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BARRIERS TO INCLUSION: A COMPARATIVE STUDY OF LONG-TERM UNEMPLOYMENT, SOCIAL EXCLUSION AND MENTAL HEALTH

A THESIS SUBMITTED
TO THE UNIVERSITY OF DURHAM
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

BY
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CENTRE FOR APPLIED SOCIAL STUDIES
DEPARTMENT OF SOCIOLOGY AND SOCIAL POLICY
MAY 2002

2 1 MAY 2003

For Laurence Markey

Abstract

The concepts of social exclusion and inclusion have become increasingly important in analysing and responding to poverty and inequality. UK social policy is focussed on measures to promote employment on the premise that work is an essential ingredient of normal, healthy life in our culture. By contrast, unemployment often leads to poverty, poor health and social isolation.

This thesis develops a definition of social exclusion and reviews the evidence of social exclusion among mental health service users. The history of mental health day care services is described which reveals a trend towards more inclusive models. The extent to which these models promote social inclusion is assessed using research evidence. Socially inclusive services are relatively undeveloped in the UK and employment rates remain low. This situation is explained by a unique analysis of the welfare benefits system.

The purpose of the study was to examine the barriers to social inclusion for people with mental health problems. This was achieved by comparing the experiences of social exclusion faced by mental health service users and long-term unemployed people. The methodology used quantitative and qualitative techniques to examine how people live with social exclusion and their aspirations for inclusion. A survey covering the key dimensions of social exclusion was completed by 72 mental health service users and 63 long-term unemployed people. This was complemented by focus groups, interviews and participant observation.

The findings exposed the nature and extent of social exclusion, characterised by long-term unemployment, poor health, persistent low incomes from state benefits, and isolation from mainstream community life. The preferred route into inclusion was work. At least 20% of mental health service users required immediate support into a job and a further 40-50% required further vocational support. The limitations of traditional day care services mean that other routes into inclusion must be found through increased community participation.

ACKNOWLEDGEMENTS

As a young boy visiting a family member at a day centre in Bradford, I found it curious that adults were making greetings cards as I had done at school. The life of Laurence Markey has inspired this thesis, though he may never understand why.

I am most grateful for the opportunity to pursue an academic goal in an area of personal interest. For this I am grateful to my supervisor Dr Justine Schneider for giving me the freedom to explore my interests and the support to refine them into an academic endeavour. I would also like to thank my colleagues at the Centre for Applied Social Studies who have offered guidance, support, and encouragement -Professor John Carpenter, Professor Gyles Glover, Di Barnes, Dr Toby Brandon, Dr Wendy Dyer. I reserve special thanks to Paul Burlison, Claire Dickinson and Alison Tate for making the whole experience much more enjoyable.

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CONTENTS

ABSTRACT 3

ACKNOWLEDGEMENTS 4

CONTENTS 5

INDEX OF TABLES AND FIGURES 7

PREFACE 10

CHAPTER ONE: FROM ILLNESS TO EXCLUSION 15
Introduction 15
Section One: Defining social exclusion 16
Section Two: Social exclusion and mental health inequalities 24
Section Three: Social exclusion and mental health service users 31
Conclusion 44

CHAPTER TWO: FROM TREATMENT TO INCLUSION 46
Introduction 46
Section One: Asylum Life 49
Section Two: The relationship between work and welfare 51
Section Three: Occupation as the first form of day care 55
Section Four: Deinstitutionalisation and day care 59
Section Five: Day care services since 1980s 68
Section Six: Drivers for change 77
Conclusion 81

CHAPTER THREE: INCLUSIVE PRACTICE OR TRIVIAL PURSUITS? 83
Introduction 83
Section One: Which models promote social inclusion? 83
Section Two: What features promote social inclusion? 98
Section Three: From treatment to inclusion 104

CHAPTER FOUR: WELFARE BENEFITS AND BARRIERS TO WORK 106
Introduction 106
Section One: The importance of social security 107
Section Two: Comparing the UK and US using case studies 108

CHAPTER FIVE: RESEARCH METHODS 130
Introduction 130
Section One: Study aims, hypothesis and research questions 130
Section Two: Research Design 131
Section Three: Qualitative Methods 136
Section Four: Quantitative methods 142

Section Five: Data analysis and ethics 163

CHAPTER SIX: FINDINGS I: INDIVIDUAL CHARACTERISTICS 167
Introduction 167
Section One: Profile of samples 168
Section Two: Employment status 182
Section Three: Personal finances 191
Section Four: Health and well-being 202
Section Five: The extent of social exclusion 212

CHAPTER SEVEN: FINDINGS II: CITIZENSHIP AND PARTICIPATION 216
Introduction 216
Section One: Social relationships 216
Section Two: Community activities and social participation 229
Section Three: Service use and costs 254
Conclusion 264

CHAPTER EIGHT: FINDINGS III: ASPIRATIONS AND BARRIERS TO INCLUSION 266
Introduction 266
Section One: Desired activities 266
Section Two: Barriers faced 277
Section Three: Supports desired 293
Section Four: Labour market attachment 298
Conclusion 303

CHAPTER NINE: CONCLUSIONS AND RECOMMENDATIONS 304
Introduction 304
Evidence from the background chapters 304
Evidence from the research study 306
Recommendations 310
Conclusion 315

BIBLIOGRAPHY 317

APPENDIX A: UK POLICY AND SOCIAL EXCLUSION 358

APPENDIX B: QUESTIONNAIRE 365

APPENDIX C: UNIT COSTS USED IN COSTING METHODOLOGY 403

APPENDIX D: SCALE RELIABILITY 405

APPENDIX E: NODE STRUCTURE 406

APPENDIX F: FURTHER QUANTITATIVE DATA 409

APPENDIX G: NSF DEFINITION OF SEVERE MENTAL ILLNESS 417

APPENDIX H: A COMPARISON BETWEEN THE CAP AND TIME USE DIARY 418

APPENDIX I: TIME USE DIARY DATA 420

INDEX OF TABLES AND FIGURES

Table 1. Supports provided by day care services 48
Table 2. The aims of day care services 104
Table 3. UK MTR Calculations 116
Table 4. US MTR calculations 120
Table 5. Comparison of disposable income for each case study.in (£ per week) 121
Table 6. Key elements of US and UK social security systems that promote a return to employment 128
Table 7. Population profile of two study areas 133
Table 8. Details of focus groups 136
Table 9. Topic guide for preliminary focus groups for people with mental health problems. 139
Table 10. Example questions for qualitative interviews 140
Table 11. Sample size for study groups by area 143
Table 12. The mental health service users sample by service 144
Table 13. Breakdown of the long-term unemployed sample in Manchester and Tameside 145
Table 14. Age, gender and ethnicity 169
Table 15. Educational background 171
Table 16. Qualifications 171
Table 17. Comparison with other mental health studies 173
Table 18. Comparing clinical and service use characteristics 174
Table 19. Comparing problem-severity and risks 175
Table 20. Comparison of age groups with Labour Force Survey 176
Table 21. Comparison of length of unemployment with Labour Force Survey 177
Table 22. Employment status 182
Table 23. Characteristics of employment history 184
Table 24. Characteristics of unemployment history 186
Table 25. Reasons for leaving last job 187
Table 26. Weekly Income by living situation 193
Table 27. Equivalised weekly incomes. 194
Table 28. Welfare benefits received by mental health service users 196
Table 29. DLA by component and rates 197
Table 30. Weekly expenditure by living situation 198
Table 31. Details of debts 199
Table 32. Money management 200
Table 33. Empowerment and self-esteem scores 205
Table 34. Subjective quality of life scores 209
Table 35. Indicators of social exclusion 213
Table 36. Social exclusion index 214
Table 37. Network size 218
Table 38. Network membership 219
Table 39. Nature of friendships 223
Table 40. Characteristics of time use diary respondents 230
Table 41. Summary of activities 231
Table 42. Work and education activities 233
Table 43. Sporting activities 235
Table 44. Entertainment and social activities 236
Table 45. Health and social care activities 237

Table 46. Multiple use of health and social care activities for mental health service users.....238
Table 47. Religious and other activities 239
Table 48. Time spent with network members by marital status.....242
Table 49. Other indicators of citizenship 249
Table 50. Cluster variables.....250
Table 51. Characteristics of clusters 250
Table 52. Comparison of leisure activities 253
Table 53. Use of day activity services 256
Table 54. Characteristics of day service users compared to service level data from day services in Manchester and Tameside 257
Table 55. Weekly health and service costs 263
Table 56. Desire to work.....267
Table 57. Work Behaviours and Attitudes Scale 269
Table 58. Type of work wanted 271
Table 59. Reservation wage (£s per hour) 272
Table 60. Labour market flexibility. 272
Table 61. Activities wanted.....273
Table 62. People with whom to do desired activities 274
Table 63. Barriers to work checklist.....278
Table 64. Barriers to desired activities 278
Table 65. Support received to find work.....294
Table 66. Support desired to find work.....295
Table 67. Labour market attachment clusters.....299
Table 68. Characteristics of labour market attachment clusters 300
Table 69. Support required for each cluster.....301
Table 70. Measuring social exclusion 307
Table 71. Barriers to inclusion for mental health service users 309

Figure 1. A triangular relationship between social and economic conditions, physical illness and psychological stress (after Gomm, 1996: 112).....31
Figure 2. Working typology of psychiatric rehabilitation vocational programs (after Bond et al., 1999) 69
Figure 3. Net income for a single person aged 28 who is eligible for Income Support with Disability Premium (no DPTC or housing costs). 112
Figure 4. Net income for a single person aged 28 who is eligible for Income Support with Disability Premium and DPTC (no housing costs).....113
Figure 5. Net income for a single person aged 28 who is eligible for Income Support with Disability Premium and DPTC.....114
Figure 6. Net income for a single person aged 28 who is eligible for Income Support with Severe Disability Premium 115
Figure 7. Net income for a single person aged 28 who is eligible for Income Support with Severe Disability Premium, reduced to Disability Premium and a loss of DLA after review.....116
Figure 8. Net income for a single person who is eligible for Supplemental Security Income (SSI) and Section 8 rent subsidy.....117
Figure 9. Net income for a single person who is eligible for Social Security Disability Insurance (SSDI of $600/month) and Section 8 rent subsidy.....118
Figure 10. Comparing net disposable income and hourly rate of pay for an SSDI beneficiary with initial entitlement of $600/month and paying rent of $250/month.....119

Figure 11. Net income for a single person who is eligible for SSDI ($350/month), SSI and Section 8 rent subsidy 120
Figure 12. Comparing average Replacement Rates for all benefits for a 28 year old single person working over 16 hours per week 121
Figure 13. Comparing additional income from work for UK and US examples 122
Figure 14. Comparing net disposable income in UK and US for a single person with equivalent hourly rate of pay and rent 123
Figure 15. Time scale of research project 135
Figure 17. Social mobility 188
Figure 18. Mean cumulative length of unemployment and social class of last job 189
Figure 19. Highest level of education and social class of last job 189
Figure 20. General health status 203
Figure 21. GHQ-12 scores (Likert scoring method) 204
Figure 22. Empowerment and self-esteem scores 205
Figure 23. Self-esteem and general health 206
Figure 24. Satisfaction with life domains 207
Figure 25. Subjective quality of life and general health 209
Figure 26. Comparing subjective quality of life 210
Figure 27. Network membership as a percentage of mean network size for study groups 219
Figure 28. Mean frequency of contact with network members 220
Figure 29. Mean duration of relationship with network members 221
Figure 30. Closeness to network members 222
Figure 31. Proportion of time spent with network members from time use diaries 224
Figure 32. Tiem spent with network members over an average day 225
Figure 33. Categories of time use over a one week period 232
Figure 34. Proportion of time spent on activities for mental health service users 240
Figure 35. Proportion of time spent on activities for long-term unemployed 240
Figure 36. Proportion of time spent on activities by network members 241
Figure 37. Location of activities. 243
Figure 38. Weekly distribution of activities 244
Figure 39. Spending on activities 246
Figure 40. Relationship between self-esteem and satisfaction with watching television 246
Figure 41. The relationship between closeness to own community and quality of life. 249
Figure 42. Service use of study groups and comparison sample 254
Figure 43. WBAS scores 270
Figure 44. Replacement Ratios 280
Figure 45. Proportions of study groups requiring three levels of support to achieve social inclusion 302
Figure 46. Pyramid of support to promote social inclusion of mental health service users 311

PREFACE

Social Exclusion, Unemployment and Mental Health

In the last chapter of his influential book *Recovery from Schizophrenia* Richard Warner (1994) asks

> How can we help schizophrenic people re-enter society as it is presently structured and achieve a genuine degree of social integration?

This question forms the starting point for this thesis. The purpose of the study is to examine the barriers to social inclusion for people with mental health problems. To do so the research is designed to explore the relationships between social exclusion, unemployment and mental health.

The concepts of social exclusion and inclusion have become increasingly important in analysing and responding to poverty and inequality. In western society where work remains central to self-esteem and standard of living, the labour market is often the focus of policy to promote inclusion. Social policies in the UK, US and Europe are become increasingly focussed on measures to promote employment. For example, the UK government seeks to "rebuild the welfare state around work" (DSS, 1998a) with the introduction of the New Deal, 'a single work-focussed gateway', personal advisers, job seekers' agreements, and in-work tax credits. These policies are built on the premise that work is an essential ingredient of normal, healthy life in our culture.

By contrast, unemployment often leads to poverty, poor mental and physical health and social isolation (Warr, 1987). In the UK, unemployment and economic inactivity remain high whilst productivity and technological advances are diminishing the number of workers required. Excluding those in education, over a quarter of the working age population is out of work (Gregg and Wadsworth, 1998). Unemployment and economic inactivity are highest in localised communities, such as in low-income neighbourhoods (Campbell *et al.*, 1998), amongst older, low-skilled men (Meadows, 1996), and the long-term sick and disabled (HM Treasury, 1997).

People with mental health problems are five times more likely to be unemployed than the general population (Sly, 1996). Despite this, many surveys of people with mental health

problems have found a growing number expressing a desire to work. This situation can be understood within the changing context of mental health care. Advances in treatment and rehabilitation, accompanied by a shift in the locus of care from hospital to community have created the need for more "normalised" opportunities. The increasing importance and influence of the User movement, combined with greater acceptance of the social model of disability have put an emphasis on integration rather than segregation. Research has demonstrated the clinical benefits of work and the effectiveness and good value for money of supported employment.

People with mental health problems are also excluded from mainstream community life and mental health services often offer a harsh choice: a life on a low income using a day service, or a life on a low income not using a day service (Kendall, 1999; Hatfield *et al.*, 1992). Many opt for the latter, living with the effects of poverty, isolation, stigma and discrimination (Dunn, 1999; Mental Health Foundation, 1994).

Despite these well rehearsed claims the evidence about the social exclusion experienced by mental health service users has many limitations. Almost all the conceptual and theoretical work has been conducted in the field of social policy, and very little attention has been paid to developing the concept of social exclusion for use in the field of mental health. The few empirical studies measure the multifaceted nature of social exclusion, and so only provide part of the picture. There are many claims about the extent of social exclusion among mental health service users (Davis and Hill, 2001; Huxley and Thornicroft, 2000; Sayce and Morris, 1999), yet there is very little evidence about their daily lives. This thesis seeks to address these problems by presenting a theoretical framework for the concept of social exclusion, developing a methodology for its measurement, and providing details of how people with mental health problems live with unemployment and social exclusion.

The lack of jobs in society, the damaging effects of unemployment, the increasing under-use of mental health day care services, such as day centres and sheltered work schemes, suggest that we must also find alternative definitions of inclusion for those most excluded from the labour market (Coulton, 1996). This thesis takes on this challenge by reviewing the literature on social exclusion, unemployment and mental health and describing a unique research project that explores the relationship between mental health status, economic status and social exclusion amongst two socially excluded groups. The research study compares the social exclusion faced by people using mental health services with long-term unemployed

people. The findings are used to identify more effective ways of promoting social inclusion for people with mental health problems.

Chapter One charts the origins of the concept of social exclusion and develops a working definition based on three dimensions: multiple deprivation, relational poverty, and the underlying process factors. This definition is then used to describe the evidence for the social exclusion of people with mental health problems: initially by the asylum system of care to contemporary experiences living in the community. The chapter concludes that social exclusion is the primary problem facing mental health service users, resulting in substantial costs to individuals and society.

Chapter Two provides an historical account of mental health day care services. Three periods of development are described: the role of work within institutional care, day hospitals day centres in the era of deinstitutionalisation, and the development of more inclusive day services since the 1980s. **Chapter Three** uses empirical evidence to examine which models promote social inclusion and identify the key features that that help mental health service users to get, keep and benefit from a job. Although the models of services have shifted from a focus on treatment to promoting social inclusion, mental health services in the UK still rely on more traditional day care services. Supported employment remains largely underdeveloped in the UK despite the weight of evidence for its effectiveness in the US.

Chapter Four compares the social security systems in the UK and the US and provides evidence that the welfare benefit system is the single main barrier to promoting social inclusion. The chapter concludes that the UK benefits system is the main reason for the lower employment rate of mental health service users in the UK compared to parts of the US. The benefits system limits the amount of money mental health service users can earn, therefore restricting the demand for supported employment in the UK.

Chapter Five presents the research design and methods used in the empirical study. A series of focus groups were used to ground the research in the experiences of the study groups. A selection of well used research instruments and measures specifically developed for this study were assembled into a questionnaire. Existing measures included:

- Work behaviours and attitudes scale (Mowbray *et al.*, 1995) as an attitudinal indicator of a potential return to work.

- The General Health Questionnaire (GHQ-12) (Goldberg and Williams, 1988) and Short Form Health Survey (SF-12) (Ware *et al.*, 1996a), popular measures of psychological and general health.
- The Empowerment Scale (Rogers *et al.*, 1997) to measure empowerment and self-esteem.
- Matching Resources to Care (MARC-2), a measure of severity of mental health problems for the sample of mental health service users (Huxley *et al.*, 1998).
- The Client Socio-demographic and Service Receipt Inventory (CSSRI) to collect information on the use of health, social care and education services, living arrangements and accommodation details (Beecham and Knapp, 1992).

Existing measures adapted for this study included:

- Social Networks Guide (SNG) (Forrester-Jones, 1998) was adapted to elicit details about each individual's social network.
- The Lancashire Quality of Life Profile (LQOLP) (Oliver *et al.*, 1995) was adapted to measure satisfaction in eight life domains, together with some objective indicators of quality of life.

Measures developed for the study included:

- The barriers to work checklist to determine the nature and extent of barriers preventing people from getting a job
- A method of collecting information about participants' work history, job search activity and labour market flexibility
- A questionnaire was developed to collect information about individuals' participation in community activities.

A total of 72 mental health service users and 63 long-term unemployed people completed the questionnaire. This information was supplemented with a time use diary completed by a subset of the sample. Focus groups, interviews and participant observation were also used to elicit further information about the concepts under study.

Three findings chapters present the data for each of the dimensions of social exclusion developed in Chapter One. **Chapter Six** introduces the study groups, and describes and compares multiple deprivation: long-term unemployment, low income and poor health. **Chapter Seven** examines the effect of poverty and unemployment on social networks and

participation in community life. **Chapter Eight** provides details of the participants' aspirations for inclusion, together with the main obstacles to achieve this.

Chapter Nine concludes the thesis by identifying the original contributions made by the thesis and makes some recommendations to promote the social inclusion of people with mental health problems.

CHAPTER ONE

From Illness to Exclusion

Introduction

Social exclusion has become a popular term among politicians, policy makers and academics. In the UK it has become a central plank of government policy with the creation of the Social Exclusion Unit (SEU). The SEU sits 'at the heart of government' at the Cabinet Office with a remit across all departments (Geddes and Root, 2000). In his foreword to *Preventing Social Exclusion*, a report by the SEU (2001a: 4), Tony Blair clearly signals the importance of the concept.

> The Government has made a start on a big programme of change. Preventing social exclusion where we can, reintegrating those who have become excluded, and investing in basic minimum standards for all. [...] We are determined to take our programme forward, towards our vision of a better, fairer society that supports the most vulnerable, focuses on the future and delivers quality of life for all. [...] we know too that in tackling the problems of social exclusion we can help make our country a better place for everyone.

Social exclusion rose to its prominent position in the UK from its central position in European social policy during the 1990s (Room, 1995). This has coincided with worsening economic conditions, higher profile of poverty, and increasing pressure on welfare budgets (Evans, 1998).

Social exclusion is now also the subject of debate within international development (de Haan and Maxwell, 1998) following the movement of jobs and industry to developing nations and increasing attention paid to welfare within these countries. Social exclusion has become a global phenomenon (Gaventa, 1998).

Social exclusion has been the focus of much attention within social research. Since the mid 1990s the number of research articles on social exclusion has rapidly increased. Social exclusion has been identified by the Economic and Social Research Council as one of its nine central themes for social science research (Burchadt *et al.*, 1999).

Social exclusion is now a household phrase. A search of The Times archive from 1990 onwards found just two references to the phrase until 1994, a further 27 articles appeared up to 1997, followed by a further 361 articles by 2001.

The concept of social exclusion is clearly important, but what does it mean? Has it generated more political heat than academic light? Or is it a concept that truly recognises the complex inter-related nature of disadvantage in society today? The following section attempts to answer these questions.

Section One: Defining social exclusion

Social exclusion is a term that is now widely used; yet it is highly contested. The respected academic, Tony Atkinson (1998: 13), suggests that the problems in its definition may well promote its use.

> Indeed, it [social exclusion] seems to have gained currency in part because it has no precise definition and means all things to all people.

However, there are features that recur in the literature. This section tracks the origins of social exclusion from three perspectives: the Euorpean perspective, the UK poverty debate, and the US cultural perspective of the 'underclass'. The role of the concept within current UK social policy is then examined and a working definition of social exclusion is proposed. This definition is used throughout the thesis to assess the extent of social exclusion faced by people with mental health problems.

The European perspective

Although the term social exclusion entered into mainstream political debate during the 1990s in the UK, it probably originated in France during the 1970s. The term is usually attributed to the French politician René Lenoir who published *Les Exclus: Un Français Sur Dix* in 1974. He referred to *Les Exclus* as those who were excluded from employment-based social security (de Haan, 1998). The term social exclusion was used to refer to various types of social disadvantage – lone parenting, long-term unemployment, disablity, ghettoisation – created by the 'rupture of social bonds' (Cannan, 1997).

The term gained popularity in France in the 1980s with new government programmes aimed at the 'insertion' of individuals, families and groups into mainstream life. For example, The *Revenue Minimum d'Insertion* (RMI) – Minimum Income of Integration - was set up in 1988 to provide work and training for long-term unemployed. By the mid-1990s there were three quarters of a million participants in RMI (Cannan, 1997).

Since the 1980s the term has spread rapidly. The European Commission, now the European Union (EU), was very influential in bringing the concept to the social policy arena. In the early 1990s there was growing concern in Europe about the various forms of disadvantage experience by the poorest in society. The influential European social policy report, *Social Europe* (European Commission, 1993), argued that poverty was not the right term for these problems, as they were not simply related to material wealth (Wessels, 1999).

The EU perspective stressed the dynamics of the processes of exclusion and the multidimensional nature of the consequent social problems. The EU saw that exclusion could begin with several factors, such as unemployment, homelessness, lack of education, discrimination, demographic or technical changes, that the combination of these factors could be different for each individual, and that these factors were constantly changing. The EU define social exclusion as:

> The process through which individuals or groups are wholly or partially excluded from full participation in the society within which they live (European Foundation, 1995:4).

The European concept is therefore a dynamic one, referring to both processes and consequent situations, that affects both individuals and groups who are subject to discrimination and segregation, or have suffered through the weakening of traditional forms of inclusion (Wessels, 1999). The European perspective emphasises the importance of paid work as a route back into true inclusion (Levitas, 1998) and the maintenance of standards of living when out of work (de Haan, 1998).

Poverty in the UK

Although the term was largely unknown in the UK before its use in the European context, the origins of social exclusion can also be found in the long history of the poverty debate in Britain. Like social exclusion, poverty is also a term subject to much debate.

> For some 'poverty' is simply about levels of income, to others, it is about much wider concepts, like security, autonomy and self-esteem. (de Haan and Maxwell, 1998)

Poverty in Britain has been an important concern since the Elizabethan Poor Laws, yet there has never been a generally accepted definition. The main debate on poverty is whether it is absolute or relative (Bradshaw, 1999).

Seebohm Rowntree (1901) developed a poverty standard based on an estimate of the expenditure required to maintain basic needs, such as water, food, shelter, health and

education in his first study into poverty in York (Bradshaw, 1999). The absolute definition of poverty has since been very influential in policy. For example, Beveridge (1942) used similar calculations that formed the basis of the National Assistance Board rates set in 1948 (Viet-Wilson, 1992). Later, these calculations became the Supplementary Benefit rates in 1966 and then the Income Support rates from 1988. The philosophy underpinning the UK social security system is therefore one of a 'basic minimum' safety net for all.

However, these subsistence notions of poverty have been criticised for their harshness and their emphasis on physical necessities that ignore the experience of poverty (Townsend, 1970). Peter Townsend was the leading exponent of relative poverty. In this notion

> Poverty is now not merely an inability to purchase the necessities for a meagre existence but also the inability to grasp the abundance, comforts and opportunities of society. (Bradshaw, 1999: 14)

Townsend's (1979) definition of relative poverty seems close to the concept of social exclusion.

> Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions which are customary, or at least widely encouraged or approved, in societies to which they belong. Their resources are so seriously below those commanded by the average family or individual that they are in effect excluded from ordinary living patterns, customs and activities.

However, this definition is still founded on a distributional nature, a focus on resources, rather than the relational features of the European perspective. The UK poverty perspective focuses on the importance of an adequate minimum income from universal state benefits through redistributive economic policies (Levitas, 1998)

The US cultural perspective and the 'underclass'

A further twist to the debate has emerged from the examination of poverty from a cultural perspective. Originally described by Oscar Lewis (1968) using an anthropological view of poverty, his article *Culture of Poverty* describes poverty as a culture with its own norms and values, which are distinct from those in the wider society (Bradshaw, 1999). Here the focus is on the personal characteristics and attitudes of the 'underclass' as the cause of poverty and disadvantage.

These ideas remerged in the 1980s and early 1990s in the US and gained political credibility in Britain during the Thatcher government with Sir Keith Joseph's notion of a 'cycle of

deprivation' (Leonard, 1998). Perhaps the leading figure in this debate is Charles Murray (1990: 17)

> If illegitimate births are the leading indicator of an underclass and violent crimes a proxy measure of its development, the definitive proof that an underclass has arrived is that large numbers of young, healthy, low-income males who choose not to take jobs. This decrease in labour force participation is the most elusive of the trends in the growth of the underclass.

The 'underclass' encompasses a diversity of groups, such as single parents and young offenders, but the most persistent feature is long-term unemployment (Leonard, 1998). According to Murray, blame is laid on the welfare state, which, he argues, creates dependency and has generated the cultural deficiencies of the 'underclass' (Murray, 1984). The cultural perspective argues for policies to reduce dependence on social security through the tightening of rules and reduction in eligibility.

The two key arguments against this view are, firstly, that the cultural difference is a consequence rather than cause of poverty (Valentine, 1968), and secondly, that there is no evidence to suggest such a difference exists at all. Lydia Morris, in a study carried out in Hartlepool, found that the long-term unemployed continued to look for work and concluded that

> There is no direct evidence in my study of a distinctive culture of the "underclass" (Morris, 1993: 410)

Shaw *et al.* (1999) reviewed the research evidence in Britain that examined the culture of poverty and dependence and concluded

> There cannot be many more thoroughly falsified theories than the undeserving poor argument in Britain. There is more evidence for the existence of the Loch Ness monster than for the existence of a homogeneous group of people who form an 'underclass' in the United Kingdom. (Shaw *et al.*, 1999: 206)

Yet Giddens (1997) reminds us that the economic and social divisions that are characteristic of the US, are increasingly found in Britain and Europe, and points to the rising numbers that experience several generations in poverty and are trapped in deteriorating neighbourhoods. The policy responses to these problems are welfare to work programmes and area-based regeneration programmes.

Locating contemporary UK social policy

The next step in defining social exclusion is to locate current UK policy within these three perspectives on social exclusion. The introduction of the concept of social exclusion was

made concrete with the creation of the Social Exclusion Unit (SEU) in the Cabinet Office, with direct support from the Prime Minister and his Policy Unit at No. 10, very early in Labour's first term (Geddes and Root, 2000). The Prime Minister set up the SEU to "improve Government action to reduce social exclusion by producing 'joined-up solutions to joined-up problems'" (SEU, 2001a: 57). The UK government has defined social exclusion as:

> a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown. (SEU, 2001a: 10)

The Social Exclusion Unit (SEU, 2001a), together with the Department for Social Security report *Opportunity for All* (DSS, 1999a), has set the agenda for tackling social exclusion. For example, *The National Strategy for Neighbourhood Renewal* (SEU, 2001b) outlines the governments approach to tackling the problems of social exclusion in the poorest communities.

However, the principal components of this agenda are supply side measures to increase employment and reduce welfare dependency. The New Deal provides guidance, work and training opportunities for key groups including disabled people, and Jobcentre plus merges the Employment Service and Benefits Agency to create a 'single work-focused gateway' (DSS, 1998a) with an emphasis on employment rather than benefit payment. Welfare reform, such as Working Families and Disabled Persons Tax Credits and the National Minimum Wage, has focussed on addressing the problems of barriers to work and low pay. In short, there is a focus welfare to work as the means to inclusion. A summary of current social policy responses to the problems of social exclusion in the UK is given in Appendix A.

On the one hand, these policies suggest the UK has adopted the European perspective. There is a clear understanding of social exclusion as a multidimensional problem and a focus on work as a means to inclusion (Wessels, 1999). On the other hand, the current UK policy responses to social exclusion are more allied to the US cultural perspective. For example, the New Deal and welfare reform has followed the US model which expanded a system of in-work tax-credits for low income wage earners and changed the welfare system to prioritise training, employment and self-sufficiency.

> We can represent the UK as being in the middle of a tug of war between American and Continental European conceptions of the future of the labour market and the welfare state. (Atkinson, 1998:9)

Thus, it is assumed in the UK that work, together with tax credits, will provide income to combat poverty. In this respect, the UK government focuses on the economic aspects of social exclusion, but ignores the dynamics.

Stigma and discrimination: the dynamics of social exclusion

What are the process factors of social exclusion? One starting point is the important distinction between 'weak' and 'strong' versions of social exclusion made by John Viet-Wilson (1998: 45)

> In the 'weak' version of this [social exclusion] discourse, the solutions lie in altering these excluded peoples handicapping characteristics and enhancing their integration into dominant society. 'Stronger' forms of this discourse also emphasise the role of those who are doing the excluding and therefore aim for solutions which reduce the powers of exclusion.

While Viet-Wilson goes on to examine the political and structural factors that cause social exclusion, others have examined the cultural and attitudinal factors, namely stigma and discrimination (Sayce, 2000).

> Stigma has its roots in 'differences'. The pain and emotional hurt experienced by the stigmatised person is linked to others' pity, fear, disgust and disapproval of this difference, whether that difference is one of personality, physical appearance, illness and disability, age, gender or sexuality. (Mason *et al.*, 2001: 2)

> Discrimination and prejudice in any form serve to separate and exclude individuals from society and from many of the benefits of society, such as equitable access to services like housing, education, health and social support. Discrimination in this way is a form of social exclusion. (Mason *et al.*, 2001:3)

Stigma, like social exclusion, is also a contested term and has its origins in the theory of 'deviance'. Deviance may be considered as a form of social behaviour defined by a particular society as undesirable. It is therefore culturally relative: what is deviant in one society may not be in another, what is deviant at one time may not be at another.

One of the earliest works on deviance is by Emile Durkheim, who made a useful distinction in the positioning of deviance as being at one level the responsibility of the individual and at the other the fault of society (Whitehead *et al.*, 2001). In the latter view, an important contribution came from Howard Becker and his theory of labelling, which suggests that deviance is a product of the social world, rather than the individual.

> Social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender'. The deviant is one to whom that label has successfully been applied; deviant behaviour is behaviour that people so label. (Becker, 1963: 3)

The main criticism of labelling theory is that it neglects the processes that lead to people being labelled as deviant in the first place. Another major influence on stigma came from Erving Goffman, a contemporary of Becker, who was interested in how and why society chooses to stigmatise a particular social group. Goffman suggests there must be some personal attribute that sets apart the stigmatised person from society

> While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind – in the extreme a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted discounted one. Such an attribute is a stigma. (Goffman, 1990: 12)

A further contribution comes from Edward Jones (Jones *et al.*, 1984), whose main concern was the psychological impact of stigma on the individual concerned and how this then affects their role in society. Jones argues that people adopt a particular coping strategy as a personal response to the social implications of their stigma. He highlights personal responses such as fear, anger, worthlessness, depression, etc. and the resultant withdrawal from society.

These theories have had much resonance within the field of mental health. Taken together they can account for the social exclusion process of people with mental health problems. From Goffman, we can see that certain behaviour associated with mental illness can identify a person as different – a deviant 'other'. From Becker, we can see that the label of a diagnosis of mental illness serves to stigmatise. From, Jones we can see that the person thus withdraws from society. Link *et al.* (1997) describe some of the coping strategies for dealing with stigma that mental health service users adopt. For example, they suggest that people do not risk applying for jobs for fear of rejection, which leads to widespread and persistent unemployment.

More recently, there have been arguments against the use of the term 'stigma' in relation to disabled people (Oliver, 1990) and people with mental health problems (Sayce, 1998). Oliver (1990) argues that stigma focuses on individual self-perceptions and micro-level interpersonal interactions rather than more widespread exclusions from economic and social life.

Sayce (1998) has described that different conceptual models point to different understandings of where responsibility lies for the problem and different prescriptions for action. For example, the term 'racism' has a focus on discrimination and the need for changes to wider society, rather than the stigma of being black, which would shift attention to the self-image of the black person. She uses this analogy to examine the stigma and discrimination with respect to people with mental health problems.

Sayce argues that discrimination is a more useful word than stigma, as it creates resonance with other fields where discrimination has occurred and has been tackled positively. The danger is that this is seen as demanding individual rights, rather than offering a positive contribution. She concludes that social exclusion may be a more appropriate term.

> Use of 'discrimination' and 'social exclusion' are powerful because they mean that user/survivors can pick up and benefit from a so-called 'commonsense' that has already been established: that discrimination is unfair, that everyone should be included in the one-nation Britain, that everyone should have a chance to contribute and be involved. (Sayce, 1998: 341)

A three-dimensional definition of social exclusion

This section has explored three perspectives on social exclusion and located UK social policy. The limits of the UK approach exposed the need to consider the process factors of social exclusion in more depth. The concepts of stigma and discrimination are the key mechanisms that serve to exclude people with mental health problems. The quote from Evans below suggests that to be useful the term must first be defined, both in relation to the excluded group and the process of their exclusion

> I think it is wrong to extrapolate from a breadth of potential definitions to a position where [social exclusion] can mean anything to anyone. 'Social exclusion' must include a definition of at least the group and the reason for the process of their exclusion. (Evans, 1998: 45)

Applied to people with mental health problems this thesis proposes a definition based on the following three dimensions.

- Multiple deprivation, based on Townsend's concept of relative deprivation, and using the indicators of current UK social policy, such as unemployment, low income, and poor health.
- Relational poverty, based on the severed relationships from civic and social life, described by the European perspective on social exclusion.
- Dynamics, or the process of social exclusion, characterised by stigma and discrimination.

This three dimension model is central to this thesis as it has shaped the research design and methodology and structures the presentation of the findings. The definition is also used by this chapter to assess the extent of social exclusion among mental health service users.

Section Two: Social exclusion and mental health inequalities

Before examining the contemporary experience of social exclusion among mental health service users this section explores the main health problems faced by people living in poverty, put in stark terms by former Health Secretary Frank Dobson.

> Inequality in health is the worst inequality of all. There is no more serious inequality than knowing that you'll die sooner because you're badly off. (Frank Dobson, Department of Health, 1997)

Several studies over the years have pointed to the relationship between poor health and poverty. For example, Phillimore *et al.* (1994) found in a study in the north of England that between 1981 and 1991 there were modest gains in life expectancy for more affluent areas, but worsening life expectancy for the same age groups in the poorest areas.

The Black Report of 1977-80 (DHSS, 1980) showed widening inequalities in health since the 1950s, largely due to inequalities in material resources. Though rejected by the then Conservative government, the report has continued to exert and influence on research since.

Perhaps the most important analysis on health inequalities in recent years was the *Independent Inquiry into Inequalities in Health* chaired by Sir Donald Acheson (1998). The report of the Independent Inquiry contained a comprehensive review of current knowledge on the extent and trends in health inequalities and contained 39 recommendations. The report highlighted the interrelated and compounding effect of a range of features of poverty, such as low income, unemployment, lack of education, poor housing, lack of transport and inadequate nutrition (Department of Health, 2001).

> To summarise these findings, people who experience one or more of: material disadvantage, lower educational attainment and/or insecure employment are likely to experience worse health than the rest of the population. In addition there is evidence to suggest that living in materially deprived neighbourhoods contributes to worse health for individuals. (Department of Health, 2001: 7)

The literature on the causes of health inequalities highlights the following determinants of health (Pickin, 2000).

Economic factors

Perhaps the key determinants of health are unemployment, low level of income relative to others and lower social class. The weight of evidence supports the view that unemployment may lead to mental ill health. Longitudinal studies have demonstrated that peoples' psychological health gets worse when they move from employment to unemployment (Gershuny, 1994). Listing some of the more common psychological effects of unemployment, Warr (1984) claims that

> unemployment may lead to apathy, loss of social contact and loss of self esteem.

Anthony and Blanch (1987) illustrate the link between unemployment and poor mental health,

> some of the symptoms caused by long-term unemployment, that is, social withdrawal, passivity, lethargy and isolation, seem to mirror some of the symptoms of a chronic mental health problem.

Likewise, reports by Warr (1985; 1987), Hepworth (1980) and Cohn (1978) have all shown evidence of a significant increase in feelings of anxiety, depression, worthlessness, hopelessness, lack of confidence, loss of sleep, and higher suicide rates amongst unemployed people.

On an ecological level, unemployment rates are a good predictor of the mental health (Kammerling and O'Connor, 1993) and long-term illness (Haynes *et al.*, 1997) of an area.

Suicide, the second highest cause of death among young men, is closely related to unemployment, social class and deprivation (Taylor and Gilmour, 1996; Meltzer *et al.*, 1995a). For example, Brenner (1973) performed a series of analyses on retrospective official data, which he claimed showed that high rates of unemployment are shortly followed by high rates of suicide and psychiatric hospital admission. However, Bartley (1994) argues that it is not unemployment per se that precipitates suicide, but rather unemployment increases the likelihood of other adverse life events and lessens the psychological resources to cope with these.

However, there is less agreement about the *mechanisms* that lead to poor mental health from unemployment. Two major arguments have been advanced: the financial strain of low income and the deprivation of the vital latent functions of employment

In the first argument low income, leading to poverty, is the cause of poor health. Indeed, unemployed people have low incomes. Several studies have shown that the unemployed

receive about 45% to 60% of their employed income (Warr *et al.*, 1988). This is more striking when one considers that many unemployed people were previously in unskilled, low paid jobs (Warr *et al.*, 1988). Moreover, a study of long-term unemployed men in Britain found that 55% had needed to borrow money since becoming unemployed (Payne *et al.*, 1984).

Moreover, there is much evidence that shows low income leads to poor health. The poorer you are the more likely you are to be diagnosed as clinically depressed (Gomm, 1996). A study using data from the British Household Panel Survey found that poverty and financial strain, rather than unemployment, were associated with significant increases in psychiatric morbidity (Weich and Lewis, 1998). In the US, Kessler *et al.* (1988) found that financial strain was the strongest mediating factor between unemployment and reported ill health. Studies of lone parents on welfare benefits in the US have shown high rates of depression and other psychiatric disorders (Danziger, 2000). Warr and Jackson (1985) argue that the restoration of an adequate income on becoming employed is the main factor in the restoration of mental health

> the primary independent influence upon improved psychological health associated with job-gaining was the increase in a person's income.

Though perhaps the second argument, most cogently provided by Marie Jahoda (1982), is the most influential account of the processes by which unemployment affects mental health. Jahoda suggests that employment fulfils a number of vital latent functions. Employment provides an enforced pattern of activity and clear time structure, it is a source of social contacts beyond the family, and it gives a sense of purpose, social status and identity. It is only through employment, argues Jahoda, that these experiences can be adequately met.

This suggests that the lack of work itself, in addition to the effects of poverty, contributes to poor mental health. For example, in a study comparing the 1930's and 1970's, Watts (1983) reported in reference to the general population:

> The impact of long-term unemployment has been broadly similar in these two periods, showing the same features of boredom, declining self - respect, and apathetic resignation.

Watts claims that the differences in absolute poverty between the 30s and 70's did not seem to matter, it was the deprivation of work that was important. A study of unemployed people in Finland found considerable improvement in psychological health on finding work regardless of financial situation before or after employment. Rodriguez *et al.*, (1997) examined the association between welfare support and mental health during periods of unemployment.

