do more than describe, but predict and explain why aligning categories such as motivational values and the line management relationship could improve mental health conditions at work. Charmaz (2006) states that many researchers are doing grounded theory in whatever way they understand it and that

different criteria are often established for different kinds of theorising. Reflecting back upon my own analysis, I may have coded too much around themes rather than actions and remained at a descriptive level, rather than digging deeper to understand why these categories may enable managing mental health conditions at work.

I have attempted to reflect this model visually in Figure 2 and more comprehensively in Appendix F to enable a closer inspection of the categories. Here there is a distinction drawn between what the organisation and the individual could implement in order to improve mental health at work. Within this model, there is also recognition, that both the individual and the organisation are responsible for improving mental health in the workplace and enabling positive management of mental health conditions. These aspects describe rather than explain and could aid a practitioner to openly discuss with an organisation or individual what maybe helpful for them to implement to change their experience of work.

As an individual, this model proposes that a person may be able to improve their own management of their mental health issues through initially considering their own values and practices. It is proposed that if values link in with organisational practice, then potentially a person will be more motivated to continue to work for that organisation. Moving beyond the type of work that the individual engages in, a person might be able to improve their own mental health through developing enhanced self-awareness about their own limitations and mental health condition. This might be a continual process that the person engages in, in order to ensure they are able to manage symptoms across time and enable others to help with their condition. In order to maintain overall improved mental health, the individual may need to develop skills

around mindfulness and engage in activities both within the working day and outside of work, which strengthen resilience. Further exploration in how and why these aspects are important would be important to consider.

Even with these important factors in place, this model proposes that the organisation has an independent role in improving mental health at work. These factors centre on the culture of the organisation and the working environment. The organisation may need to ensure that well-being is put high on their agenda and that they run a programme of education centred about mental health and disclosure and how this will be positively managed in the organisation. Attention too may need to be paid to the working environment that the individual is physically located in. Creating a space conducive to flexible ways of working may enable an individual to be able to conduct their work in ways they find individually more helpful.

Linking the roles of the individual and the organisation in achieving improved mental health conditions for employees are a number of proposed factors which may act as mediators. Within a working environment, the line management relationship and how disclosure decisions are managed could be important factors in how well employees with mental health conditions are supported. A facilitative relationship, which ensures both parties are kept informed and open with one another, may enable flexible ways of working together which enhance mental health. Neither the line manager nor employee, can be entirely responsible for making the relationship work effectively, and disclosure needs to be considered individually. Mental health conditions might also be more effectively managed through increased knowledge about these issues and implementing mental well-being groups centred on support and problem solving.

This model therefore suggests that improving mental health at work for people with long-term mental health conditions is more of a collaborative process than previously considered. Improved mental health might also be significantly influenced through line-management relationships and support groups being implemented across organisations. If these conditions are improved then it may enable people with long-term mental health conditions to stay in work and even excel. Although this process has not resulted in a theory, I believe this model could be helpful for practitioners working with organisations in terms of organisational development and change in mental health for individuals around recognising factors they can have control over. These aspects also link into the different levels of interventions, which were described in the literature review around primary, secondary and tertiary interventions within stress and wellbeing at work and will be expanded upon.

Discussion

Reviewing the current literature, I concluded that there was both a moral and financial case for change in how mental health is managed within the workplace. The literature review demonstrated that current intervention programmes such as Individual Placement Support Services have begun to improve employment and retention rates, but only target a fraction of the working population with mental health problems. It was also identified that the world of Occupational Psychology has a lot to contribute to this field of research through exploring stress management interventions and that Counselling Psychology as a profession could further champion the importance of

employment within a client's life. This study was therefore aimed at participants already in work who might be struggling to manage their mental health conditions. The study was designed to also focus on what individuals might be able to do for themselves to manage their mental health conditions without disclosing. A further aim of the study was to also focus on the role of mental health professionals and establish what further knowledge might be useful to enable change for clients struggling in work.

This study was therefore developed to identify appropriate interventions, which could enhance the working lives of people managing mental health conditions, championed by Counselling Psychologists working in clinical practice. The research question for this project was '*how can people with people with long-term mental health conditions remain and even thrive in employment?'*

Action research was selected as the most appropriate process by which to gather the data to identify appropriate interventions. This process was chosen because it offered the opportunity for participants to be actively engaged in the research and also to benefit practically by taking action and reflecting on outcomes. It also enabled myself to remain engaged in the process and linked to my core values around enabling social change and conducting research in a more active way.

Constructivist grounded theory was selected as the best method to analyse the data and produce core categories leading to an overall set of recommendations. This process of analysis fitted in with my beliefs around knowledge generation and provided a way of making sense of the transcripts generated from the action research

process. Four participants took part in four group sessions and the qualitative analysis produced 10 main categories, with subsequent interventions. Categories were grouped by whether the individual or organisation could implement them or whether they may act as mediating factors in improving mental health at work for those presenting with long-term conditions. The study therefore proposes a model *of individual and organisational interventions in managing mental health conditions at work.*

In this section I will consider how the proposed model links back to current theory and research and review recommendations from existing literature that support the findings from this study. I will then evaluate the research process, reflect upon the influencing factors on the research process and include my own reflections upon conducting action research and how it can be used more widely within Counselling Psychology research. After considering the strengths and limits of this research, I shall identify recommendations for policy and practice and conclude by identifying areas of future research.

Overview of Analysis

The model proposed from this study suggested that the individual and the organisation are both responsible for improved mental health and that there might be important mediating factors, which determine the success of proposed interventions. In Figure 4 and Appendix F, these mediating factors or categories that need both the involvement of the individual and organisation have been represented by overlapping between the two domains. It was proposed that the individual might be responsible for considering their values, developing self-awareness through support and mindfulness and engaging in practices inside and outside work, which promote well-being. At a

systemic level, the organisation may be responsible for encouraging a culture that centres on well-being and education about mental health practices, as well as a positive and flexible working environment.

Mediating these two positions might be the line management relationship, and support groups designed to discuss and enhance shared practices of improving mental health. It was also proposed that both the organisation and the individual need to be involved in employment disclosure decisions and both be informed about mental health and employment practices. This proposed model highlights a more collaborative approach between employer and employee in managing mental health at work and has important implications for people similar to those participants involved in this action research process. Outlined below, I have expanded upon the categories discussed in more detail by participants, in relation to their constructs: mediating factors or the individual and organisation, the individual and the organisation.

Links with existing research and theory

Individual and Organisational Interventions: Disclosure decisions and the line management relationship

Brohan et al.'s (2012) systematic literature review of the decision making process around disclosure identified only six out of twenty-four papers considering the perspectives of individuals with mental health problems. Those six papers identified that disclosure is a complex decision making process and there are many reasons as to why people choose not to disclose, including perceptions around rejection and unfair treatment. This supports the varied experiences reported by participants within this study concerning their decision as to whether to disclose their mental health issue or

not. Participants described how their decision to disclose was influenced by their relationship with their line manager and whether their line managers had previous experience of mental health issues. If people are choosing not to disclose because of perceptions around rejection or unfair treatment, it is likely that this perception is in part drawn from their relationship with line managers. It is therefore possible to suggest that the line management relationship does impact employees' decision-making processes around disclosure and access to possible reasonable adjustments they might be legally entitled to.

Thomas and Secker (2005) further support the importance of the line management relationship in managing mental health conditions in work, concluding that the factor "most strongly associated with successful job retention is the support and active involvement of management" (p. 126). Both Gates (2000) and Nieuwenhuijsen, Verbeek, De Boer, Blonk and Van Dijk (2004) conducted studies into how management involvement impacts employees return to work following a period of poor mental health. Both studies found that improved communication and support from supervisors reduced the length of time off work for people with mental health issues. These results indicate that support from a line manager or supervisor may not only enable reduced sickness absence, but also improve the retention outcomes for people with mental health issues.

The complexity of disclosing and finding appropriate workplace support is further outlined by a pilot project conducted by Henderson, Brohan, Clement, Williams, Lassman, Schauman, Murray, Murphy, Slade and Thornicroft (2012). They piloted the use of a disclosure tool, which aims to reduce the time in which people decide to

disclose, ensuring a more rapid approach to putting in place appropriate interventions. The tool runs through a number of different decision making criteria including the pros and cons of disclosure, personal disclosure needs, personal disclosure values, when to tell, whom to tell and a final aspect to bring it altogether. Having to use a tool in the first place, with so many criteria, further illustrates just how complex the disclosure decision-making process is for people. Part of the model from this study suggests that people may need to disclose to get reasonable adjustments and support. However, researchers in this area have demonstrated just how complex the decision making process is and not that disclosing automatically leads to improved support at work. The implication of this is that disclosure remains a personal decision making process, likely to be influenced heavily by the line management relationship.

Research around the line management relationship and managing mental health conditions seems to be limited though. As mentioned, Seymour (2010) identifies that considering this is such a key component of managing mental health in work, relatively little research has been conducted in how to improve it. Guidance for line managers and organisations such as Mind's *Guide for HR and Line Managers* and the Department for Health's *Line Management Resource – A practical guide to managing and supporting people with mental health problems in the workplace* do include practical tips for how employers can manage mental health better in the workplace. However, only 15% of line managers reported having been trained on how to manage mental health conditions (Centre for Mental Health, 2008). There is also little research from the employee's perspective about how to conduct a conversation around disclosure and improving line management support. Whilst these studies support the role of the line management relationship in managing mental health

conditions, there is still a further research gap around how to improve this relationship.

Individual and Organisational Interventions: Mental health support groups at work and information on mental health

In Bell et al's (2007) review on psychological interventions to improve work outcomes, the introduction of Work Behaviour Feedback Groups (WBFGs) played an important part in helping individuals to understand their behaviours and also provide the space for social support and increased confidence. The groups were based on problem solving activities, encouraged by a clinical facilitator in which achievements were recognised and cognitive reappraisal occurred. Each member could learn from one another about what might work and attain specified goals developed at the beginning of sessions. In Cameron et al's (2012) retention project, the group was also an important place in which participants could gain support and test out ideas.

The group formed for this project was also based on similar principles and participants commentated that they found the group to provide a space for social support and increased confidence. The evidence therefore suggests that groups are important in facilitating support for people with mental health issues at work, but that there may be processes and principles from other models of group work, which might be important for support groups to develop. In the WBFGs, participants were encouraged to engage in clear goal setting and focused on problem solving. In the action research group, although I encouraged participants to work on specific goals that they wanted to achieve, it was more of an emergent process where issues were raised and considered rather than being focused on specific goals across the sessions.

Although participants engaged in successful interventions within the action research group, using a more defined 'goal based' approach may have been helpful in achieving more specific interventions (Locke and Latham, 2002).

Mental health groups may also not just be confined to those experiencing diagnosable mental health conditions, but also to those finding it difficult to manage mental health as a result of work-based change. Within the literature review, the distinction was made between mental health problems that impair work-based activity, rather than work impairing mental health. Although this distinction was made then, it is perhaps too difficult to separate out the two issues. Blank, Peters, Pickvance, Wilford and MacDonald (2008) carried out a literature review of the factors, which predict return to work for people experiencing episodes of poor mental health. They concluded that the factors are wide ranging and that mental health is often provided anecdotally as the reason for prolonged sickness, without considering the organisational factors involved with sickness absence. This research therefore suggests that participants could use mental health support groups as a way of engaging in and discussing organisational change impacting their mental health.

The need for organisations to be informed about mental health more widely is evident by the poor application of performance management processes. De Lorenzo (2013) suggests that mental health at work is largely documented by researchers working in social sciences, rather than within Human Resources. This means that there is a lack of information within workplaces about mental health and managing mental health and De Lorenzo suggests this has a knock-on effect on performance management processes. Many employees choose not to disclose and are therefore subjected to

employee performance policies, which do not take account of mental health conditions impacting working capacity. De Lorenzo's review suggests the adoption of 'Buffer Stage' policies may help to manage mental health issues in work more effectively. What De Lorenzo's review further suggests though is the need for organisations to be more informed about mental illness at work and find a way to manage mental health more effectively.

Knowing more about mental health and employment has also been shown to be equally important for individuals to be aware of. Joyce (2013) highlights the importance of establishing a culture where employees see having a mental health condition as normal. This can only be achieved if employees across an organisation share this viewpoint and if individuals are willing to openly disclose. In the CIPD's 2013 *Employee Outlook Survey*, almost a half of employees said their organisation did not promote information on health and wellbeing, and only 28% said there were any wellbeing benefits on offer. This suggests that employees across an organisation are unlikely to be informed about mental health and unaware of help that might be on offer.