They found that welfare benefits were not sufficient to reduce the impact of unemployment on depression. James and Jongward (1978) provide a fitting summary.

> being bored for a long time hastens emotional and physical deterioration.

In summary, there is a wealth of evidence that links unemployment to poor health for all ages and both sexes. Yet recent studies show that not all jobs can have a beneficial impact (Bartley, 1994). For example, studies have shown that some unsatisfactory jobs can be as depressing as unemployment (Winefield *et al.*, 1988; 1991) and those who are obliged to take a lower status jobs had similar psychological health to unemployed people (Burchell, 1994).

This is a particular concern in Britain, where a greater number of 'junk jobs' – low paid, poor quality, temporary jobs – have been created than in any other European country (Leonard, 1998), and yet more pronounced in the US. These are the types of jobs that unemployed people get. White and Forth (1998) studied a representative sample of 861 people who were unemployed in 1990/91 over a 5 year period. 75% of the jobs which they got were temporary, part-time, self-employed, or at a substantially lower skill level than previously. People were more likely to be stuck in such jobs, or fall back into unemployment, than move onto better jobs (Gallie and Marsh, 1994). The government calls this the 'low pay-no pay cycle' (HM Treasury, 1998)

Social class is also a significant factor. Depression and other neurotic states are more common among people in lower social classes (Meltzer *et al.*, 1995a). For example, Brown and Harris (1978) found that working class women were five times more likely to become depressed than middle class women.

An early study of admissions to a psychiatric hospital in Chicago by Faris and Dunham (1939) found admission rates for schizophrenia from poor areas were seven times higher than from middle class areas. In Britain, schizophrenia is three times more common among people from working class backgrounds (Barbigian, 1985; Eaton, 1985).

The two main theories to explain this effect are the 'social drift' hypothesis and the 'opportunity and stress' hypothesis. In the first, it is proposed that people with mental health problems cannot maintain their class position and 'sink to the bottom of society' (Pilgrim and Rogers, 1999: 30). In the second, for example, Phillips (1968) found that people in lower social class have fewer positive life experiences to buffer them from stressful events, which may explain the higher incidence of poor mental health. However, empirical work suggests that different types of mental health problems affect people in different classes. In their study

in the US, Langer and Michael (1963) found that lower class people were more likely to have psychotic symptoms whereas middle class people were more likely to have neurotic symptoms. Moreover, Warner (1994) suggests the two theories are not mutually exclusive, in that the downward social mobility can be in itself an additional source of stress.

Social factors

Social factors include size and level of social support and educational attainment, sometimes referred to as social capital. Socially isolated people die at two or three times the rate of well connected people (Kawachi and Kennedy, 1997). Other studies have shown that the lack of social support is associated with increased morbidity (Forrester-Jones and Grant, 1997). For example, the risk of depression has been found to be higher among people with smaller social networks, fewer close friends and less supportive relationships (Coyne and DeLongis, 1986; House *et al.*, 1988). Brown and Harris's (1978) classic study of 500 women in inner London is considered to provide convincing evidence that the quality of a person's relationships is a powerful mediator between provoking agents, such as job loss, and depression (Rodriquez *et al.*, 1997).

Several studies have shown that unemployed people have poorer social networks than those in work (Atkinson *et al.*, 1986; Claussen *et al.*, 1993). In a study of the social networks of employment and unemployed people, Gallie, Gershunny and Volger (1994) found that unemployed people had lower levels of sociability with people outside the household and had more segregated networks, with a higher proportion of friends that were also unemployed. They conclude that these features result in the weakening of social support as unemployed friends were less likely to be in a position to offer strong psychological support, assistance with financial problems or help with finding work.

In another example, a study of long-term unemployed people in Germany, Sweden and Britain found that the lack of work cut people off from society. (Classen *et al.*, 1997). The study found that unemployment became more intolerable as the duration lengthened, with many respondents feeling lonely, isolated, stigmatised and with a loss self-respect. British people suffered the most, and tended to stick to close family and friends and avoid new contacts and moving into new neighbourhoods.

A study in Norway found that unemployed people with more social capital, defined as education, socio-economic status and social network, had a higher chance of re-employment (Claussen *et al.*, 1993).

Psychological factors

These factors include a sense of empowerment, self perception of health status and levels of stress. The effect of unemployment on psychological health was described above. The process of job-loss is a very stressful life event, characterized as a form of bereavement (Fagin and Little, 1984). For those in work, workplace stress and illness is most common among low-placed employees with little control over their work. Wilkinson (1996: 215) describes the psychological impact of poverty

> To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job or housing insecurity; to feel devalued, useless, hopeless, isolated, anxious and a failure; these feelings can dominate people's whole experience of life, colouring their experiences of everything else...

Environmental factors

Environmental factors include the level of pollution, quality of housing and extent of environmental hazards. For example, housing has been shown to be a critical determinant of health (Best, 1995). Longitudinal research shows that a spell of unemployment may lead to the loss of home (Bartley, 1994). People in lower occupational categories are more likely to experience physical strain, serious injury and high levels of chemical and noise pollution (Hasan, 1989).

Personal behaviours

The so called 'life-style' factors, such as smoking, poor diet, drug use, are often ways of coping with the stresses of life and are more prevalent in lower social classes (West 1995). Moreover, unemployment is associated with some forms of health damaging behaviour: unemployed people are heavier smokers (Cook *et al.*, 1982; Morris *et al.*, 1992) and drinkers (Wilson, 1980). Suicides have also been closely linked to alcoholism and addiction to illicit drugs (Morgan and Owen, 1990). In the US, studies have found the incidence of drug and alcohol dependence among welfare recipients to be about twice that of the general population (Danziger *et al.*, 2000).

Access to treatment and care

Access to services is another important factor, in particular primary care and effective treatments. About 25% GP consultations are for people with a mental health problem (Goldberg and Bridges, 1987) and around 90% of mental health care is provided solely by primary care (Goldberg and Huxley, 1992). However, reports indicate that only about 30% to 50% of depression in primary care is recognized by GPs (Doherty, 1997). Mann *et al.* (1998) suggested that 25% of people with mental illness have never consulted professional help.

Moreover, information about and access to treatments and therapies are often limited (Bird, 1999). For example, people from minority ethnic communities are less likely to receive psychotherapy (Mental Health Foundation, 1995). In a national survey of people using mental health Mann *et al.* (1998) found that 87% did not received sufficient information about their medication and 86% were not warned of the possible side effects. The NSF (1996) found that 25% of community psychiatrists had never prescribed newer, more effective, but more costly, atypical anti-psychotic medication. Access to vocational rehabilitation to help mental health service users return to work is very limited, as described in the following chapters.

Summary

By examining these determinants one can begin to see the negative impact of poverty on mental health. This context of poverty is all too often forgotten in mental health services. Indeed, these social and economic factors contrast with the traditional psychiatric perspectives that highlight genetic factors and biological determinants for mental ill-health (Pilgrim and Rogers, 1999).

However, this brief review by no means covers the vast literature on this topic. Other major determinants not covered include gender and ethnicity. For example, it is well reported that women and black people have higher rates of diagnosed mental illness (Pilgrim and Rogers, 1999).

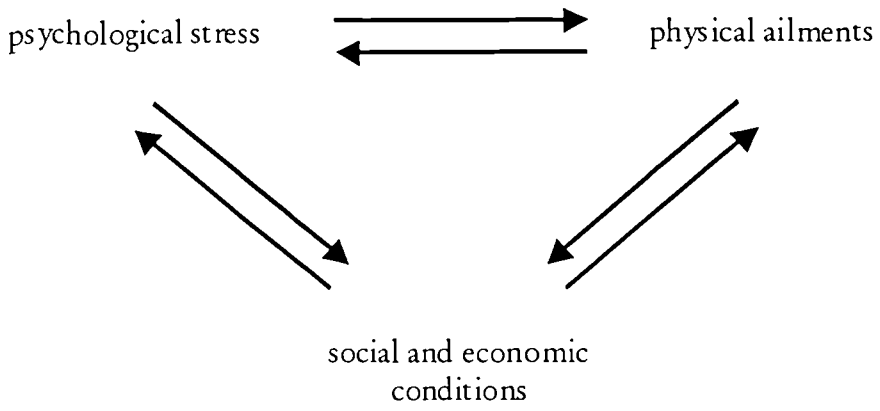
The link between health and material conditions is neatly summarized by Gomm (1996: 110)

> A very simple statement will serve to summarise all the research findings on this matter: for nearly every kind of illness, disease or disability. 'physical' and 'mental', poorer people are afflicted more than richer people: more often, more seriously, and for longer – unless, of course, they die from the condition, which they do at an earlier age.

The evidence in this section has deliberately drawn upon studies that fall roughly into two camps. Those that identify low income as the main determinant, who are more closely allied to the UK Poverty perspective described in the last section; and those that regard the lack of employment as the main cause of ill health, who are more closely allied to the European model of social exclusion. In practice, these are most likely to be interrelated: poor people are either unemployed or in unsatisfactory employment *and* have a low income.

Finally, Gomm (1996) proposed a triangular relationship between 'physical ailments', 'psychological distresses' and 'social and economic conditions'. This is illustrated below with the arrows representing causality.

Figure 1. A triangular relationship between social and economic conditions, physical illness and psychological stress (after Gomm, 1996: 112)



In this triangle causality runs in all directions. Poor people are more vulnerable to physical illnesses and disabilities, which is in turn depressing and stressful. Poorer people are also more vulnerable to mental health problems, which lower the immune system (Lewis *et al.*, 1994). To complete this triangle, ill health of any kind can often result in social and economic deprivation. This last relationship is now considered below for people with mental health problems.

Section Three: Social exclusion and mental health service users

This section will use the three-dimensional model introduced in Section One to explore the nature and extent of social exclusion among people using mental health services. The first dimension considers the nature of poverty experienced by people with mental health problems. This is followed by an examination of how mental health service users are marginalized from social participation and citizenship. Finally, the dynamic processes that trap and maintain people with mental health problems in poverty - stigma and discrimination - will be examined. The section begins by establishing the link between mental health and social exclusion using an historical context.

Total exclusion

The first attempts by the state to manage mental disorder were linked with the response to poverty (Freeman, 1998). The state intervened in only two areas of life - the Poor Law and mental illness. One of the first actions of the state was to totally exclude mentally ill people from mainstream life. Asylums were the apotheosis of social exclusion (Morral, 1999).

Until the start of the industrial revolution mental illness was explained by notions of witchcraft and possession by evil spirits. The vast majority of the insane were to be found in the community, private madhouses, workhouses and jail. There was no distinction and separate treatment for the mentally ill, they were thought of as part of the mass of needy people who could not look after themselves (Heller *et al.*, 1996).

The passing of the Elizabethan Poor Laws in 1598 and 1602 gave the state, via local parishes, the responsibility to prevent destitution by providing assistance to the so-called deserving poor, those who needed support because they were unable to work as opposed to those who were jobless yet capable of self-support. The main features of this system were care in almshouses, which later evolved into public hospitals, the workhouse and 'outdoor' relief, which paid meagre allowances to the needy (Pierson and Castles, 2000).

Britain and France during the late part of the eighteen century and early nineteenth century saw the birth of industrialisation that spawned unprecedented rise in trade, staggering population growth and the first appearance of mass waged labour. This new labour market was characterised by low skill, low paid manual work and intermittent unemployment. The problems of these low-income workers was recognised by the 'Speenhamland' system, which began in 1795, and offered wage top-ups for working families (DSS, 1998a). In practice employers lowered their wages, workers got the same money, company profits rose and the experiment was abandoned (Macarov, 1980).

It was at this time that there came the first measures in England for the separate responsibility to care for pauper lunatics. The British County Asylum Act of 1808 recommended building public hospitals for the insane.

This also coincided with a dramatic change in direction in welfare with the Poor Law Reform Act of 1834, instigated by the Royal Commission on the Poor Laws two years earlier. The huge cost of poor relief led to the abolition of outdoor relief. For example, in the business slumps of 1826 and 1841-42 unemployment in the region of 75% was not uncommon (Warner, 1994). The New Poor Law stipulated that the only place where help would be available should be the workhouse, the conditions of which should be made deliberately harsh to deter dependency on the state – a concept termed 'less eligibility'.

The passing of the 1845 Lunatics Act in England made compulsory the establishment of county and borough asylums. These were intended for no more that 300 patients and it was

assumed that a regime of fresh air and therapeutic work would achieve high rates of cures (Jones, 1996).

However, as early as 1850 the average population of the first 24 public asylums was 297 (Scull, 1993). The county asylums grew in number and in size during the nineteenth century, and housed a growing number of people, many of whom spent their whole life in the institution. In England in 1800 there were around 1,000 asylum inmates, by 1900 there were 100,000 (Jones, 1996).

The critical point to note is that the medical profession was not instrumental the creation of the asylum movement, but rather capitalised on the opportunity (Morrall, 1999).

> The sequestration of lunatics was primarily an expression of civil policy, more an initiative from magistrates, philanthropists and families than an achievement – for good or ill – of the doctors. Indeed, the rise of psychological medicine was more the consequence than the cause of the rise of the insane asylum. (Porter, 1987: 17)

Here we have seen briefly how economic conditions have influenced welfare policy, how the system of care for people with mental health problems has been shaped by these policies, resulting in the social exclusion of people with mental health problems.

Multiple deprivation

The evidence of poverty amongst people using mental health services, in particular long-term users, is very compelling. Poverty among mental health service users is characterised by long-term unemployment, low income, and poor health.

Unemployment

One of the most overwhelming features of people who use mental health services is widespread and systematic unemployment. People with mental health problems have the highest rate of unemployment amongst people with disabilities. The Labour Force Survey in winter 1995/6 found that 85% of those with long-term mental illness were out of work, compared to 72% with severe or specific learning disabilities, 43% with difficulty seeing and 36% with hearing problems (Sly, 1996).

The OPCS Psychiatric Morbidity Survey of Private Households (Meltzer *et al.*, 1995c) found that 61% of people who had experienced a psychotic episode in the last year, and 43% of people reporting two or more neurotic episodes in the past month were unemployed. Several surveys of people with severe mental health problems have found, on average, 90% unemployment (Hogman and Chapman, 1998; Hatfield, 1992; Pozner and Jones, 1994;

Turton, 1996). This is in stark contrast to the current unemployment rate in the general population of about 5.5% (ONS, 2000).

We have already seen the detrimental impact unemployment has on mental health, but what is the impact on people who already have mental health problems? Wing and Brown (1970) highlighted that inactivity in those with chronic schizophrenia seemed to be directly responsible for a proportion of subsequent clinical symptoms, particularly flatness of affect, poverty of speech and social withdrawal. Shepherd (1989) agrees,

> Enforced idleness is certainly as damaging as enforced activity, especially if you have chronic schizophrenia.

In a long-term study, specific to people with mental health problems, Vogel *et al.*. (1989) claimed that more unemployed than employed patients exhibited a deterioration in symptomatic behaviour, which usually took the form of increased anxious and depressive behaviour, feelings of tension, and tendencies to social withdrawal. Loss of self-esteem was a notable reaction in patients with affective disorders, whereas unemployed people suffering from schizophrenia succeeded far less often in overcoming the anxious behaviour and lack of energy. They conclude that

> The results indicate that mentally ill persons (especially those with organic or affective disorder), when confronted with unemployment after discharge from hospital, will respond by developing new or worse syndromes.

However, the direction of causality is still not clear. It may equally hold that people with more severe mental health problems do not obtain employment, rather than unemployment causing more severe mental health problems.

Nevertheless, the evidence is clear: mental health service users experience one of the highest unemployment rates of any disadvantaged group and that unemployment has serious deleterious effects on the mental health of the general population. It is unlikely that people with mental health problems are immune to the psychological stresses of unemployment described by Marie Jahoda. Therefore it would be fair to claim that unemployment can also have a negative impact on the health and well-being of people with mental health problems.

Low income

Most mental health service users live on low incomes for many years and so are exposed to the financial stress described in Section Two. Davies and Hill (2001: 25) claim that "mental health service users are amongst the poorest citizens in the UK" and that this is a consequence of the high levels of unemployment described above.

Several studies have shown that the majority of mental health service users live on low incomes from state benefits. For example the OPCS surveys (Meltzer *et al.*, 1995c) found the median gross weekly income was about £90 among those with a neurotic disorder compared to £150 for the general population. Further evidence comes from two recent large-scale surveys concerning the income of people with mental health problems.

Hogman and Chapman (1998) conducted a postal survey with a total of 660 responses from members of the National Schizophrenia Fellowship (NSF). The majority of the sample had a diagnosis of severe mental illness, almost half had been in hospital in the last three years, 90% were unemployed and the majority attended day care services. The survey found that 92% were in receipt of welfare benefits, with over a third claiming Incapacity Benefit and a similar number on Income Support. Of the 57% who received Disability Living Allowance (DLA), the majority of people said they spent it on basic living expenses, such as travel, bills, food and clothes. Moreover, the survey found 38% had debts, mainly with utility companies, rent, credit cards and catalogues. Almost all respondents had an income below a poverty line defined by the Council of Europe's decency threshold[1]. The survey concluded that

> People with a mental illness have enough to deal with coping with the symptoms of their illness, problems with accessing services and discrimination. Financial worries are an added burden and when they include unpaid debts they can have a major effect on a persons ability to cope. (Hogman and Chapman, 1998: 22)

Further evidence of low income comes from the Mind Disability Benefits Survey (Mind, 1998), which examined the income of 630 members. The survey found that 98% received welfare benefits, with 60% claiming disability benefits. Half the respondents were in receipt of Income Support and just over half were receiving Disability Living Allowance. The survey also found that the majority of respondents spent their benefit income on essentials, such as food, utility bills, transport and housing.

As described in Section Two, the financial stress of low income can lead to a range of health and social problems. For example, people with mental health problems lack the resources to sustain reciprocal relationships and to dress adequately to join in community events and participate in hobbies (Barham and Hayward, 1995). Low incomes reduce the ability of mental health service users to participate in everyday social life.

[1] Defined as 68% of adult mean earnings (Low Pay Unit, 2002)

Social security

The evidence also points out that the *source* of income is just as important as the *amount*. Davis (1999) highlights the problems associated with the benefit-dependent status of most mental health service users. For example, studies by Davis and Betteridge (1990) and Rose (1996) both found that attitudes of social security staff can confirm low self-esteem and a sense of worthlessness in claimants with mental health problems. These reports also highlight the problems mental health service users face in negotiating the complex rules of the benefits system. The NSF and Mind surveys also exposed the stress and anxiety that claimants felt caused by the uncertainty about how recent government reforms will impact upon their income.

Several studies have now shown that difficulties in claiming benefits can reduce incomes of people with mental health problems to below poverty levels (Linney and Boswell, 1987; Marks, 1988; Rose, 1996). For example, Pacitti and Dimmick (1996) found that 51% of people attending a mental health resource centre in the south of England were not receiving the benefits they were entitled to. In another UK study, McCrone and Thornicroft (1997) found 45% of a sample of 58 people using mental health services were not receiving benefits to which they were entitled. The average amount owed was nearly £20 per week for the whole group and £45 per week for those who were underpaid. Low up-take of benefits by claimants with mental health problems can result in further poverty which may lead to increased anxiety and prolonged recovery (Cobb, 1993).

> When benefit entitlement or up-take is low, dependence on welfare can reduce the social opportunities open to the psychiatric patients - integration into and use of community facilities requires money. (Slade *et al.*, 1995)

Health inequalities

In addition to mental health problems, mental health service users also experience poor physical health. For example, people with mental health problems have high rates of coronary heart disease and the standardized mortality ratio (SMR) for people with schizophrenia is two and a half times the average (Department of Health, 1994)

The OPCS surveys (Meltzer *et al.*, 1995b) found that 50% of those with a neurotic disorder had a long-standing physical complaint compared with 30% with no disorder. 25% of people with schizophrenia living in residential accommodation had a physical complaint, such as musculo-skeletal, heart, circulatory and digestive conditions. Over half of men living in residential care homes were classified as heavy smokers.

The treatments received by people with mental health problems can also cause further health problems. The iatrogenic effects include brain damage, permanent and disfiguring movement disorders (tardive dyskinesia), and sudden death from major tranquillisers, together with increase risks posed by the sedation effects of minor tranquillisers (Pilgrim and Rogers, 1999).

The higher incidence of physical health problems, together with the debilitating side-effects of medication can further reinforce the problems of poverty and social exclusion among mental health service users.

Citizenship and participation

The notion of citizenship has received recent attention in an attempt to re-interpret the relationship between individuals and the state (Barnes, 1997; Gaventa, 1998; Giddens, 1998; Sayce, 2000). It encompasses the belief in social rights (fair treatment, anti-discrimination legislation) and refers to the ability of people to participate within civic, social and economic life (Barnes, 1997). It is about social inclusion.

Social participation can be defined as the individual taking part in activities both within their own self-organised, self-determined communities and within those defined by the state, such as voting. It is then the *extent* to which the people in this study are able to participate as citizens that determines the extent of their social inclusion. Their ability to do so is, in turn, largely determined by their material and personal resources – education, employment, health and personal finances – described above.

During the days to institutional care people with mental health problems could never be true citizens. Patients in general were forcibly separated from their lives and communities. Over the last half century the place and organisation of mental health services have drastically changed – from institutional care to community based care. However, in the new era of community based care Sayce (2000) concludes that "at present, user/survivors enjoy only the illusion of citizenship." This section considers the evidence for this using the three themes of voting and civic participation; civil rights and the law; and day to day activities, hobbies, etc.

Voting and civic participation

Perhaps the key indicator of citizenship is the participation in the democratic process. There is little evidence about the voting behaviour of mental health service users (Huxley and Thornicroft, 2000), although some key restrictions standout. If the presiding officer determines that someone is suffering from mental incapacity, that person will not be allowed to vote in an election (Barnes, 1997). The Representation of the People Act 1983 means that

patients cannot use the hospital as a place of residence on the electoral register and detained patients cannot use their last address (Dunn, 1999). Regardless of their lucidity, people in such circumstances will not be able to vote. The Juries Act 1974 means that 'mentally disordered persons' are unable to serve on a jury.

Civil rights and the law

In discussing the civil rights of disabled people Barnes (1997) singles out people with mental health problems as having the most obviously restricted rights. For example, the legal concept of mental incapacity can mean the loss of the power to manage financial affairs or enter into a contract.

Perhaps the most powerful example of exclusion is the ability of mental health professionals to detain their patients in hospital. Patients detained under the 1983 Mental Health Act 1983 can be compelled to receive medical treatment against their will. Pilgrim and Rogers (1999) suggest about 7% of patients are detained under the 1983 Act. However, when Rogers (1993) examined the reports of 412 people who had been officially recorded as informal admissions she found that 44% remember being pressured by staff on threat of forced admission - *coactus voluit* ('at his will although coerced') as Bean (1986) described it. The extension of such powers to community settings proposed by the revised Mental Health Act could further infringe the civil rights of people with mental health problems. The legal matters outlined here have been discussed in more depth elsewhere (Pilgrim and Rogers, 1999; Bean, 1986; Rose 1986)

Community participation

> There is no one truth about what community is. (Barnes, 1997:5)

The term community has been used since the fourteenth century without any one common definition (Williams, 1976). Perhaps the most common usage has been to describe geographic locality or neighbourhood. This is a useful concept for describing an area in terms of its population, economy and social infrastructure, but is limited as it overlooks the relationships within it.

An alternative concept, proposed by Bulmer (1987), is the notion of 'primary group', which adds a social dimension to the neighbourhood concept, such as family, friends and neighbours –a person's social network.

More recently, the notions of 'communities of interest' and 'communities of identity' have evolved to reflect the wider range of opportunities now available for people to interact, organise and gain identity. This concept embraces the diversity of modern life with less

emphasis on the location of residence as the focal point of community life (Barnes, 1997). The factors promoting a shared experience can include sexual or racial identity, commitment to a cause or professional affiliation. Such communities are based on who people are and what they do –the nature and extent of participation.

This section examines both the potential for participation - social networks - and evidence about the experience of participation. These two concepts are interlinked, with social networks providing opportunities to participate, and community participation providing opportunities to develop social networks.

The move to community care for people with mental health problems has been accompanied by increasing interest in the study of social networks and social support. Several studies have shown that the social networks of people with mental health problems vary both quantitatively and qualitatively from the general population. Social networks of mental health service users have been shown to be smaller and more dense, and consisting of fewer reciprocal and supportive relationships and independent interactions outside of the family (Forrester-Jones and Grant, 1997). For example, Pattison *et al.* (1979) found that people with psychiatric illness were able to recall just 11 people to whom they felt close, compared to about 25 by people who had suffered no mental illness. People without mental health problems had much more diverse membership including family, friends, work associates and neighbours. Whereas people with mental health problems had a higher proportion of people closely related to each other, two-thirds of whom were close relatives.

More recently, Huxley and Thornicroft (2000) used data from the UK700 study of users of community mental health services in London and Manchester to explore the extent of inclusion compared to the general population. They found a much lower proportion of mental health service users lived in a family home with a partner, whereas the number that lived alone was almost three times higher than for the general population. They also found that mental health service users saw family members much less often, were more likely to report no close friend and to have fewer friends overall.

These impoverished social networks can explain the lack of community participation. The following recent qualitative studies in the UK provide some details about life as a mental health service user.

In *Living in the Community*, Diana Rose (1996) completed 76 semi-structure interviews to determine how mental health service users felt about the number and quality of their contacts

in the community. A substantial number had less than four community contacts, many tended to have their friends amongst other users of mental health services and their lives were concentrated in the mental health community. Most gave positive experiences of contact with family, friends and church. Mixed views were given about community organisations (such as adult education and advice services) and local communities (such as pubs, clubs, shops, etc.). Some people had good experiences, though many hid their diagnoses, and some had experienced rejection. The predominant experience of contacts with neighbours, housing and benefits officials, and the police were negative, with many examples of poor treatment and discrimination. Rose (1996:43) concluded that

> From the point of view of the majority of people with mental health problems, the community doesn't care. Indeed, it can be hostile.

Lost in Space (Kendall, 1999) provides a unique account of the lack of social and economic 'spaces' available for mental health service users. This study examined the experience of severe mental illness and the use of mental health services through a series of interviews with 21 people using mental health services. The study contrasted the hope and expectations with the actual experience in relation to several areas of life, including economic activity.

> Instead of "real" jobs the people involved in this study had found themselves facing a very limited choice of daytime activity –a life on benefits plus a sheltered employment scheme, or a life on benefits without an employment scheme. (p192)

Most people in the study felt they faced a lifetime on benefits, which meant in effect a lifetime of empty days. Brandon describes this as "the everyday trauma of eventlessness" (Brandon and Brandon, 1995). The participants also described how they had lost their original friendships after the onset of their mental health problems and instead developed friendships with other mental health service users.

The *Strategies for Living* project (Faulkner and Layzell, 2001) was an important study, firstly as it provides insights into how people cope with their mental health problems, but also because it was entirely grounded in the experiences of mental health service users. This second matter was achieved through the involvement of mental health service users at every stage of the research process.

The study used interviews with 71 people with mental health problems to explore their strategies for coping with mental distress. Most people found coming to terms with mental distress and a psychiatric diagnosis a long and difficult process. The report mainly focused on

the positive experiences of mental health service users in helping them cope with their lives. For many, relationships with others were the most important factor in helping them cope with their lives. Helpful relationships were those that gave emotional support, companionship and friendship, a meaning to life and practical support.

> Relationships and friendships are important to everyone ... The difference for those of us who experience mental distress is partly that the potential circle is smaller, reduced in size by public and personal attitudes to mental illness, and partly that the effects of mental distress can be socially isolating in themselves. A lack of money, employment and opportunities to meet new people can reduce the possibilities still further. All these factors can contribute to the social exclusion of people with mental health problems from the wider community. (Faulkner and Layzell, 2001: 34)

The search for such relationships results in many mental health service users either living a lonely and isolated existence, or finding 'accepting' communities within mental health day services. *Creating Accepting Communities*, a major inquiry established by Mind (Dunn, 1999), found that mental health services themselves can act to cut off service users from the rest of society- summarised here by Peter Bates, an inquiry witness.

> Traditional services have ghettoised users. They have severed their links with other citizens. In order for services to stop promoting exclusion, they must stop promoting containment. Mental health services, both statutory and voluntary, must begin to recognise that users are citizens first, friends and loved ones second, employees and enthusiasts third, and users of mental health services only fourth or fifth. (Dunn, 1999: 31)

Stigma and discrimination

The key process factors that lie behind the exclusion of mental health service users from mainstream social and economic life- such as employment, family and social life, consumerism and use of services -are stigma and discrimination. Instead of leading to a therapeutic or supporting process, a psychiatric diagnosis can be the start of a process of social exclusion (Dunn, 1999).

Service users have been rejected on applying for jobs. In their study of 778 mental health service users Read and Baker (1996) found that 34% had been dismissed or forced to resign from their jobs, 39% said they had been denied a job because of their psychiatric diagnosis, and 69% had been deterred from even applying for work because of fears of being unfairly treated. In Scotland, Patrick (1994) found that 29% of mental health service users had been refused employment for failing a medical and many would not apply for jobs because they knew they wouldn't get them.

These fears seem well justified when examining the attitudes of employers. Manning and White (1995) surveyed the attitudes of 109 personnel directors from a random sample of public limited companies in the UK. 50% said they would never or only occasionally employ someone currently depressed rising to 66% for someone with a diagnosis of schizophrenia. Similarly, Wansborough and Cooper (1980) found that employers were reluctant to recruit people with mental health problems and were more willing to recruit people with depression than those with schizophrenia. More recently, Glozier (1998) asked two hundred personnel managers to assess the employment prospects of two vignettes of job applicants who had recovered from a health problem. Both were identical except one had a diagnosis of diabetes and the other depression. The applicants with depression had significantly less chance of employment.

These poor attitudes from employers reflect the negative perceptions of mental illness among the general public. A Harris poll found that the public in the US were far more uncomfortable with mental illness than other disabilities (Harris, 1991). Just 19% of those surveyed said they would feel comfortable with someone with mental illness compared to 59% with someone using a wheelchair. A survey of residents in a British city (Huxley, 1993) found that 31% of respondents reported being personally embarrassed by mentally ill people, while 82% of mental health service users believed that they embarrassed other people. The Mind study by Read and Baker (1996) found that 47% of mental health service users had been verbally or physically abused in public. Examples of abuse include:

> eggs thrown at them while being called 'nutter', or had dog faeces or lighted paper put through their letter box. (Dunn, 1999: 8)

Negative attitudes also exclude mental health service users from services. For example, people with mental health problems have been turned down for insurance (Campbell and Heginbotham, 1991) and turned down by banks (Dunn, 1999). Read and Baker (1996) found that 25% of mental health service users had been refused finance or insurance.

As well as excluding mental health service users from employment and financial help, attitudes can also bar access to housing. Page (1977) found that mental health service users could find rented accommodation hard to obtain. Accommodation was offered by just 27% of landlords to the researchers who pretended to be mental health service users, compared to 83% to a control group. People with mental health problems have even been turned away from homeless shelters (Breakey *et al.*, 1992).

Repper *et al.* (1997) noted the rise in 'NIMBY' (not in my backyard) campaigns during the 1990s. They found that over two-thirds of statutory and voluntary mental health service providers had experienced such campaigns during the development of residential accommodation.

Mental health services themselves are stigmatising and ghettoising, and some users are in active flight from them (Dunn, 1999). Discrimination, and in particular racism, is also evident in mental health services (Wilson and Francis, 1997). Black men are more likely to be compulsorily detained and less likely to be offered alternatives to drug treatments (Dunn, 1999). Read and Baker (1996) also found that mental health service users have been unfairly treated in physical health care. Some instances include.

> Every genuine physical illness I have had over the last twenty years has first been dismissed as anxiety, depression or stress. (Dunn 1999: 8)

Discrimination continues after treatment and is associated with relapse and an intensity of ongoing problems (Link *et al.*, 1997). The ostracisation of mental health service users leads to difficulties in establishing social networks, a lack of informal job contacts, and a lack of access to everyday goods and services (Dunn, 1999). For some, these are further compounded by race and sex discrimination. The groups most likely to experience problems include people from ethnic minority groups, refugees, and single parents (Hoggett *et al.*, 1999).

Social exclusion does not just affect individuals it also affects groups of people. Mental health service users have been systematically labelled, grouped and segregated. The factors that affect the 'community' of mental health services users are caused by public attitudes and driven by media representations (Sayce, 2000; Wahl, 1995). Social stereotypes of mental illness equate the label with being 'mad', 'out of control', 'unpredictable' or 'violent' (Teasdale, 1987). Otto Wahl (1995) presents perhaps the most comprehensive picture of the negative images of mental illness in the media.

> The depictions of mental illness that have found their way into almost every medium consumed by the public remain largely unfavourable and inaccurate. [...] the public continues to be exposed to repeated presentations of people with mental illnesses as comical, different, and dangerous – images that perpetuate unfavourable stereotypes which, in turn, lead to the rejection and neglect of those with psychiatric disorders.(Wahl, 1995: 164)

The negative stereotypes of violence contrast with the evidence. Many studies now have countered the claim that mentally ill people are more violent (Dunn, 1999; Taylor and Gunn,

1999). For example, the UK Audit Commission (1994) found no increase in homicides by people with mental health problems over the last 20 years, during which time homicides in general had doubled. Other studies (MacArthur Foundation, 1999; Mullen *et al.*, 1998) have found a much stronger link between violence and alcohol and drug misuse rather than mental health problems.

The Mind inquiry into social exclusion (Dunn, 1999) found that many service users feel that a psychiatric diagnosis has made them non-citizens, with no rights, no credibility and no redress. The problem is neatly summarised by one inquiry witness

> It is easier to live in society with a prison record than a psychiatric record. (Hywel Davies cited in Dunn, 1999: xi)

Conclusion

This chapter has highlighted the importance of social exclusion for the individual, the government and society. The origins of social exclusion have been explored and a working definition proposed using three dimensions -poverty and inequality; citizenship and participation; and stigma and discrimination.

It is clear that the experience of poverty has severe and long lasting detrimental effects on the general population. The problems of poverty become starker when applied to people with mental health problems. The evidence for the social exclusion of people with mental health problems is compelling and is cause for concern.

> On virtually any indicator of 'social exclusion', people with long-term or intermittent mental health problems are amongst the most excluded in British society. (Sayce and Morris, 1999: 6)

Psychiatry came into being as a response to the social exclusion of people with mental disorder. This occurred within a context of institutional form of welfare developed in response to industrialisation and the rise of waged labour. The asylum represented the apotheosis of social exclusion. Following deinstitutionalisation in the latter half of the twentieth century people with mental health problems continue to experience social exclusion. They continue to be excluded from mainstream social and economic life, though not by asylum walls but by stigma and discrimination.

The evidence that poverty causes poor health is now beyond dispute (Kawachi and Kennedy, 1997; Wilkinson, 1997). The experience of many people with mental health problems shows that poor health also causes poverty

Widespread and long-term unemployment amongst people with mental health problems often leads to an unremitting cycle of deprivation. Unemployment causes poor psychological health and can expose mental health service users to further stress. Unemployment also leads to low income, which entails financial stress, the indignity of claiming welfare benefits, and reduces the opportunities to participate in mainstream society.

Moreover, the costs of social exclusion are not just borne by individuals with mental health problems, but also to the wider society. The total cost of mental health problems in England has been estimated as £32.1 billion (Patel and Knapp, 1998). More than a third of the total cost (37%) is attributed to costs in lost employment and productivity. Moreover, a further 24% (£7.6 billion) of the total results from social security payments. At almost £20 billion per year, the cost of social exclusion among people with mental health problems is very significant indeed.

This chapter has argued that the primary problems of mental health service users are those of social exclusion. Therefore in order to reduce the personal and societal costs of mental health problems, we first need to reduce the problems of social exclusion. The next chapter examines how mental health services have confronted that challenge.

Chapter Two

From Treatment to Inclusion

Introduction

Day care services are widely acknowledged as a vital component of a comprehensive mental health service (Audit Commission, 1994; Department of Health, 1996, 1998a, 1998b, 1999a; Mental Health Foundation, 1994; Strathdee and Thornicroft, 1996). Yet there is considerable confusion about their purpose and function (Holloway, 1988, 1991; SSI, 1992). This situation has occurred as a result of the lack of attention paid to day care, with the last fifty years of mental health policy driven by finding somewhere for services users to live, rather than something to do (Falloon and Faddon, 1993; Freeman, 1998; Peck and Parker, 1998).

The concept of day care in mental health services has developed in response to the running down of large-scale mental hospitals and the deinstitutionalisation process. Since the 1950s the reduction in number of long-stay hospital beds was accompanied by a rise in the number of psychiatric day hospitals, day centres and other day care services (Vaughan, 1985; Hirsch *et al.*, 1979).

Thus day care has arisen from a need for 'after care', that is, life after hospital treatment. However, for many, life after treatment means living with the side affects of psychiatric drugs on top of continuing debilitating symptoms (Dunn, 1999; Rogers *et al.*, 1993), whilst enduring a lifestyle often characterised by permanent unemployment (Meltzer *et al.*, 1995c; Sly, 1996), social isolation (Rose, 1996), extreme and persistent prejudice and discrimination (Sayce, 1998, 2000), low income (Hogman and Chapman, 1998; Pacitti and Dimmick, 1996), and poor, often ignored, physical health problems (Meltzer *et al.*, 1995b). By examining the widespread social exclusion of mental health service users it appears that 'life after care' has been an afterthought.

This chapter argues that the shift in the primary problem amongst people using mental health services from one of illness to one of social exclusion has been accompanied by a shift in the focus of mental health day care services from treatment to inclusion. Moreover, that day care is a redundant term, a hangover from the asylum with connotations of treatment, control and exclusion and should be replaced by those of citizenship, opportunity and inclusion.

Firstly, the problem of defining day care is discussed, followed by an historical account of how day care services have developed in terms of the services they have provided, for whom and for what purpose.

The problems in defining day care services

The attempts to define day care services (Carter, 1981; Osborn, 1985; Tester, 1989; and Tibbit, 1987) reveal a wide range of perspectives and issues, including the terminology used, who they are for, and what is provided, when, where and by whom (Brearley and Mandelstam, 1992).

Several terms have been used including day care, day centre, day care services, day services, day activity services, day treatment, day hospitals, etc. They are often used interchangeably though can quite often mean different things to different people. This chapter uses the term day care services used by the Social Services Inspectorate (SSI, 1992).

Much of the literature concerns people with physical and learning disabilities and elderly people (Brearley and Mandelstam, 1992). This information can provide context in which to examine the development of mental health day care services, though caution is due as the needs of different groups can be fundamentally different.

Attempts have been made to characterise day care (SSI, 1992). The Social Services Inspectorate characterised day care models along two dimensions: the extent to which the service is building based and the extent of user independence. This typology examines where services are based and who uses them but does not address what they are for.

There is much variation in what is provided by day care services. Examples include medical treatments, therapy groups, individual counselling, work activities, leisure pursuits, arts and crafts activities, adult education, food, and places to meet. Day care services can only be really defined by what they do not provide, that is in-patient beds and domiciliary care. To illustrate this, the PSSRU (Beecham *et al.*, 1998) have suggested the following definition.

> The term day activity settings refer to any facility (for example day hospital, day centre or work-related scheme) which typically provides social or practical communal support and which has paid volunteers or staff present in a non-domiciliary and non-residential capacity.

The terms used all include the word 'day'. This can be misleading when some services are available during evenings.

Day care services are dominated by centre-based services. The day centre, psychiatric day hospital and sheltered workshop are the backbone of day care services in the UK. However, some day care services aim to offer services irrespective of the place in which they are delivered.

Historically, the provision of day care services has been managed by health and local authorities, though more recent developments have occurred in the voluntary sector. Who provides the services can often determine what they are for.

Finally, defining what they are for provides a complex range of options. For example, Table 1 shows the results from a survey of day activities in the south Thames region of England by Beecham *et al.* (1998). They used the WHO International Classification of Mental Health Care (ICMHC) (de Jong, 1995) to determine what happens within day care services. Most services provided 4 to 5 types of support. This shows both the wide range and overlapping nature of the types of support provided.

Table 1. Supports provided by day care services

Types of support	*Percentage of settings providing each type of support*
Help for users to establish and maintain relationships	87%
Assessment of users' problems or functioning	65%
Co-ordination of other care services for users	57%
General health care	34%
Undertaking daily living activities for users	42%
Prescription or supervision of mental health medication	23%
Psychological interventions (for example, group work or counselling)	52%
(Re)education for users in daily living, interpersonal or social skills	70%
Work-related activities	50%
Training or education to help users spend their days in ways which are worthwhile to them	64%
Interventions to support family members	36%

These definitions are based upon the services provided rather than the underlying need for day care services. A further complication arises when considering whose need and how that is defined. Chapter One has described the complex needs of mental health service users caused by the problems of social exclusion. However, the Social Services Inspectorate (1992) highlighted the mismatch between needs and service provision. The report point out that services have often been developed as a substitute for more expensive hospital and residential services, rather than based on a careful assessment of need.

The fundamental problem that has caused confusion over day care services is the historical shadow cast over the mental health service landscape by the large-scale mental hospital. It is here that we begin the story of mental health day care services in the UK.