Individual Interventions: Self-awareness and personal values within work

Along with a number of other factors, the research findings for this project also demonstrated the importance of self-awareness in monitoring mental health conditions. Self-awareness refers to understanding your mental health condition, but also noticing the warning signs and developing ways to manage symptoms in the longer-term. Although described by the model presented in this study as an individual intervention, there was the suggestion from some participants and in other

studies that developing self-awareness needs to involve other people. This suggestion is supported by the Sussex *Retain* project, where participants benefitted from mental health practitioners playing a coaching role and the support group a space to share experiences and problem solve (Cameron et al., 2012).

Participants indicated that being more self-aware also involves knowing what level of pressure and challenge one can personally manage in work. Secker et al (2003) also identified this perspective after interviewing 17 people in five employment projects and their workplace managers. Their research found that people with mental health conditions need a balance to ensure "they grow in confidence at their own pace and ensure they are sufficiently stretched to remain motivated" (p8). Cunningham, Wolbert and Brockmeier (2000) compared the experience of three different groups of participants attending an Assertive Community Treatment programme. The three groups were split into those who maintained employment, those who were unable to maintain employment and those who never achieved competitive employment in the first instance. They found that the difference between those people who maintained employment and the others was their attitudes towards their mental illness. Those who continued in employment worked in roles that met their goals, but were also realistic about the demands of having to manage a mental illness.

Cunningham et al.'s (2000) findings also indicate the importance of employment matching an individuals own working values. Values-based employment has been championed by Supported Employment (SE) advocates, wanting to improve job retention rates (Burton, 2009). Burton (2009) highlights that the difference in using a values-based approach to supported employment means that, placement "readiness,

compatibility and preference" is also considered when matching people with roles. This compatibility between values and working environment may help to increase motivation and therefore the chance of an individual with mental health conditions staying in work. Prior, Maciver, Forsyth, Walsh, Meiklejohn and Irvine (2013) explored the perceptions of mental health service users perceptions of whether they were ready to return to work. They reported that employment opportunities needed to link with their own values and interests in order for work to provide a meaningful experience and continue their desire to remain in work.

Individual Interventions: Mindfulness as a mechanism for change

In order to develop greater self-awareness and understanding around values, participants from this study used mindfulness as a mechanism for change. Harris (2009) describes mindfulness as a way of being aware in the moment and not getting caught up in negative ways of appraising situations. In the *Retain* programme, participants also mentioned an ability to be able to 'reappraise' their situation, which led to reduced self-blame, isolation and increased appreciation of their skills. In a similar intervention, Kidd, Boyd, Bieling, Pike and Kazarian-Keith (2008) describe how they used a range of cognitive strategies with 16 employed participants with mood and anxiety disorders in order to improve their confidence around work based tasks. They found an improved sense of control and satisfaction around tasks following completion of the programme, which focused on cognitive restructuring, psycho-education and mindfulness.

It may be that mindfulness is an important way to manage mental health conditions at work for individuals, because it helps people to reappraise situations and improve

self-awareness. This is backed up by the fact that workplaces are beginning to see the benefits of acceptance and commitment therapy and enabling psychological flexibility on employee wellbeing (Bond, Flaxman, Veldhoven & Biron, 2010). Acceptance and commitment therapy focuses on several central components around not fusing with thoughts and the impact of values-based action on managing mental health issues. If employees are benefitting from training programmes, which focus on being mindful and considering values based action, then these skills are likely to be transferable for people in work with mental health conditions. Linking in with mindfulness practice, participants also mentioned being physically active in work and using physical activity as a way of improving mindfulness. Physical activity has long been established as a mechanism for improving mental health and is recommended by the New Economics Foundation as one of the five ways in which to improve daily mental health (Thompson, Aked, Marks & Cordon, 2008).

Organisational Interventions: The Role of the Organisation

Secker and Membrey (2003) highlight that any organisation should provide "natural supports" (p. 207) that enable employees to feel supported in their work, irrespective of mental health conditions. These natural supports are aspects around training and support on the job, supportive working relationships, workplace culture and the attitudes of line managers. Their main point is that these interventions are not just about enabling people with mental health problems to stay in work, but also developing a set of preventative measures to ensure all employees experience improved mental well-being. Both Krupa (2007) and Kirsh (2000) support the

importance of establishing natural supports within a working environment, supporting the establishment of an organisational culture of well-being.

It was mentioned earlier how achieving cultural change can be a long and complex process, and organisations are paying more attention to their role in managing well-being. The complexity of this process is reflected in the varying outcomes of different mental health initiatives (*Fit for Purpose, Absence and Workplace Health Survey*, CBI, 2013). In 2010, the Government introduced capability based fit notes, aimed at helping employers to collaboratively develop contracts with employees around what they could carry on doing rather than being signed off work. However, only one fifth of organisations in the same survey reported that the fit note was being used appropriately. Procedural changes to managing mental health do have some degree of impact, but change may need to come from more within an organisation.

Corbiere, Shen, Rouleau and Dewa (2009) conducted a systematic review of workplace interventions around preventing poor mental. Although they largely reviewed studies around work causing poor mental, they also identified both the importance of involving the organisation in any form of mental health intervention and using participatory research to enable this. This involvement of using stakeholders in enabling change to provide "a synergy for necessary changes" (p. 114) not only supports the role of using participants in a more active way as this study has done, but also suggests how organisations could enable a culture of well-being and benefit people with mental health issues at the same time. Robinson, Tilford, Branney and Kinsella (2013) reviewed the value of using mental health champions in changing organisational culture around mental health across projects in Yorkshire and Humber.

They found that these types of roles were fundamental in achieving change and depended upon champions' motivation, skill and existing work commitments.

Along with the organisational culture, participants often commentated on the impact of their physical working environment on their mental health, a component which is often under looked by both employers and employees. Cooper, Boyko and Codinhoto (2009) reviewed 280 articles on how the physical working environment impacts mental health and other factors at work. They concluded that the environment can be determined by three factors – the physical design, the quality of the ambient environment and the psychological impact of this environment. Increasingly they observed how these factors revolved around our perceptions of the physical environment - around perceived safety, the link to the natural environment and the maintenance of perceived workspaces. Cooper et al. (2009) recommend that the management of the environment leads to improved mental capital and well-being. It appears that by improving workplace well-being and working environments, the general level of mental health may improve and therefore positively impact employees across an organisation.

Interventions across a number of levels

Many of the research studies already mentioned have indicated the involvement of the organisation and the individual in achieving change within work for people with mental health conditions. The multi-intervention approach is not new, and Krupa (2007) summarises many of the individual interventions that have been considered within this research study, although many of them do rely on disclosure. He mentions the importance of early identification, diagnosis and treatment, assessment and

planning, self-awareness counselling, coping skills training, reasonable job accommodations and social network development. This indicates that there are potentially further inventions that this research project has not considered, especially around coping skills training.

Where Krupa (2007) suggests there is a lack of knowledge is around producing high-level evidence for most employment interventions, and certainly at an organisational level. Krupa's other critique of the research already conducted concerning individual and organisational interventions is around how health professionals need to be made more aware of the scope of potential interventions. This echoes the further potential role for Counselling Psychologists around championing workplace intervention and the views of participants from this project about the lack of organisational awareness about mental health. Interesting, Krupa does also not mention much about the role of line managers in facilitating interventions between individuals and organisations. This research study therefore supports both the consideration of individual and organisational factors in improving management of mental health conditions, but importantly emphasises the role of the line manager.

Evaluation of current research

Earlier, I referred to the importance of achieving trustworthiness in qualitative data, through Shenton's (2004) four criteria of credibility, transferability, dependability and conformability. Charmaz (2006) provides her own criteria for how to evaluate grounded theory studies, identifying credibility, originality, resonance and usefulness as her points for consideration. Waterman, Tillen, Dickson and De Koning (2000) suggests a number of questions that might help the action researcher to assess their

study asking whether the local context and the relationship between researcher and participants were adequately considered whilst implementing change, and whether the data was collected in a way to address the research issue and steps taken to achieve rigour.

Credibility covers the aspect of whether I was able to provide a true picture of what mental health problems in the workplace look like and appropriate interventions. Charmaz's (2006) further exploration of credibility covers whether there is sufficient data to meet claims, that the categories were sufficiently compared and if independent assessment of the data took place, similar findings would be achieved. Credibility may also tie in with Waterman et al.'s question of whether the data was collected in a way to address the research issue and in a rigorous way.

As mentioned in the results, I ensured a number of aspects to achieve credibility such as selecting participants with a range of occupational backgrounds, exploring topics fully and focusing on existing interventions. I endeavoured to ensure my analysis was thorough enough to ensure replication of ideas and believe the resulting model to be an appropriate platform for the beginning of further research into this area. I would however have wanted to gather more data, by either interviewing HR professionals or other people with lived experiences, explicitly about what they thought of the resulting model.

Transferability could be linked to usefulness as both categories question whether the findings could be applied to situations similar to the one in which the researcher is investigating. Charmaz (2006) expands this to include whether people can use the

findings in their everyday life, if there are generic qualities and whether the model contributes to knowledge. As mentioned, I tried to find commonality between participants' experiences and reflect upon what they could all do differently. I also think we developed interventions people could use in their everyday lives and provides categories which future researchers may wish to expand upon. However, there is always a consideration of context within the categories derived here and there are limits in assuming the model could be applied to any organisation or individual, given the review of the socially constructed factors mentioned earlier and the small number of participants.

Dependability and conformity overlap with Waterman et al.'s (2000) consideration of whether the local context and relationships between participants and researcher have been considered. I argued that dependability and conformity may not be such an issue for socially constructed research projects. Social constructionists recognise that the researcher is never objective and that results are interpreted within the context of the research itself. Taking this viewpoint, it is therefore possible to expect that two people conducting the same research would influence the outcomes in their own ways due to differences in personality, background and other variables.

I reflected on how I have influenced the outcomes of this research and how the context of 'here and now' impacts the outcomes. As someone who focuses on building positive relationships and has a degree of occupational knowledge I ensured a cohesive group through setting clear ground rules and commentated on occupational knowledge when it felt appropriate. I think there were points where I could have intervened more, stepped back, played less of an 'expert' role and moved the

conversation forward. I also conducted the literature review towards the end of the action research process and think this influenced my questioning and understanding around the issues of disclosure. This was also my first time in conducting action research and using grounded theory and therefore a degree of apprehension in how the project unfolded and whether 'I was doing it right'. It would therefore be difficult to claim dependability and conformity as I do not think action research requires these to be important criteria as long as results are discussed in relation to the context of the research and the influence of the researcher themselves.

However, I think the results from this project could apply to individuals and organisations across the UK because of the diversity of occupations within the group. I do recognise that a larger group, with different ages and sexes would have expanded this claim and meant I could have interpreted the findings more generically. As mentioned, I think the resulting model could be a platform for further investigations and gathering of data. Charmaz (2006) refers to the additional criteria of resonance and originality. Resonance refers to whether the categories portray the fullness of what has been researched and whether the outcomes make sense to participants. Having tested the final model out with the participants I feel the results do have resonance for the experiences we discussed. As mentioned though, exploring the model further with other researchers and professionals would be the next step for this research.

Originality obviously refers to whether a new conceptual understanding has been developed, the social and theoretical significance of this work and how the resulting model may impact current practice. This concept can be considered further in the next

section around implications for counselling psychology and future research ideas. However, I do not think that I can claim to have developed an original model. What I think this research has done is to pull together important proposed interventions and further highlight the role of the line manager in managing mental health at work.

Reflexivity

Returning to my epistemological positioning, I concluded that I took on the view of a social constructionist and that any finding or model is influenced by our society, culture and language. Within constructivist grounded theory analysis Charmaz (2006) mentions situating grounded theories in their "social, historical, local and interactional contexts" (p.180) as it strengthens them and suggests comparisons can then be easily made. It therefore seems important to reflect upon the key findings mentioned above in terms of those influences and in relation to how I influenced the process.

The categories identified above are of course considered in relation to the current climate that the research took place in. For example, UK employers are not allowed to discriminate if mental health has been declared as a disability and employees do not have to disclose. In the UK, there is at least some common understanding and medical classification around mental health issues and employees have the right to speak openly about their needs under UK law. It is therefore realistic to suggest interventions, which propose changes to organisations in how they can improve their culture or line management training around mental health and make it easier for employees to speak more openly in disclosing their mental health conditions.

However, many developing countries have no policy around basic mental health provision and stigma and discrimination are far worse (Ngui, Khasakhala, Ndetei & Roberts, 2010). In terms of socio-economic status, an inverse relationship between status and mental disorder has been documented (Dalgard, 2008). Researchers have found that participants express mental health symptoms in culturally acceptable ways and through their own meaning (Kleinman, 1988). Walker (2006) even suggests that mental illness is a socially constructed idea in itself. It therefore may not be appropriate to suggest improving disclosure, line management training or culture change when basic human rights are not even established in working cultures.

The group of participants involved in this project were all women. In the UK, women are regarded as equal employees and there are important laws in place to protect the equality and diversity of the working population. Historically, minority groups have worked to develop equal opportunities and the importance of anti-discrimination has both moral and legal implications for employers. Employees are encouraged to voice their opinions through staff surveys and feedback appraisals. However, public sector organisations are confined by Government budget constraints and there is still a culture of presenteeism around fear of losing work (*Stigma Shout Survey, Time to Change*, 2014). It therefore is appropriate to make recommendations from the categories identified above, with recognition that many of them are relevant within a UK context and at this present time and would need validating with a more diverse group.

When thinking more specifically about the group of participants involved in this project, I have to recognise that the resulting model and categories were influenced by

their worldviews too. The group itself was very supportive and there was a tendency for participants to agree with one another rather than provide contention. They were people who were open to embracing new ideas and gave one another space to consider different aspects. They were also people who had sought help and interventions of their own accord. As a group they therefore may not be representative of many people with mental health conditions who do not seek intervention or help with their mental health conditions or are not as motivated. This group were also passionate about change in the workplace about mental health issues and most were willing to speak openly to colleagues about their experiences. Managing mental health conditions is a personal decision and it is important to recognise that other people may not have the confidence or support to know how to stand up for their own rights.

As mentioned in the results section, Charmaz (2006) refers to the researcher needing to reflect upon how they represented their participants during the research process and write-up. I saw my participants as co-researchers, but also with the capacity to fully explore and reflect upon interventions that could be employed in work. Although I selected them based upon a short interview, indicating a level of engagement and ability to reflect, I recognise I have made an assumption about them fully representing a high degree of knowledge about their conditions and subsequent interventions. It might be that these participants did not actually fully reflect what people with long-term mental health conditions experience and also may represent a particularly motivated and resourceful group of individuals who had already developed greater self-awareness. It is important for me to acknowledge my bias in representing them

here and I come back to the idea that the theoretical framework presented here, may represent only one interpretation of the studied world.

As an Occupational Psychologist working on campaigns to change mental health discrimination in the workplace, I also recognised my own influence on the research process. I provided prompts to the group around discussing different topics such as disclosure and relationships at work and therefore consider this to have impacted the direction of the research. With this in mind, it is important to recognise that the findings and the way they were developed were construed through my own personal influences and understanding. I recognise that I have a belief that organisations have a greater duty of care for people's own mental health and have focused on their role more in the discussion than I intended to.

In the method section, I outlined that I conducted the literature review towards the end of the action research process. I mentioned that I did this due to time constraints and the reality of completing a research thesis. I mentioned how this did not offer me any greater insights other than looking more at the issue around disclosure. However, I am aware that the freelancing work I conducted throughout the development of this research project did heavily influence the model development and action research process. Working with a number of organisations around improving their mental health approach and policy, I interviewed employees from a range of organisations about how they were treated by their organisation in relation to their mental health. I was also made aware of key papers by Mind and other organisations, highlighting the importance of interventions working at an individual and organisational level. Throughout these interviews and reading of key papers, I was aware of how important

the line management relationship is for employees in order to manage their mental health. I continued to carry these ideas with me and undoubtedly influenced the group in questions directly focused on line management relationships.

Strengths and limitations

Strengths

In the results section, I referred to the differences between participatory action research and practical action research. One of the strengths of both of these types of action research is that it provided participants with the opportunity to be a fundamental part of the process. As mentioned in the methodology, action research is a process by which participants become 'co-researchers' (Kagan et al., 2008) focusing on outcomes directed at improved social change, founded upon social values. This research process resulted in actual positive outcomes for many of the participants and empowered them to manage some of their own solutions. It also enabled a model to develop which builds upon other researcher's findings and provides more of an emphasis on the line management relationship.

As a facilitator myself, passionate about changing how the working environment considers how mental health is managed, I found this process to be incredibly engaging. Working with people who actually would benefit from any interventions or outcomes enabled me to satisfy an important value I have around improving social results and outcomes. Although this research was only conducted with four individuals, two of them were able to take information back to their workplace and make a real change as to how their workplace manages mental health. Obviously this

result depends upon the people recruited to take part, but participants found the cohesive nature of the group a support platform to make real changes.

Another strength of using action research and constructivist grounded theory as the process by which data is collected is that it provides the researcher with flexibility and the opportunity to change direction. As the action research process unfolded, we were able to respond as a group to the needs of the group, rather than been focused on a specific agenda. If the group needed time to support one another, we were able to include this in the progression of the research itself. Although an often abstract process, this flexibility in approach also enables research to be participant led and potentially far more effective than producing recommendations based on clinical opinion.

Another strength of this research process was being able to develop a visual representation of the proposed model. This interactive diagram can be easily altered and presented to groups and organisations for further analysis and validation. I think it also draws attention to the fact that researchers can be more creative about how they conduct and represent research findings. It is likely that people with long-term mental health conditions also need guides which are easily accessible and point quickly to areas for support and guidance, so a visual representation makes this more useful. I may need to rethink the layout of this model and would like to pilot it within mental health workshops to test participant opinion.

Limitations

The first limitation identified within this research process is the fact that the group of participants were all white women, including myself. Although all presented with different mental health conditions and worked across different organisations, it is recognised that there was some homogeneity to this group. A group consisting of different ethnic backgrounds, ages and male participants would have enabled the results to have a wider application, even in recognition of my socially constructionist stance.

In the results section I also referred to the fact that the group moved between discussing wider social issues and more personal interventions around taking action. Along with identifying whether the action research process itself is practical or participatory, I think it would have been helpful to have previously conducted an action research project before. My learning would be that it is important to reflect with co-researchers around exactly what the objectives of the group are and what level of change the group is aiming for, as I think we engaged in society level reflections when we could have been reflecting more on personal, practical change.

I knew that action research was an ambiguous process, but I think that I should have considered more what taking action involves in relation to conducting a comprehensive action research process. From my experience of this research process, I think it is important for the researcher to have a realistic expectation of how long the phases of planning and reflecting upon action may take and not be put off by the fact that taking action is often conducted nearer the end of the process in my experience. It is also important to recognise that the processes of group cohesion may take time to develop and that the researcher needs to have a more relaxed approach to intervention

development. The action researcher also needs to have a broad idea around what taking action looks like and this needs to be considered and reflected upon throughout the process. My further learning from this process is that action can also be taken after the initial process has finished and that the researcher may want to evaluate action beyond the completion of the initial cycles of change.

As I reflected in the results section, the role of co-researcher is a difficult one and unlikely to follow similar processes each time it is engaged in and the researcher is likely to inhabit different roles throughout the process. The different roles that the researcher inhabits are obviously dependent upon what is being investigated, but I found that I needed to think more about the emotional content of sessions and consider how to manage them. When looking at any subject around personal experiences, it is unlikely that the content of sessions will be unemotional for people. I think another important factor coming from my experience of this research process is to consider how the research group remains a supportive place, but does not turn into a therapy group.

Earlier in this review, I also questioned the success of this action research process in relation to group reflections between sessions and using diary formats. Participants were able to reflect as a group, but not individually outside of the sessions. It may be that I could have been more forceful or ensured participants had time to fill out the logs at the beginning of sessions. I think there is always a difficulty in gaining meaningful feedback after an event and this is an aspect, which I would recommend future researchers pay close attention to.

I also think an important limit of this process was time and the number of participants. Four group sessions over three months was potentially not long enough to gather as comprehensive data as I would have wished and there is scope to fully explore these categories further in future studies. I also think a bigger group would have provided more insights and enabled me to think more widely about the application of interventions. If I was running this research process again, I would spread the sessions out and try to recruit a larger and more diverse group of participants.

Overall, I would encourage future Counselling Psychologists to consider using action research. It is a process that not only keeps the researcher engaged and involved, but also can result in positive change for participants involved in the process. However, future researchers should be more aware of what type of action research they wish to conduct by thinking about the outcomes they wish to achieve. I would also consider how long action and change may take and implement more effective ways of gaining reflective comments from participants.

Recommendations: Application to Counselling Psychology Practice and Policy

One of the main issues discussed in mental health studies at work seems to be the difficulty around disclosing or not to employers. If an employee discloses their diagnosed long-term mental health condition, then employers are required by law to put reasonable adjustments in place to help those individuals (Disability Discrimination Act, 2010). However, it was identified within the literature review that many people with long-term mental health conditions still feel they might face discrimination upon disclosing and therefore often choose not to (Thornicroft, 2008). Trying to change cultural perceptions towards mental health and facilitate open

disclosure therefore might appear an important intervention in enabling people with long-term mental health conditions to thrive in work. In reality though, changing cultural perception and attitudes towards mental health could take a significant amount of time and involve key influencers across society taking an active approach (Henderson et al., 2013).

Participants within this study though, found it difficult to reflect upon how mental health problems could be helped, without disclosing and seeking the help of their line manager. This finding around managing long-term mental health conditions at work therefore suggests a need for employers to think through carefully how they approach the issue of disclosure within mental health policies. Potentially bringing in the use of disclosure decision tools and the 'Buffer Stage' policies suggested by De Lorenzo (2013) may enable employees to understand how to make this difficult decision and consider how to gain further support. From the research findings and previous research, it is also important that organisations develop policies, which include both information on mental health conditions, but also guidance for line managers.

It was highlighted earlier how line managers themselves are not always provided with training in how to manage mental health conditions and that organisations need to do more in understanding their legal obligations (Henderson et al., 2013). Many mental health organisations run training programmes about basic mental health policies and training about mental health needs and therefore it might be important to further consider how policies can include practical aspects around providing training for line managers on how to manage mental health conditions. Gathering perspectives from employees with mental health issues may also be a further important aspect to

developing mental health policies within organisations. Counselling Psychologists could provide a role in both research and development of mental health policies within organisations and potentially act as advisers around implementing more supportive structures around decision making on disclosure.

Counselling Psychologists could also play a further role in consulting on organisational change around mental health issues. Despite advances in how mental health is talked about and considered, there is still a culture of stigmatisation and negative language associated with mental health problems (*Stigma Shout Survey, Time to Change*, 2014). There is therefore a recognition that cultural change may need to occur rather than just the implementation of mental health policies. Using mental health champions and procedural changes together may ensure more is achieved at a cultural level. Counselling Psychologists are trained to understand individuals' motivation around change, and maybe ideally placed to consult on organisational change.

Counselling Psychologists could also lead or add further to IPS programmes or retention programmes and develop a more evidence-based support group structure. The importance of using group formats for developing social support and confidence has been illustrated in a number of studies, not just this one. The exact structure of the support group still needs defining, but Counselling Psychologists could be well placed to pilot groups either between or within organisations. Groups that allow space for reflection and shared support is important, but also establishing goals and defined guidelines around confidentiality and disclosure.

Working with clients on a one to one basis is also an obvious role for Counselling Psychologists. This function could involve how to have supportive conversations with line managers to develop individual interventions or working through the difficulties associated with disclosure. The model proposed in this study also supported the importance of individuals developing their self-awareness and an understanding of their own internal values, supported by other researchers. Counselling Psychologists could provide a further role in which they work towards developing these aspects, even potentially before a future employee takes up an employment offer.

I think there are also implications from this research around the practice of Counselling Psychologists as researchers. As mentioned, action research allows the use of more emergent processes to consider best practice and what success looks like in research. It also can result in positive change for participants, rather than just a reflective process that contributes to understanding around individual experience. Developing more evidence-based research that has definable outcomes could result in further interventions, which could be applied more widely within therapeutic services. Providing the limitations mentioned previously are considered by Counselling Psychologists, action research could offer a process for achieving more evidence-based interventions within work.