Section One: Asylum Life

During the time of mass incarceration, from the early nineteenth century to the mid-twentieth century, day care services did not exist. The asylum system provided an all-embracing and systematic way of dealing with emotional deviance (Pilling, 1991).

There is much contradictory evidence about life in the asylums. Some authors paint a picture of idyllic communities where patients worked by day in the gardens, laundry and kitchens and spent their evenings enjoying recreational pursuits such as ballroom dancing (Evenson *et al.*, 1994). Others describe a life of enforced restraint, dehumanising somatic treatments (insulin coma, psychosurgery and unmodified ECT) and overcrowding (Rogers and Pilgrim, 1996). Boredom was perhaps the principal occupation, as Jan Carter (1988: 3) describes.

> In the past, institutions of all types have dealt with the passing of time by ignoring it. The calendar, not the clock, was the marker for those who lived in long-stay hospitals... In these institutions every day was like most others.

Perhaps the truth is that both views are valid, but that different experiences occurred to different people, in different places at different times. The next two sections describe the more positive aspects of asylum introduced in what is known as the 'moral treatment' era, followed by the poorer conditions that characterised the period up to the era of community care.

Moral treatment

Until 1845 there were very few institutions that looked after the mentally ill. Conditions in private madhouses were harsh. At the Bethlem Hospital in London the inmates were exhibited to the public. Inmates were often left naked in the cold, beaten and locked up in cramped conditions (Warner, 1994). It against this backdrop that 'Moral Treatment' movement (Pinel, 1806) emerged as a radical alternative to the management of mental disorder.

The two most famous proponents of moral treatment were Philippe Pinel, who took over the Bicêtre, an asylum in Paris, in 1793; and Samuel Tuke, a 60-year old tea and coffee merchant who became the medical officer at the York Retreat, built by Quakers in 1796. Tuke argued that if the insane were housed in small, homely institutions away from the bustle of every day life, and were cared for by kindly and dedicated staff then they would quickly

recover and become productive citizens. The moral treatment movement embraced work as *the* means of treatment, and used work to distract and calm patients. Pinel (1806) wrote that

> Nothing was more striking than the peace and calm which reigned among the mental patients of the Bicêtre during the period that the merchants of Paris furnished manual work to the majority of its patients (Cited in Bennet, 1997: 193)

Interestingly, there were similar movements to more humane care made independently across Europe at this time. Warner (1994) argues that the origins of moral treatment were founded in Enlightenment thinking and the capitalist transformation of production.

In many ways this movement was optimistic and enlightened. Moral treatment emphasised the intrinsic humanity of the patients and believed that they could be cured given the right kind of therapy it. Indeed, the recovery rates were much higher than in the traditional madhouses (Jones, 1996), and the York Retreat methods were used as a model for British asylums in the 1845 Act.

Early public asylums were almost self-supporting communities with farms, dressmakers, breweries and shoemakers (Connolly, 1847). At this time work was viewed as a panacea (Szasz, 1974) by upholding the morals of inmates, ensuring order and control, providing a form of treatment, whilst contributing to the overheads of the institution.

For a few years in the 1850s and 1860s a form of moral treatment was made available for the poor in county asylums. However, non-restraint treatment was more costly due to the need for a higher number of better trained staff. With an ever rising institutional population the quality of care severely diminished. Warner (1994) argues that the social policy which established large, cost-effective asylums limited expenditure on patient care and reduced the possibility of rehabilitation.

The decline of the asylum

The use of work in asylums fell into decline as hospitals became larger and more custodial in character. Work that was done by patients became that which was necessary to the economy of the institution, rather than their recovery. This situation was described by Eva Charlotte Reid, an American doctor, as a tendency

> to make drudges out of the willing and efficient, while those who require to be instructed, supervised or handled with tact were allowed to remain in complete idleness. (Reid, 1914, cited in Bennet, 1997: 194)

The very nature of life in the asylum contributed to their demise. Attacks on the system came from the 'anti-psychiatry' movement (Goffman, 1961; Laing, 1967; Szasz, 1963), regarding the dehumanisation of institutional psychiatry and from the public outcry at a series of hospital scandals following official inquiries into neglect and mistreatment (Martin, 1985).

The anti-therapeutic impact of institutional life was criticised by social psychiatrists (Wing and Freudenberg, 1961), who accepted psychiatric theory and practice. In the 1960s Wing (1962) coined the term *institutionalism*, which referred to the passive, regimented lifestyle in the hospital causing deficiencies in social and self-care skills. Barton's (1959) pamphlet on 'Institutional Neurosis' proposed that the structure of psychiatric hospitals, and staff brutality, induced a neurosis-like state for patients – the aimless pacing, mannerisms, mutism, passivity, incontinence and sudden aggression – which had long overlain their psychosis.

The other driving forces leading to the closure of large-scale mental hospitals have been well rehearsed elsewhere (Busfield, 1986; Freeman, 1998; Jones, 1988; Rogers and Pilgrim, 1996) and include the desire for cost saving, the effectiveness of neuroleptic drugs and the growing acceptance of normalisation theory. A further argument forwarded by Andrew Scull attributes the desire for deinstitutionalisation to the post war development of social security policies that could maintain people more cheaply outside of asylums (Warner, 1994).

The process of hospital closure reached a peak in the mid-1990s marking an end to the total control of life in asylums for people with mental health problems.

Section Two: The relationship between work and welfare

In the last chapter we saw how people with mental health problems were systematically excluded from society by the institutional forms of welfare largely because of their inability to sustain themselves in the new forms of waged labour. The last section has described that the first attempts at 'treatment' within the asylums were to make the inmates work. The relationship between work and welfare is clearly complex. This section attempts to unpack this important relationship.

The three key features of this relationship are that (a) work is a basic human need and the lack of it can have deleterious effects on mental health, (b) people who are sick should be excused from work, and (c) there is a moral obligation to work.

The benefits of work

The overwhelming significance of work for individual welfare and for society is evident in the long tradition of political, economic and philanthropic literature to do with employment

and unemployment. Employment, or lack of it, is central for individual well-being and for the good of society. Unemployment can be responsible for a multitude of ills including poor health, crime and poverty.

> No population can be good, intelligent, or happy, except by a rational and natural education and useful employment or occupation. (Robert Owen, 1857)

> [Work] is the way in which we meet needs, create wealth and distribute resources ... a source of personal and individual fulfilment, social status and relationships. (Commission on Social Justice, 1994)

> The best form of welfare for people of working age is work. (Harriet Harman, 1997)

Here Robert Owen envisages a 'New Moral World', based on useful employment, to replace the iniquities of the old one. The Labour government in the UK see work as central to their welfare policies. Moreover, the Council for Churches for Britain and Ireland (1997) has proclaimed that 'enough good work for everyone' should be a national aim as a way to fashion society with a sense of purpose. Work is personal, work is political; above all, work is moral.

> The greatest analgesic, soporific, stimulant, tranquilliser, narcotic and to some extent even antibiotic - in short the closest thing to a genuine panacea - known to medical science is work. (Szasz, 1974)

Szasz may apotheosise work, but Garner (1995) highlights its more commonly identifiable human value:

> Despite the current state of society, people still expect to work for a living, because, amongst other things, it provides economic security, social interaction, self-identity and self-esteem, as well as promoting life satisfaction.

In addition to providing an income for the necessities of life, Jenkins (1983), describes the more tacit gains from work:

> It provides a time structure of regular activities during the day. It usually implies shared experiences and regular contacts with colleagues. It links an individual to goals and purposes other than his/ her direct needs, and it defines aspects of personal status and identity.

Work, health and illness

It is because of the less tangible factors associated with work, such as social contact, time structure and valued status, that work has been used in mental health care. The benefits of work to the individual can be summarised by Freud (1930).

> Work has a greater effect than any other technique of living in the direction of binding the individual more closely to reality.

The idea of using work as treatment has a long history dating back to Hippocrates and Galen. This history has been punctuated by the central controversy: that the deeply held notion of the 'sick role' conflicts with the role of work in the long term care of chronic illness (Bennet, 1970). During illness it is widely accepted that people are temporarily excused from the obligation to work. This is entirely appropriate to a person's need during short-term recoverable illness but not so appropriate in long-term illness or permanent disability. What began as a humane and sensible exemption turns into a demoralising deprivation of work (Morgan, 1983).

In describing the role of work for people with mental health problems, Eikelmann and Reker (1993) state:

> Work must not be seen merely as an essential means of securing a material livelihood, the fact is rather social aspects and structuring of the day-to day routine have to be taken into account in the same way as the positive effects of work on self-confidence and the role of chronically ill people. With work and employment being indispensable for therapeutic reason and vital for social reasons, efforts directed towards rehabilitation and reintegration must be intensified as the deinstitutionalization of these people proceeds.

Wansborough (1981) suggests that stigma is reduced if you are seen as part of the homogenous, working, well population.

> work confers on the patient membership of the working population, keeps him [her] busy, and is a passport to social participation. (Morgan, 1983)

Vogel *et al.*. (1989), conducting an empirical study in Germany found successful outcomes amongst those who found work:

> Patients who found steady work were more likely to show an improvement in psychiatric condition; improvements were seen, notably in the symptoms lack of initiative, retardation, and depressive behaviour.

Employment may also contribute to maintaining people outside of hospital (Stein and Test, 1980) and Jacobs (1988) writes:

> studies have show that holding a job - even a voluntary or sheltered job - is a significant predictor of sustained remission and community tenure for chronic mental patients (Stein and Test, 1980). Moreover many patients report a decrease in psychiatric symptoms when they are actively engaged in productive work activities (Strauss and Hafez, 1981) ... Results in Great Britain indicated that work programmes could improve patient management, reduce the effects of psychotic symptoms, and serve as a productive and time-consuming activity (Bennett, 1983).

It is thought that the improved recovery rate for those diagnosed as schizophrenic in Switzerland, compared to other western nations, is due to the favourable employment and socio-economic conditions experienced by Swiss ex-patients (Ciompi, 1980). Recovery rates are also better in the non-industrialised world than in western societies. This is thought to be directly related to the ease with which people are returned to a valued working role and to more optimistic, less stigmatising cultural assumptions about recovery (Warner, 1994). Shepherd (1989: 232), in assessing the value of work, concludes that,

> Work *is* treatment and for many chronic psychotic patients it may be the most effective treatment we have. It certainly has some of the fewest side effects.

Moreover, the positive effect of work on a person's mental health can extend to other life circumstances, such as family life. An empirical study by Watts (1983) revealed that:

> Patients in full-time work were more likely to rate themselves for example, as 'having the ability to do what is expected of them', and generally seemed to have higher self-evaluation. Particularly interesting was the fact that these patients were more likely to feel that in the home they influenced what went on and were satisfied with how things were.

Many studies have revealed the positive effects of work on people with mental health problems. Pilling (1991) offers a concise reason:

> The latent functions of work address problems which are at the centre of many mentally ill people's daily struggle; loss of status, social isolation and difficulty in structuring time.

Pilling defines the latent functions of work as the imposition of time structure, the enforcement of activity, the development of goals which transcend one's own, the development of social relationships outside the primary group and the definition of personal status. Perhaps the most rigorous examination of the key factors or latent functions of work has been conducted by Peter Warr (1987).

Whereas the manifest functions of employment are the terms and conditions, the latent functions are those identified as beneficial to psychological well-being (Jahoda 1982; Warr,

1987). It is because of these less tangible factors associated with work, such as social contact, time structure and valued status, that work has been used in mental health care.

The moral obligation to work

Work as treatment for mental health service users, whether provided inside the asylum, within hospitals or based in segregated units in the community, can be viewed as an uneasy alliance between welfare and work (Macarov, 1980). Occupation has been proven throughout the ages, from the early nineteenth century (Pinel, 1806) to the end of the twentieth (Shepherd, 1989), to be perhaps the most effective treatment for mental disorder. Yet it has a distinctly moral basis, underpinned by the fear of idleness that has been consistently translated into policy, from the Elizabethan Poor Laws to the New Deal as a compulsion to work.

The first defence against idleness is the work ethic – the moral obligation to work. The next line of defence is the concept of 'less eligibility' - that no one out of work, who is capable of doing so, should receive more money than the lowest paid employees. The relationship between work and welfare is summarised by Bauman (1998).

> Work is the normal state of all humans; not working is abnormal. Most people fulfil their duty, and it would be unfair to ask them to share their benefits or profits with others, who could also fulfil their duties but for one reason or another fail to do so.

The Poor Laws established welfare institutions to care for those who could not work. Work became the most successful method of treatment within the early institutions, largely because of the therapeutic 'latent functions' of work. Yet in modern welfare provision people with mental health problems are classed as incapable of work. It is against this complex backdrop that the development of work as a particular mode of rehabilitation is now considered.

Section Three: Occupation as the first form of day care

The provision of occupation has a long history in the field of mental health care. The previous section examined the uneasy relationship between work and welfare. The following section charts the use of work in the treatment and management of mental disorder.

The rise of sheltered work

The value of work re-emerged after the First World War to play an important role in rehabilitation. The Mental Treatment Act of 1930 paved the way for a changed view of the asylum from a repository of deviance to a process of rehabilitation.

This created a climate receptive to the work of Hermann Simon in Germany, who saw work as part of an educational process aimed at countering institutionalisation and preparing patients' return to everyday life (Bennet, 1997). Interest in his work spread through Europe, though it was not until the development of industrial therapy workshops in the 1950's and 60's that work became firmly established in the UK (Bennet, 1983). By the late 60's Wansbrough and Miles (1968) reported that of 122 hospitals surveyed, 100 had an industrial unit, with 26% of patients engaged in industrial therapy. The work of these units included subcontract work, service industries, own products and priority supplies (Wansbrough, 1981). Much of the work was routine sorting, packing and assembly, though some units provided training in skills and crafts like upholstery and horticulture. The work of Early (1960) and the Industrial Therapy Organisation also lead to some workshops moving to community locations and providing conditions approximating to those found in an ordinary factory.

One of the biggest changes accompanying the rediscovery of work as therapy was the development of a wider range of treatment options. While earlier programmes were designed to occupy patients' time through structured activity, the newer programmes of the late sixties and early seventies emphasised returning the individual to competitive community employment or sheltered work environments (Jacobs, 1988), through a comprehensive system of work evaluation, training, guidance and placement (Anthony, 1979).

In a move towards more community based care, the Tunbridge Committee (Report, 1972) declared that work was an essential component of psychiatric rehabilitation and lead to the establishment of the industrial unit in district general hospitals; an early example of the exportation of asylum theory and practice (Rogers and Pilgrim, 1996).

Vocational rehabilitation

A similar approach to industrial therapy is vocational rehabilitation and training. The origins of these services lie in the Disabled Persons Act of 1944, which laid down a comprehensive plan for rehabilitation in Britain, prompted largely by the return of soldiers disabled by war. The Act also established a requirement for medium to large employers to reserve a quota of 3% of jobs for disabled people. The resulting 'Remploy' factories and Disablement Resettlement Officers (DROs) were managed by the Ministry of Labour and formed a generic disability service. However, people with mental health problems did not form a significant presence among these measures (Schneider, 1997).

Now under the Department for Education and Employment (DfEE), Remploy factories continue to operate, but are being run down in favour of the Supported Placement Scheme

(SPS), which has recently evolved into the Workstep programme. This subsidises employers when taking on a disabled person (DfEE, 1997), though opportunities for users of mental health services are still scarce (Schneider, 1997). For example, just 6.2% of the 21,840 places provided by the SPS in 1995/6 were taken by people with mental health problems (Honey, 1998).

Instead, developments in vocational rehabilitation for people with mental health problems came from the National Health Service, established in 1948 following the *National Health Service Act*. Changes to psychiatric care brought about by the introduction of major tranquillisers and a new emphasis on social aspects of mental health care in the 1950s, together with the *1959 Mental Health Act*, fostered new forms of employment rehabilitation (Schneider, 1997). An important development was the decision of the Medical Research Council's Social Psychiatry Unit to set-up an experimental workshop in Banstead Hospital (Carstairs *et al.*, 1955). The *Piercy Report* (1956) on the rehabilitation training and resettlement of disabled persons took note of this workshop development and recommended hospitals to provide "simple factory work for deteriorating mental patients and low-grade defectives." Following the *Piercy Report*, a Ministry of Health (1958) circular, *Rehabilitation in the hospital service and its relation to other services*, endorsed the provision of work with realistic terms and conditions, with open employment as the end goal. Schneider (1997) points out that this optimism must be seen in the context of low unemployment in the 1950s and 1960s.

The main emphasis of vocational rehabilitation is on the development of work skills and progression to paid employment, though many never achieve this (Pozner *et al.*, 1996). In response, a further variation on the theme of sheltered work and vocational rehabilitation is the work crew. In this approach groups of disabled people are employed to work within an existing workplace. Work crews were developed to counter the problems of segregation in sheltered workshops, whilst allowing for staff and peer support. Critics of this approach have argued that such programmes merely move sheltered work into competitive job settings (Danley *et al.*, 1994). This is undesirable due to the many objections to sheletered work.

Arguments against sheltered work

There has been strong opposition to the use of cheap or unpaid patient labour in hospital workshops (Cohen, 1990). Even during the time of relative acceptance of the asylum the workshops were regarded as exploitation (National Council for Civil Liberties, 1951). Sheltered workshops were largely abolished in the USA by a series of court rulings in the 1970's (Friedman and Yohalem, 1978).

From the view of service users, sheltered workshops have been found to be largely unsatisfactory. Rogers *et al.* (1993), in a survey of 516 people who had had experienced a mental health crisis and used psychiatric services, found that 20% had attended Industrial Therapy. The main reasons given for attending were not directly related to preparing people for, or substituting for, ordinary employment. They included something to do (29%), learning new skills (24%), company of others (24%), and staff assistance (14%). Comments about industrial therapy included

> work tasks were boring, exploitative and degrading work, jobs done on the cheap, poor pay, further devaluing.

Despite these objections, work-related activity has clear value in both aiding the rehabilitation and resettlement process and providing a positive means of occupying individuals who require long-term support (Pilling, 1988). Sheltered workshops and work rehabilitation continue to operate to this day and remain the bedrock of work related day care in the UK (Pozner *et al.*, 1996).

Occupational therapy

Closely related with the role of work as treatment is occupational therapy. Whereas work can be viewed as doing something productive for other people, occupational therapy is doing something for oneself (Bennett, 1972).

The first British school of occupational therapy was established in 1929 by Dr. Elizabeth Casson. Casson imported the profession of occupational therapy from the US (Schemm, 1994) and was influenced by the Arts and Crafts movement of William Morris and others (Schneider, 1997).

The activities were not specified, but occupational therapy concentrated on diversionary and recreational activities such as rug making, needlework, leatherwork, art and music, valuing the creativity of the activity. In their survey of 100 hospitals, Wansbrough and Miles (1968) found that 31% of patients attended occupational therapy.

During the post war years occupational therapy and industrial therapy followed separate courses in the mental hospital. The short-stay neurotic patient tended to be the occupational therapy client, while the longer-stay patient was more likely to be engaged in an industrial workshop (Bennet, 1997).

While the value of occupation had been demonstrated, the relative efficacy of the types of occupation available remained untested (Hutt *et al.*, 1964). MacDonald (1960), a pioneer of

occupational therapy, was generally critical of industrial work, saying that when work is accepted on contract patients are 'press ganged' into production regardless of who might benefit. Bickford (1954) was critical of occupational therapy for letting patients just do something they had a gift for. Hutt *et al.* (1964), in a study comparing patients employed in hospital utility departments, occupational therapy, industrial therapy, found 'virtually no difference' in outcomes between them.

Wilson (1983) described three types of activity as the major therapeutic measures used in occupational therapy as physical (exercise and relaxation), social (arts, drama and recreation) and personal (personal care, household and working tasks). To some, occupational therapy can be viewed as the medicalisation of every day life.

> To be a Mental Patient is to participate in stupid groups that call themselves therapy. Music isn't music, it's therapy; volleyball isn't a sport, it's therapy; sewing is therapy; washing dishes is therapy. (Rae Unzicker of National Alliance of Mental Patients, cited in Burstow and Weitz, 1988)

The expansion of activities used by occupational therapists came to a halt when Art Therapy and Music Therapy expanded in 1970's and became established as separate career structures within the NHS 1980's (Bennet, 1997). More recently, occupational therapists have become more interested in the assessment and development of people's functional skills (Hagendorn, 1992) though there remains some confusion over what occupational therapy is and does (Busuttil, 1992).

Industrial therapy and occupational therapy have continued to exist in hospitals partly in the response to the need for occupation for in-patients. In the days of asylums patients had extensive grounds to pursue limited freedoms, but there are few such opportunities on the acute wards of district general hospitals. The power of psychiatrists in planning services, coupled with the hospital ward as the traditional focus of psychiatry, has lead to the continued use of industrial therapy and occupational therapy.

Section Four: Deinstitutionalisation and day care

Mental health day care services in community settings developed in response to the run down of large-scale mental hospitals and the move to community care dating from the 1950's.

Psychiatric day hospital

The first development in mental health day care outside of the asylum was the psychiatric day hospital. Although the first day hospital opened in Russia in the early 1930's (Wortis, 1950), it was not until 1946 when the first day hospital open in the UK (Farndale, 1946). The

intention was to create a psycho-therapeutic centre separate from any hospital and independent of the institutional practices of the time (Brier, 1951).

The impetus for day hospital development came with the 1959 Mental Health Act, which opened up the possibility of acute psychiatric admissions being diverted to general hospitals and formalised the move towards community care. The day hospital was considered fairly radical at the time it was swiftly embraced as a means of running down the large mental hospitals (Vaughan, 1985). This resulted in a rapid growth of day hospitals into the 1960's and 1970's.

The early years of the day hospital saw a number of different models of service organisation, based on the different understandings of the origins and appropriate treatments of mental illness (Pilling, 1991). Psychiatric day hospitals offered a range of treatments, such as social and recreational activities, group therapy, individual counselling, everyday coping and social skills, occupational therapy, and work counselling and training (Austin *et al.*, 1976; Falloon and Talbot, 1982; Linn *et al.*, 1979), though no coherent strategy.

This lack of coherence originates from the lack of detail about community facilities in the 1962 Hospital Plan for England and Wales and the 1963 Health and Welfare Plan (Ministry of Health, 1963) and the limited involvement of staff in the communities of the patients they admitted (Baruch and Treacher, 1978).

The 1975 White Paper 'Better Services for the Mentally Ill' (DHSS, 1975) drew a clear distinction between the treatment function and the long-term supportive function of day services. Day hospitals, run by Health Authorities, were to provide day treatment facilities primarily on a short-term basis.

The day hospital became accepted as a viable alternative to in-patient care. It was thought that such partial hospitalisation would reduce the demand for in-patient beds, keep patients in touch with their families (Vaughan 1985), reduce stigma (Pilling, 1991; Teasdale, 1987), allow substantial cost savings (Holloway, 1988) and be generally more effective (Vaughan, 1985). On reviewing the evidence Shepherd (1984) states that

> there is sufficient evidence to demonstrate that day care offers an effective alternative to in-patient admissions for many individuals.

Several studies have shown the general superiority of day hospital care over out-patient (e.g. Weldon, 1979) and in-patient care (e.g. Herz *et al.*, 1977). Though on reviewing the extensive literature on the subject, Wilkinson (1984) is less convinced about the extent to which day

care is associated with improvements in either patient symptoms or the social care, and exposes the methodological inadequacies of many studies. Similarly, Vaughan (1983) states that while there is much attraction in accepting the effectiveness of the day hospital, there is little substantive evidence to show this.

For example, the results from a series of studies in US (Herz *et al.*, 1975, 1976, 1977), which compared standard in-patient, outpatient, and day care, showed that there were few differences among the treatment groups on any measures of psychiatric and social disorder, though in-patient care was found to be more expensive.

Moreover, where improvements were found (Linn *et al.*, 1979; Falloon and Talbot 1982) those centres with good results were characterised by the use of work, informal social interaction and participation by service users. Those with poor results were characterised by higher professional staff input.

Despite the guidance from the 1975 White Paper there remains considerable variation over what a day hospital is, whom it is for and what it is for. Creed *et al.* (1989) describes a psychiatric day hospital as

> A facility that provides diagnostic and treatment services for acutely ill patients who would otherwise be treated on traditional psychiatric in-patient units.

In a one-day census on 341 patients at 10 day hospitals in the northwest only 13% of places were used as an alternative to in-patient admission (Mbaya *et al.*, 1998). In a similar survey in the Netherlands this figure was only 9% (Schene and Gersons, 1986; Schene *et al.*, 1988). Steinhart and Bosch (1983) found that most referrals to day care in West Germany came *after* hospitalisation, though it was seen as an *alternative* to hospitalisation.

Rather than a short-term measure, day hospital use can end up long-term. A national study by Edwards and Carter (1979) found over one third of those in day hospitals attending for more than a year. In a follow-up to a census of 113 day care attendees, Holloway (1991) found 75% of the sample still attending one year later, with the average length of stay in day hospitals of over 3 years. In a ten year study of a day hospitals in Cardiff, Pryce (1982) found a more striking pattern of long-term use.

In an attempt to define day hospitals, a Lancet editorial (Anonymous, 1985) listed the following three uses.

> An alternative to in-patient care; Rehabilitation and support of the chronically ill; and Treatment for patients with neurotic and personality disorders not considered ill enough for in-patient care.

In their recent one-day census, Mbaya *et al.* (1998) found that the majority of places were used for 'rehabilitation', yet they also found

> half of the patients with psychotic disorders were only receiving general support ... such patients could have their needs served in a day centre.

Further evidence of a lack of treatment comes from a survey of needs conducted amongst users of day services in a well-resourced inner-city area. Wykes *et al.* (1982) found 35% of individuals with at least one unmet need and Brewin *et al.* (1988) found 44%. For these individuals, unmet need was clearly identified in a number of therapeutic areas that should have been met by day care.

The evidence about the purpose of day hospitals from their users is much clearer. A series of semi-structured interviews with 31 users of a day hospital found that they saw the day hospital as providing social contact with others, as many of them considered that social isolation from the 'outside world' was their predominant problem (Firby, 1994). This view is supported by a number of other studies (Edwards and Carter, 1979; Ricketts and Kirshbaum, 1994).

Day hospitals are designed to be a short-term, cost effective alternative to in-patient admissions for people with acute illness. However some have evolved into a long-term, costly form of day centre for people with chronic illness with little to do and few others to share their boredom.

Day centres

The duty of local authorities to provide day services is set out in the National Assistance Act 1948, Section 29, though from the post-war years to the early 1970's almost all developments in day services in the UK were led by the NHS (Pilling, 1991). The creation of local authority social service departments in 1971 led to a widespread development of day centres.

In adult day care, the majority of resources were claimed by other client groups such as the elderly, the physically disabled and learning disabled (Vaughan, 1985). The 1975 White Paper 'Better Services for the mentally Ill' (DHSS, 1975) sought to address the underdevelopment of local authority day care.

> Although it is sixteen years since the Mental Health Act of 1959 gave legislative recognition to the importance of community care, supportive services in a non-medical, non-hospital setting are still a comparative rarity. In March 1974, 31 local authorities ... had no residential accommodation for the mentally ill, and 63 no day facilities.

Pilling (1991) suggests some functions of a mental health day centre as

> The provision of a venue for the development of social relationships.
>
> The provision of personal and social support to clients and their carers.
>
> The provision of training in a range of community, personal and daily living skills.
>
> The provision of a venue for a range of leisure activities.
>
> The promotion of integration into and use of a range of community resources.
>
> The provision of work-related activity.

Pilling goes on to state that, whilst many centres carry out most, if not all of these functions, attempts to provide for all these activities on one site are fraught with difficulty. Pilling goes on to state

> Most [day centres] offer a range of services on one site which is more often indicative of confusion over purpose and function than it is of a wide range of choice ... such confusion often arises at the planning stage as a result of too much being expected of too little, with the consequence that a multitude of potentially contradictory goals are identified for the centre.

In addition to the lack of clarity of purpose, there is confusion over who the centre is intended for. The 1975 White Paper states long-term service use as a 'maintenance function' (Vostanis, 1990). However, when Bender and Pilling (1985) studied a large mental health day centre that provided a range a psychological treatments, work-related activity and social support, the drop-out rate was accounted for almost entirely by the group the centre was intended for, that is, long-term mentally ill people.

Day centres have an uncertain function, though are often described as having a social role with the intention of promoting independence. The small amount of research done on day centres cannot confirm their effectiveness, nor lack of.

Day treatment and partial hospitalisation in the US

The situation in the US serves to illustrate the common problems with day care services. In the US partial hospitalisation programmes were mandated by the Mental Retardation and

Community Mental Health Centres Construction Act of 1963, with over 1000 nationwide (Parker and Knoll, 1990). Bond *et al.* (1999) suggest that the terms partial hospitalisation and day treatment can be used interchangeably, yet may be differentiated for funding purposes. This mirrors the UK day hospital and day centre situation. In a review of the literature, Rosie (1987) described the changing role of day treatment from an original emphasis as a cost-effective alternative to hospital admission to more recent use to provide rehabilitation services. Bond *et al.* (1999) suggest that day treatment is used as a place for people with severe mental health problems to spend part of their daytime hours in socialising and receiving skills training.

The advantages of day treatment described in the literature include providing an efficient means of co-ordinating a variety of services, such as structured daily activities, medication management, and skills training (Liberman *et al.*, 1986a, 1986b), a social network beyond the family (Mosher and Keith, 1980), vocational training (Bond, 1987). Day treatment can also provide structure and support to prevent hospitalisation (Greene and DeLaCriz, 1981) and ease the transition from hospital to community (Herz *et al.*, 1977).

However, these advantages are eclipsed by the concerns about day treatment programmes from the literature. For example Drake *et al.* (1994: 520) report

> (1) Day treatment emphasizes prevocational activities within a treatment facility, and skills may not generalize to vocational activities in the community. (2) Because clients in day treatment are segregated from the community, participation may induce institutional dependency and impede the development of natural support networks and social integration. (3) The clinical setting in which day treatment occurs may focus the energies of staff and clients on illness, symptoms, and treatment rather than on functional behaviors and rehabilitative goals. (4) Although day treatment is less expensive than inpatient treatment, clients stay much longer in day treatment and may become involved in day care with little focus on goal-directed rehabilitation. (5) Day treatment may be overused because it generates fees from insurance reimbursements and is a financially lucrative program for some mental health centres.

Indeed there have been recent reports of the successful conversion of costly day treatment programmes in other forms of more inclusive services, such as supported employment (Drake *et al.*, 1994).

The parallel universe of psychiatric day care

The functions of local authority day centres and NHS day hospitals were differentiated by the 1975 White Paper. This division can be traced back to the passing of the 1946 National Health Service Act which split responsibility for the 'mentally disordered' between the

Ministry of Health and local authorities, with the former running hospitals as treatment, while the latter providing services for prevention, care and after-care.

In reality there is considerable doubt as to whether day services can be separated so neatly, with some day hospitals operating like day centres with an implicit 'social' function, while some day centres rival day hospitals in the range of services offered (Vaughan, 1985). In a survey undertaken by the National Institute for Social Work, many similarities were found in the aims, the range of activities, the user group and the outcome on discharge of the two types of day service (Carter, 1981).

There is lack of distinction between day centres, day hospitals, drop-ins and sheltered workshops. McCreedie *et al.* (1984), in a study of day hospitals in Scotland, found that about one fifth of attendees could equally well have attended a local authority day centre. Many of the claimed benefits of day centres are that they provide relief from boredom and that they provide stimulation and social support (Wilder, 1978). It has been noted that these benefits could be obtained equally well from attending a social club or sheltered workshop (Vaughan, 1985).

To highlight the cause of this Holloway (1988) reports that one general feature of the literature on psychiatric day care is

> the failure to provide an adequate account of the process of day care. Where 'process' refers to the service provided: whether it meets users needs and offers appropriate and effective treatment deployed in an efficient and cost effective manner.

As we have seen, the range of services provided are numerous. The Personal Social Services Research Unit questioned 155 day care settings to provide a 'map' of day activity services for the South Thames NHS region (Beecham *et al.*, 1998). The report listed over 90 different activities given by these settings, covering four areas of leisure activities, education, training and work activities, therapeutic services, and other activities. The report found enormous variation between the numbers of activities actually provided by each setting. This shows that although collectively the range of opportunities provided in the South East is impressive, there is considerable variation from one setting to the next and that each setting provided a very limited range of activities.

Moreover, the survey questioned each setting about the extent of integration with mainstream provision. Over three quarters lacked a reasonable level integration with leisure services, employment or job opportunities and education services. Here we see day care

services providing the functions of employer, leisure centre, social club, college, advice centre, etc.

This evidence suggests that mental health services have created a parallel universe in which their service users live, work and socialise. So who inhabits this parallel universe?

McCreedie *et al.* (1984) described a typical 'patient' of day care as a middle-aged man with schizophrenia, living on his own or with aged parents, who had a long history of contact with services. The main deficiency identified was a lack of meaningful occupation. Hatfield *et al.* (1992) in their survey into satisfaction and expressed needs of 120 service users found that the users of day care were more likely to be male, in the older age range and long-term users of the facility.

Lynch *et al.* (1994) found that two thirds of the 158 attendees at a day centre in its first year of operation were male. Similarly, Rogers *et al.* (1993) found that two thirds of those who had attended Industrial Therapy were men. In a study of day care in an inner London borough, Holloway (1991) found a mean age of 46 years among the 133 attendees. In a survey of 155 day care settings in the southeast, 69% of regular users had attended for over one year and 20% for over five years (Beecham *et al.*, 1998). Mbaya *et al.* (1998) found a relationship between age and length of use of day hospitals in the northwest. The ageing, long-term users of day care has led to a growing 'stage army' of long-stay service users (Pryce, 1982).

The problem of the slow turn over in day care places is compounded by the rejection of traditional day services by younger people (Sainsbury's Centre for Mental Health, 1998). Shepherd (1998) highlights that the most difficult, younger people with psychosis actively reject conventional day and work programmes.

In the Camberwell High Contact Survey, Brugha *et al.* (1988) noted that 29% of people using day services wanted to leave 'immediately or soon' and that those whose first contact with specialised psychiatric services dated back the furthest were the most likely to want to stay.

The high drop-out rate has become a significant characteristic of centre-based day care in general. In a longitudinal study of 158 attendees during the first year of operation of a day centre, Lynch *et al.* (1994) found a high drop-out rate with 53% of clients with a diagnosis of schizophrenia and 45% of those with a diagnosis of neurotic illness defaulted from attendance. The main reasons were

> Not enough to do, too boring; difficulty getting on with other attenders; and didn't want to go in the first place.

Similar results were found by Linn *et al.* (1979) who found within 3 months 15 of the 40 referrals made to day centres were said to be 'under attenders', and likewise by Carter (1981) who found a 40% under attendance rate in a national study of day care.

Hatfield *et al.* (1992) found that people attended day care for 'somewhere to go' and a 'place to meet people', and that

> the use of the day-care option by people with severe mental illness may then relate as much to the lack of availability of day care in terms of meeting client need.

These findings concur with those of the Mental Health Foundation (1994), who concluded that the most likely alternative to the day care setting was no day provision or activity at all.

This is further evidenced from Meltzer *et al's.* (1995b, 1995c) surveys of psychiatric morbidity. Of those people surveyed living in private households just 10% of the adults with a psychosis went to a 'club for people with mental health problems' and only 5% attended 'a Day Centre for social reasons', yet 60% were not working and 54% had felt a moderate or severe lack of social support. By comparison, of those surveyed living in institutions, such as residential care homes and group homes, almost a quarter (24%) attended day centres, ranging from 8% of those in hospital to 47% of those living in hostels, yet 71% were permanently unable to work.

Rather than support the *de*institutionalisation process the centre-based nature of day centres has resulted in *re*institutionalisation of service users into residential and day care (Rogers and Pilgrim, 1996; Brown and Walmsley, 1997). From personal experience Jim Read (1997) summarises the problems of day care services.

> All too often, day services become 'special needs' ghettos for people who do not have a place in wider society.

The centre-based day care services - psychiatric sheltered workshops, day hospitals and day centres have endured to the present day. Modernising Social Services (Department of Health, 1998b) still talks of the provision of day centres as an essential task and The National Service Framework (Department of Health, 1999a) makes specific reference to the use of day hospitals as an alternative to hospital admission. This replays a familiar tune, first heard from the 1959 Mental Treatment Act and reiterated by the 1975 White Paper.

Summary

The concentration on the point of transfer became a stumbling block of the community care policy (Brown, 1985) as it neglected the process of change in the institution, paid little

attention to the life led after leaving the institution, and paid even less attention to preventing the need for institutional life in the first place (Ramon, 1991). Community care included the recognition that many disabled people residing in institutions had the potential to lead a more ordinary life in the community. However, there was a misplaced assumption that integration would take place spontaneously (Brown and Walmsley, 1997).

It appears that mental health services have created a new system of 'total institution' in the community where 'existential neurosis' has replaced 'intuitional neurosis' of the asylum. Warner (1991) writes

> The institutional neurosis has been replaced by an existential neurosis which is the product of the psychotic person's alienation in the community. Meaninglessness is one of the core existential concerns which confronts any individual, and many people with mental illness face lives of profound purposelessness, their social relationships are few and often dependent and unrewarding.

Day care services have failed to tackle the social exclusion of people with mental health problems resettled in the community. Day care services in the era of deinstitutionalisation are an afterthought and their methods are a hangover from the asylum.

Section Five: Day care services since 1980s

Traditional work and day services have generally failed to empower people with long-term mental health problems in the sense of providing choice, listening to and acting on their views, and enabling them to take on meaningful roles. In day centres, people with long-term mental health problems are often passive recipients of a limited and inflexible programme. The situation may be little better in sheltered workshops offering a fixed routine of assembly or packing work for minimal payment. Opportunities for users of these services to become autonomous are very limited (Nehring *et al.*, 1993).

By the early 1980s hospital dominance was still evident. In the ten years to 1986 the average number of daily occupied beds in mental illness hospitals fell from 109,000 to 82,500, a decrease of 26,500. During this time only 9,000 new day places became available, and most of those were based on hospital sites (Audit Commission, 1986). Since then there has been a growth in the number, diversity and creativity in providing day care services, such as clubhouse, social firms, user-run drop-ins, and supported employment schemes.

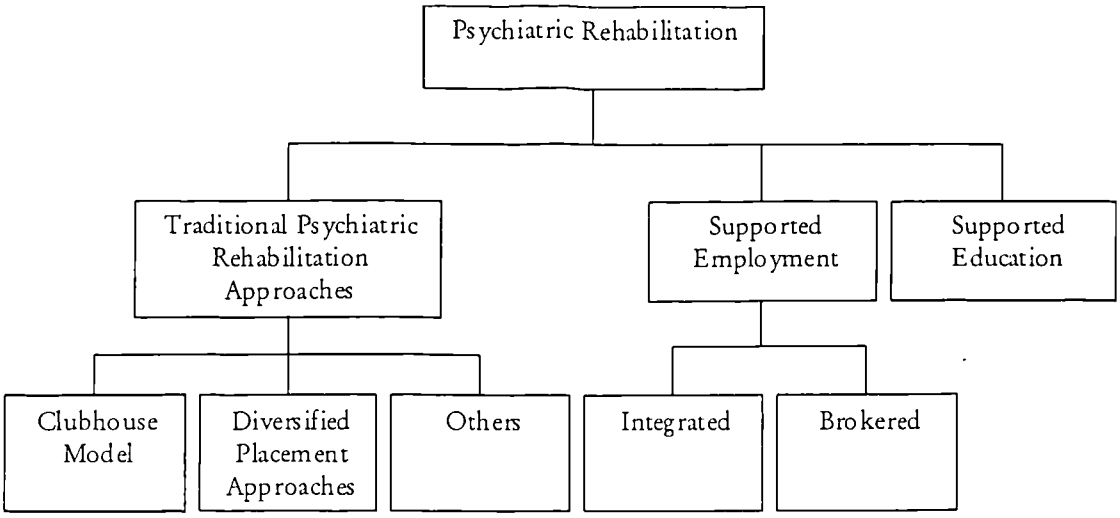
Diversification of day care

The growth in the range of day care services is well illustrated by the range of occupational programmes now available. The research literature describes many work schemes, projects

and programmes that enable people with mental health problems to work. In the UK Crowther and Marshall (2001) categorised 50 work schemes in the North West into four main approaches, Pozner *et al.* (1996) categorised 29 schemes into 10 models, Reynolds and Higgins (1997) devised 12 models from 120 schemes, Lehman (1995) describes 6 models of vocational rehabilitation, and Turton (1996) categorised 23 work schemes into 5 models.

For example, Bond *et al.* (1999) proposed the categories shown in the psychiatric rehabilitation 'road map' in Figure 2. Here Bond and colleagues compared the effectiveness of four main approaches to psychiatric rehabilitation in the US: clubhouse and transitional employment, diversified placement approach, other traditional psychiatric rehabilitation approaches (such as consumer-run businesses and skills training) and supported employment.

Figure 2. Working typology of psychiatric rehabilitation vocational programs (after Bond et al., 1999)



These models are characterised by the provision of ordinary opportunities in community settings, with an emphasis on employment and empowerment, and the provision of accessible opportunities that are responsive to needs to people whatever their disability, gender or ethnic background. This section describes some of the types of day care services that evolved recently.