All of the proposed recommendations mentioned above though rely on Counselling Psychologists broadening their knowledge about organisations and culture change within work. As mentioned in the literature review, Counselling Psychologists are trained as pluralistic practitioners and could really champion the further use of psychological interventions in relation to work. There could be an argument around

the fact that Counselling Psychologists can apply their existing knowledge around psychological interventions to the world of work, but findings from this project suggest that Counselling Psychologists could also further explore and use interventions from the world of stress management literature.

Within the Division of Counselling Psychology's Professional Practice Guidelines, more could be mentioned about the role of work in enabling therapeutic change in clients. Counselling Psychologists in the UK already work outside of NHS or private mental health services, in roles within Employee Assistance Programmes, stress management services, traumatic incident management work and other vocational services. If Counselling Psychologists are already working in more vocational fields, there is evidently capacity for Counselling Psychologists to further champion change at an organisational around mental health at work.

Traditionally, Occupational Psychology is the branch of psychology concerned with the world of work and employee well-being. However, when referring to the BPS guidance on occupational areas for Occupational Psychologists, the criteria outlines more of a coaching role for managing stress at work, rather than the application of therapeutic interventions for mental health and wellbeing (DOP Candidate Handbook, 2012). Areas of psychology naturally overlap and there could be a further role for Counselling Psychologists to work more directly with Occupational Psychologists to enhance and share existing knowledge.

In the US, Counselling Psychologists are defined as practitioners working towards developing healthy aspects of clients within the "context of life-span

development….and the role of career and vocation on individual development and functioning" (APA, 1999, p. 587). Munley, Duncan, Mcdonnell and Sauer (2004) refer to that fact that many Counselling Psychologists in the US work in vocational settings, providing vocational counselling. This could be an important role for Counselling Psychologist to begin to inhabit, as more emphasis is put on improving mental health in work by the UK Government.

A recent report by the Organisation for Economic Co-operation and Development, (OECD, 2014) on mental health in work identified the UK as one of the most advanced countries in terms of awareness around the costs of mental illness across society. The OECD report recommends key improvements for where the UK will need to develop in terms of achieving real change within mental health at work. Amongst the recommendations, the report cites interventions around improving the integration of health and employment services and investing in programmes able to provide adequate support for disadvantage consumers. With greater occupational knowledge, there is no reason that Counselling Psychologists could not champion this work further.

Aside from the argument around expanding this dimension to the Counselling Psychologist role, it is also important that all Psychologists have a greater understanding around how to improve retention for clients with mental health issues. As mentioned in the OECD report, the UK is well aware of the advantages that employment brings to mental health, and there could be a focus for all Psychologists around how to improve client resilience within this area. As practitioners, we have a

duty of care to consider all of the needs of our clients, including improving access to and retention in work and should be part of any therapeutic intervention process.

In summary, the implications of this research on Counselling Psychology are two-fold. Firstly, more research conducted by Counselling Psychologists about improving working outcomes for people with mental health conditions will be an important area for the profession to expand further into. Practitioners could also pay greater attention to the role that purpose and value has in a client's life and how this relates to work. Secondly, Counselling Psychologists could further champion change at an organisational level about mental health at work and develop further evidenced based interventions in order to expand the Counselling Psychologist's vocational role.

Future Research

Within this discussion, a number of ideas have already been mentioned into where future research could be taken. Starting with the model itself, this could be explored within other research groups and across organisations. I mentioned wanting to understand the reactions of HR professionals and successful employees who experience mental health problems to the model. An additional piece of research could be around exploring the success stories of people who have very productive careers, but lifelong mental illness. This may result in being able to add to the model or indeed identify components that have not been considered. It will also be important to validate this model with different groups and consider testing the model with participants that represent a more diverse population. Extending this model to test in other Countries may also be important, but it is recognised that this current model is based upon the views of only four participants and myself.

The model itself is only a starting position for interventions and future researchers could drill down and expand upon specific psychological components of the categories. One of the main components could be around improving line management support and see if this impacts disclosure rates. Practitioners could evaluate what effective training would look like and understand whether improving line management relationships would have an impact in general on mental health. Researchers could also extend research to consider more about the role of this relationship from the employee's perspective. Linked in with understanding more about the line management relationship, future researchers could explore more about an individual's capacity and capability to be a manager. Often management is seen as an add-on aspect to people's roles, for which they often do not have training. There may need to be some revision of management capacity and consider whether providing more time and emphasis on management practice enables improved mental health.

Highlighted within the literature review was the need to conduct research with people already in work about individual interventions they could develop without the need for disclosing. This project has partially begun to answer this question, but more research needs to be conducted to fully answer this question. Researchers therefore may want to develop further the concept of self-awareness and values in work in relation to mental health and how to enable both aspects early on upon diagnosis or acceptance of a mental health condition. Some of the participants within this research noted that when they were experiencing deep depression or anxiety they were unable to think clearly. There could be a piece of research in evaluating whether it is possible

to improve self-awareness during episodes of depression for example. Whilst ideas such as coping cards and monitoring diaries were considered, it might be important to identify the most appropriate mechanisms for improving self-awareness.

There could also be a valuable piece of working in testing out different versions of mental health groups and different formats of support. It could be important to explore both confidential groups which employees can join without disclosing, or groups that are set up between organisations to ensure this confidentiality further. Support groups could also be developed according to different facilitative models and results compared to develop best practice guidelines for mental health groups.

As mentioned, there are already exciting programmes being developed around improving organisational culture towards mental health conditions. It could be helpful to further develop comprehensive case studies, which illustrate how this could be achieved, which other organisations could adapt for their own use. There are existing programmes within the UK, such as the BITC's Workwell scheme, which offer a starting point for organisations to assess workplace interventions. Future studies could focus specifically on how to enable change to organisational culture by reviewing whether improving line management relationships, self-awareness, providing group support and investing in the working environment impact mental health across an organisation. It is recognised that some studies have already begun to do this, but a wider application of change is important.

This project asked the fundamental question of how to improve the working lives of people with mental health conditions, but largely relied on the anecdotal evidence of a

small research group. In order to understand more completely about the concepts discussed here, researchers could use these concepts more widely in retention programmes to see if they have a quantifiable effect. It would be also helpful to understand if some of these interventions were able to improve working lives and not just ensure improved retention rates.

Linking back to the literature review, there was also the question of whether all work is fundamentally 'good' for people with mental health problems. There are likely to be conditions and phases during which some employees are just unable to work. This is often the difficulty faced by employers around weighing up the decision to retain employees during absence whilst still ensuring their business is able to meet demands and others are not left feeling overloaded. There could be a piece of research in examining the negative impact of working and developing more creative ideas around how organisations can maintain their productivity levels even when employees might need to take important time off to recover.

There are many avenues as to how future researchers could take the model generated here forward. It is probably more important that this model is researched and expanded upon with different groups and within different organisational settings. Future researchers may wish to consider how to capture what successful people do in work to manage their mental health conditions as a next step with understanding and adding more to this model.

Conclusion

Throughout this research project, I have attempted to illustrate that work is fundamental to recovery and that people with long-term mental illness can work, given the right support. I have endeavoured to find interventions that could enable people with mental health conditions to remain in work and found a research process that enabled participants to reflect upon and even put in place what these interventions might look like. Although I would have liked these interventions to be tested out and reflected upon more, the overall model has provided a starting place for future researchers to develop a greater understanding of how this might be achieved and also builds on previous research findings.

The findings from this research suggest both the organisation and the individual have a joint responsibility in establishing conditions for improved mental health. For the individual, developing greater self-awareness about their own mental health, how to manage it and consider warning signs seems to be important. Spending time considering their capacity and values may also help to improve motivation and the right level of challenge and security. For the individual and the organisation, there is a question of how to improve fundamental line management relationships, which may enable greater self-awareness and levels of disclosure, leading to changes around stigma and discrimination. The organisation needs to also consider how they can support mechanisms for supporting improved mental health through groups, mental health champions and improving general working conditions. Evidently all these factors need further research and could present a wealth of varying opportunities for Counselling Psychologists to broaden their research base.

The model derived from this research seems to echo previous research findings by researchers within the field of employment retention. It seems that in order to survive and thrive in work, the employee and employer need to work together to develop more supportive practices. As Cameron et al. (2012) identified, interventions need to focus on the individual, their role and the working environment. The findings from this research have offered a number of further starting points for areas of combined improvement, and could help inform change programmes to ensure they target individual and organisational intervention outcomes.

I believe I have been able to answer in part the main research question for this project, with a series of suggestions of interventions which need further testing in the real world. It might be that IPS programmes are already encompassing many of these interventions, and if so, may need to publicise their findings more widely. Interventions also need to be explored with people who are not accessing mental health services and so considering how to enable this information to be circulated widely will be important to consider. In terms of taking this researcher further myself, I intend to consider approaching future partners in how to develop the ideas around mental health groups and self-help information to the next level. I also intend to consider how I can further combine Occupational and Counselling Psychology in order to influence future research within this area.

References

Andrews, T. (2012). What is Social Constuctionism? *Grounded Theory Review: An international Journal, 11(1)*, 1 – 8.

American Psychological Association (APA). (1999). Archival description of couseling psychology. *The Counseling Psychologist, 27,* 589 – 592.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review*, *84*(2), 191.

Baumann, A., Muijen, M. & Gaebel, W. (2010). *Mental health and well-being at the workplace – protection and inclusion in challenging times*. World Health Organisation Regional Office for Europe. Retrieved July 2014 from http://www.euro.who.int

Becker, D. R., & Drake, R. E. (1993). *A working life: The individual placement and support (IPS) program*. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center.

Bell, M. D., Choi, J. & Lysaker, P. (2007). Psychological Interventions to Improve Work Outcomes for People with Psychiatric Disabilities. *Journal of The Norwegian Psychological Association, 44,* 2 – 14.

Behson, S. J., Eddy, E. R., & Lorenzet, S. J. (2000). The importance of the critical psychological states in the job characteristics model: A meta-analytic and structural equations modeling examination. *Current research in social psychology, 5,* 170-189.

Berger, P. L., & Luckmann, T. (1991). *The social construction of reality: A treatise in the sociology of knowledge* (No. 10). Penguin UK.

Bevan, S., Gulliford, J., Steadman, K., Taskila, T., Thomas, R. & Moise, A. (2013). *Working with Schizophrenia: Pathways to Employment, Recovery & Inclusion*. UK: The Work Foundation. Retrieved in July 2014 from http://www.theworkfoundation.com

Blank L, Peters J, Pickvance S, Wilford J, MacDonald, E. (2008). A systematic review of the factors that predict return to work for people suffering episodes of poor mental health. *Journal of Occupational* Rehabilitation, 18, 27–34.

Blankertz, L. (2001). Cognitive components of self esteem for individuals with severe mental illness. *American Journal of Orthopsychiatry*, *71*(4), 457.

Blonk, R.W.B., Brenninkmeijer, V., Lagerveld, S.E. & Houtman, I.L.D. (2006). Return to work: A comparison of two cognitive behavioural interventions in cases of work-related psychological complaints among self-employed. *Work & Stress 20*(2), 129 – 144.

Boardman, J., Grove, B., Perkins, R., Shepherd, G. (2003) Work and employment for people with psychiatric disabilities. *British Journal of Psychiatry, 182,* 467 – 468

Bond, G. R. (2004). Supported employment: evidence for an evidence-based practice.

Psychiatric rehabilitation journal, *27*(4), 345.

Bond, G.R., Becker, D.R., & Drake, R.E. (2001). Implementing supported employment as an evidence-based practice. *Psychiatric Services, 52*(3), 313–322.

Bond, F. W. amd Bunce, D. (2001). Job control mediates change in a work reorganization intervention for stress reduction. *Journal of Occupational Health Psychology, 6,* 290 - 302

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

Bond, F.W., Flaxman, P.E., van Veldhoven, M.J.P.M. and Biron, M. (2010). The Impact of Psychological Flexibility and Acceptance and Commitment Therapy (act) on Health and Productivity at Work. *Contemporary Occupational Health Psychology: Global Perspectives on Research and Practice, 1*, 296-313.

Boycott, N., Schneider, J., & McMurran, M. (2012). Additional interventions to enhance the effectiveness of individual placement and support: a rapid evidence assessment. *Rehabilitation research and practice, 2012.* Article ID 382420. Doi:10.1155/2012/382420

British Psychological Society (2015). Careers: Occupational Psychology. Retrieved in

March 2015 from http://careers.bps.org.uk/area/occupational

Brohan, E., Henderson, C., Wheat, K., Malcolm, E., Clement, S., Barley, E. A. & Thornicroft, G. (2012). Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC psychiatry*, *12*(1), 11.

Brydon‐Miller, M. (1997). Participatory action research: Psychology and social change. *Journal of Social Issues*, *53*(4), 657-666.

Brydon-Miller, M., Greenwood, D., & Maguire, P. (2003). Why action research?. *Action research*, *1*(1), 9-28

Burr, V. (2003). *Social constructionism*. Routledge; 2Rev Ed edition.

Burton, J, D. (2009). Moving towards value-based supported employment programs. *Psychiatric rehabilitation journal*, *32*(4), 257-258

Bury, M. (1986). Social constructionism and the development of medical sociology. *Sociology of Health and Illness, 8(2),* 137 - 169

Business in the Community (BiTC) (2014). *Workwell Scheme*. UK: Business in the Community. Retrieved in July 2014 from: http://www.bitc.org.uk/programmes/workwell/workwell-model

Butterworth, R., Costello, D., Looker, L., & Cuming, H. (2011). *Job retention practitioner's handbook*. City and Hackney Mind, London.

Cameron, J., Walker, C., Hart, A., Sadlo, G., & Haslam, I. (2012). Supporting workers with mental health problems to retain employment: users' experiences of a UK job retention project. *Work, 42* (4), 461-471.

Centre for Mental Health (formerly The Sainsbury Centre for Mental Health) (2007). *Policy Paper 8 – Mental Health at Work: Developing the Business Case.* UK: Centre for Mental Health. Retrieved in July 2014 from: www.centreformentalhealth.org.uk

Centre for Mental Health (2008). *Line Manager Survey: Great Places to Work UK & The Employers' Forum on Disability 2008.* UK: Centre for Mental Health. Retrieved from: www.centreformentalhealth.org.uk

Centre for Mental Health (2010). *Briefing paper 47: Barriers to employment: What works for people with mental health problems.* UK: Centre for Mental Health. Retrieved in July 2014 from: www.centreformentalhealth.org.uk

Centre for Mental Health (2012). *Briefing paper 44: Implementing what works: The impact of the Individual Placement and Support regional trainer*. UK: Centre for Mental Health. Retrieved in July 2014 from: www.centreformentalhealth.org.uk

Centre for Mental Health (2013). *The economic and social costs of mental health problems in 2009/10.* UK: Centre for Mental Health. Retrieved July 2014 from: www.centreformentalhealth.org.uk

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative research.* Sage Publications Ltd.

Chartered Institute of Personnel Development (CIPD) (2011). *Managing and supporting mental health at work: disclosure tools for managers*. UK: CIPD. Retrieved July 2014 from: www.cipd.co.uk

Chartered Institute of Personnel Development (CIPD) (2012). *Absence Management Survey 2012*. UK: CIPD. Retrieved July 2014 from: www.cipd.co.uk

Chartered Institute of Personnel Development (CIPD) (2013). *Employee Outlook Survey 2013.* UK: CIPD. Retrieved July 2014 from: www.cipd.co.uk

Chmiel, N. (2000). *Introduction to Work and Organizatioal Psychology: A European Perspective*, Blackwell Publishers Ltd, London

Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction*, *26*(4), 553-576.

Confederation of British Industry's (CBI) (2013). *Fit for Purpose - Absence and workplace health survey 2013*. Retreived in July 2014 from: www.cbi.org.uk

Connell, M., King, R., & Crowe, T. (2011). Can employment positively affect the recovery of people with psychiatric disabilities? *Psychiatric rehabilitation journal*, *35*(1), 59.

Cooper, R., Boyko, C., & Codinhoto, R. (2009). The effect of the physical environment on mental capital and wellbeing. In Cooper, C. L., Goswami, U., & Sahakian, B. J. (2009). *Mental capital and wellbeing*. John Wiley & Sons.

Corbiere, M., Shen, J., Rouleau, M., & Dewa, C. S. (2009). A systematic review of preventive interventions regarding mental health issues in organizations. *Work: Journal of Prevention, Assessment and Rehabilitation*, 33(1), 81 – 116.

Corrie, S. & Callahan, M. (2000). A review of the scientist-practitioner model: Reflections on its potential contribution to counselling psychology within the context of current healthcare trends. *British Journal of Medical Psychology. 73,* 413 - 427

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614.

Cox, T., & C. J. MacKay. (1981). A transactional approach to occupational stress in E. N. Corlett and J. Richardson (eds), *Stress, Work Design an Productivity*. Chichester: Wiley and Sons.

Cunningham, K., Wolbert, R., & Brockmeier, M. B. (2000). Moving beyond the illness: Factors contributing to gaining and maintaining employment. *American Journal of Community Psychology*, *28*(4), 481-494.

Cummins, R. (1989). Locus of control and social support: Clarifiers of the relationship between job stress and job satisfaction. *Journal of Applied Social Psychology, 19(9),* 772-787.

Curran, C., Knapp, M., McDaid, D., & Tómasson, K. (2007). Mental health and employment: an overview of patterns and policies across western Europe. *Journal of Mental Health*, *16*(2), 195-209.

Daurka, K. (2010). Disclosing Mental health problems could work against you. *The Guardian*. Retrieved in July 2014 from http://www.theguardian.com/law/2010/jun/25/mental-health-and-discrimination-work

Dalgard, O. S. (2008). Social inequalities in mental health in Norway: possible explanatory factors. *International journal for equity in health*, *7*(1), 27.

De Lorenzo, M. S. (2013). Employee mental illness: Managing the hidden epidemic. *Employee Responsibilities and Rights Journal*, Vol 25(4), 219 - 238

Dick, B. (2003). *What can action researchers learn from grounded theorists.* Paper prepared for the research symposium at the Australian and New Zealand.

ALARPM/SCIAR conference, Gold Coast. Retrieved in July 2014 from: www.aral.com.au/DLitt/DLitt_P60andgt.pdf

Dooley, D., Fielding, J., & Levi, L. (1996). Health and unemployment. *Annual review of public health*, *17*(1), 449-465.

Demarco, M. & Willig, C. (2011). Significant Processes in Action Research with a group of physiotherapists. *Counselling Psychology Review*, 26(4), 31-40.

Deverill, C., & King, M. (2009). Common mental disorders. *Adult psychiatric morbidity in England, Results of a household survey*, pp 25 - 37

Division of Counselling Psychology (current edition). *Division of Counselling Psychology: Professional Practice Guidelines.* Retrieved in July 2014 from: www.bps.org.uk

Division of Occupational Psychology (2012). *Qualification in Occupational Psychology (Stage 2): Candidate Handbook.* Retrieved in July 2014 from the British Psychological Society website (Qualifications Office): www.bps.org.uk

Duncan, L. E., Munley, P. H., Mcdonnell, K. A., & Sauer, E. M. (2004). Counseling psychology in the united states of america. *Counselling Psychology Quarterly, 17(3),* 247-271.

Drake, R.E., & Bond, G.R. (2008) The future of supported employment for people with severe mental illness. *Psychiatric Rehabilitation Journal, 31,* 367-376

Flaxman, P. E., & Bond, F. W. (2010). A randomised worksite comparison of acceptance and commitment therapy and stress inoculation training. *Behaviour research and therapy*, 48(8), 816-820.

Fleten, N. & Johnsen, R. (2006). Reducing sick leave by minimal postal intervention: a randomised, controlled intervention study. *Occupational and environmental medicine*, *63*(10), 676-682.

Forrester, M. A. (Ed.). (2010). *Doing qualitative research in psychology: A practical guide*. Sage.

Gates, L. B. (2000). Workplace accommodation as a social process. *Journal of Occupational Rehabilitation*, *10*(1), 85-98.

Glaser, B. G. (2002). Constructivist grounded theory? *Forum: Qualitative Social Research*, 3(3).

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Transaction Publishers, UK.

Greig, T. C., Zito, W., Wexler, B. E., Fiszdon, J., & Bell, M. D. (2007). Improved cognitive function in schizophrenia after one year of cognitive training and vocational services. *Schizophrenia research*, *96*(1), 156-161.

Greig, R., Chapman, P., Eley, A., Watts, R., Love, B., & Bourlet, G. (2014). *The Cost Effectiveness of Employment Support for People with Disabilities: Final Detailed Research Report.* UK National Development Team for inclusion. Retrieved in 2014 from: http://www.ndti.org.uk

Hackman, J. R., & Oldham, G. R. (1980). *Work redesign*. Financial Times/ Prentice Hall; 1 edition (1 Jan 1980).

Hallberg, L. R. (2006). The "core category" of grounded theory: Making constant comparisons. *International journal of qualitative studies on health and well-being*, *1*(3), 141-148.

Harris, R. (2009). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy*. New Harbinger Publications.

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior therapy*, *35*(4), 639-665.

Heaney, C. A., Israel, B.A., Schurman, S.J., Baker, E. A., House, J.S. & Hugentobler. (1993). Industrial relations, worksite stress reduction, and employee well-being: A participatory action research investigation. *Journal of Organizational Behavior, 34,* 495 - 510

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis.

The Psychologist, 24(10), 756-759.

Hemsley, C. (2013). An enquiry into how counselling psychology in the UK is constructed as a profession within discipline-orientated publications. *Counselling Psychology Review, 28* (1), 8 – 24

Henderson, C., Brohan, E., Clement, S., Williams, P., Lassman, F., Schauman, O., Murray, J., Murphy, C., Slade, M., & Thornicroft, G. (2012). A decision aid to assist decisions on disclosure of mental health status to an employer: protocol for the CORAL exploratory randomised controlled trial. *BMC psychiatry* 12(1)

Henderson, C., Williams, P., Little, K., & Thornicroft, G. (2013). Mental health problems in the workplace: changes in employers' knowledge, attitudes and practices in England 2006-2010. *The British Journal of Psychiatry*, *202*(55), 70-76.

James, P. E. (2013). Counselling psychology in the UK: A 30-year passage. *Counselling Psychology Review, 28 (3),* 75 – 80.

Jahoda, M., Lazarsfeld, P., & Zeisel, H. (1932). *Marienthal: The Sociography of an Unemployed Community*. USA: Transaction Publishers

Johnson, J. V., & Hall, E. M. (1988). Job strain, work place social support, and cardiovascular disease: a cross-sectional study of a random sample of the

Swedish working population. *American journal of public health, 78(10),* 1336-1342.

Jordan, J., Gurr, E., Tinline, G., Giga, S., Faragher, B., & Cooper, C. (2003). *Beacons of excellence in stress prevention* (research report 133 Health and Safety Executive). London: Health and Safety Books.

Joyce, J. (2013). Facing the challenge of mental ill health in the workplace. *Journal of Public Mental Health*, 12(2), 93 – 97.

Karasek, R. (1979). Job demands, job decision latitude and mental strain: Implications for job design, *Administrative Science Quarterly, 24,* 257 - 65

Karasek, R. T., & Theorell, T. T. (1990) *Healthy work–stress, productivity and the reconstruction of working life.* US: Basic books.

Kagan, C., Burton, M., & Siddiquee, A. (2008). Action research. In Willig, C. & Stainton-Rogers, W. (Eds), *The SAGE handbook of qualitative research in psychology*, 32-53. Sage

Kern, R. S., Liberman, R. P., Kopelowicz, A., Mintz, J., & Green, M. F. (2002). Applications of errorless learning for improving work performance in persons with schizophrenia. *American Journal of Psychiatry*, *159*(11), 1921-1926.

Kidd, S. A., Boyd, G. M., Bieling, P., Pike, S., & Kazarian‐Keith, D. (2008). Effect of

a Vocationally‐Focused Brief Cognitive Behavioural Intervention on Employment‐Related Outcomes for Individuals with Mood and Anxiety Disorders. *Cognitive behaviour therapy*, *37*(4), 247-251.

Kirk, J. M., & Miller, C. ML (1986). *Reliability and validity in qualitative research*. Bevely Hill: Sage.

Kirsh, B. (2000). Factors associated with employment for mental health consumers. *Psychiatric Rehabilitation Journal*, *24*(1), 13-21.

Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. Free Press.

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development* (Vol. 1). Englewood Cliffs, NJ: Prentice-Hall.

Knight, S. (2015). Realising the benefits of reflective practice. *Nursing Times; 111: 23/24,* 17-19

Krupa, T. (2007). Interventions to improve employment outcomes for workers who experience mental illness. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *52*(6), 339-345.