Clubhouse

In the 1950s a new approach for helping people with severe mental health problems adjust to community living was established at Fountain House in New York. This became known as the clubhouse and operated outside of the mental health system as a social club by a group of ex-patients (Sweet, 1999). The Clubhouse model is a rehabilitation scheme utilising meaningful work and community as the tools of rehabilitation.

The clubhouse model is much better defined than day centres, day hospitals and sheltered workshops, with four fundamental principles. A Clubhouse belongs to its members, daily attendance is expected and makes a difference to other members, members feel wanted as contributors, and consequently members feel needed. Staff are treated in the same way, are usually indistinguishable from members, with numbers kept to a minimum (Beard *et al.*, 1982). Components of the original Fountain House include prevocational training, transitional employment, apartment and reach-out programmes, evening and weekend hours, the thrift shop, the newspaper, therapeutic interventions and clubhouse evaluation.

The clubhouse standards were adopted by an international conference of clubhouses (Propst, 1992) called the International Center for Clubhouse Development (ICCD). The ICCD, based at Fountain House, has a formal accreditation process which includes a site visit to determine adherence to these standards (Moxley, 1993). In 1996, the ICCD directory listed 230 clubhouses in the US, with 150 in substantial compliance with the standards (Macias *et al.*, 1999).

Clubhouses also offer members a Transitional Employment Programme (TEP), which supports members into paid employment. Members can undertake a series of supported, time-limited, paid work placements that are shared with other members. The experience of a number of such placements allows members to build-up confidence at their own pace to the point where they can consider permanent paid employment. This has enabled the clubhouse to overcome the problems of dependency and blockage of places.

Admission criteria for clubhouse programmes is highly variable (Bond *et al.*, 1999) as most operate with open, voluntary membership. Mastboom's (1992) survey of 40 clubhouses in the US found that 63% of members had a diagnosis of schizophrenia, 42% had spent more than two years in hospital, their mean age was 40 years, 70% were male and 65% lived alone. Finch and Franz (1991) found that staff at Fountain House had longer tenure and fewer symptoms of burnout than staff in traditional mental health settings.

The number of clubhouses in operation across the world has more than doubled over the past ten years (Mastboom, 1992), though few operate in the UK. One of the first clubhouses to open in the UK was in Dartford in 1992, funded jointly by MISG and the Health Authority. By 2001 the ICCD directory reports 22 Clubhouses in England (ICCD, 2001).

The clubhouse model is not without its critics. Perkins (1997) criticises the clubhouse for replicating a mini-institution and operating in a 'cult' fashion. Though it appears to bring

most benefit, not all members participate in TEP. For those that do, the temporary nature can be a disappointment.

Social firms and co-operatives

Social Firms are small to medium sized enterprises in which disabled and non-disabled people collaborate to produce goods and services in the open market (Grove *et al.*, 1997). The Confederation of European Firms, Employment Initiatives and Co-operatives for People with Psychological Handicaps (CEFEC) also suggest that every worker is paid a wage or salary at market rate, that work opportunities are equal between disabled and non-disabled employees, and that all workers have the same employment rights and obligations. Reynolds and Higgins (1997) describe social firms as

> A business created for the employment of people who are disadvantaged in the labour market. At least 30% of employees fit this description. Work opportunities should be equal between disadvantaged and non-disadvantaged employees.

Social firms originated in Germany and have since been developed in Germany, Italy, The Netherlands, and Eire. It has been estimated that in Europe and North America between 500 and 800 firms offer thousands of work opportunities to disabled people (Schwarz *et al.*, 1994). Social firms have proved successful in Italy, where they are usually run as co-operatives (Savio and Righetti, 1993; Warner, 1995) but, even so, they are heavily subsidised by about 10- 50% (Warner, 1994: 254). Turton (1996) differentiates co-operatives from social firms by their democratic legal structure and management arrangements.

> Co-operatives based on the 'Rochdale Principles' of 1844: Open, voluntary membership; one member, one vote at general meetings; limited interest on share capital; fair profit distribution; a commitment to education; and co-operation between co-operatives (Mellor *et al.*, 1988).

The first social firms for people with mental health problems in the UK started in the early 1990s though there are only a limited number in the UK that meet the CEFEC definitions (Grove, 1999). The Social Firms Website lists about 100 social firms in the UK which include people with mental health problems among their clients. In 1997 the *Social Firms Handbook* (Grove *et al.*, 1997) indicated that the 'average' social firm had 7 employees of whom 2 would be disabled (all disabilities). Therefore, at most 100 people with mental health problems could be in paid work in social firms.

The reasons for a much smaller number of social firms in the UK adhering to CEFEC guidelines than found in Europe are due to the lack of state support for social firms, the

disincentives of the benefit system that deter services users from taking paid employment and the difference in aspirations, including a stronger work ethic, and a broader social consensus around alternative forms of working and living (Hatch, 1994).

User-run services

A further development is the consumer-run enterprise, in which individuals with mental health problems have full control over the business. This model places greater emphasis on genuine ownership and management roles. User-controlled services have been operating in the US, Canada, New Zealand and Japan for some years. They run a wide range of commercial enterprises and health and social care services, such as day centres, vocational projects, independent living schemes and case manager aides. However, very few such services operate in the UK (Pozner *et al.*, 1996).

One example is a 'consumer-oriented' pharmacy, developed by James Mandiberg in California, and described by Warner (1994). In this model service users sit on a board that distributes the profits to other 'consumer-oriented' projects and services, such as a drop-in centre/café, advocacy network, and other consumer-employing businesses. The viability of the business is based upon the large market for medication in the US. Such projects are unlikely to work in the UK due to the different ways in which healthcare is funded.

Supported employment

Supported employment was first defined in the US in the 1980s (Bond *et al.*, 1997). The Rehabilitation Act Amendments of 1986 (1987) provided a formal definition which included such features as: clients work for pay, preferably at the prevailing wage rate, as regular employees in integrated settings and in regular contact with non-disabled workers, and receive ongoing support.

In their definition of supported employment in the UK the Association for Supported Employment (AfSE, 2002) emphasise the focus on 'real jobs'.

> The purpose of supported employment is to secure jobs in businesses with all the regular outcomes of being employed. Employment should only be considered if the job is a real one, ie would otherwise be done by a non-disabled worker, and is valued by colleagues. Employers must operate going concerns. Their main purpose must be to offer goods and/or services (not simulated employment). Wages, pay intervals, and methods of payment at the going rate for the job: safe working conditions; hours similar to other employees.

Supported employment was intended for people with severe disabilities who would not normally be eligible for traditional vocational rehabilitation (Wehman, 1988). Originally pilot

tested for people with learning disabilities, supported employment was justified as a more effective, humane, and cost effective alternative to sheltered workshops (Bond *et al.*, 1997; Marrone and Gold, 1995). Wehman (1986), who advocated a "place then train" approach, as opposed to the traditional "train then place", showed the feasibility of an "individual placement" model, with job coaches at the job site providing training and support, and withdrawing over time.

The supported employment approach for people with severe mental health problems was pioneered by the Boston Centre for Psychiatric Rehabilitation (Danley and Anthony, 1987) and has become well developed in the US. The development of supported employment marked an important shift in the history of vocational rehabilitation for people with mental health problems.

An influential model is the Individual Placement and Support (IPS) pioneered in New Hampshire (Bond *et al.*, 1997). Based on the Wehman model, IPS takes its influences from the field of mental health from the transitional employment placement programme of the clubhouse model (Beard *et al.*, 1982), the assertive community treatment model of case management (Stein and Test, 1980), and the 'Choose-Get-Keep' model of psychiatric rehabilitation (Danley and Anthony, 1987). The IPS incorporates the following eight principles (Becker and Drake, 1994).

1. Rehabilitation is an integral part of mental health treatment. IPS assumes that nearly all people with severe mental health problems can engage in some kind of work, that work is good treatment and that rehabilitation and treatment require careful co-ordination.

2. The goal of IPS is competitive employment in integrated work settings, as clients prefer jobs in a normal workplace.

3. People with severe mental health problems can obtain jobs rapidly. IPS emphasises entering work as soon as possible rather than preparing for work.

4. Vocational assessment is continuous, as an ongoing process even after acquiring a job.

5. Follow-along supports are often necessary as job retention is often more difficult than job finding for people with severe mental health problems.

6. Services are based on clients' preferences and choices. IPS encourages clients to select job preferences and provides support based on individual needs.

7. Services are usually provided in the community in the clients' natural environment.

8. A team approach promotes integrated services. Collaboration and good communication between rehabilitation and treatment specialists promotes better responses to changing needs and circumstances of clients.

Bond *et al.* (1999) suggest that most supported employment approaches for people with severe mental health problems subscribe to some of the IPS principles. Deviations from the IPS model include:

- The use of a brokered approach with the employment programme operating separate from the community mental health teams (Gervey *et al.*, 1995).
- Prevocational skills training and careers guidance prior to job search (Danley *et al.*, 1994; Gervey and Bedell, 1994).
- The employment of people with mental health problems as part of the rehabilitation team as mentors (Mowbray *et al.*, 1995)
- The employment of people with mental health problems in jobs within mental health services (Perkins *et al.*, 1997). In this model people are given support to gain and maintain existing jobs within mental health services that have the additional requirement of experience of mental health problems.

A study by Bond *et al.* (1997) suggested that clients of supported employment programmes are generally typical of the general population of people with severe mental health problems using community mental health services. However, others (Bond *et al.*, 1995) reported high drop-out rates of about 40%.

Supported education

Supported education has been developed in the US to counter the problems that people with mental health problems face in further and higher education. These include the disruption to education by an early onset of mental health problems, together with the barriers to adult study, such as discrimination, unmet needs for support, cyclical nature of illness and personal fears of failure (Mowbray *et al.*, 1999). Most importantly, education is key to achieving occupational mobility and maintaining economic status.

This approach provides ongoing support to service users to facilitate completion of courses of further and higher education. It is argued that this then enables people to compete for jobs with career potential (Moxley *et al.*, 1993). In this respect it promises to promote social inclusion. This recent development also provides an option for those who are often bored of more traditional day services.

The main concern about supported education is that although it aims to improve social inclusion, the most excluded often benefit least. Collins *et al.* (2000) found that outcomes were best for those who were engaged in productive activities at enrolment, had better social support and more financial resources.

Diversified placement approaches

Perhaps the notable development in the diversification of day services is the rise in number of hybrid work schemes. It is worth noting that such work schemes provide more than one model of intervention, though the combination should not really constitute a model in itself.

Bond *et al.* (1999) grouped together a range of eclectic schemes under the heading 'diversified placement approaches'. They used this term to describe work schemes in the US that encompass a group of psychiatric rehabilitation approaches, largely based upon clubhouse values. Often there is a progression through jobs in a stepwise approach to progressively more independent employment, for example:

Unpaid pre-vocational work crews
Paid and unpaid work in sheltered businesses
Paid group placements with employers
Supported employment

A number of other names have been proposed for this type of programme, including the 'job bank' (Bond, 1992) and the 'menu approach' (Chandler *et al.*, 1999) in the US, and the 'eclectic' approach (Crowther and Marshall, 2001: 374) in the UK, described below.

> This [eclectic] type of approach offers a range of services to clients, which can be seen as being taken from other types approaches available. For example many eclectic services offer sheltered work for a period of time, job placements when the client is ready to move away from the sheltered environment and unlimited supported employment once the client is placed into open employment. Eclectic services may offer all of these or a combination, depending on the resources they have available to them.

Perhaps the two most notable programmes of this nature in the US are Thresholds in Chicago (Dincin, 1995) and The Village in Los Angeles (Chandler *et al.*, 1999). Thresholds is

a comprehensive psychiatric rehabilitation agency where members typically move through a series of successively more independent forms of employment, from unpaid prevocational work crews, to paid group placements, then independent employment (Cook, 1992). They operate businesses, including a laser-jet cartridge business, flower delivery and custom copying, which provide sheltered work, an employment agency to provide temporary employees to community employers and a supported employment service. Bond *et al.* (1999) report that the a recent survey found that 67% of members were men, 60% were from an ethnic minority community, 97% were not married, 80% had a diagnosis of schizophrenia and members had a mean age of 31 years.

The Village Integrated Services Agency is a programme of the Mental Health Association of Los Angeles. In was established in 1990 as an integrated model of Assertive Community Treatment (ACT) and psychosocial rehabilitation services. The Village offers a 'menu' approach to employment that combines a gradual progression and supported employment. The principles that underpin this model are:

- A broad definition of the benefits of employment. Benefits include a sense of accomplishment, making a contribution, a positive social role, and can be gained from any paid work.
- Virtually all people can work. With a broader definition more people can work.
- Different needs necessitate a broad 'menu' of options, including education and training, paid work in an agency owned business, transitional work and community employment.
- Multiple trials of work are encouraged, as people can learn and reflect on experience and move on to their next job.

In their review of supported employment Bond *et al.* (1997) reported that

> As a hybrid vocational model, the Village approximated the way vocational services are frequently implemented.

Yet they conclude that this precluded evaluation of the unique contributions of different vocational components.

In the UK, a few such schemes have been described in the literature. For example, Working It Out (Pozner *et al.*, 1996) describes a range of employment projects in the UK, including

some that use a diversified placement approach, such as Feathers Project and Many Hands in London.

Section Six: Drivers for change

This section attributes the growth in number and diversity of day care services to the sweeping reforms in the way mental health services are planned and delivered introduced by the Thatcher government in the 1980's and early 1990's by the Mental Health Act 1983 and the NHS and Community Care Act 1990.

The impact of the 1983 Mental Health Act on day care services was minimal owing to its concern about individual rights and compulsory detention in hospital at a time of the rapid closure programme. The 1983 Act had no direct implications for service organisation, though Section 117 did raise the question about duty of aftercare for discharged patients (Rogers and Pilgrim, 1996).

By contrast 1990 NHS and Community Care Act was a crucial piece of legislation that established a new framework of service organisation underpinned by the concepts of privatisation, marketisation and managerialism (Rogers and Pilgrim, 1996) and influenced by the theory of normalisation (Brown and Walmsley, 1997).

The influence of normalisation

There has been a shift in ideology from a medical model to the social model of disability, influenced by normalisation theory. The term 'normalisation' was coined when people lived in large-scale institutions and gave an impetus to their closure. Normalisation was used initially in the 1950s in Scandinavia to reform institutional services for people with learning disabilities to model normal life in the asylum. The Scandinavian model used a rights-based approach to create a valued place and normal patterns of life within protected communities (Brown and Walmsley, 1997). By contrast the US model developed by Wolf Wolfensberger has been much more influential.

The Scandinavian principles were taken up by Wolfensberger in the US, who was also influenced by Goffman's (1961) work on asylum and total institutions and labeling theories. Wolfensberger's work was used to promote the integration of people with learning disabilities with 'valued' individuals and institutions. Atkinson (1988: 140) explains that normalization

> combines a set of values about the rights of people with a mental handicap to enjoy a valued lifestyle, with a design of services which promote opportunities for developing reciprocal relationships with others and becoming integrated into wider society.

The 1990 Act gave local authorities the lead in community care and the responsibility to produce community care plans. This meant that for the first time service planning occurred across client groups, contributing to an increasing cross-fertilisation of ideas, and resulting in fundamental ideological changes. Most notably this has contributed to the influence and emerging acceptance of principle of 'normalisation' from learning disabilities services (King's Fund, 1980) and provided a channel for the introduction of the 'social model' of disability (Barnes, 1996; Oliver, 1990; Preistly, 1999) to influence services.

However, normalisation is not without its critics. Jones (1988) points to the origins of normalization in relation to people with physical and learning disabilities, whose circumstances and needs are very different, and that Wolfensberger's work is more often quoted than read.

Normalisation involves a complex set of ideas, which is often difficult for practioners to take on board. Some researchers (Brown and Walmsley, 1997; Jackson, 1988) suggest that professionals will develop their own 'folk' versions of normalisation. Brown and Walmsley go on to state that the simple language of ordinariness denies facts that people with learning disabilities do have 'special needs' and that ordinariness has been interpreted as an excuse for minimalist intervention, resulting in serious gaps in service provision.

Wolfensberger's model of normalisation assumes conformity as a condition of acceptance into the mainstream. This view believes in a 'wider society' whose members have 'valued social networks'. Lawson (1991) argues that

> This is fine stuff if we as individuals benefit from the value system that we are heir to. Unfortunately, for some of us, the predominant value system is in itself unacceptable. The system of highly competitive, profit-making ethos currently dominating the first world is not a desirable situation for many of us. It is therefore paradoxical to equate the normalization principle with decent living when the principle itself is bounded by an unacceptable political structure.

Normalisation places the onus to change on individuals and makes few demands on members of the wider society to adapt to the needs of individuals who are perceived as different. The disability movement provides an alternative model that demands that the world changes to enable disabled people to take part.

> Having given such a negative meaning to abnormality – the non-disabled world assumes that we wish to be normal, or to be treated as if we were. From this follows the view that it is progressive and liberating to ignore our differences because these differences have such negative meanings that the non-disabled people. But we are different. We reject the meanings that the non-disabled world attaches to disability but we do not reject the differences which are such an important part of our identities. (Morris, 1991: 17).

This is the essence of the social model of disability. Commentators in mental health have proposed that the agenda for employment must be informed by this model (Gove, 1999).

The influence of welfare market reforms

The creation of the 'welfare market' was formalised by the separation of commissioning and provider functions of local authorities and, following the White Paper 'Working for Patients' (Department of Health, 1989b), the NHS internal market. The 1990 Act ushered in a new era of needs-led, rather than provider-led approach. Where commissioners had a clear vision about proper community support services they have been able to exert control over providers who were entrenched in in-patient work and provide a mechanism to develop innovative practice (Rogers and Pilgrim, 1996). The search for innovation has lead to the influence of the successful models developed in the US and Europe such as Clubhouse, supported employment and social firms.

For some, the market reforms had their limitations. Carpenter (1994) believes the shift from hospital to community has resulted in a shift from expensive to cheap or unpaid labour, and the dumping of the responsibility onto the informal sector in the guise of demedicalisation and empowerment. Also, the fragmentation of agencies has made rehabilitation more difficult, as the successful care of people in the community is only achievable by the healthcare system approaching other systems (Bean and Mounser, 1993)

The influence of programme funding

A further development was the introduction of the Mental Illness Specific Grant (MISG). MISG, now termed Mental Health Grant (MHG) was introduced in 1991 to improve and expand social care services for people with mental health problems in response to Section 117 of 1983 Mental Health Act. Since the introduction of MISG the number local authority funded mental health day care places of places rose from 7,800 in 1990-91 to 54,700 in 1997-98 (Department of Health, 1999b).

A review of MISG funding (Barnes, 1994) found that the largest portion, 25%, was used to fund day care. The report also revealed the trend towards individualised care, normalised

opportunities, community based settings, a high level of user involvement and a move away from building based activities.

The influence of welfare consumerism

During the 1970's and 1980's there has been increasing interest in the need to consider the views of the users of mental health services. This began with the rise of the mental health consumer movement in the US, the development of Community Health Councils in 1974, and legislation in the United States requiring the Community Mental Health Centres to evaluate the services they provided in order to receive funding (Brandon, 1991). Mental health pressure groups such as MIND encouraged the development of patients' councils and advocacy groups and publicised users' views (Rogers and Pilgrim, 1996).

The 1990 Act included a duty to conduct individual needs assessment, draw up community care plans in consultation with local people, and to involve service users in the planning and delivery of services. Rogers *et al.* (1993) found that the issues of greatest concern were money, accommodation, a need for employment or occupation, as well as services and their staff. The most striking feature is the number expressing the desire to work (Burnett, 1993; McCollam, 1993, 1994; Mind, 1993; Setti, 1994; Thomason, 1989; Turton; 1996).

Much of the discussion on consumerism has centred on consumer choice (Department of Health, 1989b), rather than participation in the planning, development, management and evaluation of services. According to the NHS and Community Care Act 1990, the needs of users and carers would be primary in service planning and provision, but there have been difficulties in moving beyond the rhetoric of user involvement and empowerment (Carpenter, 1994). Bewely and Glendinning (1992) found that only one in eight local authorities had consulted disabled people before drafting community care plans.

Barriers to change

Despite these influences, in the UK it appears that sheltered work remains the dominant model of work based day care. In their survey of vocational rehabilitation services in the North West, Crowther and Marshall (2001) found that 26 out of 50 services identified offered sheltered work. Moreover, 39% of places were in sheltered workshops, 57% in 'eclectic' services, which includes a mixture of sheltered work and work placements, and just 4% in supported or transitional employment. Moreover, in 1996, the British Employers' Forum on Disability pointed out that there were 370,000 segregated day centre places for disabled people in Britain compared to just 21,000 support employment places.

It appears that the influences since the 1980s have created the opportunity to radically develop new forms of day care services. However, it seems that mental health services in the UK have not taken this opportunity and continue to provide segregated, excluding services rather than integrative, inclusive day services.

Several factors have combined to ensure that the development of occupational interventions has remained slow. Severe unemployment since the early 1980's posed a significant threat to vocational rehabilitation and reversed the trend back to work as occupation rather than preparation for employment (Garner, 1995). Despite the evidence in favour of work related activity, mental health professionals in the UK remained ambivalent towards it, owing to the contradiction inherent in helping 'sick' people to work, the unease felt by health authorities in providing work (Shepherd, 1989) and the dubious therapeutic nature of workshops, where simple repetitive work had replaced simple repetitive sitting (Morgan, 1983).

Though perhaps the dominant reason for the lack of development is that the UK welfare benefits system provides few circumstances that would make a move into paid work financially viable (Turton, 2001). This will be explored more thoroughly in Chapter Four.

Conclusion

The history of day care has been characterised by the development of psychiatry and social security within the envelope of the changing economy. The literature revealed two broad eras in the development of day care services for people with mental health problems: moral treatment and social psychiatry (Warner, 1994).

In the former, interventions were based upon the notion of 'treatment' from the point of view of psychiatry, which corresponded with the importance of institutional welfare from the standpoint of the state. Continued high levels of unemployment, coupled with the moral repugnance of idleness lead to this focus on indoor relief and institutional psychiatry. These factors lead to treatment and social control as the outcome, and the Asylum, and later the day centre, as the process of day care.

In the era of social psychiatry, interventions were deemed 'rehabilitative', aimed at promoting early discharge and recovery. Post war employment shortages, the shift to non-institutional care, social security payments to disabled people, a moral framework based upon individual rights, and the resultant importance of rehabilitation within psychiatry lead to employment as the outcome of day care services. Warner (1994) has argued that these developments were

largely driven by prevailing economic conditions: the economy has shaped the welfare systems; the welfare system has shaped psychiatry; psychiatry has shaped day care services.

The role of day services reflects the philosophical debate on the purpose of mental health services. This debate concerns the argument between the 'medical model', characterised by medical treatment, attention to risk and a focus on the deficiencies of the individual, on the one hand and the 'social model', with an emphasis on the need for society to tolerate difference and adapt to include disabled people, and an emphasis on the strengths of the individual.

This chapter has demonstrated that the most recent developments in day care services are based on a 'social model' of disability. Their emergence in the UK has been attributed here to the health reforms of the 1980s and 1990s, which introduced the theory of normalisation into mental health services, imported models such as supported employment, clubhouse and user-run services from the US, placed the views of mental health service users in the arena of service planning and provided funding for the development of new day care services.

It appears we are we now entering a third era in the development of day care services. Has the function of mental health day care services shifted from treatment, via rehabilitation, and now to one of social inclusion? The next chapter examines the evidence to consider this question.

Chapter Three

Inclusive Practice or Trivial Pursuits?

Introduction

The previous chapter charted the development of day care services from a historical perspective and examined the ideological and policy framework that has changed the face of day services.

This chapter considers whether day care services promote social inclusion. As we saw in Chapter One, employment is considered one of the most effective ways of promoting social inclusion. There is a relative wealth of literature about the factors that predict a return to employment for people with mental health problems (for example, Heyman, *et al.*, 2002; Anthony, 1994; Anthony and Jansen, 1984; Cook and Razzano, 2000; Strauss and Carpenter, 1972, 1974, 1977; Tsang *et al.*, 2000).

The research evidence suggests that employment outcomes seem to vary largely as a positive function of prior employment experience, and correlate at best weakly with other characteristics such as diagnosis, symptomatology and social skills. Vocational rehabilitation has been shown to be necessary in achieving vocational outcomes, but less effective in helping people to gain competitive employment. This chapter examines this more closely, together with evidence for improvements in other non-vocational domains which may indicate social inclusion, such as quality of life, income and empowerment.

Section One examines the research evidence whether the main models of day care services promote social inclusion. Section Two draws out the key features from these models that promote inclusion through employment. In Section Three these models are characterised according to the extent to which they provide treatment, deliver rehabilitation, or promote inclusion.

Section One: Which models promote social inclusion?

This section considers the effectiveness of the main models of day care services in promoting social inclusion. The essence of inclusion, defined by the user movement as recovery, is getting on with one's own life despite mental health problems (Anthony, 1993; Copeland, 1999), including the pursuit of personal goals such as work, education and social relationships (Mueser *et al.*, 2001).

For each model the evidence for its effectiveness in promoting social inclusion is considered: firstly by looking at the evidence for the effectiveness at promoting employment, followed by evidence for the improvement in other indicators such as quality of life, social networks, empowerment and finance.

Sheltered work, day centres and day treatment

Linn *et al.* (1979) found that the most effective kinds of day programmes for the support of people with schizophrenia in the community contained a large element of occupational and recreational activities. The least effective offered group therapy or individual psychotherapy. This suggests that day services with a strong commitment to vocational rehabilitation are most effective. But are these services effective at helping people to get a job?

Employment outcomes

Employment outcomes from traditional methods of vocational rehabilitation have generally been poor. In their systematic review of vocational rehabilitation services Crowther *et al.* (2000, 2001) identified five trials comparing prevocational training to standard care. All showed no evidence that prevocational training was superior to controls in helping clients to obtain employment. However, the studies were of limited quality and the data was insufficient to make judgements.

These poor outcomes are due to the lack of progression from sheltered settings to open employment. Several studies have shown that clients in prevocational work units remain there for an extended time (Bond and Dincin, 1986; Cook, 1992) and that this is an unintended consequence rather than an intentional part of the model (Bond *et al.*, 1999). This has been attributed to two main reasons. Firstly, it is notoriously difficult to predict who is capable of moving on to competitive employment (Anthony and Jansen, 1984). Secondly, those who may be most capable of obtained competitive employment are often the most productive and are retained within the sheltered setting to meet the demands of contract work (Turton, 1996).

To illustrate this, Martin (1996) conducted observations and informal interviews with clients and staff at a sheltered workshop in the UK. She found that the actual operation conflicted with the intended operation as a rehabilitation facility which promoted independence. For example, tensions arose between the need to meet production targets and the clients' needs for rehabilitation which resulted in retaining the best workers, who sometimes acted as supervisors, rather than helping them into open employment. Conversely, too little work resulted in clients not benefiting from a realistic work environment.

Other vocational outcomes

Anthony and Blanch (1987) suggest that the lack of success of traditional vocational rehabilitation services may be attributed to a limited view of what vocational rehabilitation is. What they mean is that vocational rehabilitation is effective but in other ways than getting people a job. They argue that vocational rehabilitation should acknowledge many different but equally legitimate client goals, as well as the focus on changing the individual to fit employers' needs

Indeed some studies have found good vocational outcomes from more traditional vocational rehabilitation. Though in each of the following two examples a more skilled base approach was adopted, rather than the work-based training found in sheltered workshops.

In the first example, Blankertz and Robinson (1996) evaluated the effectiveness of a vocational service added to a mental health centre in the US. A total of 122 clients were randomly assigned to a programme with an employment specialist or standard service. They found that 34 of 61 (56%) clients in the experimental group achieved a positive outcome after first 9 months. However, just 10% clients were in competitive employment, 13% in a state vocational rehabilitation work training programme and 7% in other work training programmes, 7% were in further education and one was volunteering. The rest were in process of entering the state Vocational Rehabilitation service or attending interviews. There were improvements in skill level, functioning and motivation for all experimental clients regardless of outcome, apart from self-esteem. Participation in the experimental group, and the receipt of awards, significantly accounted for the variance in outcomes. Demographic, clinical and service use factors did not predict successful outcomes.

In the second example, McCrum *et al.* (1997) described the first 15 month's operation of a job clinic model in Antrim, Northern Ireland. After 15 months 91% of clients assessed were in some form of occupational activity. Of all 77 clients referred, 39% were in a government training scheme, 20.5% in a mental health vocational rehabilitation scheme, 17% in open employment, 8% in sheltered employment, 5% in further education and 2.5% in voluntary. Just 8% dropped out. They found that younger people were more likely to be engaged in training options, older people in work. However, the study did not report on severity of illness, which may explain the higher proportion of those finding open employment than usual for sheltered workshops in the UK.

Non-vocational outcomes

Despite the serious limitations there are arguments in favour of sheltered work placements. For example, reviews by Bond (1988, 1992) concluded that vocational interventions are associated with reduced hospital admissions. Though, this finding applied equally to a range of vocational rehabilitation programmes, not just sheltered work.

Studies by Morris Bell and Paul Lysaker perhaps contribute the most to our understanding of the clinical benefits of sheltered employment. Bell *et al.* (1993) reported that paid sheltered employment in the hospital results in improved symptoms of depression, though not other symptoms.

They then examined the effect of payment and participation on clinical outcomes. Bell *et al.* (1996) found that those that are paid in prevocational training had a significantly reduced level of symptom severity, lower rate of rehospitalization and used less than half the number of hospital days than those not receiving pay. They attributed these clinical improvements to increased participation that resulted from payment. Though they could not rule out the converse - that symptom reduction increased participation - they concluded that symptom reduction could be due to the reality-oriented nature of work and greater social interaction. In a 1-year follow-up to this study, Bell and Lysaker (1997) found a significant decrease in work activity once individuals had completed the work programme. However, levels of symptoms remained significantly better in the former 'pay' condition, though they had declined after six months. Their findings indicate that clinical benefits had been retained, but concluded that work services are required to sustain participation.

Lysaker and Bell (1995) also examined changes in 'insight', or understanding of their illness, in 44 people diagnosed with schizophrenia who were enrolled into a sheltered vocational rehabilitation programme. They found significant improvement in 61% of sample, with greater cognitive impairment predicting lesser improvements. They concluded that vocational rehabilitation can favourable affect peoples understanding of their illness, which can lead to more favourable treatment outcomes.

It is also reported that traditional day services can help increase client's social skills and increase their social networks (Bond *et al.*, 1998). Kuldau and Dirks (1977) found that those using vocational rehabilitation services were more likely to have activities with friends than those in a control group. Wolkon *et al.* (1971) concluded that clients of vocational rehabilitation had better social participation compared with controls. In a study of people diagnosed with schizophrenia in two hospital workshops Miles (1972) found that those

attending the industrial unit had more extensive social networks than the group engaged in occupational therapy, though there was no difference in the quality of relationships. Lysaker and Bell (1995) found that social skills of people with schizophrenia improved significantly over a 17-week job placement.

Further evidence to support this comes from the adverse affects of closing day treatment, where Torrrey *et al.* (1995) found that a small number of clients expressed loneliness. To counter this drop-in centres, consumer run programmes and other types of social clubs have been advocated as replacements for traditional day treatment programmes in the US (Torrey *et al.*, 1998).

There are other studies that have not found the non-vocational benefits of vocational rehabilitation. For example, a study (Chan, 2000) of vocational rehabilitation in Hong Kong found that the quality of life of those in sheltered work environments declined with length of stay. Dean and Dolan (1991) found that people labelled as 'emotionally disturbed' did not significantly increase their earnings after completing vocational rehabilitation services, unlike people with physical disabilities and learning disabilities.

Finally, there is evidence that the closure of traditional day treatment may *improve* outcomes. Drake *et al.* (1994) conducted a natural experiment by comparing a day treatment centre which converted to a supported employment programme with a second site in which day treatment centre was provided along with brokered vocational services. An interesting finding from this study was that many clients who did not find work also benefited. The closure of the day treatment programme led many to develop activities outside of mental health services (Torrey *et al.*, 1995).

An alternative to competitive employment

It has been argued that sheltered work meets the vocational needs of the most disabled, who would otherwise never gain employment. Reker *et al.* (1992) describe the value of sheltered work as the only alternative to unemployment and inactivity for people with long-term and severe mental health problems. For example, Eikelmenn and Reker (1993) studied 502 representatively selected people in sheltered workshops in Germany. They found that individuals were most likely to be long-term users of mental health services with significant disabilities. They found high job satisfaction despite low pay and that just 20% hoped to move into open employment. They concluded that, positively formulated, sheltered employment offers vital social and psychological aspects of work, that it normalises living conditions and enhances quality of life.

Some believe sheltered work is less threatening as it provides easy entry and exit and offers peer support (Marrone, 1993). Moreover, there have been concerns about the ability of people with severe mental health problems to cope with immediate placement into competitive employment using the 'place and train' approaches; whereas the preparation of 'train and place' models are believed to protect clients from high stress (Black, 1992; Scheid and Anderson, 1995).

There is ample theoretical and indirect evidence to support this view. Perhaps most relevant here is the work of John Wing (1978) who identified critical environmental factors that lead to optimal outcome in schizophrenia. One criterion is that there should be stable expectations geared to the level of performance the person can actually achieve. Perhaps one of the key reasons why sheltered work was devised and continues to thrive is that industrial society gives few opportunities to adapt to the needs of such a worker (Warner, 1994).

However, a study by Bedell *et al.* (1998), which compared stress levels of participants involved in a supported employment programme with those in a paid pre-vocational training programme, found no significant differences between groups. They concluded that supported employment offers substantial superiority and has no drawbacks. Though the study was limited by a small sample (N=26) and only included people who were successfully employed.

Clubhouse and transitional employment

In a similar fashion to traditional day services clubhouses do not exclude people who are not interested in work. Despite this there is reasonable evidence that employment outcomes are good.

Employment outcomes

Some studies have reported employment rates over 40% for clubhouse members in the US (Malamund *et al.*, 1988; Ruffner, 1986). Though a criticism of clubhouses in the UK is that they have had difficulty in replicating the success found in the US of gaining adequate number of TE placements (Schneider, 1997). Yet Mastboom's (1992) survey suggests that many clubhouses in the US also have limited number of transitional employment (TE) placements. He reported that 82% of clubhouses had a TE programme and that 39% had 4 or fewer placements, 50% had 5 to 23 positions and just 11% had 24 or more. With an average of 68 members per clubhouse this suggests that even in the US only a minority of members have access to employment. Indeed Mastboom (1992) reported that almost 25% of

active members had been in a TE position. More recently, Macias *et al.* (1999) found an average of 19.6% of members in TE positions.

It has been argued that transitional employment allows members to experience different types of jobs (Bilby, 1992) and work in a less demanding role (Marrone and Gold, 1994). The main arguments against temporary placements are that they do not give members a sense of personal investment and tie-up valuable resources in intermediate placements rather than more effective supported employment placements (Bond *et al.*, 1999).

In the final report of an experimental study comparing Clubhouse with a PACT programme with vocational rehabilitation Macias (2001) reported competitive employment rates of 59% and 64% respectively after 24-months. Clubhouse participants worked for longer and received higher earnings than the PACT group. On average Clubhouse jobs lasted twice as long as PACT. These differences were attributed to the focus on the most impaired people in PACT together with the stronger links with employers enjoyed by the Clubhouse.

These findings were for work-interested clients from a 'typical and heterogeneous' sample of people with severe mental health problems. Importantly, about a third of all participants who were initially not interested in getting a job (those who would not ordinarily enrol in supported employment) obtained a competitive job. This demonstrates the major advantage of programmes that enrol a wide range of people, including those with no interest in employment.

Non-vocational outcomes

Studies by Rosenfield (Rosenfield, 1992; Rosenfiled and Neese-Todd, 1993) in a clubhouse setting found that transitional employment was associated with greater satisfaction with income, but not with empowerment. For example, in a cross-sectional study of 157 clubhouse members Rosenfield and Nesse-Todd (1993) found that transitional employment was related to greater satisfaction with finances and higher subjective well-being scores in the social relationship and leisure domains. The results suggested that empowerment is most closely related to a broad range of aspects of quality of life.

In a case-controlled study of a clubhouse Warner *et al.* (1999) found that the clubhouse members achieved a reasonable employment status and good social relationships and that employed clubhouse members had the least treatment costs. These two results suggest that employment has achieved successful outcomes, rather than clubhouse per se.

Diversified placement approaches

One of the key problems with the research on day services is the lack of clarity about programme fidelity. The model that suffers the most from this is the eclectic model. In presenting the evidence, this section attempts to relate the findings to the description of the actual model, which are described in Chapter Two.

Employment outcomes

Most research on this type of approach comes from Thresholds and The Village (described in Chapter 2) in the US. Paid employment rates among active members of these programmes have averaged 40% (Cook, 1992; Cook and Razzano, 1995). These programmes show some evidence to support the additional preparation for employment that this approach brings.

For example, Cook and Razzano (1995) used a discriminant function analysis of 602 clients of Thresholds to identify the most important predictors of employment. They found that the closer clients' job experiences were to 'real world' job situations the better their employment outcomes. However, they also found that clients benefit from longer periods of job support on a number of different jobs in order to achieve the maximum impact from vocational rehabilitation. They suggest that this may be due to clients feeling more supported and the closer working relationship with programme staff, and hence more targeted and timely support.

A study by Chandler *et al.* (1996) randomly assigned 210 clients of a county mental health service, unscreened for an interest in work, to either the Village, with its range of vocational options, or usual mental health services, including referrals to the state vocational rehabilitation system. Over the three-year study period, 32% of Village clients obtained competitive employment compared to 11% of the control group. This study was important as it considered a broader group of clients including those who had not expressed a desire to work.

In a 5-year follow-up study of 102 clients of the Village Chandler *et al.* (1999) reported that 74% had tried work, 50% of these working competitively, with average job tenure of 5-6 months and a mean wage of $2,054 per job. Though virtually all started work in the first three years. There was no selection for any reason in the study, yet 95% of all participants chose to accept employment services.

Bond and Dincin (1986) studied 107 clients of a psychosocial rehabilitation programme (Thresholds) randomly assigned to the standard 'gradual' vocational programme (including pre-vocational work crews) or an 'accelerated' programme requiring early involvement in

transitional employment. After 15 months 20% of the accelerated group were in competitive employment compared to just 7% of the gradual group. However, 34% of members assigned to the accelerated condition dropped out and /or failed on placement, compared to 19% of gradual condition. They also found that the accelerated approach did not result in better vocational outcomes for clients with no prior work experience. The authors conclude that there is no evidence that sustained pre-vocational preparation prepares clients for community employment, or that rapid placement is detrimental to clients' mental health. In a later study by Solomon (1998, reported in Bond *et al.*, 1999) among younger adults also found that the longer members spend in prevocational work crews the less likely they were to move towards more independent employment.

Starks *et al.* (2000) described an eclectic model called the Denver approach. This model combines elements of clubhouse and supported employment. In 1999, 445 members were enrolled in employment services with 74% achieving employment. However, a lower figure of 168 (38%) obtained competitive employment, with the remainder in individual and group placements.

Findings from eclectic models that are based on sheltered work have less successful employment outcomes. In the US an evaluation of a transitional employment (TE) programme added to a sheltered workshop Laird and Krown (1991) found that 21% held independent employment and 28% held a TE position at a 22-month follow-up. This result has important implications for the UK where most eclectic vocational services are also based on sheltered work.

Non-vocational outcomes

McGilloway (2000) reported an evaluation of the services of ACCEPT in Northern Ireland. This programme provided a range of advice, guidance, training, placements and support in employment. Pre and post-training assessments found significant improvements in satisfaction with employment status, religion and purpose in life, social relationships, an overall well-being and increase in self-esteem and decrease in GHQ scores. At end of study approximately half (32/63) were in paid employment, voluntary work or work experience (11 in paid employment and 9 in sheltered work), 21 in voluntary work and 2 in further education classes. 17 enrolled in further ACCEPT training and five dropped out. Trainees and staff views about ACCEPT were positive, though some staff expressed concerns about staffing, placements and inter-agency communication.

Supported employment

There is no doubt that supported employment has the sole aim of helping people obtain work. There is now ample evidence that suggests this model meets its aim effectively.

Employment outcomes

Several reviews (Bond, 1992; Bond *et al.*, 1997; Bond *et al.*, 1999; Crowther *et al.*, 2001) indicate that supported employment increases the likelihood that people with mental health problems will obtain competitive employment, the length of time they are employed, and their employment earnings compared to traditional vocational services. Most supported employment programmes report placement rates of up to 73% compared to 10% for traditional vocational programmes (Bond and Dincin, 1986; Drake *et al.*, 1994; Gervey and Bedell, 1994). In a review of supported employment Bond *et al.* (1997) found the mean rate of employment was 58%, ranging from 32% to 78%, for supported employment programmes compared to just 21% for control groups in experimental studies, with similar figures reported for non-experimental studies.

Examples of research studies are given below to further illustrate the effectiveness of supported employment from several different perspectives: the Indiana model, job coach model, 'choose-get-keep' model and IPS.

In the first example, Bond *et al.* (1995) conducted a study that randomly assigned 77 unemployed clients to either 'accelerated' or 'gradual' referral to supported employment from day treatment programmes in five CMHCs in Indiana. The accelerated condition involved immediate referral to a supported employment programme, while the gradual condition involved four months prevocational training prior to referral to the same model supported employment programme. However, of the two agencies one provided integrated services while the other provided a brokered model. After 12 months the percentage of clients who had obtained employment in the accelerated groups was higher, at 56%, than the gradual group, at 29%. Moreover, clients in the accelerated condition work for longer and had higher earnings. The integrated model had better outcomes than the brokered model.

Gervey and Bedell (1994) randomly assigned 34 young adults (between 15 and 25 years old) from a CMHC in New York to either a supported employment programme, using a job coach model, or a sheltered workshop in the mental health centre. After 12 months 76% of the supported employment group obtained competitive employment compared to just 6% of those in the sheltered workshop. Supported employment clients worked twice as long. Moreover, the drop-out rate was much higher for the sheltered workshop.

Danley *et al.* (1994) followed-up 19 people two years after enrolling in a 'Choose-Get-Keep' model of supported employment. They found that 60% obtained employment, for an average of 17.5 hours per week and $156 per week earnings. Those that did well had greater readiness for employment and had clarity about their job goals. Many of those that worked expressed dissatisfaction with their initial employment and had moved to jobs that demanded higher skill. The authors concluded that people with mental health problems may require a minimum of two years in a supported employment programme to achieve the greatest gains.

The most widely researched support employment approach for people with severe mental health problems is the IPS model (Becker *et al.*, 1993, 1994; Drake *et al.*, 1996, 1997). As described in the previous section, the first study of IPS was a quasi-experiment conducted in two cities in New Hampshire (Drake *et al.*, 1994). The site that converted from a day treatment programme to supported employment saw an increase in the competitive employment rate of consumers, from 33% to 56%. No significant change occurred at the site that remained as a day treatment facility (14% to 9%). Moreover, the employment rates increased markedly for those that previously attended the day treatment programme regularly.

The second site subsequently converted to IPS with similar favourable results (Drake *et al.*, 1996). During this study 112 people using the CMHC were assessed over three one year intervals from the time of conversion. The competitive employment rate increased from 12% to 23%, with the greatest gains made by a sub set of 35 day treatment attendees who increased their employment rate from 9% to 40%. As with the previous study there were no increase in negative outcomes. Another study in New Hampshire examined the vocational outcomes for 32 long-term users of a sheltered workshop that switched to IPS (Bailey *et al.*, 1998). Within one year 74% obtained competitive employment compared to 26% in a matched comparison group.

In an experimental study Drake *et al.* (1996) randomly assigned 143 unemployed clients with an interest in competitive employment and attending CMHC in New Hampshire to two models of supported employment. One group received an integrated IPS model, while the other group was referred to a separate vocational rehabilitation agency that provided two months training prior to a brokered supported employment service. After 18 months 78% of those in the IPS group gained competitive employment compared to 40% in the control group. IPS clients also worked more hours and had higher earnings. Two years after this study McHugo *et al.* (1998) found that competitive employment rates for the two groups did

not decline, and that the IPS group maintained higher employment rates. They conclude that continued vocation services are critical to the maintenance of employment.

A more recent study examined the impact of a state-wide project to convert day treatment to IPS in Rhode Island (McCarthy, 1998). Initial results found competitive employment rates for previous unemployed consumers of day treatment increased from 0% to 44% and to 60% in two mental health centres (Drake *et al.*, 1999b). To examine the possibility that the day treatment programme may have prepared these people for employment, the study also examined outcomes for a group of clients who had never been in day treatment. The employment rate among these people increased to 50%, suggesting that day treatment does not prepare people for employment.

Drake *et al.* (1999b) replicated the New Hampshire study in Washington D.C. to evaluate the effectiveness of IPS in a deprived urban environment. This experimental study compared 152 clients enrolled in a vocational rehabilitation programme randomly assigned to either IPS or an enhanced vocational rehabilitation programme, which delivered services in a step-wise approach. During the 18-month study period the IPS group were more likely to obtain competitive employment than the comparison group (61% compared to 9%) to work at least 20 hours per week (46% compared to 5%). The comparison group were more likely to work in sheltered employment (71% compared to 11%). However, the study found no significant difference in earnings and job satisfaction. This study demonstrated the effectiveness of IPS in gaining employment outcomes for people with poor employment history, dual diagnosis and homelessness. Though the participants also had the benefit of intensive case management with integrated mental health, substance misuse and housing services.

A further study compared IPS with a psychiatric rehabilitation programme, which operated along clubhouse principles including the transitional employment model, and standard services of a regional mental health centre in Connecticut. This involved 204 clients randomly assigned to one of the three options and followed for 2 years. The study included a higher than average proportion of non-white people (45% African American and 31% Latino). Those receiving the IPS programme were most likely to obtain competitive work (75%), followed by standard services (27%) and then the psychiatric rehabilitation programme (18%).

Finally, a survey in New Hampshire (Drake *et al.*, 1998) found that CMHCs that emphasised supported employment achieved better employment outcomes that those emphasising day treatment or sheltered workshops.

In summary, there have been several studies to evaluate the effectiveness of IPS including two experimental studies. For those people who express an interest in competitive employment IPS has demonstrated that most can achieve that outcome, even for those with a limited employment history. Moreover, that IPS is more effective that other models of vocational rehabilitation at achieving competitive employment. The success of IPS has been ascribed to the core principles (Drake *et al.*, 1999a), as described in Chapter Two.

Supported employment in the UK

Studies of supported employment in the UK are much more limited. The majority of schemes described or evaluated in the literature involve generic disability services where the numbers of people with mental health problems are either not given, are too small or are not analysed separately. One example where details are given is in a study of a supported employment service in Wiltshire (Pilling, 1997). In this study people with mental health problems had fewer positive outcomes (55%) that other disability groups (e.g. 74% for people with learning disabilities). The largest proportion of positive outcomes were for voluntary work (22%) and part-time employment (12%), which included therapeutic work. Few gained full-time employment (12%) and many rejected their placement (25%). The project concluded that the emphasis on voluntary work and part-time work whilst on benefits were due to limitations caused by the benefits situation.

Another derivative of supported employment is user employment, described in Chapter Two. Rachel Perkins (Perkins *et al.*, 1997) established the first such scheme in the UK at the South London and St. George's NHS Trust. In its first 18 months of operation the project had recruited services users to 15 posts. The most recent progress report (Hardisty *et al.*, 2001) revealed that between 1995 and 2001 64 people with mental health problems had taken up jobs in clinical and non-clinical posts and a further 96 people had worked in a voluntary capacity within the Trust. 86% of the former and 25% of the latter have either sustained or moved onto open employment.

Non-vocational outcomes

Mueser *et al.* (1997) reported on the non-vocational outcomes from the New Hampshire study. They found that formerly unemployed people with mental health problems who obtained competitive employment tended to have lower symptoms, better overall functioning, higher self-esteem, and high satisfaction with vocational services and finances compared to their baseline.

Despite this, there is little evidence that supported employment has improved non-vocational outcomes. The New Hampshire studies found no increases in hospitalisation, incarceration, homelessness, or suicide attempts for those in IPS (Drake *et al.*, 1994), though found no difference in non-vocational outcomes (Drake *et al.*, 1996), such as quality of life and self-esteem.

Fabian (1992) conducted two studies to examine the effect of supported employment on quality of life using Lehman's Quality of Life Interview (Lehman, 1988). In the first, a group of 54 people in and supported employment programme were compared to 56 people in the standard community support services. A multi-variate analysis with post-hoc tests revealed higher quality of life for the supported employment group on the Global well-being and Finances sub-scales only. On further analysis of those in the supported employment programme no significant difference in quality of life was found in job tenure, job type and job wages. In the second study Fabian (1992) compared quality of life before and after job placement for a subset of 10 participants in the supported employment programme. She found a significant increase in the Global well-being and Work subscales after 3 months placement, though objective indicators did not increase. She concluded that since employment can make some improvements in work-related domains but not in others rehabilitation professionals should not regard employment as a panacea, rather it is just one aspect of overall quality of life. Similarly, Mueser *et al.* (1997) suggested that employment does not lead to a generalized improvement in subjective quality of life.

A qualitative study of people with mental health problems in the work place revealed more encouraging results (Kirsh, 2000). Kirsh interviewed 17 people in employment for at least 6 months and 19 who had recently left within 6 months. Participants from both groups described positive effects on health and self-esteem and expressed the wish to be competitively employed in order to feel personally satisfied.

Finally, studies by Meisel *et al.* (1993) and Rogers *et al.* (1995) found that people with mental health problems may derive relatively small short-term economic gains from supported employment. Similarly, Clark *et al.* (1998) used data from the New Hampshire study to examine the individual economic perspective of people in supported employment. They reported that the income of people with mental health problems significantly improved when they enrolled on supported employment programmes. Though the increase was mainly due to government sources, mainly grants for education and housing studies and additional clients taking up their entitlements, rather than earned income. They suggested that the lower

earnings were due to the caution exercised by people who fear the loss of their entitlements if they earn too much. This issue shall be returned to in the next chapter.

Summary of models

It appears that work based interventions are normally more effective that other forms of day services in improving symptoms, skills, and social networks, but employment outcomes are poor for traditional day care services. It seems that traditional day care services have a treatment function and are intended for people with long-term and most severe mental health problems.

However, the previous chapter found that though many traditional day care services are intended for the most disabled, in practice they take people with a range of impairments and created a parallel world that exacerbates further exclusion, rather than promoting inclusion. This is an argument also levelled at the 'work ordered day' of the Clubhouse model (Perkins, 1997). In their review of psychosocial rehabilitation Bond *et al.* (1999) conclude that

> If the vocation goal is to assist clients to achieve paid employment, then it appears that many clubhouses do a creditable job, although the overall rate of participation in TE appears to be fairly modest. If the goal is to involve clients in vocational activity (including clubhouse work units and TE), then the clubhouse is an effective approach for members who remain active.

However, they also state that the lack of rigorous research precludes any firm conclusions about the effectiveness of clubhouse in helping people with severe mental health problems to obtain competitive employment.

A promising new direction for traditional day care services are user-run projects. There is as yet little evidence about such projects, though Torrey *et al.* (1998: 75) claim that 'consumer run services, when developed, can offer significant social benefits.'

As with most vocational rehabilitation programmes the diversified placement approaches attract the more motivated people with severe mental health problems, perhaps untypical of the caseload of a community mental team (Bond *et al.*, 1999). For example, Bond and Dincin, 1986) reported that 95% of clients referred to Thresholds had a vocational goal and about 50% had at least 1 year of prior work history. Moreover, Setze and Bond (1985) found a drop-out rate of 25% after 3 months. Bond *et al.* (1999: 29) draws some optimistic yet cautious conclusions about this approach.

> The major advantage of diversified placement approaches over the clubhouse approach is greater flexibility in employment options for both clients and employers. Despite its appealing features, evidence regarding diversified placement's effectiveness is fragmentary. Anecdotal data are encouraging, and theoretical arguments for its worth are plausible, but the only available experimental data do not support the utility of intermediate steps.

Finally, there is growing evidence of the effectiveness and good value for money of supported employment for people with mental health problems in the US, where 30 – 40% of participants have achieved employment (Bond, 1996; Bond *et al.*, 1997; Clarke and Bond, 1996; Drake *et al.*, 1996; Gervey and Bedell, 1994), though such evidence is only available for people with learning disabilities in the UK (Beyer *et al.*, 1996).

It appears that the focus of supported employment is to promote inclusion via employment. Questions still remain about the effectiveness of finding jobs for the most disabled. In particular, there is a lack of empirical evidence on the benefits of supported employment in the UK.

Section Two: What features promote social inclusion?

Employment is perhaps the best route to social inclusion, whereas traditional day services exacerbate exclusion. This section examines the key characteristics from the evidence presented above to determine which elements promote effectiveness. Effectiveness is dependent on the desired outcome. Here, effectiveness is defined in three ways, getting, keeping and deriving benefit from a job.

Getting a job

The evidence above suggests that supported employment, and in particular IPS, is most effective at helping people get a job. The elements that promote effectiveness in getting a job include the following.

Rapid placement. Several studies have found that most clients prefer rapid placement approaches to unpaid work experiences prior to placement (Bond *et al.*, 1995; Rogers *et al.*, 1991). Evidence presented above (e.g. Crowther, 2001; Drake *et al.*, 1994; Bond and Dincin, 1986, Solomon, 1998) found better employment outcomes for 'place and train' as opposed to 'train and place' approaches.

Individual placement. Bond *et al.* (1999) suggest that contact with non-disabled workers and the satisfaction of a real job are two key advantages of working in an integrated and competitive employment position.

Programme integration. Several studies (Bond *et al.*, 1995; Drake *et al.*, 1996; Test, 1992) indicate that the integration of vocational and clinical services in one agency is more effective than providing these services separately.

Community integration. Drake *et al.* (1998) examined the vocational outcomes across the ten regions of New Hampshire. Statewide and CMHC administrative data on competitive employment outcomes, region labour markets and client case mix was collated together with semi-stuctured interviews with key personnel in the CMHCs. They found that there were many differing routes to high employment outcomes. Among the programmes with the highest employment rates were integrated vocational models with multidisciplinary teams, close interagency collaboration between mental health and state vocational rehabilitation and consumer-run businesses. The common features of these services was a strong belief in the value of normalisation and full community integration.

Keeping a job

Most studies of supported employment find relatively low job tenure. In a study of 69 people enrolled in an supported employment programme in Maryland Fabian and Wiedefeld (1989) found a 6-month retention rate of 47%. Bell and Lysaker (1995) found that despite feelings of increased well-being and satisfaction among people in paid work placements about half dropped out and a third chose not to engage in any productive activity in the six months following the end of the placement. Trotter *et al.* (1988) reported that 83% of early placement terminations were due to mental health problems. Others have reported that 6-month employment outcomes tend to hover at around 50% (Tashjian *et al.*, 1989).

Increasing job tenure can promote social inclusion. There are mediating factors can contribute to longer job tenure. These include the following.

Matching jobs with client preferences. In the New Hampshire study of supported employment Becker *et al.* (1996) found that clients enrolled had realistic job preferences in relation to the type of work, the hours and wages they could expect. They also found that those who were working in jobs that matched their baseline job preferences had significantly greater job satisfaction and worked for twice as many weeks in these jobs than those whose job did not match their preference. This finding was replicated in a further study of IPS (Mueser *et al.*, 2001), which also noted that job matching is especially important for those who are more ambivalent about working or have greater impairment.

Paid employment. In a study by Bell *et al.* (1993) 100 Vietnam veterans diagnosed with schizophrenia were randomly assigned to either 'pay or 'no pay' conditions in a hospital work

programme. They found participation rates of 97% and 37% respectively after the first week, and concluded that pay had a major impact on participation in a vocational rehabilitation. Furthermore, Bell *et al.* (1996) also found that those in the 'pay' condition worked significantly more hours than 'no pay'.

Accommodations in the work place. Fabian *et al.* (1993) studied the types of accommodations that were required for 32 people with mental health problems in employment. She reported 231 job modifications for the 47 jobs held by these individuals. She found a significant relationship between job retention and number of accommodations. For example, when employers are educated about mental illness they may more readily overlook some mistakes. It was also noted that job tenure was much lower for those who had not disclosed their illness.

Ongoing support. For people with learning disabilities ongoing support tends to peak in intensity at the initial phase of placement and then gradually taper off (Beyer *et al.*, 1996). For people with mental health problems though, the initial phase of placement has a similar peak in support, followed by a dramatic drop-off in support, but the ongoing support needs are often characterised by a series of peaks, a pattern related to the nature of many mental health problems (Fabian and Wiedefeld, 1989).

A qualitative study of people with mental health problems experiences of employment found a recurrent theme was the difficulty in balancing the need for predictability and stability at work with the potential recurrence of illness (Kirsh, 2000). Indeed, the Whitehall II study found that high demands at work were associated with increased risk of psychiatric disorder (Stansfeld *et al.*, 1997). Intermittent mental health problems suggest on-going support is likely to increase job retention.

Supported education. The low tenure in the jobs obtained by people with mental health problems can be attributed to the types of jobs they get. Bond *et al.* (1997) found that between 35% and 62% of the jobs gained by clients of supported employment were 'entry-level' service jobs (e.g. catering and cleaning). Non-disabled workers have a similarly low tenure in such jobs (Adams-Shollenberger and Mitchell, 1996). Supported education aims to improve qualification and therefore gain better jobs (Mowbray *et al.*, 1999). In a study of supported education in the US by Cook and Solomon (1993), not only had 78% of the 125 participants held at least one job but 47% were employed three years later.

Benefiting from a job

Fabian (1992) suggested that during the initial months of employment individuals with severe mental health problems experience a transition that affects all areas of life. In her study of supported employment in the US Fabian (1992) found that subjective quality of life was actually lower for those in the first six months of employment compared to those not working. She concluded that the losses experienced might outweigh the gains of employment that may result in job loss.

In contrast, Arns and Linney (1993) examined the relationship between vocational status, self-efficacy and self-esteem and quality of life. They found that a six-month change in vocational status was significantly associated with increased self-esteem and an enhanced sense of self-efficacy. Their findings suggest that it is change in vocational status, i.e. getting a job, that has an important impact upon self-esteem and quality of life. Similarly, a comparative study in Ireland of 25 people in supported employment and 19 people in occupational therapy found improved global well-being and satisfaction with employment status, finances and social relations using the Lancashire Quality of Life Profile (Browne, 1999). There were no significant differences on the other life domains and in gross weekly income.

Data from the New Hampshire study (Torrey *et al.*, 1998) found no clinically significant change in self-esteem when people gained employment. They concluded that there is only a weak association between work and self-esteem, and that self-esteem is a complex concept that is trait-like and insensitive to life changes.

It is clear that many do benefit from employment, particularly where choice is given and continued support offered. The dangers of continued unemployment among people already vulnerable to stress far outweigh the risks of well planned and support employment interventions.

Limitations of the research evidence

There are problems with the research evidence in defining the types of clients served, problems in defining the process and outcomes of the various day services, and methodological problems (Bond *et al.*, 1999).

Considering the first limitation one may ask: Are different interventions more effective for different types of clients? The research literature offers little guidance to answer this question (Bond, 1992, Bond *et al.*, 1999). Lehman (1995) suggests that owing to the dearth of research in this area a range of vocational services should be offered. Bond and Dincin (1986) suggest

that rapid placement is better suited for those with prior employment history, though little research has been conducted to examine this further.

Chan (2000) compared the social functioning and quality of life of 152 people with mental health problems using three types of vocational rehabilitation programmes in Hong Kong: 91 in a mobile work crew, 54 in a simulated business and 7 in individual placements. A multi-level analysis was used to examine how quality of life scores were influenced by social functioning and length of stay in vocational rehabilitation. In terms of optimising quality of life, Chan found that individual placement was most effective for people with none to minimum of social dysfunction, simulated business for those with a minimum to obvious level of social dysfunction, and work crews a better option for those with the highest social dysfunction.

In order to determine whether case managers referred clients with different needs to programmes with different goals and outcomes Berthaume *et al.* (1994) asked 150 case managers to select one of three day services – day treatment, clubhouse and supported employment – for four hypothetical clients. The 70 who responded consistently referred the most functionally impaired clients to day treatment, whereas the least impaired were referred to clubhouse and supported employment.

The evidence presented above suggests that the diversified placement approach may be more effective as a range of options are provided for a range of preferences and abilities. Yet proponents of the other models, including supported employment, still maintain that this model is targeted at those with the most severe mental health problems.

To complicate matters still further there are ambiguities about definitions of models (Bond *et al.*, 1999). Several research articles failed to adequately describe the intervention method and merely refer to a particular model. The most well defined programmes originate in the US: clubhouse and IPS in particular. For example a scale for measuring programme fidelity to the IPS model of supported employment has been devised and tested (Bond *et al.*, 1997; Bond *et al.*, 2001). Others have noted problems in the implementation of model programmes (Meisler and Williams, 1998).

The outcomes of these interventions are also contested. Proponents of supported employment prize open competitive employment as the main goal. Others such as the clubhouse movement may identify increased quality of life and empowerment as the main outcomes. However, it has been argued that competitive employment leads to a better quality

of life and higher self-esteem. (Bond *et al.*, 1999). The analysis here has attempted to fuse these approaches into the concept of social inclusion.

A further criticism of the research evidence is the small samples often recruited in studies, the lack of controls and insufficient period for follow-up. Many studies experience high drop-out rates, as high as 40% (Bond *et al.*, 1997), and some do not evaluate the characteristics of drop-outs and only give a partial view of the impact.

Summary

There is now ample evidence to conclude that supported employment is more effective than other interventions in enabling people with mental health problems to gain competitive employment. Yet many questions remain. Why has it been so successful in the US? And if supported employment is so effective then why has it not been adopted in the UK? These questions are answered by Chapter Four, which proposes that the success of supported employment programmes in the US is mainly due to the social security system.

Does supported employment actually promote social inclusion? Two points must be noted in relation to this question. Firstly, what of the 50-60% of people who do not gain employment from supported employment projects and those who do not use them at all? In effect supported employment only gains employment for a minority of people using mental health services, usually not those with long-term and most severe problems. What support is available to such people to promote their inclusion?

The evidence suggests that supported employment alone will not promote social inclusion, but rather a range of programmes are required. These could be provided by one agency, using the diversified placement approach, or by other agencies, such as the experience in New Hampshire of providing consumer-run day services and IPS programmes.

Secondly, do the jobs achieved through supported employment promote inclusion? This chapter found that most mental health service users who get a job often work in low paid, low status, part-time, temporary jobs. These are classed as 'entry level' jobs, described by Marianne Farkas as 'food, filth, filing and flowers'. Just the types of jobs identified in Chapter One as causing poor mental health. However, Clark and Bond (1996) considered that it is implausible that a vocational rehabilitation programme can have poor results in achieving employment and increasing earnings and at the same time succeed in improving self-esteem and social functioning. In other words, the risk of poor health by gaining real jobs is no worse than through other day care services.

In addition to health there are financial risks of paid employment. Chapter One also discussed the problems of in-work poverty and the cycle of 'low-pay, no-pay' inherent in low paid jobs. Is there a danger of replacing one form of poverty with another? In response to this important question the next chapter deals with issues of financial impact of gaining work.

So which model is best? Ultimately the answer to this question comes down to values, as described by Drake *et al.* (1999: 632)

> Do we believe it is better to integrate people with mental illness into mainstream society, or do we want to maintain separate work settings and keep them segregated from society?

The following section considers this question.

Section Three: From treatment to inclusion

Chapter Two examined the history of day care services and proposed that the focus of day care services had shifted from treatment, to rehabilitation and to social inclusion. This chapter has provided the empirical evidence for this shift. In the preceding sections several models of day care services have been examined. Table 2 categorises these into three types based upon their purpose: to treat, to rehabilitate, and/or to include.

Table 2. The aims of day care services

Models	*Treatment*	*Rehabilitation*	*Inclusion*
Day Hospital	*	*	
Occupational Therapy	*	*	
Day centre	*	*	
Sheltered work	*	*	
Vocational rehabilitation		*	
Clubhouse		*	*
Social Enterprises		*	*
Social Firms			*
User-run enterprise			*
Supported employment			*

A treatment function provides therapy based treatments and medical support with the aim of reducing symptoms and reducing in-patient admission. Staffing is mainly by professionals and activities will include medication, monitoring of mental state and individual and group therapies.

A rehabilitation function serves to act as a stepping-stone on the road to recovery. There is a spectrum of views on rehabilitation, from the creation of specialist environments in which to

conduct simulations of social situations (Bennet, 1978) to the support of individuals to achieve valued social roles (Wolfensberger, 1980). All focus on the individual and assume some kind of norm to aspire to, and thus subject to the criticisms made above. Staffing is mainly professional and para-professional, interventions are usually time limited and skills based.

Inclusion refers to supporting a person to take a valued social role, but in this case a role valued by the person, not by society. The emphasis moves away from the inadequacies of the individual to those of adaptation made within communities. Staffing is replaced by a network of support from professionals, volunteers, colleagues, and other service users. The notion of intervention is replaced by those of empowerment and tackling discrimination, with an emphasis on citizenship, choice and meaning.

It is clear from the evidence presented in this chapter that there is a trend emerging towards more inclusive day services. However, the bulk of resources in the UK remain with day hospitals, day centres and sheltered workshops and employment outcomes remain very low. The next chapter turns to the welfare benefits system to explain why.

CHAPTER FOUR

Welfare Benefits and Barriers to Work

Introduction

Chapter One revealed the widespread and long-term unemployment of people with mental health problems. Despite this many studies have found a growing number of mental health service users expressing the desire to work (Burnett, 1993; McCollam, 1993, 1994; MIND, 1993; Setti, 1994; Thomason, 1989; Turton; 1996).

The desire to work from people with mental health problems can be understood within the changing context of mental health care. In Chapter Two we saw that in the days of large psychiatric hospitals unemployment was a natural and accepted consequence of mental illness. The chapter then described a series of developments that have caused policy makers to re-examine the employability of people with mental health problems. The advances in treatment and rehabilitation, accompanied by a shift in the locus of care from hospital to community (Department Of Health, 1989a) have created the need for more normalised opportunities (see Chapters Two and Three). The growing importance and influence of the user movement, combined with greater acceptance of the social model of disability have put an emphasis on integration rather than segregation.

Chapter Three found that employment rates among mental health service users are much higher in some parts of the US than in the UK. For example, New Hampshire reports employment rates of 30-50% over the last 10 years compared to about 10-15% in the UK. These superior outcomes have been achieved by supported employment programmes, which have been under developed in the UK where the reliance is on sheltered work.

This chapter attempts to explain why employment outcomes for mental health service users are better in the US than in the UK. The social and economic factors that may determine this difference are considered first. Then case study examples are used to compare the financial incentives created by the social security systems in the UK and US.

These case studies examine how the welfare benefits system affects work incentives for people with mental health problems. Idealised budget constraints are presented to illustrate the complex relationship between work and welfare, showing how a person's net income changes as they move off welfare and into paid work. The discussion uses this data to

examine the main criticisms of the welfare benefit system and attempts to explain the difference in employment outcomes between the UK and the US.

Section One: The importance of social security

The differences in employment outcomes between the US and UK are largely due to differences in the social security systems. In the UK, welfare benefits are regarded as the most serious barrier to work identified by numerous reports and user surveys (Secker *et al.*, 2001; Anaya *et al.*, 2000; Barnes *et al.*, 1998; Davis and Betteridge, 1997; Turton, 1996). For example, a study of supported employment schemes in Great Britain found that 52% of workers said the benefits system was the main barrier to employment (Beyer *et al.*, 1996). The most common problems associated with the benefits system are financial disincentives, income insecurity and restrictive rules (Beyer *et al.*, 1996; Davis and Betteridge, 1997).

In contrast, there is little evidence about how public benefits affect work behaviour in the US (Clark *et al.*, 1998). Some studies have found that welfare benefits are a barrier to work. For example, Tashjian *et al.* (1989) found that loss of entitlements is seen as a barrier to employment by both mental health and vocation rehabilitation practitioners. An ethnographic study by Alverson (1998) found that most clients were very fearful of losing benefits, and suggested that some may avoid reporting their true earnings. Higher amounts of SSDI and SSI[2] prior to enrolment in supported employment programmes seem to have a negative impact on future work status (Bond *et al.*, 1995).

However, there is evidence in the US that social security does not create financial disincentives to employment for people with mental health problems (Clark, *et al.*, 1998; Bell *et al.*, 1993; Dean and Dolan, 1991; Rosenheck, 1995; Moffit, 1992). These studies demonstrated that earnings did not significantly increase after employment and that the benefits system provided a only a slight deterrent effect. Danley *et al.* (1994) and Rogers *et al.* (1991) found no relationship between vocational outcome and benefits received.

Other factors, such as the economy are less important in accounting for differences in employment rates, though there have been few controlled studies in varying labour markets to test this effect. Research conducted in New Hampshire found a marginal effect on employment rates between areas with different economic conditions (Drake *et al.*, 1998). Moreover, Purlee (1993) found a weak correlation between unemployment rates and job

[2] Social Security Disability Insurance. Paid to people with a prior work record. The amount is linked to the number of years worked. People in work can keep claiming SSDI whilst in work, subject to certain rules, when earnings are below $750 per month. Supplementary Security Income (SSI) is a means test benefit. Recipients are able to claim SSI when in work, subject to certain rules, though for each dollar earned SSI is decreased by 50 cents.

placements for people with mild mental health problems and no association for people with severe mental health problems.

It has been widely reported that the nature of jobs gained by mental health service users are entry-level, low paid, temporary jobs. It is argued that these jobs are readily available in most economies (Catalano *et al.*, 1999) based on the assumption that most regional economies support a primary and secondary labour market (Fine, 1987). The primary labour market includes jobs with extended periods of full-time employment, usually requiring specific skills. The remainder of the labour force participates in the secondary labour market. This market is characterised by part-time, temporary, and high turnover jobs that require relatively few skills. The secondary labour market operates independently from the primary labour market and is more susceptible to the economic climate (Catalano *et al.*, 1999).

It is suggested that people with severe mental health problems are more likely to participate in the secondary labour market (Catalano *et al.*, 1999). Paradoxically, Catalano *et al.* propose that employment opportunities for people with severe mental health problems can actually improve during economic contraction, as they can be desirable employees who do not demand additional benefits or long-term security from employers. In other words, people with mental health problems can become inexpensive substitutes for other workers.

This is at odds with Richard Warner's (1994) thesis which argues that unemployment among mental health service users increases with rising unemployment. Warner's data was based on economic conditions prior to the mid-1980s. Since then, the globalisation of the economy has given rise in the number of jobs in the secondary labour market (Hutton, 1995).

The social security system is a necessary but not sufficient cause in the differing employment rates. The other key factor is the difference in service provision. There is clear evidence that supported employment programmes achieve the best employment outcomes and employment rates are highest in those US states with supported employment programmes (see Chapter Three). Chapter Two saw how supported employment for mental health service users is relatively under-developed in the UK. The effectiveness of supported employment must therefore be considered within the context of the social security system.

Section Two: Comparing the UK and US using case studies

Hypothetical case studies are used to explore the effect on income as a person moves from welfare into work in the UK and the US. Systematic measures are applied to each case study to examine financial disincentives.

Case studies

Each example uses a single person, aged 28, living alone with no children and eligible for the most common disability benefits in the UK and US. A single person was chosen as half of all successful claims for Disability Working Allowance were made by single people with no children (DSS, 1998b). Additionally, in a nation-wide study of people with disabilities in or on the margins of work 40% were single (Rowlingson and Berthoud, 1996). The age was chosen to typify a person using supported employment, with a common onset of schizophrenia (mid-20s for men) and who has used mental health services for a few years.

Their income is considered both in and out of work. When out of work the person is eligible for Income Support with disability premium (£73.30 per week) and the low rate care component of Disability Living Allowance (DLA, £14.05 per week) in the UK. The US examples assume SSDI of $600/month in SSDI only example and $350/month in the SSI&SSDI example. Chapter One described surveys that most people with mental health problems in the UK have to claim Income Support in addition to other disability benefits (MIND, 1998; Bateman, 1999). For those people with a disability who do not qualify for Incapacity Benefit, Income Support with disability premium remains the benefit package most people rely on (AfSE, 1999).

When in work, wages are chosen to examine the effect of the UK National Minimum Wage (Low Pay Commission, 1998), at £3.70 ($5.66) per hour, and it is assumed that the person remains eligible for DLA in the UK and SSI and SSDI in the US. Where housing costs are used, it is assumed that the person pays £40 per week ($250 per month) rent in rent and £9.47 council tax per week. The level of rent was chosen to reflect the average among social renters used by Giles *et al.* (1996) and a council tax corresponding to band A in Manchester with a 25% discount for a single person.

The data for each case study were calculated using Imperial College's benefits calculator with 1999/00 benefits, national insurance and income tax rates. It is assumed that the person is not eligible for tax allowances other than the personal allowance. US taxes were calculated using the IRS tax tables for 1999 and the UK tax and benefit rates for 1999/2000. All US benefit rates are for 2000. HUD rules were used to calculate Section 8 rent subsidy based on information from the Mental Health Centre of Boulder. An exchange rate of $1.53 to £1 was assumed based on the Purchasing Price Parity in 2000 (OECD, 2000).

It is assumed that the person has no savings and claims all the benefits to which they are entitled. However, there are significant problems associated with benefit 'take-up', whereby

people who are eligible do not claim the benefit (Corden, 1994; Craig, 1991), which is a particularly significant problem for people with mental health problems (Hedges and Thomas, 1994; Linney and Boswell, 1987; Marks, 1988; Pacitti and Dimmick, 1996).

These assumptions are designed to cover a wide number of people using mental health services. However, there is enormous scope for variation within the personal circumstances and the assumptions used and therefore no attempt has been made here to generalise the findings to a wider population. Rather, the intention is to illustrate some of the broader concepts through typified scenarios.

Income definitions and budget constraints

For each case study an idealised budget constraint has been calculated using 1999/00 tax and benefits rules. A budget constraint shows net weekly income levels for a selected range of working hours, from no work at zero hours to full-time work at 40 hours per week. The total height of each bar represents the total income at that number of hours of work. The component parts of each bar represent particular types of income.

Where disposable income is used it is defined as weekly income (including any state benefits received) after paying income tax, National Insurance, rent and council tax. This 'after housing cost' method has been adopted to include the effect of housing benefit, which is often ignored in studies of income as it is administered separately, by local authorities rather than the Benefits Agency.

Measures of welfare dependency

The two main indicators of financial incentives, used by government (HM Treasury, 1997) and many others (Atkinson, 1993; Giles *et al.*, 1996) are the unemployment and poverty traps. The unemployment trap occurs where people find themselves not a great deal better off financially if they return to work (Atkinson, 1993). A traditional measure of the unemployment trap is the Replacement Rate (RR), which is defined as the ratio of disposable income in work to that out of work (Giles *et al.*, 1996).

$$RR(\%) = \frac{Disposable \quad inome \quad out \quad of \quad work}{Dispoable \quad income \quad in \quad work} x \quad 100$$

RR's over 70% may represent a significant level of unemployment trap (HM Treasury, 1997). RRs over 100% indicate that a person would be worse off financially in work. In a UK study of unemployed people, Atkinson (1993) used the DSS model tables and found average RRs for a single person varied from 60% at 42.5% of median earnings, rising to 25% at median earnings, which was then £247 per week. In a study of incomes and work incentives of

unemployed tenants in the social rented sector, Giles *et al.* (1996) calculated the average RR for single men as 35% and single women as 44%.

The poverty trap occurs when a working person or family is little, or no better off as a result of earning additional income (Atkinson, 1993). This is because earning more means more tax is paid and less benefit received. Benefits that can be claimed by working people, such as Housing Benefit and DPTC, have a 'taper' that is used to calculate the amount of benefit a person can receive. For example, DPTC has a taper of 55%, which means that a person would lose 55p in benefit for each extra £1 earned.

The poverty trap affects those who wish to work more hours. People may work longer hours to earn more money, work towards promotion, try out part-time work before moving onto full time, or be required to do so by their employer. A useful measure of the poverty trap is the Marginal Tax Rate (MTR), which measures the percentage of income deducted through increased tax and reduced benefits when the person earns an extra £1. Where high MTR's exist over a wide spread of income, then several extra hours of work may yield very little additional income. MTR's of over 60% represent a significant level of poverty trap, experienced by only 2.5% of the working population (HM Treasury, 1997).

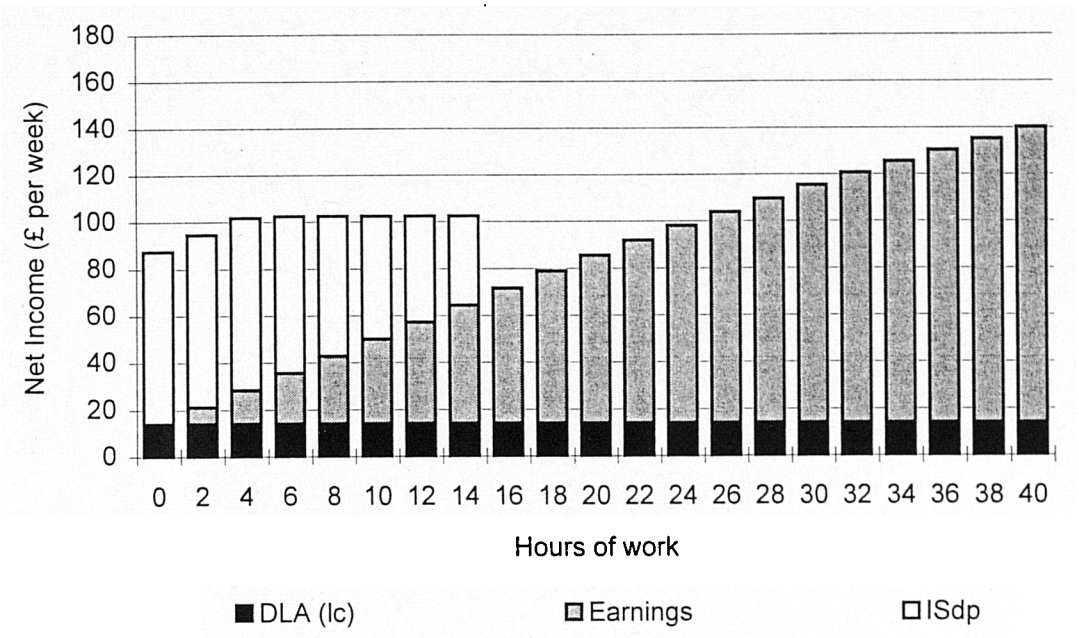
UK case studies

The following five case studies show the effect of various elements of the welfare benefits for a person in the UK.

Case A. The effect of means-testing

Figure 3 shows the budget constraint for a person eligible for Income Support with disability premium (ISdp) shown by the white portions on the income bars and DLA shown by the black portions. Earnings, net of income tax and National Insurance are shown by the dark grey portions. The person receives no DPTC and has no housing costs.

Figure 3. Net income for a single person aged 28 who is eligible for Income Support with Disability Premium (no DPTC or housing costs).



The graph illustrates the poverty trap caused by means-testing. As the person works additional hours from 4 to 15 hours they experience a MTR of 100%. That is, for every pound they earn over £15 per week they lose a pound in Income Support. This is caused by the Income Support earnings disregard limit.

This example also clearly demonstrates the unemployment trap. As the person moves into work for 16 hours per week or more they lose their entitlement for Income Support. Figure 3 shows clearly that this person would be worse off financially if they got a job working for 16 to 20 hours. Table 5 shows that the person would be worse off by £15.70 by taking a job for 16 hours per week than they would had they remained out of work. Figure 12 shows that the average RR is over 84%.

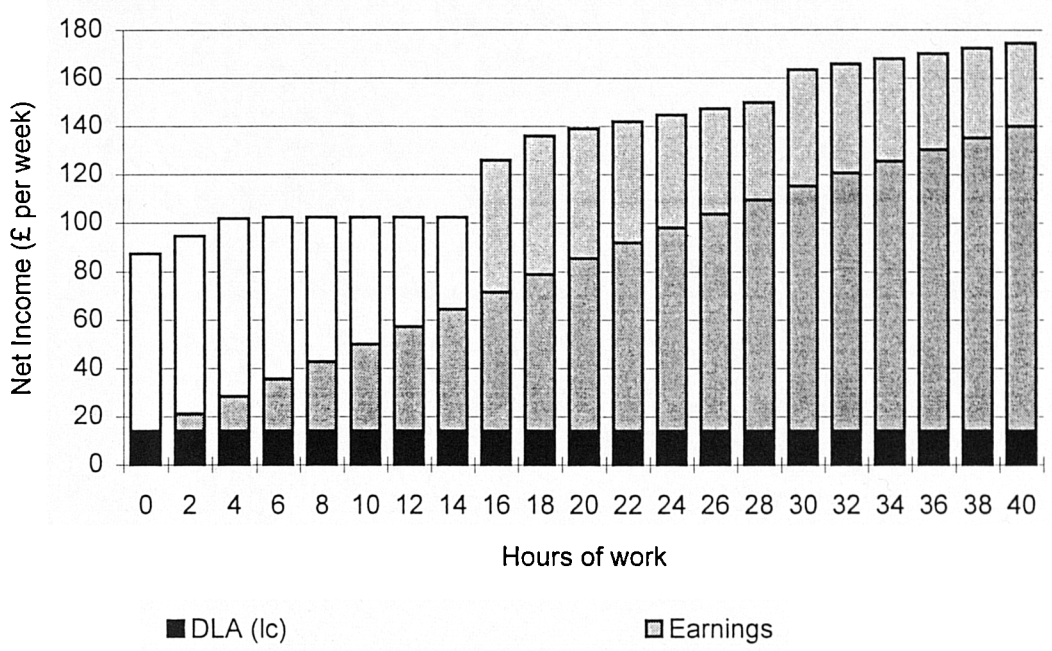
The person would experience a low MTR of 33%, calculated in Table 3, experienced by many in the lowest tax band.