Kukla, M., & Bond, G.R. (2012). Job match and job tenure in persons with severe

mental illness. *Journal of Rehabilitation, 78(*1), 11-15

Kukla, M., & Bond, G. R. (2013). A randomized controlled trial of evidence-based supported employment: non-vocational outcomes. *Journal of Vocational Rehabilitation, 38*, 91-98

Layard, R. (2013). Mental health: the new frontier for labour economics. *IZA Journal of Labor Policy*, *2*(1), 1-16.

Lewis, R. & Zibarras, L. (2013). *Work and Occupational Psychology: Integrating Theory and Practice.* Sage

Lloyd, C., King, R., & Moore, L. (2010). Subjective and objective indicators of recovery in severe mental illness: a cross-sectional study. *International Journal of Social Psychiatry*, *56*(3), 220-229.

Locke, E. A., & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American Psychologist*, *57*(9), 705.

Loveland, D., Driscoll, H., & Boyle, M. (2007). Enhancing supported employment services for individuals with a serious mental illness: A review of the literature. *Journal of Vocational Rehabilitation*, *27*(3), 177-189.

Lysaker, P. H., Bond, G. R. & Davis, L.W. (2005). Enhanced cognitive – behavioural

therapy for vocational rehabilitation in schizophrenia. Effects on hope and work. *Journal of Rehabilitation Research and Development, 42,* 673 – 682.

Marwaha, S., & Johnson, S. (2005). Views and experiences of employment among people with psychosis: a qualitative descriptive study. *International Journal of Social Psychiatry*, *51*(4), 302-316.

Marwaha, S., Balachandra, S., & Johnson, S. (2009). Clinicians' attitudes to the employment of people with psychosis. *Social psychiatry and psychiatric epidemiology*, *44*(5), 349-360.

MacDonald-Wilson, K, (2005). Managing disclosure of psychiatric disabilities to employers, *Journal of Applied Rehabilitation Counseling, 36* (4), 11-21.

McGill, I. and Beaty, L. (2002). *Action Learning: a guide for professional, management and educational development*, Kogan Page Limited, London

McGurk, S. R., Mueser, K. T., & Pascaris, A. (2005). Cognitive training and supported employment for persons with severe mental illness: one-year results from a randomized controlled trial. *Schizophrenia Bulletin*, *31*(4), 898-909.

Melchior, M., Caspi, A., Milne, B. J., Danese, A., Poulton, R. and Moffitt, T. E. (2007) Work Stress precipitates depression and anxiety in young, working women and men. *Psychological Medicine,37(8),* 1119-1129

Meltzer H, Gill B, Petticrew M and Hinds K (1995). *Report 3: Economic activity and social functioning of adults with psychiatric disorders,* OPCS Surveys of Psychiatric Morbidity in Great Britain. HMSO: London.

Mental Health Foundation (2007). *The Fundamental Facts – the latest facts and figures on mental health.* UK: Mental Health Foundation. Retrieved in July from: www.mentalhealth.org.uk

Mind (2012). *Taking care of business – Employers Guide to Mentally Healthy Workplaces*. UK: Mind. Retrieved in July 2014 from www.mind.org.uk

Mind (2014). *Online legal briefing on disability discrimination act and UK equality act.* UK: Mind. Retrieved in July 2014 from www.mind.org.uk

Munley, P. H., Duncan, L. E., Mcdonnell, K. A., & Sauer, E. M. (2004). Counseling psychology in the United States of America. *Counselling Psychology Quarterly*, *17*(3), 247-271.

Nakamura, J., & Csikszentmihalyi, M. (2002). The concept of flow. *Handbook of positive psychology*, 89-105.

National Institute for Clinical Excellence (NICE) (In progress). *Workplace policy and management practices to improve the health of employees*. Will be available May 2015 from www.nice.org.uk

Ngui, E. M., Khasakhala, L., Ndetei, D., & Roberts, L. W. (2010). Mental disorders, health inequalities and ethics: A global perspective. *International Review of Psychiatry*, *22*(3), 235-244.

Nieuwenhuijsen, K., Verbeek, J. H. A. M., De Boer, A. G. E. M., Blonk, R. W. B., & Van Dijk, F. J. H. (2004). Supervisory behaviour as a predictor of return to work in employees absent from work due to mental health problems. *Occupational and environmental medicine*, *61*(10), 817-823.

Orlans, V. & Van Scoyoc, S. (2009). *A Short Introduction to Counselling Psychology.* Sage Publications Ltd.

O'Driscoll, M. P., & Cooper, C. L. (2002). Job-related stress and burnout. . In P. Warr (Ed.), *Psychology at Work*, 203-228. London, England: Penguin

Office for National Statistics (ONS) (2011). *Employment and Mental Health Survey 2011*. Retrieved in July 2014 from www.ons.gov.uk

Office for National Statistics (ONS) (2013). *Underemployment up 1 million since 2008.* Retrieved in July 2014 from www.ons.gov.uk

Organisation for Economic co-operation and Development (2014). *Mental health and work: United Kingdom.* Retrieved in July 2014 from www.oecd.org

Peterson, D., Currey, N., & Collings, S. (2011). 'You don't look like one of them' –

disclosure of mental illness in the workplace as an on-going dilemma. *Psychiatric Rehabilitation Journal.* *35*(2), 145-7. doi:10.2975/35.2.2011.145.147.

Popper, K. (1963). *Conjectures and Refutations. The Growth of Scientific Knowledge.* Routledge Classics (2nd Edition – 2002)

Prior, S., Maciver, D., Forsyth, K., Walsh, M., Meiklejohn, A. & Irvine, L. (2013). Readiness for employment: Perceptions of mental health service users. *Community Mental Health Journal, 49 (*6), 658-667.

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

Randall, R. and Lewis, R. (2007). Stress management interventions, in E. Donaldson-Fielder (ed.), *Wellbeing and Performance*. London: CIPD

Reininghaus, U. A., Morgan, C., Simpson, J., Dazzan, P., Morgan, K., Doody, G. A., ... & Craig, T. K. (2008). Unemployment, social isolation, achievement–expectation mismatch and psychosis: findings from the ÆSOP Study. *Social Psychiatry and Psychiatric Epidemiology*, *43*(9), 743-751.

Reason, P., & Bradbury, H. (Eds.). (2001). *Handbook of action research: Participative inquiry and practice*. Sage.

Rinaldi, M., Perkins, R., Glynn, E., Montibeller, T., Clenaghan, M., & Rutherford, J. (2008). Individual placement and support: from research to practice. *Advances in Psychiatric Treatment*, *14*(1), 50-60.

Rinaldi, M., Miller, L., & Perkins, R. (2010). Implementing the individual placement and support (IPS) approach for people with mental health conditions in England. *International Review of Psychiatry*, *22*(2), 163-172.

Robinson, M., Tilford, S., Branney, P., & Kinsella, K. (2013). Championing mental health at work: emerging practice from innovative projects in the UK. *Health promotion international*, doi: 10.1093/heapro/das074

Sbaraini, A., Carter, S. M., Evans, R. W., & Blinkhorn, A. (2011). How to do a grounded theory study: a worked example of a study of dental practices. *BMC medical research methodology*, *11*(1), 128.

Schneider, J., Slade, J., Secker, J., Rinaldi, M., Boyce, M., Johnson, R., ... & Grove, B. (2009). SESAMI* study of employment support for people with severe mental health problems: 12‐month outcomes. *Health & social care in the community, 17(*2), 151-158.

Schneider, J., & Akhtar, A. (2012). Implementation of individual placement and support: The Nottingham experience. *Psychiatric rehabilitation journal*, *35*(4), 325.

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

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), 395-404.

Secker, J., Membrey, H., Grove, B., & Seebohm, P. (2003). The how and why of workplace adjustments: contextualizing the evidence. *Psychiatric Rehabilitation Journal*, *27*(1), 3-9.

Seymour, L. (2010). Common mental health problems at work. *What We Know about Successful Interventions. A Progress Review*. London: Sainsbury Centre for Mental Health.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63-75.

Shimmin, S. and Wallis, D. (1994). *Fifty Years of Occupational Psychology in Britain.* Leicester: Division and Section of Occupational Psychology, British Psychological Society.

Singleton, N., Lee, A., Bebbington, P., Brugha, T., & Jenkins, R. (2002). *The social*

and economic circumstances of adults with mental disorders. Stationery Office.

Siu, P. S., Tsang, H. W., & Bond, G. R. (2010). Nonvocational outcomes for clients with~ severe mental illness. *Journal of Vocational Rehabilitation*, *32*(1), 15-24.

Strawbridge, S. & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R.Woolfe, S. Strawbridge, Douglas, B and W.Dryden (Eds.), *Handbook of counselling psychology* (3rd ed.). London: Sage. pp 3-22

Thomas, T. & Secker, J. (2005). Getting off the slippery slops: what do we know about what works. In B. Grove, J. Secker & P. Seebohm (Eds.), *New Thinking about Mental Health and Employment*. Radcliffe: Oxford.

Thompson, S., Aked, J., Marks, N., & Cordon, C. (2008). *Five Ways to Wellbeing: The Evidence.* London: New Economics Foundation. Retrieved in July 2014 from www.neweconimics.org.uk

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiologia e psichiatria sociale*, *17*(01), 14-19.

Time to Change (2014). *Stigma Shout Survey.* Retrieved from www.time-to-change.org.uk

Tsang, H. W. H. (2003). Augmenting vocational outcomes of supported employment with social skills training. *Journal of Rehabilitation, 69 (*3) 25 - 30

Tsang, H. W., Fung, K. M., Leung, A. Y., Li, S. M., & Cheung, W. M. (2010). Three year follow-up study of an integrated supported employment for individuals with severe mental illness. *Australian and New Zealand Journal of Psychiatry*, *44*(1), 49-58.

van Niekerk, L. (2009). Participation in work: A source of wellness for people with psychiatric disability. *Work: A Journal of Prevention, Assessment and Rehabilitation*, *32*(4), 455-465.

Waddell, G., & Burton, A. K. (2006). *Is work good for your health and well-being?*. The Stationery Office, London.

Walker, M. T. (2006). The social construction of mental illness and its implications for the recovery model. *International Journal of Psychosocial Rehabilitation*, *10*(1), 71-87.

Warr, P. (Ed.). (2002). *Psychology at work*. Penguin UK.

Waterman, H., Tillen, D., Dickson, R., & De Koning, K. (2000). Action research: a systematic review and guidance for assessment. *Health technology assessment, 5*(23), iii-157.

Whyte, W. F. (1991). *Participatory Action Research,* Sage, Newbury Park, CA.

Willig, C. (2008). *Introducing qualitative research in psychology*. Maidenhead.

Woolfe, R. (1996). The nature of counselling psychology . In R. Woolfe & W. Dryden (Eds.), *Handbook of Counselling Psychology*. (1st ed.). London: Sage.

Wong, K. K., Chiu, R., Tang, B., Mak, D., Liu, J., & Chiu, S. N. (2008). A randomized controlled trial of a supported employment program for persons with long-term mental illness in Hong Kong. *Psychiatric services*, *59*(1), 84-90.

Chapter C: Professional Case Study

Developing an Understanding of Using Integrative Formulations with a Complex Client and the Role of Purpose in the Importance of Recovery

Chapter D: Publishable Paper

A Question of Disclosure: the Gateway to supporting people with mental health conditions?

Title Page: A Question of Disclosure: the Gateway to supporting people with mental health conditions?

Journal for Submission: Counselling Psychology Quarterly

Author name: Helen Ferris, CPsychol.

Profession: Counselling Psychologist in Training; Chartered Occupational Psychologist

Current professional training/ affiliation: City University, London

Contact details: [redacted]

Word length: 7102 (including references)

This article has not been published elsewhere and is not under consideration by any other journal or publication

About the Author/Biographical Note

Helen Ferris is a Chartered Occupational Psychologist and currently completing her Doctorate in Counselling Psychology at City University. She works as an Organisational Engagement Consultant for *Time to Change* and is interested in piloting new ways to manage mental health at work.

A Question of Disclosure: the Gateway to supporting people with mental health conditions?