Case B. The effect of Disabled Persons Tax Credit

Now consider the effect when a person makes a successful claim for Disabled Persons Tax Credit, as shown by the light grey portions of the income bars in Figure 4. To be eligible for DPTC a person must have an illness or disability which puts them at a disadvantage in getting a job, be working 16 hours a week or more in a paid job, and either be currently receiving Disability Living Allowance (DLA) or have been formerly in receipt of a qualifying disability benefit for a certain length of time (CPAG, 1999; DSS, 1999).

DPTC supplements in work income over 16 hours. This alleviates the worst affects of the unemployment trap, meaning this person would always be better off in work (see Table 5). The average RR has reduced to 57%, a similar level of unemployment trap experienced by non-disabled people claiming Job Seekers Allowance (JSA), as shown in Figure 12.

Figure 4. Net income for a single person aged 28 who is eligible for Income Support with Disability Premium and DPTC (no housing costs).

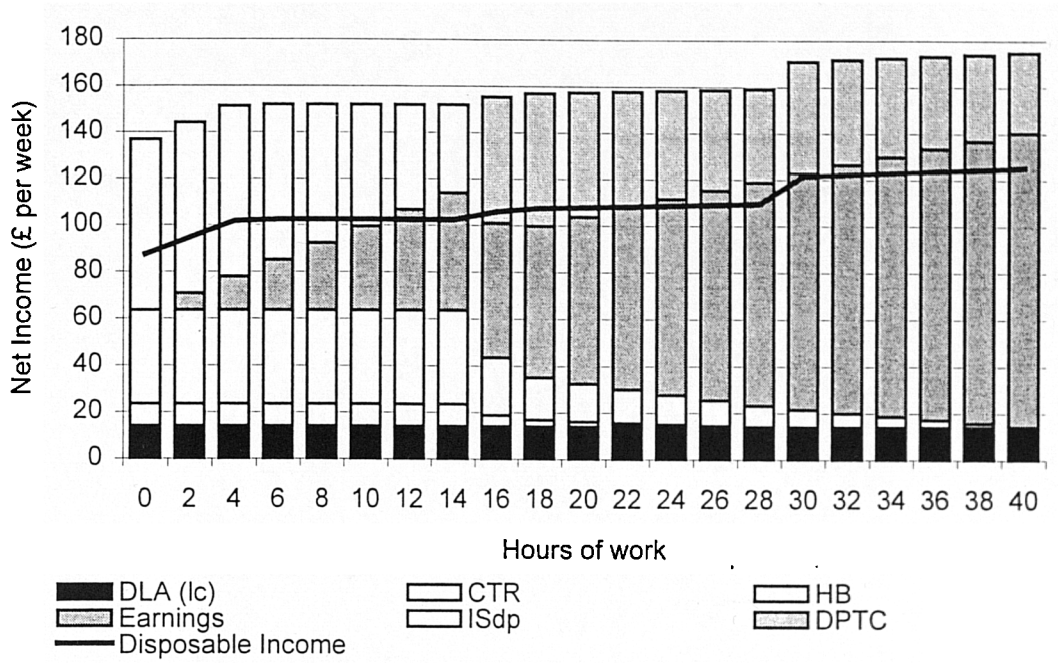


In addressing the unemployment trap, DPTC has the effect of creating a poverty trap, with this person experiencing a 70% tax rate (see MTR calculation in Table 5).

Case C. The effect of housing and council tax benefit

The following examples include the effect of rent and council tax. The effect of Housing Benefit (HB) and Council Tax Benefit (CTB) can be seen in the budget constraint shown in Figure 5. Housing Benefit is reduced as the person comes off Income Support and moves into work at 16 hours, which then tapers as the person's income increases.

Figure 5. Net income for a single person aged 28 who is eligible for Income Support with Disability Premium and DPTC.



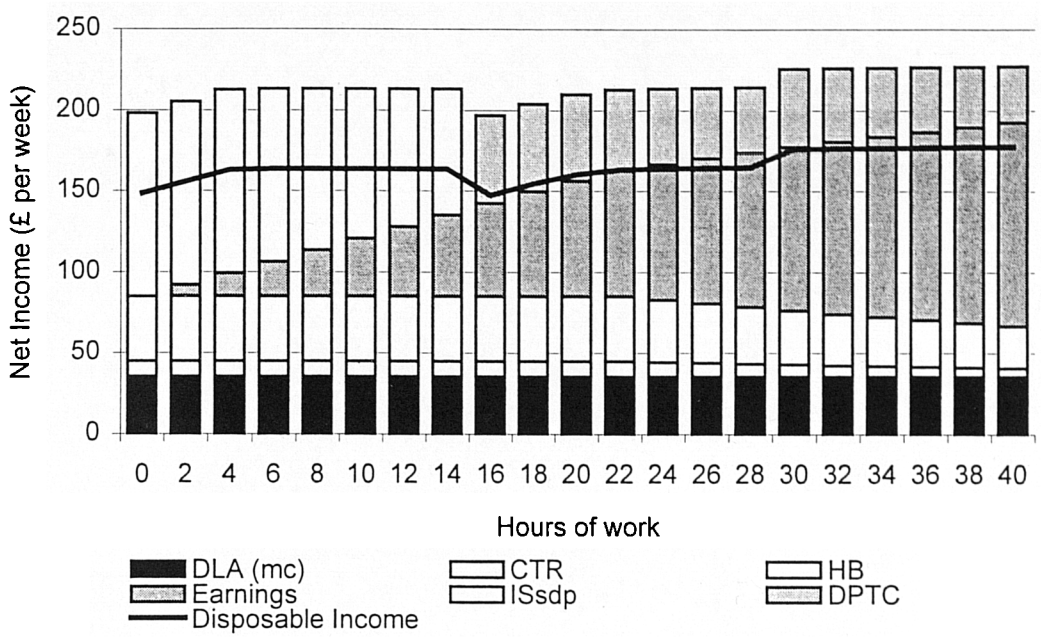
The reduction in Housing Benefit removes the incentive effects of DPTC, creating an unemployment trap. The average RR has increased to 76%. Table 5 shows that the person is only £21 better off working 24 hours per week. Moreover, if this person wished to move from therapeutic work earning £15 per week, say in a sheltered workshop or training scheme, they would experience an even greater unemployment trap, with the RR increasing to over 89% (see Case C1, Figure 12). With the new permitted work rules this will increase to £20 per week.

The poverty trap continues to exist, shown graphically by the flattened budget constraint in Figure 3. Table 5 shows that with disposable income of £108.70 at 24 hours and £119.95 at 40 hours, the person will receive just £11.25 extra for an additional 20 hours work. The MTR is high due to the combined effect of the DPTC taper at 55% and the Housing Benefit taper at 65%. For a disabled standard rate taxpayer this creates an effective tax rate of 90%, calculated in Table 3, a punitive tax rate.

Case D. The effect of severity of illness

Now consider the situation for a more severely disabled person. Figure 6 shows the budget constraint when the person is now eligible for Income Support with disability and severe disability premiums (ISdp + sdp) worth an extra £39.75 per week and middle rate care of DLA, worth £35.40 per week.

Figure 6. Net income for a single person aged 28 who is eligible for Income Support with Severe Disability Premium



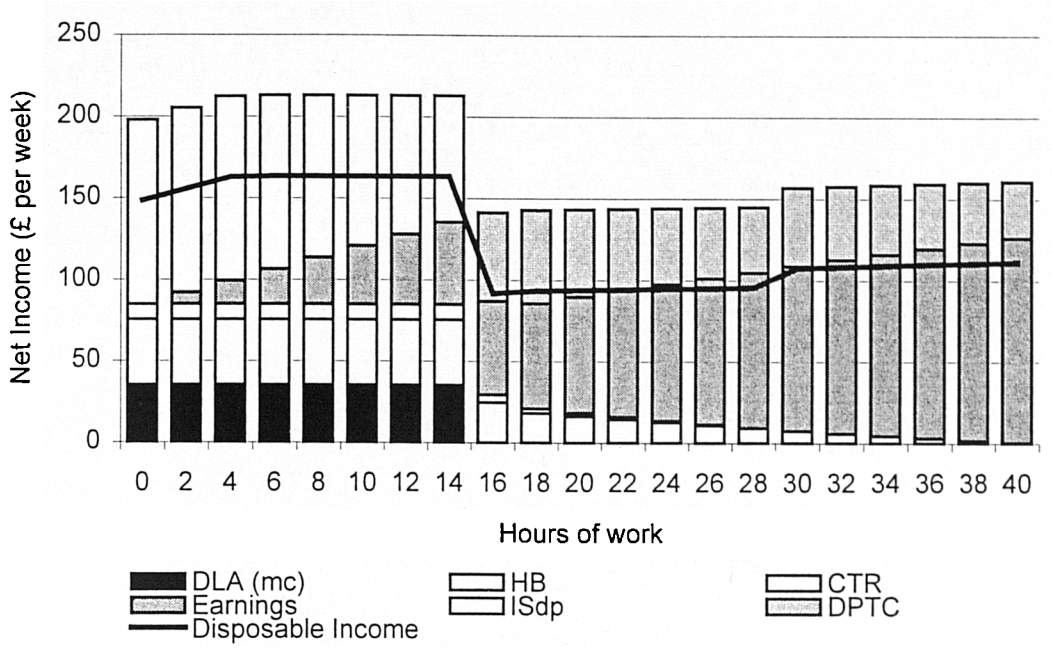
The unemployment trap can be seen clearly in Figure 6, where a sharp fall in net income occurs when the person moves into work at 16 per week. Table 5 shows that the person is worse off by £1.15 when working 16 hours per week and better off by £15.39 when working 24 hours per week. The average RR for this person is almost 90%, a much higher unemployment trap than for the previous examples.

Case E. The effect of a review of eligibility

When a person begins to work over 16 hours and starts a claim for in-work benefits, their Income Support is stopped. This may trigger a review of their eligibility for DLA (Davis and Betteridge, 1997). Indeed, a review may occur if the person does any work, as this may suggest that the person has less need for benefits. For the person in Case D, this may mean the loss of eligibility for the severe disability premium and DLA.

Figure 7 shows that the person would never be financially better off moving into work. Table 5 shows that the person is worse off by £56.61 when working 16 hours and by £37.15 when working 40 hours. The average RR is nearly 150%.

Figure 7. Net income for a single person aged 28 who is eligible for Income Support with Severe Disability Premium, reduced to Disability Premium and a loss of DLA after review



The MTR remains as high as in Case B. Not only will this person lose income by returning to work, they will not be able to work themselves out of their low income by taking on more work. The combination of unemployment and poverty traps is likely to discourage paid work.

Table 3. UK MTR Calculations

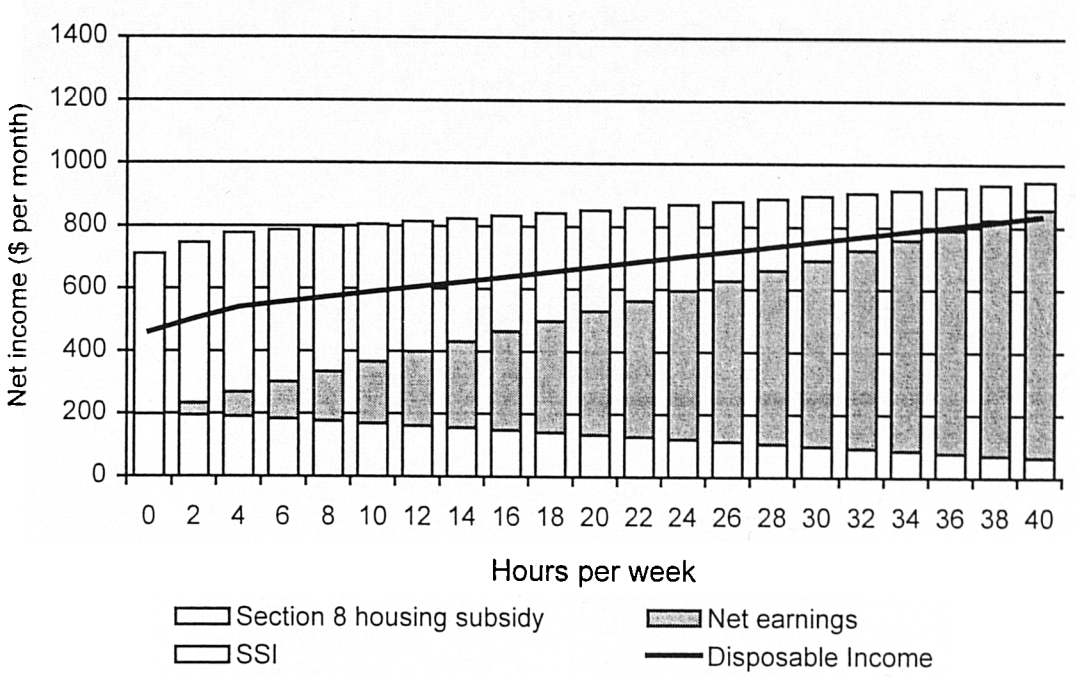
	Case A No DPTC	*Case B DPTC*	*Case C HB & CTB*
Gross earnings increase by	£1	£1	£1
Income tax rises by	23p	23p	23p
National Insurance Contributions rise by	10p	10p	10p
After tax earnings rise by	67p	67p	67p
DPTC falls by 55% of 67p =	-	37p	37p
HB falls by 65% of the remaining 30p =	-	-	20p
Income rises by	67p	30p	10p
Marginal Tax Rate	33%	70%	90%

US case studies

Case F. Supplemental Security Income

Figure 8 shows the budget constraint for a person eligible for Supplemental Security Income (SSI) shown by the white portions on the income bars. The dark grey portions show earnings net of income tax and the dotted portions show rent subsidy.

Figure 8. Net income for a single person who is eligible for Supplemental Security Income (SSI) and Section 8 rent subsidy.



The graph illustrates the absence of an unemployment trap, i.e. the person is always better off in work. Figure 12 shows that the average RR is 63%, lower than any of the comparable UK examples that include housing benefit. Figure 12 also shows that Case F1, which was calculated without rent, has an average RR of 58.7%. This is comparable to Case B, the UK example without Housing Benefit.

The earnings limit used to be $700 per month, above which SSI payments stopped. However, Section 1619(a) allows a person to earn over $700 per month and still receive SSI payments. In this example the person could work up to 36 hours before this rule becomes effective.

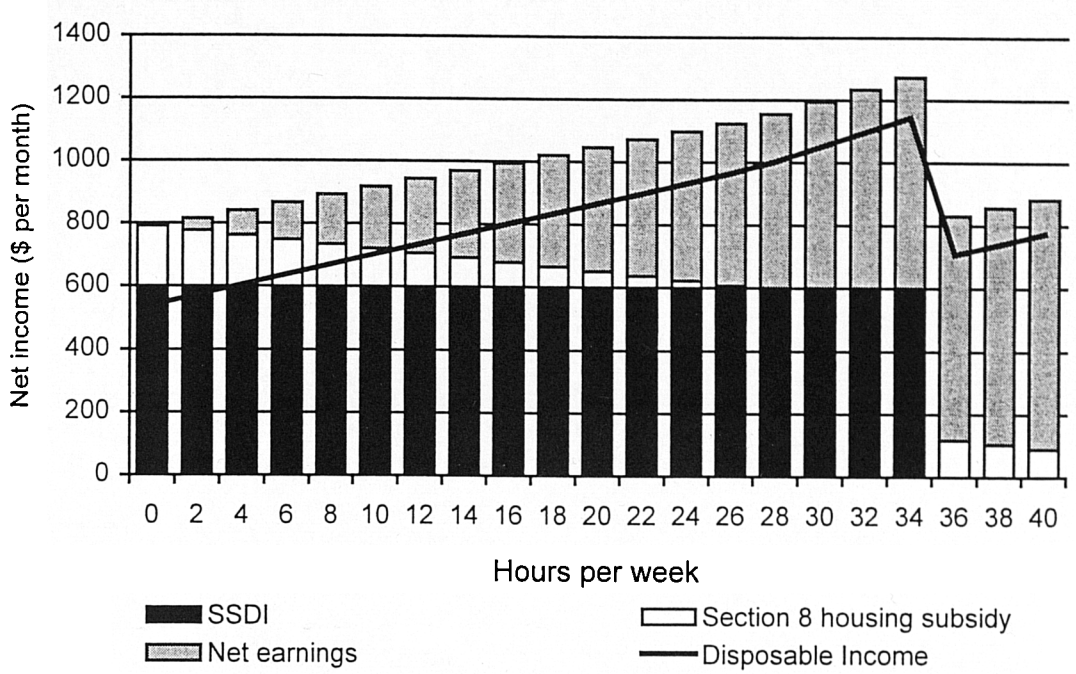
However, there is a poverty trap (Table 4 shows a MTR of 70%) as SSI payments are reduced by $1 for every $2 earned, i.e. a 50% taper, and rent subsidy has a continuous taper of 30%, though ameliorated by a $400 per month (£65 per week) disregard.

Case G. Social Security Disability Insurance

Figure 9 shows the budget constraint for a person eligible for Social Security Disability Insurance (SSDI) shown by the black portions on the income bars. SSDI is for people who have worked and paid Social Security taxes. The amount of SSDI depends upon the amount

paid into the Social Security trust fund through payroll taxes. As this person receives more than $512 in SSDI they are not eligible for SSI.

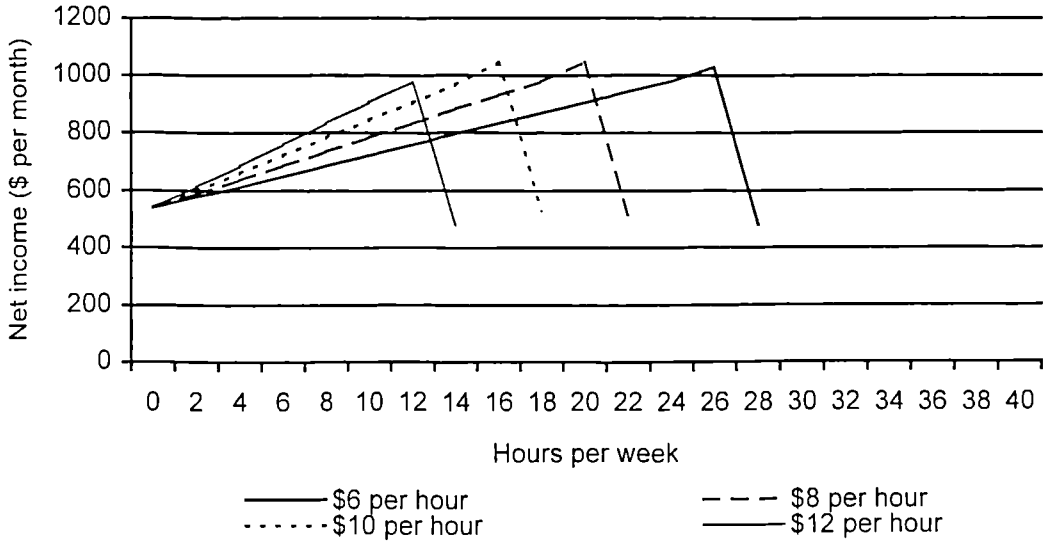
Figure 9. Net income for a single person who is eligible for Social Security Disability Insurance (SSDI of $600/month) and Section 8 rent subsidy



The graph shows that this person faces neither the unemployment trap (Figure 12 shows that the average RR is 57%) nor the poverty trap (Table 4 shows the MTR is 40%). The person is better off in work and will see increased income from extra working hours.

However, there is a sharp cut-off point caused by the loss of all SSDI payments when the person earns more than $700 per month. Figure 10 shows how net disposable income changes with the hourly rate of pay. The more highly paid, the sooner the cut-off point, e.g. a person earning $10 per hour could only work for 16 hours a week before they lost their entitlement. A further disincentive is the loss of Medicare eligibility. The combined effect is to trap those on SSDI in low paid jobs.

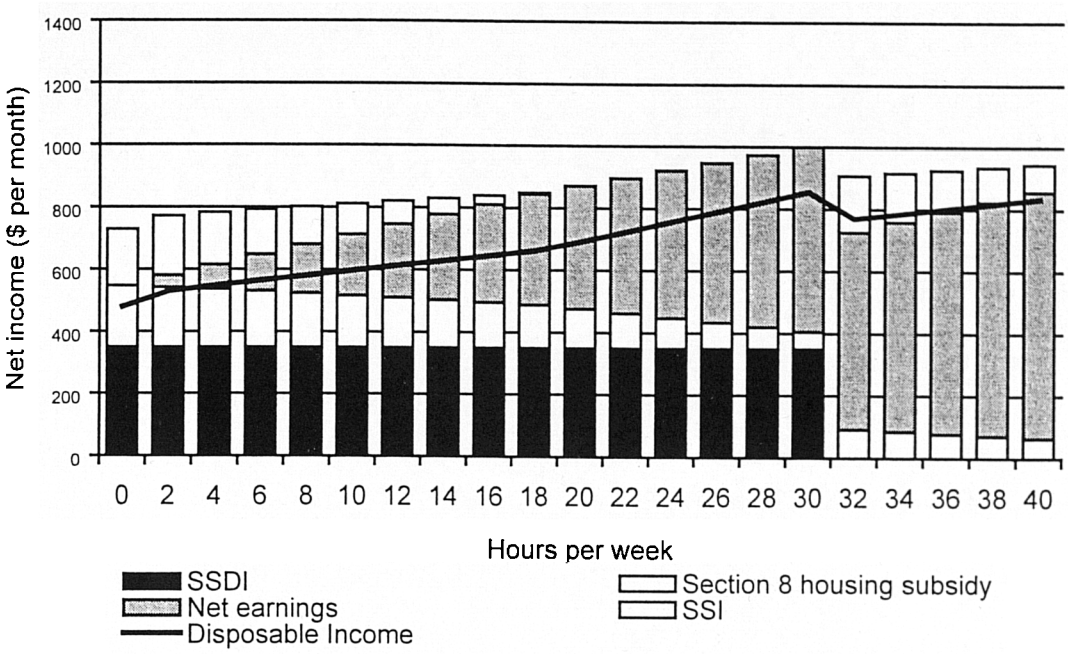
Figure 10. Comparing net disposable income and hourly rate of pay for an SSDI beneficiary with initial entitlement of $600/month and paying rent of $250/month



Case H. Social Security Disability Insurance and Supplementary Security Income

Figure 11 shows the budget constraint for a person eligible for Social Security Disability Insurance (SSDI) shown by the black portions on the income bars, plus Supplemental Security Income (SSI) shown by the white portions. This situation would arise if the person had earned some social security credits but SSDI payments were below the $512 per month threshold for SSI eligibility.

Figure 11. Net income for a single person who is eligible for SSDI ($350/month), SSI and Section 8 rent subsidy



This graph shows a similarly low unemployment trap to Case F (RR is 63%), The poverty trap is the same as Case F until the person is no longer eligible for SSI. From 16 hours per week the person has a similarly low MTR as case G. Table 5 shows that earnings are greater than case F from 16 hours and over.

Table 4. US MTR calculations

	Case F	*Case G*	*Case H*
Gross earnings increase by	$1	$1	$1
Income tax rises by	15c	15c	15c
After tax earnings rise by	85c	85c	85c
SSI falls by 50% of 85c =	42.5c	-	42.5*
Rent subsidy falls by 30% of the remainder =	12.75c	25.5	12.75
Income rises by	29.75c	59.5	29.75
Marginal Tax Rate	70%	40%	70%

* Only up to 16 hours then MTR as case G.

Figure 12. Comparing average Replacement Rates for all benefits for a 28 year old single person working over 16 hours per week[3]

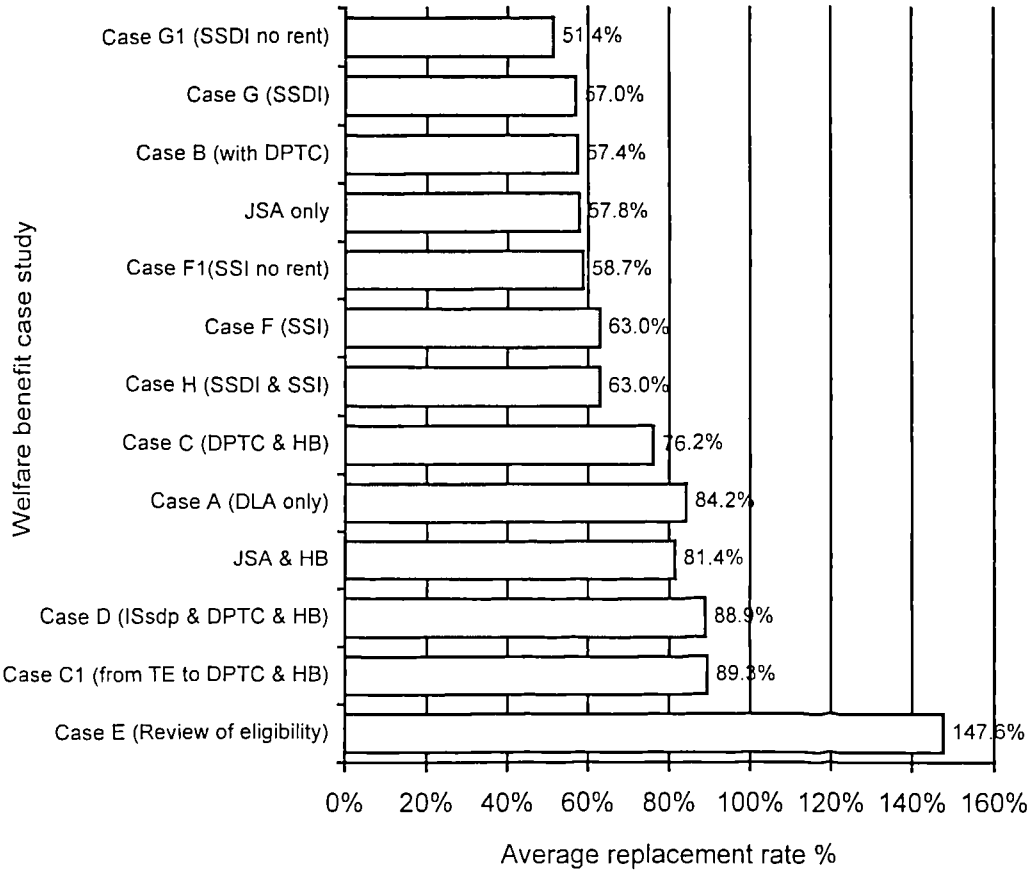


Table 5. Comparison of disposable income for each case study. in (£ per week)

	Hours of work per week					
Case study	*0*	*8*	*16*	*24*	*32*	*40*
Case A	87.35	102.35	71.65	98.11	120.76	140.05
Case B	87.35	102.35	125.95	144.68	165.92	174.60
Case C	87.35	102.35	105.89	108.70	122.31	125.35
Case D	148.45	163.45	147.30	163.84	176.42	177.72
Case E	148.45	163.45	91.84	94.65	108.26	111.30
Case F	69.27	86.20	96.02	105.84	115.66	125.48
Case G	81.17	100.81	120.45	140.08	-	-
Case H	71.97	87.26	97.07	113.78	-	-
JSA & HB	51.40	56.40	56.58	60.55	64.54	76.53

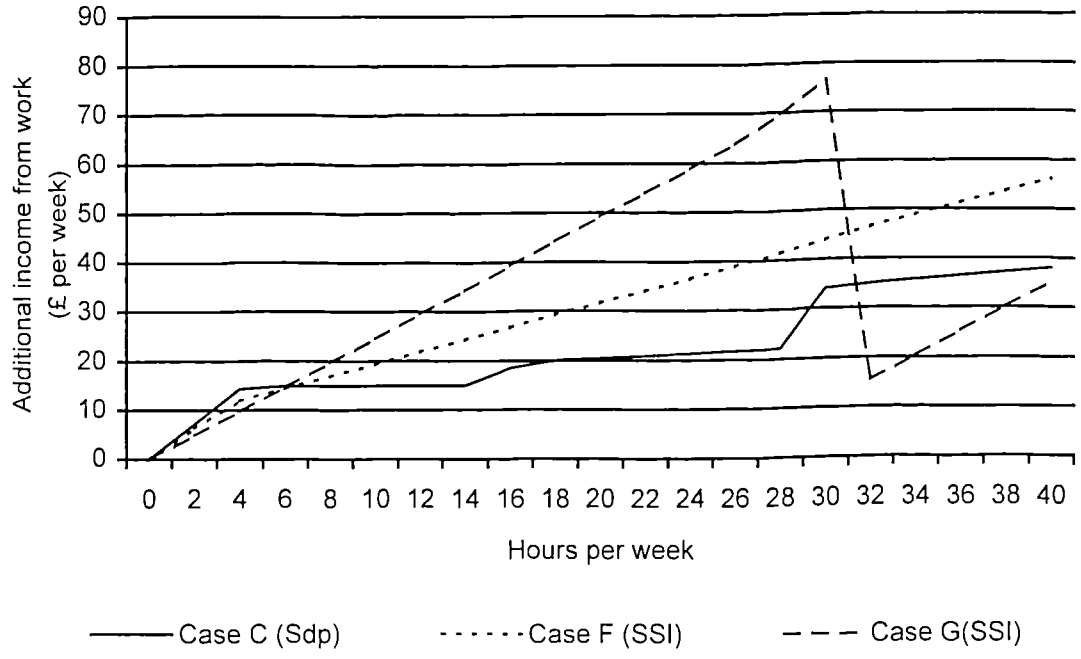
[3] Average RRs calculated from 16 hours per week to 40 hours per week except for SSDI, which were calculated up to 34 hours per week to avoid the effect of the benefit cut-off point.

A comparative analysis of UK and US social security systems

The data presented here demonstrates two key points. Firstly, people with mental health problems face greater financial barriers to work than unemployed people on Job Seekers Allowance. Mental health service users in the UK are right to cite the benefits system as their main barrier to work.

Secondly, financial barriers to work for people with mental health problems are greater in the UK than in the US. Figure 13 shows a much steeper income gradient for US examples, suggesting stronger work incentives. For example, the maximum income difference in the UK is approximately £35 (Case C), rising to £80 for someone on SSDI (Case G). Why does the US system appear to create better financial incentives? The following sections examine the factors that create these disincentives for mental health service users in the UK.

Figure 13. Comparing additional income from work for UK and US examples

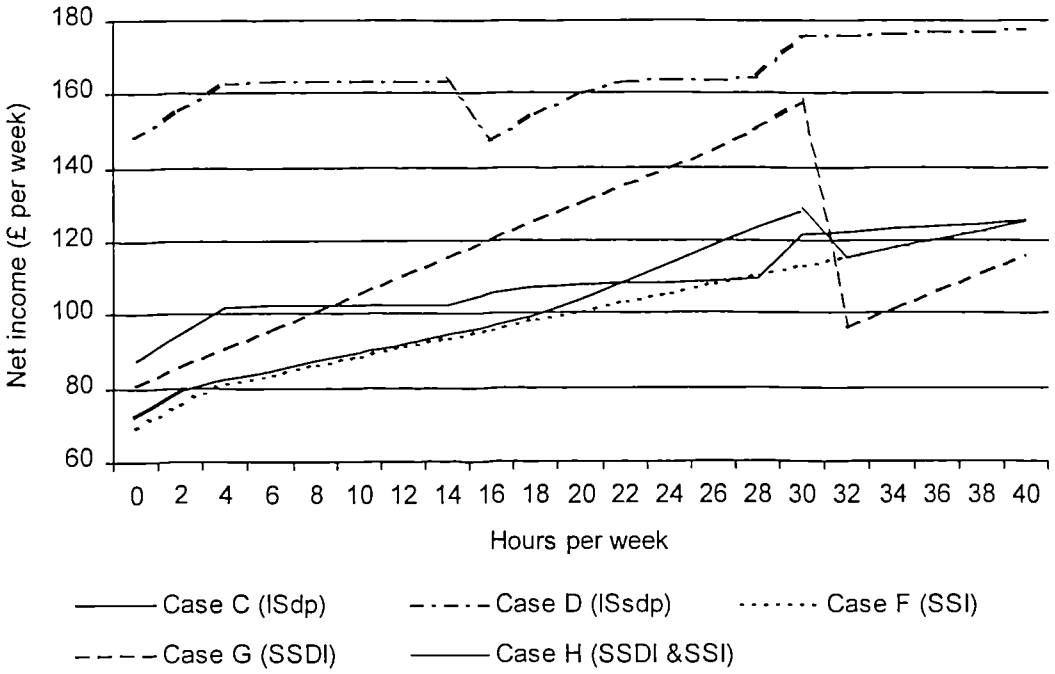


Out of work income

Higher out of work benefit levels contribute to a higher unemployment trap. Figure 14 provides a direct comparison of net disposable incomes between US and UK examples (in UK sterling). This graph shows that the UK examples have higher incomes when out of work (the figures are in Table 5). Here, we discover a fundamental problem for people with disabilities in the UK who wish to work. The more severely disabled the person, the higher the benefit, and therefore the lower the financial incentive to work.

This does not affect people in the US. The US benefit levels maintains those people who do not work in higher levels of poverty than counterparts in the UK, and effectively coerces those people who can work to do so in order to achieve a barely decent income. However, it should be noted that the US system has further benefits not covered by this analysis such as food stamps and help with utility bills.

Figure 14. Comparing net disposable income in UK and US for a single person with equivalent hourly rate of pay and rent



Reducing out of work income to encourage work in the UK would be misguided. Even the highest out of work income of £197.92 (including housing and council tax benefits in Case D) was only 56% of national average earnings in April 2000 (ONS, 2001). Chapter One clearly demonstrated that most people with mental health problems live on very low incomes and many have debts. Moreover, Oppenheim (1999) found that those with a cushion of income to rely on are *more* likely to take risks of going into paid work.

Hours of work

The number of hours of work has an effect on financial disincentives. In the UK the unemployment trap reduces with moves into work with more hours. Taking Case C as an example, the RR is 81% at 20 hours and 72% at 30 hours. Most of this effect is created by the additional £11.05 in DPTC a person receives when they work for 30 hours or more. This supplement is too crude and arbitrary to act as a sufficient incentive to encourage full-time work.

The supplement also works counter to current labour market trends which have seen a shift to part-time work (HM Treasury, 1997; Albeson, 1997; Brown, 1994) and militates against working part-time, the choice of many disabled people (Barnes *et al.*, 1998; Bass *et al.*, 1996; Berthoud, 1998; Beyer *et al.*, 1996).

The situation in the US is much better for those working part-time. In particular Case G demonstrates clearly why most people with mental health problems in the US work part-time in the US (Clark and Bond, 1996; Clark *et al.*, 1998). For those on SSDI, there is a window of work opportunities from 16-26 hours per week for those on relatively low wages.

Earnings disregard

The earnings disregard is an important feature of financial disincentives. In theory, the disregard allows people to earn money without affecting benefit levels. In the UK, the Income Support earnings disregard creates an arbitrarily imposed poverty trap for those working less than 16 hours per week, it caps their work income at £20. This amount has increased recently from £15 when these calculations were made, though this has a minimal impact on the results. In the US, the situation for SSI recipients is slightly better. The disregard is of a similar value at $85 per month (about £13 per week). However, SSI recipients can continue to claim SSI though lose 50 cents for every dollar earned. The situation for SSDI beneficiaries is better. The $700 per month upper limit on earnings operates in effect like a much more generous earnings disregard.

The evidence from the US supports this. Jacobs *et al.* (1992) found, in a study of 89 participants in a job finding club, that those receiving SSDI were more likely to obtain a job than those on SSI. However, people on SSI also had poorer employment histories, higher number of hospitalisations and were younger. These were the factors that Chapter Four described as reducing the chances of work. But one must also consider the types of jobs people with mental health problems get. Employers who recruit into entry-level jobs are often not looking for skilled and experienced staff. So perhaps employment outcomes are more a function of social security than individual characteristics that are undesirable in the labour market. It is clear that the relationship between work history, social security and employment outcomes requires further research.

The earnings disregard traps in low income many people with mental health problems who work. For example, in the UK a recent study found 86% of people with mental health problems working for less than 16 hours, and 72% earning £15 per week or less (AfSE, 2000). Similar results were found in a national survey of supported employment (Beyer *et al.*,

1996). Similarly, in the US most employed mental health service users are in low paid jobs. These low wages may then relate more to the benefits system, caused by the earnings disregard, than the job or person's productivity (Simons, 1998). Moreover, any significant amount of work can raise the question of the persons continued eligibility for disability benefits.

In the UK, the £20 per week disregard has only recently been increased from £15. This is the first increase since 1988, though this still lags behind inflation and is less than the £24.50 it would have been worth in 1996 (Hansard, 18.12.96, cols. 887 and 888). Increasing this to 2001 levels, or to the therapeutic earnings limit, currently £66 per week, recommended by Davis and Betteridge (1997), would allow many people with mental health problems to work part time (up to 16 hours on the minimum wage) without fear of loss of any benefit.

In the US, Warner (2001) reported that the increase in the SSDI disregard from $500 per month to $700 coincided with an increase in employment of SSDI beneficiaries. Such a change in the UK, at minimal expense to the government, would significantly improve work incentives, increase employment opportunities and income, and impact positively on quality of life. However, this measure alone would further increase the unemployment trap for people wishing to work over 16 hours. This problem is illustrated by Case G for those wishing to work for higher rates of pay.

In-work tax credits

Rather than continued eligibility for out of work benefits in the US system, the UK has a separate system of in-work tax credit, DPTC. The DPTC does little to alleviate disincentives to work, paying an additional £2.64 per week on average for Case C. The more generous effects of DPTC seen in Case B, which pay an additional £12.41 per week on average, are offset by the loss of £9.77 per week on average in housing and council tax benefits.

Moreover, DPTC does not solve the problem faced by people with more severe impairments. Whereas out-of-work benefits increase with severity of impairment, in work benefits are paid regardless of severity. This results in greater disincentives for more severely disabled people. Figure 12 shows that the RR for case D is 13% more than for case C.

Housing costs

The unemployment and poverty traps are increased for those with housing costs. The effect of housing benefit on a person's income in the UK can be seen by comparing Figure 4 and Figure 5. This shows clearly that the effect of losing housing benefit, at a rate of 65%, almost negates the effect of DPTC. The lower taper of the US rent subsidy at 30%, together with

the more generous $400 per month disregard (£65 per week compared to £25 in the UK), reduces the effect of poverty trap. For example, Figure 12 shows a smaller effect of housing costs on the unemployment trap in Case F - the RR is just 4% less for those without housing costs.

Housing costs have an important impact on a person's decision to work. Much has been written recently about the effect of Housing Benefit on work incentives (Ford and Kempson, 1996; Giles *et al.*, 1996; Griffiths, 1995; Joseph Rowntree Foundation, 1994; Kemp, 1998;). Giles *et al.* (1996: 95) found, in a study of the social rented sector, that people had little chance of escaping means-tested housing benefit, even in full-time work earning £6 per hour. Moreover, that this wage level would be out of reach of most long-term unemployed, particularly people with disabilities.

This situation is a result of the desire for better targeting, which has seen a shift over the last 10 years from 'bricks and mortar' subsidies to rent support (Joseph Rowntree Foundation, 1994). Between 1989 and 1994 average local authority rents in England increased by 73% (Ford and Kempson, 1996). This move towards market rents has created a form of dependency on a scale not found in neighbouring European countries (Joseph Rowntree Foundation, 1994). There have been recent calls for a return to subsidised rents (Albeson, 1997; Giles *et al.*, 1996; Simons, 1998), but other options include a housing tax credit and a simplification of the rules (Kemp, 1998).

In reality very few people have no housing costs and good quality housing and supported housing is essential for people with mental health problems to manage their lives in the community (Audit Commission, 1994). However, accommodation costs and supported care charges are too high to be covered by low and average incomes from work (Simons, 1998). The current review of Housing Benefit (Social Security Committee, 1999) must take into account the needs of people with mental health problems. Reform must tackle work disincentives whilst promoting decent accommodation and security of tenure, which are perhaps the most important concerns (Hatfield *et al.*, 1992).

Additional costs of working

The unemployment traps shown by the average RRs in Figure 12 exclude the additional costs of working. Bass *et al.* (1996) found, in a study of supported employees with learning disabilities, that work expenses varied from a modest £2 per week to £10. Work expenses were found to include travel costs, extra clothing, meals and drinks, social events, charity collections and lottery syndicates. For the examples explored here the costs of working can

create significant disincentives, where differences between in and out of work income could be as little as £5 per week for the UK examples.

In a study of the disincentive effects of the benefits system, NACAB (Albeson, 1997, p. 61-63) identified further additional costs of childcare, the gap before payday, and one-off expenses. These costs very much depend on individual circumstances and can be met through a web of government initiatives, so long as the person is aware of them, is eligible and claims within time limits, using the right forms and answering the questions sufficiently. There are similar incentives available through the US social security system (Malloy, 2000).

Clark (1994) found that people with mental health problems often receive a substantial amount of informal help from family and friends, such as gifts, loans, food, etc, even when they receive welfare benefits. These additional benefits may be withdrawn if the individual is earning a wage.

Healthcare costs

People in the UK moving into work who do not claim DPTC will lose help with costs such as prescription charges, eye tests, and school meals for children. At £6.20 per item, the loss of free prescriptions alone could make a person worse off in work.

The US examples described here do not included the effect of health care costs. The two state insurance systems – Medicaid for SSI recipients and Medicare for SSDI beneficiaries – provide the main disincentive factors in the US system. Health care costs for people with severe mental health problems in the US can be very high (Clark *et al.*, 1998), while most jobs gained by mental health service users are low paid, 'entry level' jobs usually without the necessary insurance scheme. Therefore, anyone considering employment must make sure that they stay within the eligibility for state medical insurance.

This is perhaps the major disincentive for people with mental health problems in the US. It effectively traps people who wish to work in low-paid, part-time work. This is in stark contrast to the UK, where the system promotes moves into more highly paid, full-time work, often out of reach of many people with mental health problems.

Ability to work

The current system of disability benefits in the UK hinges around the notion of 'incapacity', which fails to take into account the wider social context, such as availability of jobs and in-work support (Simons, 1998), and which does not recognise fluctuating or partial capacity for work. People with mental health problems are classed as either 'incapable of any work' to be

eligible for disability benefits, or being judged as 'fit for work' and receive Job Seekers Allowance.

The fact that many who are classed as incapable of work do so, for example those in sheltered workshops or those who have found paid work demonstrate that this is not the case. Indeed, the Government allows disabled people to do a certain amount of 'permitted work'.

Summary

There are two key features of social security systems that promote or hinder a return to work for mental health service users. Firstly, the ability to maintain sufficient income whilst in work. No one really wants to be worse off. Secondly, the ability to try out work without risk of losing eligibility for hard won social security payments. Table 6 relates these two issues to the experience of mental health service users in the UK and US. It is clear from this table why more people in the US tend to be in employment when the right kind of support is available.

Table 6. Key elements of US and UK social security systems that promote a return to employment

	UK (Case C)	*US (Case G)*
Additional disposable income at 24 hours per week work at minimum wage levels	£21.35	£58.91
Level of risk free earnings	£20 per week	£104 per week
Continued eligibility whilst in work over 16 hours?	No. But a linking rule enables a return to previous benefit levels.	Yes. No break in claim.

Conclusion

The decision to work is a complex one. The economic model of decision-making does not always prevail, as other social and attitudinal factors play a crucial role. A study of welfare and work in this country by Janet Ford and Elaine Kempson (1996) found that 25% of people were working for less money than they were eligible to receive in benefits. A NACAB study about welfare and work (Albeson, 1997) found a similar situation. Financial factors were not central to the decision-making of those people. However, the decision to work and not be much better off is one largely taken by people in ignorance of the financial consequences (Albeson, 1997; Millar *et al.* 1997).

People work for personal fulfilment, sense of esteem, social integration and structure to daily lives (Albeson, 1997; Atkinson, 1993; Ford and Kempson, 1996). When asked why they

want to work, these are the main reasons given by people with mental health problems, rather than financial motives. However, the wealth of evidence suggests that poverty causes poor health (Cobb, 1993; Grant, 1995), that low pay increases working poverty (Millar *et al.*, 1997), and that people with disabilities, including people with mental health problems, who gain employment do so on very low pay (Barnes, 1998; Beyer *et al.*, 1996). This chapter demonstrates clearly the disincentive effects created by the welfare benefits system, to trap disabled people in unemployment and trap them in poverty. It appears that there are few circumstances that make a move into paid work viable. Financial disincentives must be reduced, otherwise people with mental health problems will continue to be one of the most marginalised groups in society.

There are lessons to be learned from US, in particular the more generous disregards and continued eligibility encourage work. But there are many serious problems with the system that would be foolhardy to import, not least the poverty level out of work incomes and the disastrous consequences on incentives of the health insurance system. Changes to the benefits system maybe a necessary condition to improve employment outcomes, but it is not sufficient. Variations in employment rates amongst people using mental health services between US states seems to show that where vocation outcomes are a priority people get jobs. Chapter Four demonstrated that the model type is not as important as the focus on open employment: supported employment, clubhouse and diversified placement approaches all have their successes.

Whereas social security may trap people in part-time work in the US, it traps people in sheltered work or no work in the UK. This chapter has argued that the combination of the provision of supported employment and the ability to earn a reasonable wage without loss, or fear of loss, of welfare benefits are the necessary and sufficient conditions that promote high levels of employment among mental health service users.

CHAPTER FIVE

Research Methods

Introduction

The purpose of this chapter is to introduce the study aims and design, describe the research questions, explain why certain methods were chosen, how they were applied in the context of this study, and the framework for the subsequent analysis.

Section One: Study aims, hypothesis and research questions

The purpose of the study was to examine the barriers to social inclusion for people with mental health problems. To do so the research was designed to explore the relationships between mental health, unemployment and social exclusion. The aims of the study were to:

- Describe how people with mental health problems and long-term unemployment people live with unemployment;
- Highlight the similarities in the problems of social exclusion faced by these two groups; and
- Discover the needs for work, leisure and social activities for these two groups.

The hypothesis for this study, developed from an initial qualitative enquiry, is that no significant difference will be found in labour market attachment and mental health status between the two study groups. The study will explore whether the desire to work is more a function of social exclusion than mental health status. This will suggest that the desire to work is more a function of other factors than mental health status such as social exclusion, which when analysed will point towards a re-examination of the policies designed to help people find work

Following from the government's policy to promote 'work for those that can... ' (DSS, 1998a: 1) two key areas will be explored in more depth: specialist employment support and the welfare benefits system. Firstly, the need for supported employment for mental health service users will be identified and compared to current resource allocation.

- What percentage of people using mental health services want employment? i.e. have a strong labour market attachment.

- Are there any significant differences in labour market attachment between the two study groups?

Secondly, the access to resources to help people find work may well relate to factors such as income, social networks, health status, life satisfaction and empowerment rather than the main criteria – the welfare benefits people claim.

- What characteristics are associated with strong and weak labour market attachment?
- What is the extent of the financial disincentives to work for people with mental health problems created by the welfare benefits system provide added?

The government also promises '... security for those who can't [work]' (DSS, 1998a: 1), but offers no alternative. The study takes its cue from standard one of the National Service Framework which aims to promote social inclusion. Accordingly, ways of promoting inclusion that do not involve the formal labour market are explored. The study takes as its starting point the ways in which people use their time and how they would like to use their time to point towards inclusive opportunities. These opportunities should be based within communities and optimise therapeutic value and empowerment to the individual within acceptable limits of costs to the state.

- How do people using mental health services use their time? What range of activities do people engage in? How structured are these? How satisfied are people with what they do? Are there any significant differences in participation in community activities between the two study groups?
- What are the characteristics of people who are active and inactive?
- What would people like to do? What prevents them from doing this? Are these barriers related to personal circumstances or external factors?
- With whom do people spend their time? Is there a relationship between activity levels and social network?
- How do people interact with others in the community environments in which they live? e.g. day centres, job clubs, cafes, etc. What are the similarities and differences between the places used by the two study groups?

Section Two: Research Design

The research for this study was completed in two phases. A preliminary enquiry using qualitative methods was conducted prior to a comparative study using both qualitative and quantitative methods. Figure 15 shows that the data collection for the preliminary study was

completed between March and December 1999 and for the main study between September 1999 and March 2001.

The Preliminary Enquiries
Initial focus group discussions with the two study groups, together with semi-structured interviews with key service providers and a literature review, were used to explore the main issues faced by each of the two study groups. This ensured that the research questions were grounded in the experiences of its participants, that subsequent methods were relevant and appropriate.

The Comparative Study
Following the preliminary enquiry a detailed study was conducted using structured interviews together with qualitative methods to explore the three dimensions of social exclusion described in Chapter One. A triangulation of quantitative methods and qualitative methods was used to provide detailed answers to the research questions. The quantitative methods, in this case a structured questionnaire and time-use diary, ensured the inclusion of a broad number of cases for a more representative sample and enabled direct numerical comparisons between the independent groups of people. Qualitative techniques - focus groups, interviews and participant observation - were used to enhance the validity of the survey findings and ensure that the complexity of the lives of participants was not lost and the resultant interpretative value was gained (Bryman, 1988).

The study areas
The research was conducted in two metropolitan districts of Greater Manchester: Manchester and Tameside. The characteristics of the populations are summarised in Table 7 below. This is followed by a description of services provided for mental health service users and for long-term unemployed people.

Population characteristics
Manchester is a national and regional urban centre with a population of over 430,000 served by Manchester City Council. Tameside is located 10 miles south east of central Manchester with a mixed urban/rural community with some wards having inner city characteristics. The combined area of Tameside and Glossop used in this study has a population of 250,000, delineated by Tameside Metropolitan Borough plus the additional area of Glossop, a rural area located in the Derbyshire High Peak.

Table 7 shows some key indicators for the two study areas. These data show that the areas, and Manchester in particular, suffer high unemployment, high levels of deprivation and poor general health. Unemployment rates were higher than the national average of 3,4% (ONS,

2000b). The Standardised Mortality Ratio (SMR) through all causes for Manchester was the third highest in the Northwest region (average 111). Manchester has the highest mental health needs of all but one other district in England (Manchester Health Authority and Manchester City Council, 1999). In terms of relative deprivation the DETR Indices of Deprivation's Employment Scale (DETR, 2000), which measures the number of people experiencing employment deprivation, places Manchester as 3rd and Tameside as 49th most deprived districts. The Extent Score places Manchester as 4th and Tameside as 102nd most deprived local authority district out of the 354 districts in England.

Table 7. Population profile of two study areas

Indicator	*Manchester*	*Tameside*
Population[4]	431,000	250,000
Unemployment %[5]	4.4 / 8.2	3.6 / 3.0
Standardised Mortality Ratio[6]	129	118
Mental Illness Needs Index (MINI)[7]	119	103.3
Index of Local Deprivation[8]		
Rank of Employment Scale	3	49
Extent Score Rank	4	102

Mental Health Services

In Tameside mental health services are provided by Tameside MBC Social Services Department and Tameside and Glossop Community & Priority Services NHS Trust. A formal interagency agreement exists between these two agencies for single line management of mental health services in three sectors. Associated with each sector are consultant psychiatrists, a Community Mental Health Team (CMHT), a Community Rehabilitation Team (CRT), Wards and Day Services. Among the latter there were two day centres, one psychiatric day hospital and one voluntary sector drop-in. In May 1999 there were 703 people registered on the enhanced CPA and 1466 on standard CPA.

In Manchester the Manchester Mental Health Partnership provides the vast majority of statutory psychiatric services, including wards at three hospital sites, eight community mental

[4] Figure for Manchester from ONS (1999) and for Tameside and Glossop from Primary Care Group statistics (ONS, 1999)

[5] Claimant Count Rate (ONS, 2000) / Unemployment Rate (GMR, 2000)

[6] SMRs for all causes (ONS, 2000)

[7] The Mental Illness Needs Index (MINI) (Glover, 1996) indicates the relative degree of need for mental health care in an area. It is based on a number of socio-economic variables, which have been shown to be predictive of admissions for mental illness. Figures from Manchester Health Authority (199?) and Tameside and Glossop NHS Trust (1999)

[8] DETR, 2000

health teams, three day hospitals, three day centers, two sheltered workshops, one supported employment service and other specialist services. These services are organized into three districts covered by the three Primary Care Trusts. In April 1999 there were 2071 people on registered on the enhanced CPA.

Services for long-term unemployed

The are various services available for unemployed people, including Job Centres, Restart, Work Trial, Job Clubs and Jobplan Workshops (ES, 1998). The latter two are of interest to this study. Job Clubs offer guidance and training in jobsearch, such as telephone and interview skills, CV preparation and advice on where to look for jobs. Additional practical support is available from the Jobclub leaders. Jobplan Workshops are for people aged 25 and over who have been unemployed for more than 12 months. It is a five day programme of individual assessment, job search and confidence building.

Figure 15. Time scale of research project

October 1998	December 1998	March 1999	June 1999	September 1999	December 1999	March 2000	September 2000	December 2000	March 2001	June 2001	September 2001
Literature review											
		Preliminary enquiry into people with mental health problems									
			Preliminary enquiry into long-term unemployed								
			Survey design and piloting								
					Survey of mental health service users in Tameside						
					Survey of long-term unemployed people in Manchester and Tameside						
								Survey of mental health service users in Manchester			
										Data analysis	

Section Three: Qualitative Methods

Focus Groups

Seven focus groups were conducted with a total of 63 mental health service users in Tameside for the preliminary study. A further three focus groups were conducted with a total of 23 mental health service users in Manchester for the main study. Together, these groups were selected to capture the experiences of widest constituency of people with mental health problems within the time and resources available. The perceptions of those working directly with service users were gained through focus groups with a community mental health team and the day services team in Tameside. Additionally, one focus group was conducted with 3 long-term unemployed people. The composition of these groups can be seen in Table 8 below.

Table 8. Details of focus groups

Location	*Date*	*Number of participants*	*Ages*	*Gender M/F*	*Ethnicity*
Mental health service users					
Tameside					
Day centre 1	21.4.99	8	25 – 64	6 / 2	All white
Day centre 2	28.4.99	7	35 – 59	0 /7	All white
Psychiatric day hospital	30.6.99	10	26 – 57	3 / 7	All white
Drop-in	20.4.99	14	21 – 52	8 / 6	All white
User group	10.5.99	9	31 – 47	6 / 3	All white
Ethnic minority service users	29.8.99	3	40 +	1 / 2	All Asian
Hard to engage people	22.6.99	12	19 – 51	9 / 3	11 white + 1 Asian
Manchester					
Focus group 1	29.11.00	8	25 - 62	5 / 3	7 white + 1 black
Focus group 2	30.11.00	7	24 - 58	6 / 1	6 white + 1 black
Focus group 3	1.12.00	8	29 - 59	4 / 4	All white
Mental health staff					
Community mental health team	10.3.99	4	30 – 43	1 / 3	White
Day services team	17.6.99	8	24 – 46	2 / 6	White
Long-term unemployed					
Lower Broughton	7.9.99	3	19 - 45	1 / 2	2 White + 1 Asian

Sampling
A convenience sampling approach was used to recruit participants for the focus groups. Following permission from the respective organisations posters were used to advertise the focus groups. Interested people were asked to put their name on a list held by the staff.

In addition to this, a snowball sampling approach was used to recruit participants who were 'hard to engage'. The snowball was started from informal contacts with users of day services and via the User Development Officer for Tameside, who had a wealth of informal contacts amongst service users. The snowball sample was supplemented by placing an advert in the local paper requesting the views of those who feel they have a mental health problem but avoid formal services. A similar snowballing approach was used to recruit members for the group for members of minority ethnic community. In this case an Asian worker was contracted to recruit members from Tameside's south Asian community.

Though these sampling strategies do not posses the rigour of a random sample, the sample bias only matters if it is ignored (Morgan, 1988). The details in Table 8 ensure this bias is recognised.

Size and composition
The numbers of participants in the groups ranged from 3 to 14. This is within the recommendations in the research literature, (Morgan, 1988; Kitzinger, 1995; Goss and Leinbach, 1996).

The locations of the focus groups were at the places most familiar to that group, as strange setting may have made people feel uncomfortable (Reed and Payton, 1997). Refreshments were provided, which also acted to make a more relaxed and congenial atmosphere (Kitzinger, 1995). In each case a comfortable room was chosen and seating arranged in a circle (Hostick, 1995).

People from the two study groups were interviewed separately and pre-existing groups were chosen, e.g. those who attend the same drop-in, rather than an artificially selected group of strangers. Most nursing research uses groups that have known each other, often for some considerable time (Lankshear, 1993), where it is more important that the participants in the group feel comfortable with each other to contribute effectively.

Heterogeneity was achieved over the spread of groups, with an age, gender and racial mix. However, there was a high degree of homogeneity within each group. The research literature suggests that when groups are too heterogeneous the differences can make a dramatic impact

on the contributions, whereas when they are too homogenous then a diversity of opinions may not be revealed (Gibbs, 1997).

Moderating the groups

Each group lasted for approximately two hours, with a ten-minute break midway through. Key issues from each group were recorded on a flip chart in view of the group during the meeting and in comments books available before and after the meetings. Five focus groups were tape recorded, with consent of the whole group, and transcribed. Field notes were made immediately after each focus group regarding the composition and dynamics of the group.

The two main roles of the moderator are to guide the discussion and ensure that all participants can make an effective contribution by creating a conducive atmosphere (Robinson, 1999). To start the groups the purpose of the group was explained, assurances about confidentiality and anonymity were given, some ground rules suggested, and the topics for discussion were introduced.

Topics

The topics for discussion were developed from an extensive review of literature and designed to permit a detailed exploration of the participants' points of view. The semi-structured format of the groups guided the discussion whilst permitting the maximum elaboration of responses (Garley *et al.*, 1997). The topic guide can be seen in Table 9.

Table 9. Topic guide for preliminary focus groups for people with mental health problems.

About what you do
What range of activities do you take part in regularly? (such as work, hobbies, leisure, etc.)
Why are these important to you?
What activities would you like or prefer to do?
About working
What are your feelings towards work?
What are your past experiences?
Do you expect to work in future? Would you like a job?
What sort of work would you like to do?
About barriers
What stops you doing the things you want to do?
What stops you from finding a job?
What is your experience of the benefits system?
About the help you receive
What help have you received to find work?
What help have you received to take part in other activities? (hobbies, leisure, social, etc.)
What are your views on current day services?
What single thing would make the biggest difference to your life?

Individual Interviews

In-depth interviews with three people from each group were used to explore peoples' experience over time, significant life events and the value they place on their economic and health status. For each study group the three individuals were selected at random from each sampling frame for the structured survey (see quantitative methods below). Contact was made in accordance with the protocol for the survey interviews given below. Two people in the long-term unemployed sample had previously used mental health services in the past.. The data from these two interviews was considered in light of this context.

Although the interviews did not use a schedule of questions there were elements of structure to the interviews. Patton (1987) recommends that good questions in qualitative interviews should be open ended, neutral, sensitive, and clear to the interviewee. With this in mind some core were questions, listed in Table 10, though respondents were encouraged to lead the interview with their own insights into the issues they faced. Indeed, as the interviews proceeded new questions were generated. As recommended by the literature (Britten, 1995) interviews were started with questions the respondent could answer easily, then moved on to more difficult or sensitive topics. Interviews were conducted in a flexible manner to respond to the ways in which the respondents interpreted and answered the questions. In this way detailed information was obtained about their perceptions and reasons behind them

Table 10. Example questions for qualitative interviews

How long have you been out of work?
How did you get to this point?
How do you use your time now?
How has you life changed since leaving work?
What affects has this had on you mental and physical health?
How do you manage on the money you get?
What does the future hold for you?

Ethnographic Fieldwork

The community environments used by the participants were explored using observations in job clubs and day centres. Participant observation was chosen as a method of understanding the meaning ascribed to the roles adopted by, and the nature of interactions between, the members of these 'official' places.

Planning

Planning the participant observation began by clarifying and developing research problems. Hammersley and Atkinson call them 'foreshadowed problems' (1983: 28). In this study the foreshadowed problems related to the environments where people who are out of work are able and/or expected to go and why they go there. The research questions developed from this foreshadowed problem were

- How do people interact with others in the community environments in which they attend?
- What are the similarities and differences between the places used by the two study groups?

Choosing the settings

The range of possible settings for the long-term unemployed group included job centres, job clubs, pubs, cafes, bookmakers, canal banks, in fact any of the fast disappearing local, easily accessible, public amenities. However, as long-term unemployed people are no more readily distinguishable from anyone else Jobclubs were chosen as they are exclusively for unemployed people. For mental health service users day centres and drop-ins were selected.

Sampling strategy

The setting is the context in which the phenomena of the investigation will occur and this may be studied from any number of angles (Hammersley and Atkinson, 1983). Not all features of a setting can be studied, therefore, in this section, the angles of view, or cases, are

selected. The cases identified at the outset included the similarities between the two settings of:

- The relationships between the staff in the day centre and job clubs and their service users and members;
- The relationships between services users in the day centre and members in job clubs;
- The nature of activities in each setting; and
- How day centre users and job club members relate their experience of the setting in the context of employment

However, the selection strategy often changes over the course of fieldwork and the cases chosen for investigation may not matter greatly (Hammersley and Atkinson, 1983). Additionally, it is important to select within cases.

> In ethnography, decisions must be made about where to observe and when, who to talk to and what to ask, as well as about what to record and how. (Hammersley and Atkinson, 1983: 45)

Hammersley and Atkinson (1983) suggest three dimensions, time, people and context, to help make these decisions. Time sampling was used to reveal any patterns of activity that relates to the time of the day and day of the week. The job club settings were only open for limited times during the week. A total of 14 separate observations were completed during August 2000 at three Jobclubs. Observations at day centres were conducted during morning, afternoon and evening sessions on a variety of days during the week

There are severe limitations to this sampling strategy. Observations were not conducted at every time point on every weekday, nor to determine any seasonal variations, and interactions were not possible with every user and staff member in the settings. However, Hammersley and Atkinson (1983) warn against the temptation to try to see, hear and participate in everything that goes on. They suggest a more selective approach will normally result in data of better quality.

In the field

There is no more serious a problem than gaining access since the ethnographer operates in settings where they have little power (Hammersley and Atkinson, 1983). In each setting permission was sought and given from respective managers. Key points that related to fieldwork included:

- Explaining the purpose of the research to participants.

- Varying roles to gain access to different data: as a 'complete observer', spending most time watching and listening; as an 'observer as participant' when interacting with staff and users / members; and as 'participant as observer' when sitting with members and users and doing as they did (Hammersley and Atkinson, 1983: 93).
- Maintaining a more or less marginal position -a simultaneous insider-outsider -as recommended by the literature (Powdermaker, 1966; Loftland, 1971; Everhart, 1977).

> The ethnographer must be intellectually poised between 'familiarity' and 'strangeness', while socially he or she is poised between 'stranger' and 'friend'. (Hammersley and Atkinson, 1983: 92)

- Generating accounts by asking questions directly, termed 'solicited accounts', and by listening to what is said, termed 'unsolicited accounts'. Accounts provided both 'information' and 'perspective' (Hammersley and Atkinson, 1983). The former are can be read for what they tell us about the phenomena to which they refer, while the latter can contribute to theory and aid the assessment of validity.

A common problem faced by the ethnographer is what to record. It is impossible ever to record all the data, yet one cannot rely on memory. The latter is unavoidable, though posses a serious risk of distortion (Hammersley and Atkinson, 1983). Therefore the use of field notes, the traditional means of data recording, was used.

The standard injunction of 'write down what you see and hear' (Hammersley and Atkinson, 1983) was difficult to adhere to. The majority of field notes were fairly general, with very few instances of verbatim dialogue. This was largely due to the difficulty writing field notes in the settings, to have done so would have been quite inappropriate and erode the trust with staff and users / members.

Section Four: Quantitative methods

Survey design

The aim of the survey was to conduct face-to-face interviews with 64 people from each study group using a structured questionnaire. The intended and actual sample from each study area are given in Table 11.

Table 11. Sample size for study groups by area.

Study Group		*Manchester*	*Tameside*	*Total*
People with mental health problems	Target	40	24	64
	Actual	63	9	72
Long-term unemployed	Target	40	24	64
	Actual	42	21	63

Methods of enquiry were standardised as far as possible between the study groups and within the study areas. The measures used were appropriate to both users and non-users of mental health services. Standard questionnaire formats were used to enable comparison with normative data sets and some specific measures were designed for this study.

Inclusion and exclusion criteria

The inclusion criteria for both study groups were that people should be of working age (16 to 60 for women and to 65 for men) and currently unemployed. For the purposes of this study a broad definition of unemployment was used, based on the administrative rules of the Benefits Agency. The long-term unemployed group included all those who had claimed Job Seekers Allowance (or claimed Class I National Insurance contributions) for at least one year. The mental health service user group included all those who were in receipt of state benefits and / or not employed for 16 hours or more.

A further criterion for people with mental health problems was current use of specialist psychiatric services subject to the Care Programme Approach. People were excluded only if their primary diagnosis was not one of a mental illness. Any long-term unemployed person who was currently using, or had used, specialist statutory psychiatric services was excluded.

Study samples

The target sample size for each group was estimated using the SPSS statistical power calculator to yield a statistical power of 80%, on the primary measure, the Work Behaviours and Attitudes Scale[9]. The estimate was also subject to more pragmatic considerations of the reasonable number of interviews possible within the limits of time and cost.

[9] Statistical power is the chance that the study will find an effect when it occurs. A power of 80% is standard and sufficient in a study of this nature. The criterion for significance (alpha) was set at 0.05, which means there will be a 5% chance that the observed result is due to chance. The sample size was calculated to detect the smallest effect size of 0.14 with a confidence level of 95%. The primary measure has a mean score of 2.94 and a standard deviation of 0.4 from its US study (Mowbray *et al.*, 1995). The primary measure was chosen as the main indicator used in the study. The risks of using a US sample for the power calculation were examined in the analysis of the Work Behaviours and Aittitudes Scale data.

The samples were recruited using convenience sampling methods. One effect of this prevalence sampling method is that both groups contain an over-representation of long-term group members. This means the findings and recommendations are most applicable to those with longer-term experiences of mental health problems and unemployment. The following sections describe how the samples were recruited for the two study groups from the two study areas.

Mental health service users

The six community mental health teams in Manchester and Tameside were asked to select at random from their caseload at least 8 people meeting the inclusion criteria. Additionally, the managers of six statutory mental health day services in Manchester were asked to randomly select at least 5 people meeting the inclusion criteria. A total of 72 people using mental health services were interviewed in Manchester and Tameside. Table 12 gives the details of how the sample was recruited.

The convenience sampling method meant that the mental health service users sample was largely selected by care co-ordinators, thus filtering the sample. This is not a systematic sampling error and therefore cannot be corrected in analysis. However, Chapter Six compares the sample with data from representative samples of community mental health team caseloads.

Table 12. The mental health service users sample by service.

Service	*Sample*	*Refusals*	*No contact*	*Interviewed*	*% Included*
Manchester CMHTs	56	13	4	39	70%
Tameside CMHTs	39	18	12	9	23%
Manchester day services	26	0	2	24	92%
Total	121	31	18	72	60%

Long-term unemployed people

A total of 48 interviews were completed with volunteers at seven Jobplan Workshops and 15 with volunteers at six Jobclubs. Table 13 shows the composition of the long-term unemployed sample. Jobplan workshops are mandatory for all JSA claimants over 25 years who have been unemployed for over 12 months. All long-term unemployed aged between 18 and 25 were subject to the New Deal and so could not be included in this study.

Table 13. Breakdown of the long-term unemployed sample in Manchester and Tameside.

Service	*Job Club*	*Jobplan*	*Interviewed*
Tameside	3	16	19
Manchester	12	32	44
Total	15	48	63

The convenience sampling method meant that the long-term unemployed sample was largely self-selected. There may be important differences between people who do and those who do not volunteer, though in almost all cases the whole group at each Jobplan Workshops volunteered, thus reducing those differences.

A much more important and systematic error in the long-term unemployed sample is that Jobplan and Jobclub attendees do not represent the universe of long-term unemployed people. Firstly, they represent JSA claimants only. Excluding the long-term sick and disabled, the two other main groups who face long-term unemployment are lone parents and the partners of the unemployed. Secondly, long-term unemployed JSA claimants are selected by the Employment Service to attend a Jobplan Workshop. This selection is triggered by Job Centre staff after the person has claimed for over one year. Thirdly, interviews with Jobplan leaders found that at least 25% of those invited do not attend. It was suggested that the reasons for non-attendance are illness and informal work.

Research instruments

This section describes the research instruments used together with a rationale for its inclusion in the study. These reasons follow the considerations set out by Switzer *et al.* (1999) in their paper on the selection, development and evaluation of research instruments

Firstly, the instruments relevance to contextual issues was considered. The four main criteria for the selection of each instrument were as follows.

- The instrument must be relevant to the research goals. Data from the instrument should provide the range and depth of data necessary to answer the research questions. For example, whereas a general measure of physical health was sufficient, a more detailed picture of mental health was required.
- The instrument should be appropriate to the populations under study. This includes people of working age, of both genders, and from the range of ethnic backgrounds in Manchester and Tameside. The terms and concepts must be relevant and understandable

to a wide variety of people, including those with low educational achievement and problems with concentration.

- The instrument should enable comparisons to be made with other relevant research. The availability of normative data is important in order to determine representativeness of the sample to the population, for example, to compare the mental health sample to typical community mental health team caseloads.
- The total length of the questionnaire should be acceptable to the potential respondents. Compromises were made where the desire to maximise content, in order to get the most data for the time and cost spent in gaining access to each person, was mitigated by the need to minimise the length of the questionnaire owing to potential problems with concentration and to make its completion more acceptable. Very long instruments were rejected and others shortened

Secondly, psychometric issues were evaluated; namely reliability and validity. The reliability of a measure is its ability to detect the true score rather than measurement error. Considerations in determining reliability include the 'internal-consistency', the reliability commonly assessed with Cronbach's alpha (Cronbach, 1951). It is recommended that research which concerns group comparisons, such as the present study, require reliability coefficients of 0.5 to 0.8 (Nunnally, 1978).

Reliability is required so that the instrument will produce repeatable results for the same subject when used under different conditions. This is termed 'multiple measurement consistency', based on the view that a person's responses should be stable in the short-term, and assessed using methods such as (Bowling, 1997):

- test-retest reliability, which is the level of consistency in a measure when used by the same rater with the subject at two points in time, of about 2 – 4 weeks (Nunnally, 1978);
- spilt-half reliability, which assesses the degree of correlation between two halves of an instrument;
- intra- and inter-rater reliability, which assesses the consistency in a measure by a single rater at different time points, and two different raters at a single time point respectively; and
- parallel form reliability, which refers to the correlation between scores from two instruments developed in parallel and which measure the same attribute.

The other principal requirement of a research instrument is validity. In simple terms this is the extent to which an instrument measures what it was intended to measure. However, it is important to stress that validity is context specific and so the accumulated evidence should be reviewed that supports the meaningfulness of the chosen instrument. General types of validity include (Bowling, 1997):

- Content, or face validity concerns whether the instrument reflects the full breadth of, and are appropriate and relevant to the subject to be measured;
- Criterion, or correlational validity concerns the extent to which the measure is able to produce the same or similar results to a "gold standard" of the intended construct, the validity of which has already been established;
- Construct validity requires that an instrument can be viewed as measuring an underlying construct and tested to see whether its theoretical relationships with other variables can be established; and
- Consensual validity relates to the assessment of experts in the field as to the validity of the instrument.

In determining which measure to include the hierarchy of four categories according to how well it has been used was followed (Switzer *et al.*, 1999). Firstly, if an established measure existed, its suitability was assessed using the considerations given above. If no established measure was available or suitable, then modifcation to an existing measure was considered to fit the research goals. Where a modified measure is used a rationale for any alterations is given. Another alternative is to construct a hybrid measure, which combines items from more than one source to assess a single construct. Finally, the development of a new measure was considered for a specific research goal. Where a new measure was devised the reasons why this was necessary and a description of the purpose and the method of generating the measure is given. The following sections describe the research instruments used in the structured interviews. Appendix B provides the whole interview schedule.

Work Behaviours and Attitudes Scale

The Work Behaviours and Attitudes Scale (WBAS) developed by Mowbray *et al.* (1995), was used as an attitudinal indicator of a potential return to work. The WBAS was adapted from the Work Behaviour Scale (Griffiths, 1973), a situational assessment tool that requires observation in a work setting. The WBAS was designed to evaluate the impact of rehabilitation interventions. It measures attitudes and feelings towards work, co-workers, and supervisors and provide an assessment of personal performance and capability (I Iarris *et al.*,

1993). The scale consists of 29 items answered on a four-point scale, and has three subscales: work pride and independence, work anxiety and work performance.

There are a number of approaches to the vocational evaluation of people with mental health problems, each with their limitations. The work sample approach has been criticised as it does not take into account the fluctuating nature of functioning experienced by most people with mental health problems (Hursh *et al.*, 1988). On-site job evaluations provide valid assessment of productivity but are usually job specific and may not generalise to other work settings (Bryson *et al.*, 1997). There are also a number of situation assessment checklists, such as the Griffiths Scale (Griffiths, 1973), the Work Personality Profile (Bolton and Roessler, 1986), and the Work Behaviour Inventory (Bryson *et al.*, 1997), though many are outdated, are without demonstrated reliability and validity, and often have too many items and are time consuming to administer (Tsang and Chiu, 2000).

The psychometric or standardised test has been a traditional approach to measure work behaviours, though Anthony and Jansen (1984) found this method to be a poor predictor of work performance. However, this latter approach was taken, despite its limitations, out of necessity as observational or situation methods were simply not possible.

To its credit the WBAS has produced good results in the US using a large sample of people with mental health problems (Mowbray *et al.*, 1995). The study investigated current work status and expectations about work for a sample of over 270 people with mental health problems using case management and assertive community treatment teams. The scale had a high internal consistency (Cronbach's alpha = .81) and significantly correlated in the expected directions with five other established instruments. The scale was shown to be a significant predictor of work expectations and future work status, with working participants scoring consistently higher on the total WBAS scale and the work pride subscale. In an evaluation of an employment intervention for offenders with a history of substance misuse (n=70), colleagues at the Centre for Applied Social Studies, University of Durham found that the WBAS had Cronbach's alpha of greater than .7. There are few other studies that have used the WBAS, which suggests the scale requires further testing to establish its psychometric properties.

There is a substantial literature on the measurement of work attitudes in employment and unemployment research for the general population, including a large number of assessment scales (see for example Warr *et al.*, 1979; Lodahl and Kejner, 1965; Stafford *et al.*, 1980; Banks and Henry, 1993; Warr and Lovatt, 1977; Gallie, 1994). A scale that was appropriate to

people with mental health problems was chosen over one of these scales. The literature on rehabilitation in mental health suggests that scales developed for the general population are not appropriate due to their often complex wording. However, the WBAS was found to be acceptable to the long-term unemployed during piloting of the questionnaire.

A further question was added to determine employment motivation that asked whether or not the person would wish to work if they had as much money as they needed. This is a well-tested measure of work commitment developed by the Peter Warr (1982).

Barriers to Work Checklist

A checklist of items was developed for the purpose of this study to determine the nature and extent of barriers preventing people from getting a job. The checklist asks respondents to consider ten statements related to personal (health, skills, etc.) and structural (jobs, discrimination, etc.) factors. Each answer is rated on a five point scale from strongly agree (=1) to strongly disagree (=5).

The items on the checklist were selected from previous studies of unemployment amongst people with mental health problems (see Anaya *et al.*, 2000; McCollam, 1994; Pozner and Jones, 1994; Rogers *et al.*, 1993; Setti, 1994; Turton, 1996) to ensure a degree of content validity, whereas the wording was taken from actual statements made during the preliminary study to ensure face validity.

Work Histories

A method of collecting information about participants' work history was devised. A structured approach was used as in one previous study using open-end questions only one third of respondents completed their work history (Mowbray *et al.*, 1995).

Respondents were asked about their current or last job: job title, hours per week, type of work (employed, self-employed, voluntary work, etc.), length of job and length of unemployment since leaving last job. Respondents were then asked to work back over time and name their jobs and for how long they did them. Standard categorisation (Social Trends, 2000) of each job was subsequently made according to occupation and industry, and, for last/current job, social class. As with Mowbray *et al.*'s (1995) study respondents were also asked to identify their best job.

Details of individuals' education were also collected. These included highest level of education, age of finishing full-time education, number and type of qualifications using Labour Force Survey categories, and details of any certified courses currently attended.

Labour Market Flexibility and Job search

Details about recent job search were collected, as it is highly unlikely that a person will return to work without first looking. Moreover, those who display a more flexible approach to employment are more likely to return to work (Gallie *et al.*, 1994).

Firstly, respondents were first asked whether they would like to work – now, in one year, in three years and ever again. Then, for those who answered positively to any of those questions, they were asked to give details about the nature of their preferred work: job title, type of work, hour per week, the time they would be prepared to travel to work, and their reservation wage - the minimum hourly rate they would consider working for. People who expect a higher pay than average for their occupational class were considered to have low pay flexibility.

Secondly, people were asked the three questions identified by Gallie *et al.* (1994) relating to flexibility. The threefold typology of labour marker flexibility used by Gallie *et al.* (1994: 128) was used, namely

> The first was how demanding people were in their expectations about the pay they would get for a job; the second was their willingness to consider changing their skills; and the third was their openness to geographic mobility.

Thirdly, people were asked if they could start work within the next two weeks and whether they had looked in the last four weeks. The answers to these questions were then used to categorise people into ILO definitions of economic activity.

Fourthly, for those who had looked within the last four weeks details of their job search was collected, including number of applications and interviews, the various job search methods used, and their prospects of finding work.

Finally, all respondents were asked about the nature of any support offered in the last year and the type of help they felt they needed to get and keep the work they desired. Categories for these items were taken from previous research in mental health (Anaya *et al.*, 2000).

General Health Questionnaire (GHQ-12)

The 12-item version of the General Health Questionnaire (GHQ-12) (Goldberg and Williams, 1988) was used to determine the mental health of participants. The GHQ is the most commonly used measure of psychiatric morbidity in the UK (Bowling, 1997), and has been used in a number of studies that have examined the effect of unemployment on mental health (Banks *et al.*, 1980; Hepworth, 1980; Iverson & Sabroe, 1988; Kilpatrick and Trew,

1985; Jahoda, 1988; McCabe *et al.*, 1996; Avery *et al.*, 1998). The full 60-item version was developed in the 1960s and 70s for use in general practice as a screening questionnaire for detecting independently verifiable psychiatric illness (Goldberg, 1972). Although the instrument was not intended to be used for the detection of functional psychoses, this has been found to be possible (Bowling, 1997).

The GHQ consists of a series of statements asking respondents to compare their recent experience to their usual state on a 4-point scale of severity. Because of this 'usual state' measurement its suitability for the detection of long-term problems has been questioned (Bowling, 1997). However, the authors (Goldberg and Williams, 1988) suggest that this effect is minimal as most people view their usual state as being without symptoms.

Several scoring systems have been proposed, including a Likert scale (0 1 2 3), and two 'caseness' scores (0 0 1 1 and 0 1 1 1) (Bowling, 1997). Total scores on the GHQ-12 are formed by summing the 12 item response, giving a range from 0 to 36 on the Likert and 0 to 12 on the caseness score. Both scoring systems were used here. The caseness method is used in conjunction with threshold scores, were the concept of caseness corresponds to the average patient referred to a psychiatrist. A threshold score of 4 or 5 is recommended by the authors, however, for the 12-item version a threshold of 3 is recommended. This latter cut off point has been shown to have high sensitivity (71.4%) and specificity (79.8%) in the detection of psychological disorder as measured by the Present State Examination (Banks, 1983). Various cut-off points were explored in the analysis. The GHQ will also allow comparison with an abundance of normative data.

The GHQ is perhaps the most extensively tested scale for validity, reliability and sensitivity (Bowling, 1995). Original and subsequent empirical studies, of which there are over 50, show evidence of content validity. Correlations with other gold standards have established criterion validity (Bowling, 1997), with good linear associations with independent clinical assessments (typically r = .7 or greater) (Banks *et al.*, 1980). All versions (12-, 28-, 30- and 60-items) correlated highly with one another, though the shorter versions are slightly less valid and sensitive (Goldberg, 1978). The 12-item version is said to be as efficient as the 30-item as a case detector (Bowling, 1997). The development studies showed that the full scale exhibited high internal consistency (Cronbach's alpha range from .77 to -.93) and good retest reliability over a period of 6 months (Banks *et al.*, 1980).

Empowerment Scale

The Empowerment Scale (Rogers *et al.*, 1997) was used to measure empowerment and self-esteem. The version of the scale used here was adapted for use in the UK (Hatzidimitadou, 1998). It is a service user-defined scale, developed by researchers and service users at the University of Boston, USA (Rogers *et al.*, 1997). An advisory board, consisting of 10 leaders in the consumer-survivor movement, delineated attributes of empowerment against which they reviewed existing psychological measures. All existing measures were rejected as none captured the dimensions of empowerment of relevance to people with mental illness. A 28-item instrument was developed based on five dimensions of empowerment: self-esteem/self-efficacy, power-powerlessness, community activism and autonomy, optimism and control over the future, and righteous anger (Rogers *et al.*, 1997). Each item is answered on a four-point agreement scale, from strongly agree (=1) to strongly disagree (=4).

In the development study of 271 users of US consumer self-help programmes, Rogers *et al.* (1997), found the scale to be valid and reliable. They found a high internal consistency (Cronbach's alpha = .86) and a satisfactory factor solution, resulting in five factors accounting for 54% of the variance in scores. In terms of construct validity, the scale was found to correlate with self-esteem and quality of life. Corrigan *et al.* (1999) tested the scale with a more psychiatrically disabled population. In their study of 35 consumers of a partial hospitalisation programme they found good reliability ($r > .75$) in all subscales except righteous anger ($r = .38$). In a state-wide survey of 283 users of mental health services in South Carolina, Wowra and McCarter (1999) found the scale to have a high internal consistency (Cronbach's alpha = .85) and stable factor structure. However, in a UK context, Carpenter *et al.* (2001), found only the total score and self-esteem subscale to be reliable (Cronbach's alpha from .84 to .89 within 95% confidence interval). This is unsurprising as the scale borrows heavily from the Rosenberg Self-Esteem Scale (Rosenberg, 1965), a widely used scale with evidence of validity and reliability.