Abstract (200 word limit)

Content and Focus: *People with mental health issues see employment as part of their recovery process and factors associated with being employed have been shown to improve mental health on the whole. Mental health also costs employers billions of pounds each year in terms of both absence and presenteeism. Individual Placement Support services have been developed as a validated way for trying to improve the employment rates for mental health services users. However, there are many people in work struggling with their mental health conditions who have chosen not to disclose their poor mental health to their employer. Yet without disclosing, employers are not legally obligated to provide reasonable adjustments or interventions. It is proposed that disclosure decision rates could be increased through line managers utilising disclosure decision tools, resulting in more organisations being obligated to provide suitable adjustments for employees upon disclosure. Through increased disclosure, psychologically healthier workplaces could develop through increased pressure to respond to mental health needs and benefit those people whose mental health conditions cannot be described as a disability under the 2010 UK Equality Act.*

Conclusion: *Counselling Psychologists could lead the way in facilitating improved support for employees with mental health conditions by utilising recently developed disclosure tools and training or working with line managers and organisations to improve disclosure rates and interventions offered as a result.*

Keywords: *disclosure, employment, retention, mental health, organisations, line-managers, training, support groups*

with~ severe mental illness. *Journal of Vocational Rehabilitation*, *32*(1), 15-24.

Steadman, A. (2014). *Blog – Is it time your business had a 'Big Conversation' about mental health?* The Work Foundation Blog. Retrieved from website: www.theworkfoundation.com

Thomas, T., & Secker, J. (2005). Getting off the slippery slope: what do we know about what works. In Grove, B., Secker, J., & Seebohm, P. (Eds.). (2005). *New thinking about mental health and employment*. Radcliffe Publishing.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N & Leese, M. (2009). Global patterns of experienced and anticipated discrimination against people with shciazophrenia: a cross sectional survey. *Lancet*, 373, 408-15

Waddell, G., & Burton, A. K. (2006). *Is work good for your health and well-being?* The Stationery Office, London.

Appendices

Appendix A: Recruitment and Information Sheet for Research Project

Therapeutic Interventions for people with long-term mental conditions in employment: How to Survive and Thrive at Work

Researcher: Helen Ferris

How do you feel when you go to work on a Monday morning?

Are you someone with a long-term mental health condition who would like to share and enhance your experiences in managing work? Would you like your working life to be more rewarding and feel more supported at work?

Our relationship with work is complex. Our workplace can be an inspiring, challenging and enjoyable environment to be part of, providing us with the support, affirmation and sense of well-being, which gives meaning to our lives. However, many of us have experienced the opposite of this, especially if we are also trying to manage a long-term mental health condition.

There is very little research which has really helped to identify what employees and employers can do differently to make work a more positive and supportive experience for people with long term mental illness.

Would you be interested in being part of a therapeutic group over two months, whose aim is to develop and test out some brief interventions? Do you suffer from long-term mental illness, but feel it shouldn't hold you back in your working life?

Working with City and Hackney Mind, I am running a series of four group events, over two months, aimed at building and testing out interventions that will help to improve working life. I am looking for up to six participants with any long-term mental health condition who would be willing to be part of this unique experience.

The dates of this programme are (Thursdays):

3rd October

17th October

31st October

14th November

At City and Hackney offices from 6 – 8pm (flexibility of starting at 6.30pm)

My name is Helen Ferris and I am a chartered Occupational Psychologist and a trainee Counselling Psychologist. I am a chartered member of the British Psychological Society and you can find out more about what I offer on the BPS website: www.bps.org.uk

What you gain by taking part:

- A therapeutic, supportive group experience, run by an Occupational Psychologist and Counselling Psychologist in Training
- A support network, in which to discuss and test out interventions which will aim to improve your working experience
- To be part of a piece of research which aims to inform employment policy on how to improve mental health in the workplace
- Cognitive behavioural skills and development
- A safe, confidential space to discuss your issues
- Practical interventions, tested in the real world

What we require from you:

- To have a long-term mental health condition
- To be employed or self-employed for more than three months
- To be able to attend each session (over two months), keeping a brief experiential diary
- Be able to test out most of the proposed interventions within your workplace
- To respect group confidentiality and agree to key ground rules of the group
- To be willing to have sessions recorded, but remain anonymous upon recording, using first names only

Although the group will be a safe, confidential, therapeutic space for you to explore the impact of mental illness on your working lives, it will ultimately be a practical research group. We will be asking you to be open and explore interventions, trial and assess them, some which may or may not work in practice. Whatever the outcomes of the group, the intention is to produce a key piece of research, which will inform future counselling practices of how to improve work for anyone with a long-term mental illness.

Still interested? Please email me for an informal, confidential brief chat.

Group sessions would be held in City And Hackney Mind offices (in Hackney), at an hour convenient for everyone.

For more information you can contact me at Helen.Ferris.1@city.ac.uk OR my research supervisor Dr Jessica Jones Nielsen at Jessica.Jones.Nielsen.1@city.ac.uk

Appendix B: Participant Information Recruitment Sheet

Therapeutic Interventions for people with long-term mental conditions in employment: How to Survive and Thrive at Work

Name (please just use your initials):

Age:

Occupation/Job Role:

Please answer the following questions:

- Are you currently employed or self-employed and intend to be over the next three - six months?

- Do you have a long-term mental health condition (such as experiencing a diagnosed mental health condition such as depression, for six months or more, or reoccurring episodes)?

- Would you mind briefly outlining your experiences here, and what you would like the group to focus on?

Thanks, and your details will be kept confidentially.

Appendix C: Consent Form for Research Project

Therapeutic Interventions for people with long-term mental health conditions in employment: How to Survive and Thrive at Work.

Researcher: Helen Ferris

The project

I consent to be part of a research group run by Helen Ferris as part of her Doctorate in Counselling Psychology at City University, in partnership with [redacted]. This research group is to develop *Therapeutic Interventions for people with long-term mental health conditions in employment: How to Survive and Thrive at Work.*

Practicalities

This group will meet over the next 2 months, where I agree to attend four group sessions. These group sessions will be every two weeks, starting 3rd October 2013. I also agree to keep a brief fortnightly diary and contribute to the aims of the group. I understand that I will also be asked, where possible, to test out interventions with in the workplace, as long as they do not compromise my working contract with my employer. I also understand that the group will meet at City and Hackney Mind's offices, where there will be other members of staff present within the building.

Purpose of Group

I understand that this group will be a safe, confidential, therapeutic space for me to explore the impact of mental illness on my working life, but ultimately to be a practical research group.

I understand the intention is to produce a key piece of research, which will inform future counselling practices of how to improve work for anyone with a long-term mental illness.

Confidentiality

I adhere to the group ground-rules of confidentiality and understand these sessions will be recorded and diaries used within this research.

I understand that these materials will be kept securely, encrypted on a secure laptop. I also understand my name and details will be anonymous.

I understand that the content of these materials will be analysed and used to produce general conclusions or insights, but may be anonymously quoted within the final research dissertation.

Further Information

I recognise that if I have any concerns with the group or the data used from the group, I can immediately raise this with Helen Ferris or her supervisor at City University, Dr Jessica Jones-Nielsen (contact details end of page)

If I need to pull out of the research at any point, I will provide as much notice as possible and understand my contributions may be used within the research up until this point.

Signature of Research and Trainee Counselling Psychologist, Helen Ferris:

Date

Signature and name of Participant:

Date

For more information you can contact the researcher at [redacted]

OR the research supervisor Dr Jessica Jones Nielsen at

[redacted]

Appendix D: Debrief Form for Research Project

Therapeutic Interventions for people with long-term mental health conditions in employment: How to Survive and Thrive at Work .

Researcher: Helen Ferris

Thank you very much for taking part in this group process. Your contributions will be used to develop a research project recommending future psychological interventions to help other people with long-term mental health conditions survive or thrive in work. Any written material you have provided will be kept securely for a period of five years from the beginning date of this research. Any recordings of sessions will be deleted six months after the end of this project completion. All materials will be kept on a personal laptop, encrypted appropriately. All information will be kept anonymously, with no participant names or organisations mentioned.

- If for any reason you would like more support or information following this group, you can contact me at [redacted] or you can contact my supervisor, Dr Jessica Jones Nielsen via City University at [redacted]

- If you would like further counselling support, you can also contact [redacted]

- In case of emergency, you can also contact your local ambulance service on the emergency number 999 or the Samaritans on 08457 90 90 90

- A resource for understanding more about psychological interventions at work is through the British Psychological Society: www.bps.org.uk

Appendix E: Reflective Diary and Final Reflective Diary

Therapeutic Interventions for people with long-term mental conditions in employment: How to Survive and Thrive at Work

Researcher: Helen Ferris

Before trying intervention:

- What were your thoughts immediately after the session?
- What interventions are you aiming to try out over the next month?
- How will you implement them?

Reflecting upon Intervention:

- How successful has this been?
- What helped?
- What got in the way?
- What would you do differently?
- Any other thoughts? And what do you want to feed into the group next time?

Final Reflective Diary

- Do you remember any interventions proposed from the group?

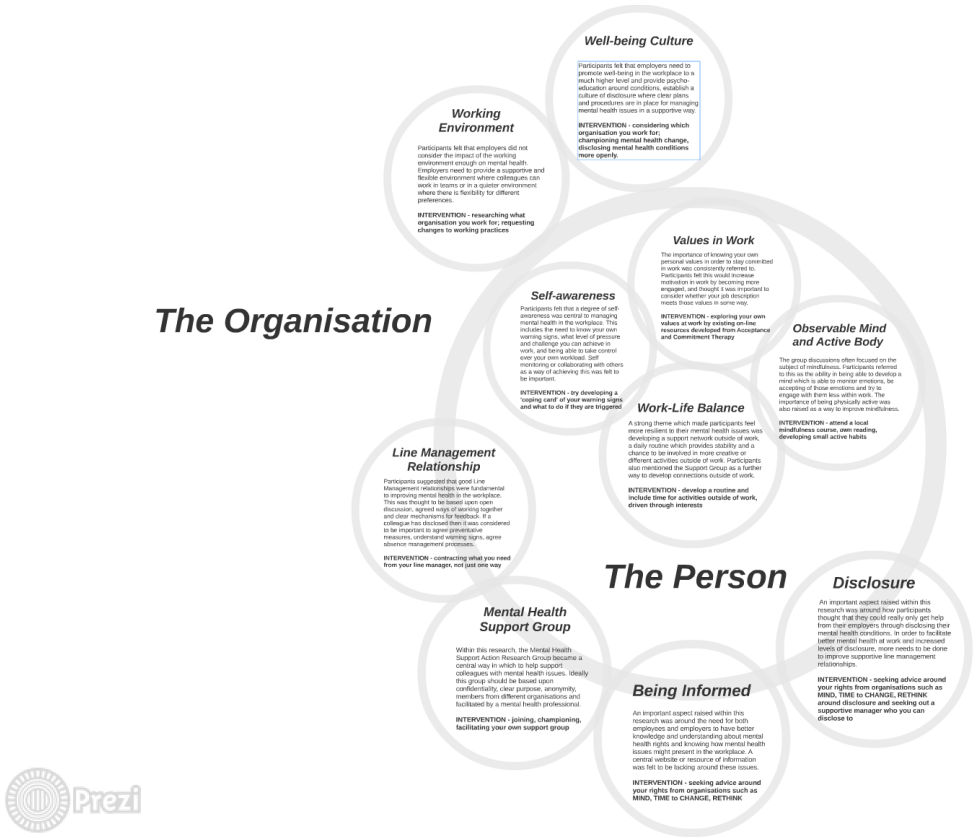
- Were you able to apply any of the interventions discussed within the group in your workplace? What was the outcome?

- Did you find the group helpful? If so, why?

- If you had a friend with long-term mental health issues who was struggling in work, what tips might you give them?

- What further research do you think needs to be conducted in this area?

Appendix F: Visual Presentation of a Model of Individual and Organisational Interventions in Managing Mental Health at Work



Line Management Relationship

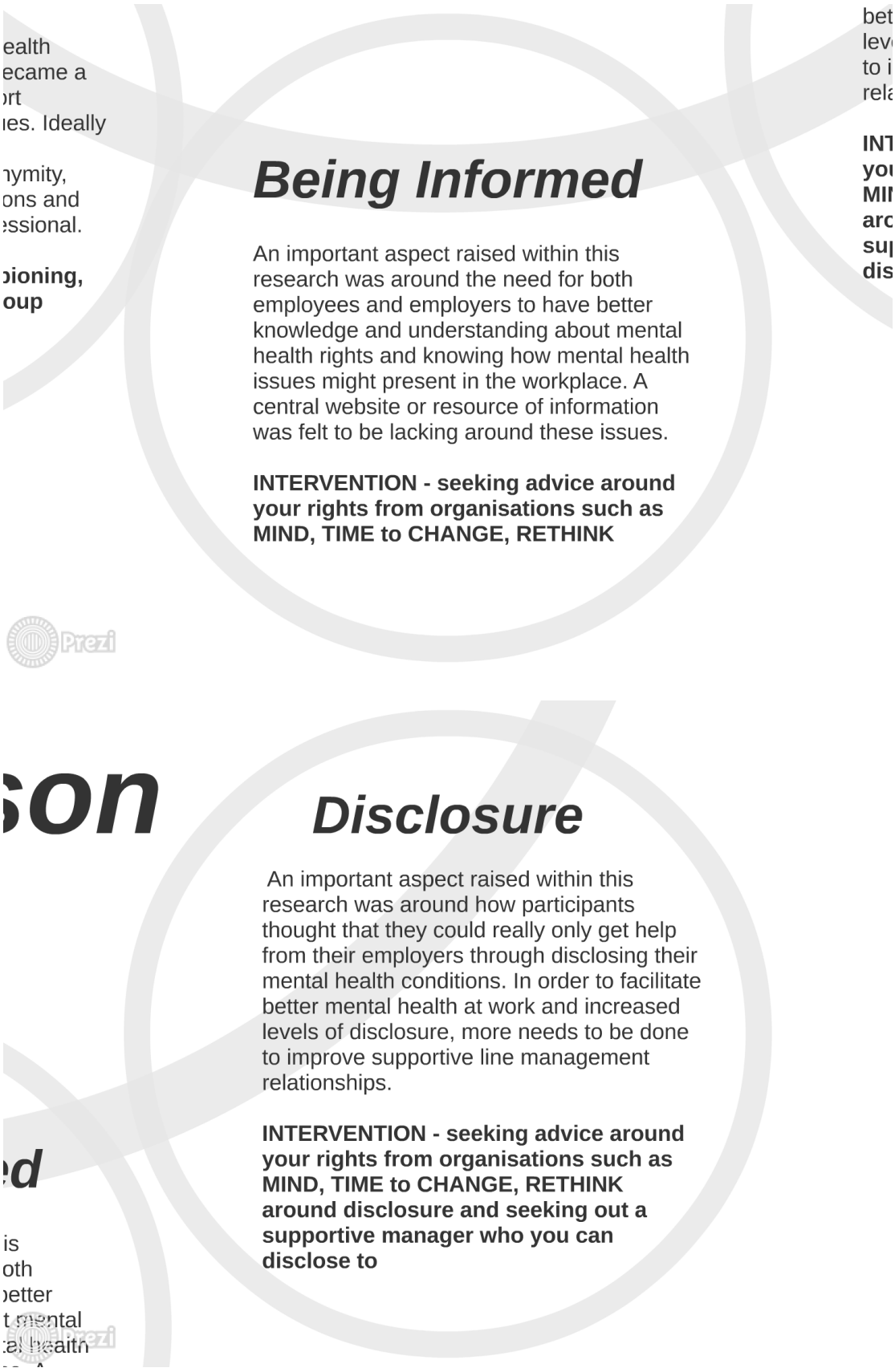
Participants suggested that good Line Management relationships were fundamental to improving mental health in the workplace. This was thought to be based upon open discussion, agreed ways of working together and clear mechanisms for feedback. If a colleague has disclosed then it was considered to be important to agree preventative measures, understand warning signs, agree absence management processes.

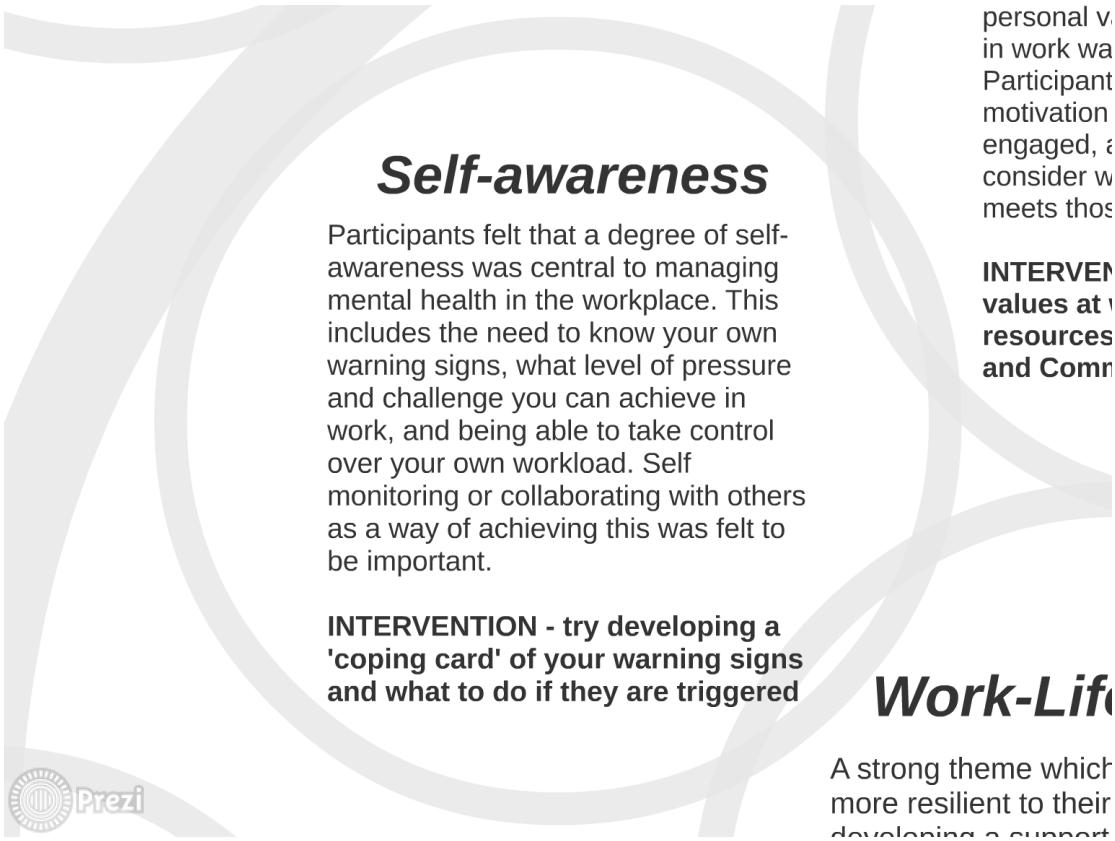
INTERVENTION - contracting what you need from your line manager, not just one way

Mental Health Support Group

Within this research, the Mental Health Support Action Research Group became a central way in which to help support colleagues with mental health issues. Ideally this group should be based upon confidentiality, clear purpose, anonymity, members from different organisations and facilitated by a mental health professional.

INTERVENTION - joining, championing, facilitating your own support group


Being Informed
An important aspect raised within this research was around the need for both employees and employers to have better knowledge and understanding about mental health rights and knowing how mental health issues might present in the workplace. A central website or resource of information was felt to be lacking around these issues.
INTERVENTION - seeking advice around your rights from organisations such as MIND, TIME to CHANGE, RETHINK
Disclosure
An important aspect raised within this research was around how participants thought that they could really only get help from their employers through disclosing their mental health conditions. In order to facilitate better mental health at work and increased levels of disclosure, more needs to be done to improve supportive line management relationships.
INTERVENTION - seeking advice around your rights from organisations such as MIND, TIME to CHANGE, RETHINK around disclosure and seeking out a supportive manager who you can disclose to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Self-awareness
Participants felt that a degree of self-awareness was central to managing mental health in the workplace. This includes the need to know your own warning signs, what level of pressure and challenge you can achieve in work, and being able to take control over your own workload. Self monitoring or collaborating with others as a way of achieving this was felt to be important.
INTERVENTION - try developing a 'coping card' of your warning signs and what to do if they are triggered
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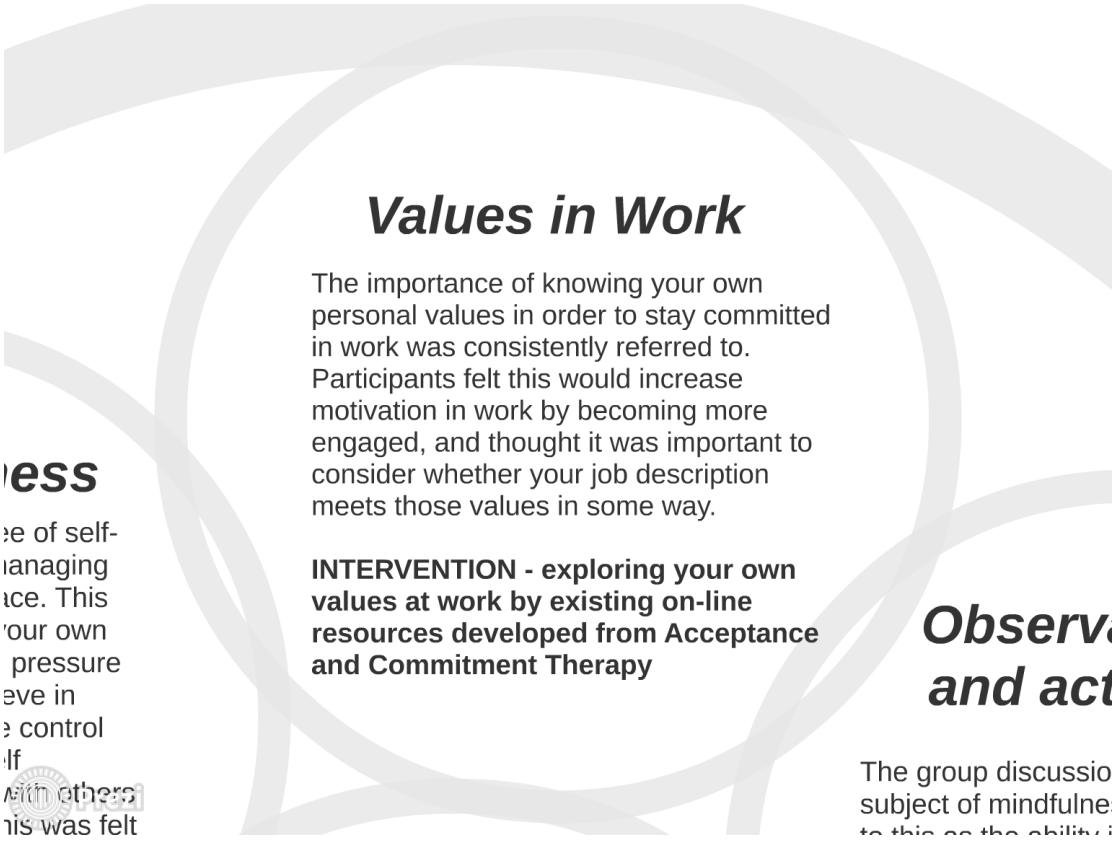
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Values in Work
The importance of knowing your own personal values in order to stay committed in work was consistently referred to. Participants felt this would increase motivation in work by becoming more engaged, and thought it was important to consider whether your job description meets those values in some way.
INTERVENTION - exploring your own values at work by existing on-line resources developed from Acceptance and Commitment Therapy
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Observable Mind and Active Body

The group discussions often focused on the subject of mindfulness. Participants referred to this as the ability in being able to develop a mind which is able to monitor emotions, be accepting of those emotions and try to engage with them less within work. The importance of being physically active was also raised as a way to improve mindfulness.

INTERVENTION - attend a local mindfulness course, own reading, developing small active habits

Work-Life Balance

A strong theme which made participants feel more resilient to their mental health issues was developing a support network outside of work, a daily routine which provides stability and a chance to be involved in more creative or different activities outside of work. Participants also mentioned the Support Group as a further way to develop connections outside of work.

INTERVENTION - develop a routine and include time for activities outside of work, driven through interests

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Well-being Culture

Participants felt that employers need to promote well-being in the workplace to a much higher level and provide psycho-education around conditions, establish a culture of disclosure where clear plans and procedures are in place for managing mental health issues in a supportive way.

INTERVENTION - considering which organisation you work for; championing mental health change, disclosing mental health conditions more openly.

Working Environment

Participants felt that employers did not consider the impact of the working environment enough on mental health. Employers need to provide a supportive and flexible environment where colleagues can work in teams or in a quieter environment where there is flexibility for different preferences.

INTERVENTION - researching what organisation you work for; requesting changes to working practices