Matching Resources to Care (MARC-2)

MARC-2 was used as a measure of severity of mental health problems for the sample of mental health service users. MARC-2 was developed as a simple screening questionnaire in determining the severity of mental illness of clients on the caseloads of mental health professionals (Huxley *et al.*, 1998). MARC-2 is a multi-dimensional measure of severity which gives it advantages over more traditional categorical definitions of identifying people with severe mental illness (SMI), such as diagnosis or hospital admissions (Huxley *et al.*, 1998).

The dimensions used were taken from those identified by Powell and Slade (1996) and include demographic, diagnosis, duration, service history, clinical and social functioning variables (Huxley *et al.*, 1997). The items also correspond to many of those collected within the proposed National Mental Health Minimum Data-Set (Glover *et al.*, 1997).

In a recent large study (n=2139) the pilot version, MARC-1, was found to be acceptable, and demonstrate adequate validity and reliability (Huxley *et al.*, 2000). MARC-1 was able to correctly distinguish between those people subject and not subject to statutory provision ($p < .001$) and displayed better performance than four other definitions of SMI. MARC-1 correlated modestly ($r=.28$) but significantly ($P < .001$) with the Global Assessment Scale (GAS/GAF), a widely used measure of current mental health status. The modest correlation was expected as the MARC-1 also contained items on past symptoms and functioning. Reliability was also assessed; with a mean inter-rater agreement of 87% across the 18 items and a Cronbach's alpha of .77.

MARC-2 questionnaires were sent to the care-coordinator of each of the mental health service users who agreed to be interviewed. Although this is how the measure was intended to be administered, the authors acknowledge that this method generates data which falls short of the higher standards of validity achieved by a prospective structured interview (Huxley *et al.*, 2000).

Short Form-12 Health Survey (SF-12)

The Short Form 12 Health Survey (SF-12) (Ware *et al.*, 1996a; 1996b) was chosen to measure both physical and psychological health problems. The SF-12 is a 12-item sub-set of the original 36 items of the SF-36 (Ware and Sherbourne, 1992), probably the most popular generic measures of health outcomes (Jenkinson *et al.*, 1997).

In addition to a measure of general health the 12 items yield the eight scale profiles of the SF-36. These are a self-assessment of general health, physical functioning, physical role limitation, mental role limitation, social functioning, mental-health items, vitality and bodily pain (Bowling, 1997). More disease specific measures can appear overwhelming to many respondents not suffering them, while general measures of health are more useful for policy analysis (Kaplan, 1988).

The SF-12 is appropriate to many populations and has been used extensively in many countries (Gandek *et al.*, 1998). Alternative measures, such as the Sickness Impact Profile (Bowling, 1997), can only be used on those who regard themselves as ill.

There is a wide range of normative data available. The SF-12 is able to reproduce at least 90% of the variance in the physical and mental subscales of the SF-36 and so the population norms for SF-36 can be used (Ware *et al.*, 1996a; 1996b). Information from all 12 items is used to construct physical and mental component summary measures (PCS-12 and MCS-12). A recent study in nine countries, including the UK, also found that the SF-12 provided good reproductions of the SF-36 summary measures, with correlations in the UK sample (n=1372) of 0.96 on the PCS and 0.94 on the MCS (Gandek *et al.*, 1998).

The SF-12 is very easy to complete (two minutes) and has been used successfully in studies, such as this one, in which the subject's burden is already high (Jenkinson *et al.*, 1997). Most alternative measures are much longer, such as the SF-36 (36 items, 10 minutes), the Sickness Impact Profile (136 items, 30 minutes) or the Nottingham Health Profile (38 items) (see Bowling, 1997 for descriptions of these measures).

Finally, substantial research has been undertaken to determine the validity and reliability of the measure across various populations and patient groups in this country (Brazier *et al.*, 1992; Garratt *et al.*, 1993, 1994; Jenkinson, 1993, 1996; Ruta *et al.*, 1994). For example, Ware *et al.* (1996b) found a test-retest reliability of 0.86 and a internal consistency coefficient of 0.77 for their UK sample.

CLIENT SOCIO-DEMOGRAPHIC AND SERVICE RECEIPT INVENTORY (CSSRI)

The CSSRI was used to collect information on the use of health, social care and education services, living arrangements and accommodation details. The CSSRI was developed in 1986 at the Personal Social Services Research Unit at the University of Kent at Canterbury (Beecham and Knapp, 1992). Since then it has been used in over 100 evaluations of community care services, including people with mental health problems in general (Beecham, 1995) and with those in employment in particular (Schneider and Hallam, 1996, 1997). Since the CSSRI has been widely used there exists comparative data from other studies of people with mental health problems.

The CSSRI is designed to collect detailed information, in a standardised way, about the types and level of services used so that cost estimates can be made. These costs include accommodation, service use (health and social care, education and employment), and social security. Details of accommodation size, type and ownership and the social security benefits claimed were collected. Service use data for each person was collected according to type of service, together with frequency and duration of attendance, over the prior three month period. Details of any medication taken were also collected.

Social Network Guide

Measuring social networks is fraught with difficulty owing to the lack of fully tested measures (Payne and Graham-Jones, 1987; Bowling, 1997) and confusion over the concept itself (O'Reilly, 1988).

> There is currently no assessment scale which comprehensively measures the main components of social network and social support with acceptable levels of reliability and validity. (Bowling, 1997: 91)

In the absence of an agreed method, Bowling (1997) stresses the importance of matching methodology to the empirical issues and the disciplinary approach of the study. With this in mind, the Social Networks Guide (SNG) (Forrester-Jones, 1998) was adapted for this study to elicit details about each individual's social network structure - the size and frequency of contacts, and social support – plus membership and intimacy. Further details of social support were gleaned from the Community Activities Profile (see below) and from in-depth interviews and participant observation.

Therefore, this study combines a quantitative measurement of social networks with qualitative techniques for studying relationships. This design follows recent research in the UK on social networks and mental health. The TAPS project (Dunn *et al.*, 1990) developed the Social Networks Schedule (SNS), its validity tested with observational data. Forrester-Jones and Grant (1997) developed the Social Network Interview (SNI) from the SNS and used it together with un-structured interviews and participant observation to study social networks of resettled psychiatric patients living in two residential care homes. The SNI was found to be useful for determining structural characteristics in a systematic way (Forrester-Jones and Grant, 1997).

The size or number of network members is one of the most commonly assessed structural properties of social networks (Dilks and Shattock, 1996). To achieve this, the SNG begins with a name eliciting procedure that uses a map to display network membership visually with eight segments relating to social contexts and membership categories. Whereas two other measures, the Social Network Interview (SNI) (see Forrester-Jones and Grant, 1997) and the Social Network Schedule (SNS) (see Dunn *et al.*, 1990), use a time budget method of the previous day and weekend to identify usual social contacts. In their study of social networks in two residential homes Forrester-Jones and Grant (1997) found the use of a visual aid (in their case a family tree) provided better quality information than routine questioning.

Network size alone should not be regarded as a measure of network strength (Grant and Wenger, 1993). Therefore, subsequent questions on the SNG concern the nature of the relationship with each network member. Items on frequency of contact, network membership and closeness of relationship were retained. The membership categories (family, friend, service contact, etc.) may provide an indication of the nature of support function available to an individual (Forrester-Jones and Grant, 1997).

The SNG also includes the seven types of social support identified by Forrester-Jones and Grant (1997) from their fieldwork in residential care homes. However, during the pilot study many of these items (e.g. personal help with bathing, dressing, etc.) were found to be of limited relevance to the sample under study, the vast majority of whom lived in domestic accommodation, and many of those alone. Moreover, these items were very lengthy to complete, became repetitive for those with large networks and so were removed to reduce the burden on respondents. Yet details about network structure are of little value if interactions are negative and stressful (Bowling, 1997). Consequently, an item was retained that asked respondents if the person is ever 'nasty, critical, or bad and has upset you'.

Studies using the SNS and SNI have measured network density as a parameter, where respondents are asked about the interrelationships between network members. However, there are logistical problems involved, particularly with large social networks, as the number of questions increases in proportion to the square of the network size (See Brugha *et al.* (1987) for formula). Moreover, network density scores are affected by network size - high densities are biased by small networks and vice versa (Forrester-Jones and Grant, 1997). Network density was removed for this study.

More relevant to this study was to determine with whom individuals did their various activities and leisure pursuits. This information was gathered from the Community Activities Profile described below.

Social networks are important in facilitating a person's return to work (Gallie *et al.*, 1994). Informal networks are often the most important sources of information about jobs, particularly in lower skilled occupations (Holzer, 1987; Sullivan, 1989). A question was included about the employment status of each network member.

The Lancashire Quality of Life Profile

The Lancashire Quality of Life Profile (LQOLP) (Oliver *et al.*, 1995) was adapted for this study to measure satisfaction in eight life domains, together with some objective indicators of

quality of life. The LQOLP was specifically developed for use by British social care staff to assess mental health problems in community settings (Oliver *et al.* 1991a, 1991b; Oliver and Mohammad, 1992). It is based on Lehman's Quality of Life Interview (QLI) (Lehman *et al.*, 1982), which is, together with the Quality of Life Scale (QLS) (Heinrichs *et al.*, 1984), perhaps the most widely used quality of life scales with people with mental health problems (Bowling, 1995). Lehman's concept of quality of life is based on general population studies (Andrews and Withey, 1976) and has two central points, as described by Lauer (in Priebe *et al.*, 1999: 14).

> [...] that (i) ultimately, quality of life is a subjective matter, reflected in a sense of global well-being, and (ii) this experience depends on at least three types of variables: (a) personal characteristics, such as age and sex, (b) objective quality of life in various domains of life, such as income level, and (c) subjective quality of life in these same life domains, such as satisfaction with income.

The construct for the LQOLP shares this combined model of quality of life and retains eight of Lehman's life domains: health, social relations, legal and safety, living situation, leisure and participation, family, work and finances, with religion added as a ninth domain. The LQOLP also includes a general-well being domain. Objective information is collected in these domains together with subjective satisfaction measured using the Life Satisfaction Scale, a version of Andrew and Withey's (1976) Delighted – Terrible (D-T) Scale. The LSS is a 7-point visual analogue scale, scored from low ('couldn't be worse') to high ('couldn't be better'). In this study some of the objective indicators were removed during piloting. Items covering leisure and participation and family relations were examined in much greater detail by other measures. Items covering religion and legal and safety were considered outside of the scope of interest of the study. All subjective items were included apart from those in the religion domain, owing to poor validity (Knight, 1999).

The two measures of psychological well-being – the 10-item Affect-Balance Scale (Bradburn, 1969) and Rosenberg's 10-item Self-Esteem Scale – were also removed. The concepts tapped by these measures duplicated those in the health section above, namely, the GHQ-12, SF-12 and the Empowerment Scale. Additionally, Cantril's Ladder (Cantril, 1965) was used to measure global well-being, together with an item measuring life happiness and an opportunity for respondents to identify quality of life enhancers.

The overriding desire to remove items from the LQOLP was to shorten the overall questionnaire and so make it more acceptable to the interviewees to reduce the number of

incomplete questionnaires. In this respect the LQOLP was more appropriate than Lehman's QLI which has 200-items and takes 45 minutes to complete (Bowling, 1995).

The LQOLP's generic concept of quality of life ensures it is relevant to those without psychiatric disorders, such as the long-term unemployed, as well as those with mental illness. However, the majority of studies using LQOLP have been with this latter group, many in the UK and the northwest in particular. A number of recent studies of people with mental health problems have used or adapted the LQOLP (van Nieuwenhuizen, 1997). Knight (1999) reports the widespread use of the LQOLP – 75 individuals and organisations, in 29 projects, in 15 countries – though issues of validity and reliability were not complete. The wealth of comparative data available made the LQOLP appropriate for this study.

Evidence for content validity has been supported through exercises with mental health professionals (Huxley, 1994), while evidence for construct validity is reported as good (Knight, 1999). Knight (1999) reports that correlations between subjective estimates of global well-being were good (Pearson's r ranging from .35 to .37), correlations between measures of global well-being and the quality of life sub-scales showed significant but variable strengths of association, and correlations between the sub-scales themselves were strong (Person's r ranging from .14 to .45), with the exception of religion. Knight (1999) also reports a high level of consistency with Lehman's work, though criterion validity is difficult to establish without an agreed 'gold standard' in quality of life measures.

There are mixed reports as to the reliability of the instrument, made more difficult as the abstract concept of quality of life cannot be directly observed. Bowling (1995) reports reasonable test-retest correlations (.49 to .78), low mean inter-item correlations (.16 to .19), and high Cronbach's alpha (.84 to .86) and split-half (.73 to .82) correlations for the LSS. Bowling concludes that the LQOLP can be successfully used in the UK.

Community Activity Profile

Community Activity Profile (CAP) questionnaire was specifically developed for this study to collect information about individuals' use of their time - in work, social, leisure and treatment. This has been developed in response to the lack of interview measures that 'map' an individual's involvement in community activities. Perhaps the most common method of achieving this is the time-use diary. This is not an interview method, though was included in the study and is described below.

A similar concept to time use is time structure. Several studies have examined the effect of time structure on mental health (Bond and Feather; 1988; Fasting, 1982; Feather and Bond, 1983; Wanberg *et al.*, 1997; Winefield *et al.*, 1992). These studies were largely inspired by Jahoda's (1982) work on the psychological consequences of unemployment. A popular instrument used in such studies is the Time Structure Questionnaire (Bond and Feather; 1988; Feather and Bond, 1983), which measures the degree to which individuals perceive their use of time to be structured and purposive. This method was not used in this study as details of actual activities taken part in were required. Moreover, time structure, as well as other issues, can be derived from these primary details (Hayes and Halford, 1996).

The inspiration for the development of the CAP comes from the Household and Community Survey (Gallie *et al.*, 1994), which included the nature and frequency of various pre-coded community and household activities. Rather than give fixed activities, which represent norms that may not be relevant to the study samples, the CAP provides loose categories for respondents to specify any activities which they had done in the preceding four weeks. These categories were taken from time use studies (Gallie *et al.*, 1994; Kirkpatrick and Trew, 1985; Richardson *et al.*, 1993) and include work and training, sports, entertainment, religion, health and social care, social, and others.

In common with many time-use studies the frequency and duration of each activity was also recorded. The Household and Community Survey, studied by Gallie *et al.* (1994) to compare the leisure activities of employed and unemployed people, used pre-coded time intervals to weight frequency. The CAP asks respondents to give the number of times they engaged in each activity in the previous four weeks together with the typical duration of the activity in this time period.

Findings from the preliminary studies suggested that there were times during the week when people were more or less active. To measure this respondents were asked whether each activity mentioned took place during the day or evening, and whether this normally happened during the week or weekend.

Respondents were also asked with whom they did any activities mentioned and who initiated them. The former information was used to give further details about social networks. The latter indicates the level of choice and control people had in their life. Respondents were also asked how satisfied they were with each activity, whether they would like to do it more or less often and how much it cost.

Respondents were also asked if they would be prepared to give up any activities if offered a chance to work, and if so, which ones. This was asked to provide additional information about labour market flexibility and commitment to employment.

A general measure of activity level was also included with a question whether people had enough to do during the day. Three statements about the difficulties in engaging in activities were included from the findings of the preliminary study. Respondents were asked to rank their agreement with each statement.

Two semi-structured questions were included about what people liked and disliked about the things they did. This was included to gain some information about people attitudes and perceptions about how they use their time.

The second part of the CAP asks respondents to name activities they would like to do, what barriers they face and what support would help. This was used to determine the aspirations for and barriers to inclusion.

TIME-USE DIARIES

Time-use diaries were completed by the participants over a one week period to collect information about individuals' daily lives. These diaries were also used to determine the validity of the CAP, as time-use diaries are more reliable than interviews relying less on recall (Hayes and Halford, 1996).

Respondents were given a seven page A4 booklet, each page representing a day, and with each day split into 24 one-hour segments. Respondents were asked to provide a very brief description of what they were doing, where and with whom for each hour of the day. Guidelines were also provided, with respondents encouraged to complete the diary throughout the day were possible.

Both open- and pre-categorised diary formats were rejected in favour of this semi-structured format. Open format, which allows respondents to record activities and events in their own words and time-scales, can be burdensome on the respondent, may only be completed by those used to keeping diaries, and are very labour intensive to code and analyse (Corti, 1993). Whereas pre-categorised may provide very limited data with restrictive categories, or may become increasingly complex to complete with a longer list of categories (Corti, 1993).

A one-week period was chosen so as to include weekdays and weekends (Szalai, 1972). This period seemed to meet the balance between being long enough to capture the behaviour and events of interest and short enough to encourage successful completion (Corti, 1993).

The draw back is that they can be time consuming, evidenced by the limited response rate in this study. Also their validity can be questioned as individuals often perform several activities at the same time and they may not truly reflect a person's life if it changes from week to week (Szalai, 1972).

Income and Expenditure

Details of personal income and expenditure was collected. A study by Warner and Polak (1995) collected cash and non-cash income and personal expenditure details of people with mental health problems. Adapting this for the UK, and borrowing heavily from the Family Expenditure Survey (FES), income included earnings after tax, welfare benefits, housing benefit, gifts, loans and illicit activities. Expenses included housing, bills, food, travel, entertainment, clothes, household goods, healthcare, transportation, entertainment, alcohol, tobacco and illicit drugs. Details of any debts were also asked for.

Costing methodology

To enable a comparison of costs to the state between the two study groups costs were estimated for each respondent. The data was collected using the CSSRI, described above. Following the methodology described by Schneider and Hallam (1997), three types of costs were used.

Accommodation

Accommodation costs may be expected to make up the greatest part of community-based support (Hallam *et al.*, 1994). National unit costs were used for those few individuals living in residential care homes and sheltered housing. For those who were living in domestic accommodation Housing Benefit, or mortgage interest payments, were used.

Service costs

The unit cost for each service, or service type was estimated. The majority of service costs were taken from the *Unit Costs of Health and Social Care* (Netten and Curtis, 2000). Appendix C provides a breakdown of unit costs and their origins. The information from the CSSRI on frequency and duration was combined with unit costs to produce total costs for each person.

Other costs
Medication costs were calculated from the *British National Formulary* (BNF, 2000) according to the dosage received. After Schneider (1997), the costs of syringes and the time taken to administer depot injections, at 10 minutes of CPN time, were added where applicable.

Interview process
Due to the nature of the sampling procedures the method of contact differed for the two study groups. Contact with each mental health service user was made by letter inviting them to take part, with information about the study and a contact telephone number. Assurances about confidentiality and their right to refuse to be interviewed was clearly stated. Each person was given time to think about participation before a follow-up phone call to arrange a time and place at their convenience. All but two interviews took place at the person's home, the remainder at community centres.

Contact with the long-term unemployed sample was made via Jobplan Workshops and Jobclubs. At each location a talk was given to the group and volunteers asked for. Interviews were mainly conducted in a private room.

On commencing each interview the research was described, the interviewee's rights were explained and they were asked to sign a consent form. A £10 honorarium was paid before the interview as a gesture of good will and trust. For the mental health service users group each interview lasted on average for just over 70 minutes. For the long-term unemployed group each interview lasted on average for just over 60 minutes. On the hour each person was asked if they wished to continue, to take a break, to arrange another date for completion or terminate the interview.

The interviews opened with demographic and accommodation details from the CSSRI, the questionnaire was then split into seven sections following the life domains described by Lehman (1983), namely health and well-being, work, leisure, family and social relations, finances, service use, legal and safety and general well-being. The interview was designed to finish on a positive note, asking about how people would like to improve their quality of life. After each interview notes were made detailing any relevant points – the nature of the setting, the attitude of the interviewee, any notable issues in the way the interviewee answered the question, and any additional information not recorded elsewhere on the questionnaire.

Data was recorded by hand on questionnaires, and stored in a locked filing cabinet during data collection. Information which would make it possible to identify individuals by name

was kept separate from the questionnaires. Anonymised data was entered onto a computer for analysis using SPSS for Windows.

Pilot Study

Eight people were interviewed in a pilot study to test the acceptability and reliability of the questionnaire. Three long-term unemployed people at a job club in Manchester and five users of mental health services in both Manchester and Tameside volunteered.

For the purposes of piloting a semi-structured interview was completed with the respondent after each version of the questionnaire. This information was then used to further refine the questionnaire. The pilot interviews resulted in a shortening of the questionnaire, with the removal of items described above, and the refining of the items specific to this research.

Section Five: Data analysis and ethics

The different methods used by this study required different approaches to the treatment and analysis of the data generated. To enable the methods to complement each other a triangulation approach was used. The following sections provide a description of how the data from each method was analysed to meet the aims of the study.

Quantitative data

The statistical analysis of the quantitative data was completed using the Statistical Package for Social Science (SPSS) Version 10.0. The following statistical techniques were used with a 5% level of significance. This means that there is a 5% chance that any significant finding could be due to chance.

Scale reliability was assessed using Cronbach's alpha plus an approximate 95% confidence interval for alpha. Demographic data were tabulated and differences tested. Dichotomous and nominal variables, such as gender and ethnicity, were analysed using Chi-square tests (χ^2). Interval data, such as age, income, and years of unemployment, were analysed using both parametric tests, such as the two-sample t-tests and one-way analysis of variance (ANOVA), and non-parametric tests, such as and Mann-Whitney U test and Kruskall-Wallace test. Relationships between variables were analysed using Pearson and Spearman correlations and ordinary least squares multiple regression. Non-parametric tests were used when the data were not homogeneous and did not have a normal distribution.

Comparisons were also made with normalised data. Dichotomous variables were compared with data from other research using a binomial test. Nominal variables were compared using a chi-square test for one sample and interval variables using a one-sample t-test.

The characteristics of those with strong and weak labour market attachment and those who were active and inactive were found using a cluster analysis of the relevant variables (Hartigan, 1975). Hierarchical techniques were used to determine the number of clusters, which were then confirmed using a K-means analysis. ANOVA and Krushall-Wallace tests were used to test for differences between clusters on the relevant variables. Clusters were then analysed to determine make-up in terms of demographics, health status, and other descriptive variables.

Time-use diaries were coded according to the nature of activity from the emergent themes. Differences over the seven day period were analysed using a single-group repeated measures multivariate analysis of variance.

All financial details have been left at their values at the time of interview. All calculation used 1999/2000 tax and benefit rules for the UK and US.

Qualitative data

The preliminary enquiry revealed the main issues faced by each of the two study groups, ensured that the research questions were grounded in the experiences of its participants, and that subsequent methods were relevant and appropriate. This was achieved through the analysis of field notes and the flip chart notes from initial focus groups. This produced key themes and concepts highlighted by the participants. In a local mental health needs assessment Hostik (1995) found that the level of detail generated from tape recordings, which produce large amounts of data, was not necessary when identifying the main themes was the sole requirement and when the methods of triangulation are adopted.

The purpose of the comparative study was to answer the research questions and to enhance the validity of the survey. This required a much more rigorous analysis of the data. This involved the use of qualitative methods to analyse the verbatim transcription of tape recordings together with field notes. This was completed using the computer package QSR NUD*IST Vivo (N Vivo) Version 1.1.127. Documents were created for focus groups, interviews, and field notes. Names of participants were altered, and the specific locations removed, to preserve anonymity.

The first step in analysis was to become familiar with the data through a careful reading of the transcripts; looking for any interesting patterns, things that stand out (see Hammersley and Atkinson, 1983). The next step was to develop concepts, which can be observer identified or come from the participants themselves. N Vivo allows the user to create 'nodes' for these concepts.

The distinct feature of working with focus group data is the need to indicate the impact of the group dynamics and take advantage of the interactions between participants (Kitzinger, 1995). Catterall and Maclaran (1997) suggest that cut and paste approaches often fail to exploit the full advantages of the focus group method. With this in mind, the analysis of the focus groups also examined the discussions in sequence to see how views were modified and developed Reed and Payton (1997).

Ethical considerations

The research was conducted within the guidelines in the Centre for Applied Social Studies' code of conduct. This ensured the confidentiality and anonymity to all participants; that informed consent was always sought; a sensitive and tactful approach was taken to all encounters; the possibility of harm to participants was always avoided; bias was recognised; and misrepresentation of findings was avoided.

All participants were paid £10 to take part. It is often a concern that payments will result in contamination or bias, or may represent a form of coercion (Melrose, 1996). On the other hand Thompson (1996) found evidence to show that paying respondents in structured surveys increases response rates. Thompson (1996) goes on to argue that payment can reduce bias as more people will be included in a study, gaining a wider range of views. Moreover, payment can also help to reduce the power imbalance between researcher and participants when studying disempowered or disadvantaged groups, as highlighted by feminist researchers such as Stanley and Wise (1993) and Oakley (1981). The payment of participants therefore goes some way towards empowering them, particularly for the long-term unemployed for whom £10 represented a 20% increase in that week's income. To ensure protection for this group assurances were gained from the Benefits Agency that this payment would not affect their benefit entitlement[10]

During focus groups confidentiality cannot be guaranteed because there will always be more than one participant in the group. To minimise potential harm the following steps were taken. At the beginning of the group it was made clear to all participants that their contributions would be shared and encouraged participants to keep the proceedings of the group confidential. Groups were assured that their contributions would remain anonymous when reporting the data. Everyone had an opportunity to choose not to participate or withdraw at any time. It was made clear to the groups that note taking and tape recording

[10] JSA claimants have a £5 disregard on income. A £10 payment classed as income would therefore reduce that week's JSA by £5. After explaining the situation to the Benefits Agency they agreed to count the amount as capital.

would be used during the discussion. Permission to tape record was always obtained from each member before proceeding. Where any participant refused notes were taken by hand instead.

A final matter concerns whether questions regarding mental health cause distress. In their survey of the general population in Australia, using the GHQ amongst other measures, Henderson and Form (1990) found that up to 10% of the community report being distressed by questions about psychological symptoms, and that distress was highest in those with higher symptom scores. This finding, when applied to the particularly vulnerable population of this study, suggests the interviews may indeed cause distress. In view of this, and as recommended by Henderson and Form (1990), considerable care was taken in obtaining truly informed consent. To this end detailed information was given about the study, the questionnaire was shown to each respondent, the nature of the questions were described, and respondents were assured that they did not have to answer a question if they did not wish to do so and that they could terminate the interview at any time. In practice no participant became distress, and most said they had enjoyed the experience and valued the opportunity to talk about their lives.

CHAPTER SIX

Findings I: Individual Characteristics

Introduction

The purpose of this chapter is to introduce the two study groups -mental health service users and long-term unemployed people; to provide the context for further analysis by describing their key characteristics; and to present an initial assessment of the extent of social exclusion. To do so, the findings from the quantitative and qualitative methods are presented under the following sections.

- Profile of samples
- Employment status
- Personal finances
- Health and well-being
- The extent of social exclusion

The first section describes and compares the demographic details of the study groups and considers how typical the samples are of the populations from which they were drawn. This section also includes an introduction to the participants in the qualitative study. The following three sections are concerned with exploring the differences between the study groups on three key factors of multiple deprivation -the first dimension of the model of social exclusion used by this thesis. The final section draws together the evidence and describes the extent of social exclusion amongst the two groups. But first, the chapter begins by examining the reliability of the scales used by the quantitative data and describing the coding of the qualitative data.

Scale Reliability

The results of the scale reliability tests on the main instruments using Cronbach's alpha, together with an approximate 95% confidence interval, are given in Appendix D. Good reliability may be set at 0.8 or more, however an acceptable internal consistency may be in the range 0.5 to 0.8 for a scale that has not been widely used (Nunnally, 1978). The results show that the GHQ-12, the Empowerment Scale and its self-esteem subscale, and the total LSS score of the Lancashire Quality of Life Profile (LQoLP) all have good reliability, with alpha over 0.8.

All the remaining subscales demonstrated acceptable levels of reliability, with alpha between 0.5 and 0.8, with the exception of the Performance subscale of the Work Behaviours and Attitudes Scale (WBAS) with an alpha of 0.46 and the work subscale of the LQoLP. Caution should also be exercised when examining the results using the Control and Anger subscales of the Empowerment Scale, the Anxiety subscale of the WBAS and the Family subscale of the LQoLP, as alpha was on the margins of acceptability (alphas of 0.55 to 0.56).

Coding the qualitative data

The findings from the qualitative data were derived from the focus groups with mental health service users, in-depth interviews with both study groups, and participant observation in day centres and job clubs. The main purpose of the qualitative data is to complement the findings from the survey. However, the two data sets were generated from different sources, so the qualitative data also provides *new* insights into the issues of unemployment, mental health and social exclusion not revealed by the questionnaire.

The findings from the qualitative data covered four broad areas: current activity of the two study groups, the activities desired by them, the barriers preventing people from doing these, and the supports desired to overcome them. These themes emerged from an analysis of the text using NUD*IST Vivo (the node structure is given in Appendix E).

Section One: Profile of samples

This section describes and compares the two study groups in terms of demographic indicators and key descriptive variables, and introduces the participants in the qualitative study. It also determines the extent to which the samples used in the quantitative study are typical of the populations from which they were drawn, and hence the scope for, and limitations of, any generalisations. This is achieved for mental health service users by comparing demographic, clinical and service use characteristics with other large-scale research projects that claim to represent typical caseloads of community mental health teams. Establishing the extent to which the sample can be defined as severely mentally ill further enhances the policy relevance of this study. The demographic characteristics of the long-term unemployed sample are compared to the Labour Force Survey and other more detailed studies of long-term unemployment.

Demographic characteristics

Table 14 shows that the mean age was about 40 years for both study groups, with a similarly broad age range. No significant differences were found either between the two groups, in mean age (using an independent samples t-test), or their distributions (using the Mann-

Whitney U and Kolmogorov-Smirnov tests). There were also no significant differences in the mean ages between genders and ethnic groups (using one-way ANOVA).

There was a bias towards men in both study groups. Nearly 90% of the long-term unemployed sample were men, compared to 64% of mental health service users (χ^2 = 11.37, df 1, p = .001).

The majority of both groups were white British, though there were no significant differences in ethnic breakdown, or in white/non-white split, between study groups, genders or age groups (see Table 1 in Appendix F for details).

Table 14. Age, gender and ethnicity

	Mental health service users N=72	*Long-term unemployed* N=63
Mean Age	40.9	40.8
S.D.	10.1	9.8
Range	21-64	23-59
% Female	36	11
% Male	64	89
% White British	79.2	88.1
% Black	12.5	1.7
% Asian	2.8	5.1
% Other	5.6	5.1

There were no significant differences in marital status between study groups or genders. Approximately half the samples were single, just under a third were married or living together and the rest were either separated, widowed or divorced (see Table 2 in Appendix F for details). As expected, the differences in mean ages between marital status categories were significant: 36 years for single people, 44 years for married people and those with a partner, and 46 years for widowed, divorced or separated people. (ANOVA, F = 15.21, p < .001).

Social class was assumed for each individual from the occupation of their parents (the highest when both given) according to a standard schema (ONS, 2000b). As expected among long-term unemployed people and mental health service users most people came from semi-skilled and unskilled backgrounds. No significant differences were found between groups, with about 17% from professional, managerial and technical occupations (classes I & II),

40% in semi-skilled occupations (classes III-N & III-M), and 43% in partly skilled and unskilled occupations (classes IV & V). See Table 3 in Appendix F for details.

Accommodation

There were no significant differences in living situation between study groups, with the majority, about 55% living alone, 25% with a permanent partner, 11% living with parents, and 9% living with others (details are given in Table 4 in Appendix F).

Most people, 64% of mental health service users and 71% of long-term unemployed people, lived in local authority and housing association accommodation (see Table 5 in Appendix F). The mental health service users group had more owner-occupiers and fewer living in privately rented accommodation than the long-term unemployed group ($\chi^2 = 9.317$, df 2, p = .009).

The residential stability of both groups was high. There was no significant difference between them in the proportions who have moved in the last year, 16% of long-term unemployed people and 11% of mental health service users, or in mean length of residence, with an average of about 8 years for both groups. The people with the most residential stability were owner-occupiers (average of 164 months compared to 84 months for other tenures, t = 3.11, df 130, p = .002), married people (average of 121 months) and Asian people (average 115 months). Though the latter two groups were not significantly different from the least stable groups, single people (83 months) and Black people (35 months).

The proportion of people living in workless households was high in both groups. For those living in family households and with their partners, 82.4% of long-term unemployed people and 61.1% of mental health service users had no other adult in employment, though the difference between the groups did not reach statistical significance. For long-term unemployed people there were more workless households in Manchester than Tameside ($\chi^2 = 6.03$, df 1, p = .014), probably a reflection of the higher levels of unemployment and deprivation in Manchester. There were no significant differences between genders, age groups, and ethnic groups.

Education

Table 15 and Table 16 shows some characteristics of the educational background and the qualifications held by the two groups. There were no statistically significant differences between the two groups in the highest level of education, school leaving age, the proportion currently studying, number of qualifications, or those with qualifications in general,

vocational or further education. The only significant difference was that a higher percentage of mental health service users had a higher education qualification ($\chi^2 = 6.33$, df 1, $p = .012$).

Table 15. Educational background.

%	*Mental health service users* *N=71*	*Long-term unemployed* *N=62*
Highest level of education		
Secondary	56.3	69.4
Further education	19.7	21.0
Higher education	22.5	8.1
Not known	1.4	1.6
Full-time education leaving age		
< 14	7.0	3.2
15	29.6	32.3
16	32.4	40.3
17 >	31.0	24.2
Currently studying	12.7	11.3

Table 16. Qualifications

% *Number of qualifications*	*Mental health service users Total* *N=71*	*Long-term unemployed Total* *N=62*
Any	62.0	50.0
None	38.0	50.0
One	25.4	24.2
Two	7.0	11.3
Three or more	29.6	14.5
Level of qualifications		
General education	45.1	32.3
Vocational education	31.0	30.6
Further education	21.1	19.4
Higher education	26.8	9.7

Mental health service users sample compared to typical caseloads

This section compares the sample of mental health service users with the results of other recent studies that examined typical caseloads in order to determine how representative the study sample is.

Table 17 shows a selection of characteristics of the sample compared to five other major studies: the CPA sample (Carpenter *et al.*, 2001) from four districts in England by colleagues at the Centre for Applied Social Studies; the PRiSM sample (Thornicroft, *et al.*, 1998) in London; the people studied in Wales by Barr and Huxley (1999); the two samples from the caseloads of Health and Social Services Departments (SSD) in eight districts in England (Huxley *et al.*, 1999); and the UK700 sample (UK700 Group, 1999) in London and Manchester.

The study sample was younger than the CPA sample ($t = -2.399$, $df\ 71$, $p = .019$), though older than the UK700 sample ($t = 2.415$, $df\ 71$, $p = .018$). These differences were very slight, with no significant difference with the PRiSM and Huxley Health and SSD samples. The study sample had a lower proportion of women, reaching significance for the CPA ($p = .042$), PRiSM ($p = .019$), Barr & Huxley ($p = .001$), Huxley Health ($p = .006$), and Huxley SSD ($p = .008$) samples. There were no significant differences in marital status. The study sample had a significantly higher proportion of non-white people than the CPA and Barr & Huxley (both $p < .001$) samples, though lower than the PRiSM ($p = .002$) and UK700 ($p < .001$) samples.

A lower percentage of the sample was currently employed than the CPA and Huxley samples, for which comparable data was available. The higher figures for the PRiSM and UK700 samples perhaps include those in sheltered or voluntary work. Including these categories increases the percentage of the study sample in work to a comparable 14.1%.

The study sample had a lower proportion of people living in supported accommodation than the CPA ($p = .019$), PRiSM ($p = .029$), Barr & Huxley and UK700 (both $p < .001$) samples. Perhaps related to this is the higher number of people living alone than the CPA, Huxley Health and PRiSM samples. The living situation of the study sample was not significantly different from the Huxley SSD sample.

In terms of diagnosis there was no significant difference in the percentage of people diagnosed with schizophrenia with the CPA or Barr & Huxley samples, though the study sample has a higher proportion than the two Huxley samples. An accurate comparison cannot be made with either the PRiSM or UK700 samples as they focused exclusively on those people with psychosis. The study sample used a wider definition of severe mental illness, though a high proportion, 76.4%, had been diagnosed with a psychotic illness.

Table 17. Comparison with other mental health studies

%	*Study sample*	*CPA sample*	*PRiSM*	*Barr & Huxley*	*Huxley Health*	*Huxley SSD*	*UK700*
	N=72	*N=260*	*N=514*	*N=100*	*N=2214*	*N=964*	*N=708*
Female	36.0	47.0	49	56	51.6	51.1	43
Single	52.8	45.4	72[a]	50	42.1	51.7	67**
With Partner	27.8	23.8	24	25	34	21.4	12
Non-white	20.8	6.6	38	2	-	-	48
Employed	1.4	4.6	16	12	15.4	8.6	20
Supported accommodation	5.6	15	14	37	-	-	24
Living alone	56.9	42.3	36	-	38.4	52.1	-
Schizophrenia	51.4	53.0	-	56	40.7	37.2	38
Mean age (years)	40.9	43.7	42	-	42.2	39.5	38

*includes widowed, separated and divorced

**includes widowed

Severe mental illness in the mental health service users sample

Government policy is focussed on those with severe mental illness, so it is important to determine the make-up of the sample with this respect (Department of Health, 1998a; 1999a). This was achieved by two methods. Firstly, the National Service Framework (NSF) for Mental Health (Department of Health, 1999a: 126) provides an *a priori* definition of severe mental illness (see Appendix G). According to this definition the entire mental health service users sample met the first criteria, as all had a diagnosis of mental disorder. In the absence of HoNOS scores, a cumulative total of 89.5% of the sample[11] met at least one of the three items of the second criteria.

A second measure of severity is based on personal characteristics, collected by the MARC-2 interview, rather than a set definition. Table 18 and Table 19 compare some MARC-2 characteristics with similar data from two other studies of people using mental health services - the CPA study (Carpenter *et al.*, 2001) and the study by Huxley *et al.* (1999), both for the Department of Health.

Table 18 shows that there were very few significant differences between the study and CPA sample, with a higher percentage of the study sample having ever been in custody ($p < .001$) and a lower percentage with concurrent substance abuse ($p = .053$). There were more differences compared to the Huxley samples. A higher percentage of the study sample had a

[11] Figures are given for a sub-set (n = 38) of the sample for whom this information was collected via MARC-2 forms.

diagnosis of schizophrenia than the Health (χ^2 = 12.838, df 6, p = .046) and SSD (χ^2 = 18.523, df 6, p = .005) samples; a higher mean M3 score than the total Huxley sample (3.7, n=3178), though not quite significantly (t = 1.946, df 37, p = .059); a higher percentage who scored 5 or more on the M3 than the SSD sample (p = .001); a higher percentage who had ever been in custody than all three samples (p < .001); and a higher percentage with a psychotic condition than the SSD sample (p = .013).

Table 18. Comparing clinical and service use characteristics

%	*Study sample*	*CPA*	*Huxley Health*	*Huxley SSD*
	N = 72	*N = 260*	*N=2214*	*N=964*
Diagnosis				
Schizophrenia	51.4	53	41	37
Paranoid illness	9.7	-	5	5
Manic depression	12.5	22	12	11
Psychotic depression	2.8	-	4	6
Anxiety/depression	16.7	21	28	26
Other	2.8	-	8	13
Not known	4.2	-	2	2
	N=38	*N=239*	*N=2214*	*N=964*
M3 score (mean)	4.45	4.60	3.70	
S.D.	2.37	2.39		
%				
Score 5+ on M3	52.6	42	28	44
Ever in hospital for 6 months +	19.4	30	15	30
Ever compulsorily admitted	47.4	48	35	50
Ever homeless	16.2	15	11	25
Ever in custody	36.6	14	10	16
Psychotic condition	78.9	80	64	60
Concurrent substance abuse	13.2	26	16	22

Table 19 shows that the study sample had comparable, if not more severe, social problems and risk indicators than the other study samples. In particular, the study sample had more severe problems with housing, (CPA, p = .001; Health, p = .004, using Chi-square tests), homecare (Health, p = .011), money (CPA, p = .011; Health, p = .052), friends (CPA, p = .047), occupation (CPA, p = .013; Health, p = .04), past self-neglect (CPA, p = .002; Health, p = .008), and present self-neglect (SSD, p = .023). The study sample had fewer problems

with present aggression to family (CPA, p = .037) and present aggression to others (SSD, p = .033).

Taken together these characteristics suggest that the sample is similar to the CPA study in severity, and slightly more so than the larger Huxley sample. This suggests that the study sample is typical of the caseload of people with severe mental illness using community mental health teams. However, nearly half of the sample had missing data due to a low response rate, which seriously limits the reliability of this estimate. On further analysis there were no significant differences between those with and without these data by age, gender, ethnicity, GHQ-12, and Empowerment Scale scores.

Table 19. Comparing problem-severity and risks

%	*Study sample* *N = 38*	*CPA* *N = 260*	*Huxley SSD* *N=964*	*Huxley Health* *N=2214*
Moderate or severe problems with				
Housing	55.3	23	37	25
Personal care	44.7	36	47	34
Home care	60.5	47	50	41
Money	55.3	36	53	41
Family	68.4	66	71	55
Friends	73.7	59	74	61
Occupation	78.9	60	70	64
Past and present risk				
Past self-neglect	36.8	18	27	20
Present self neglect	21.1	14	10	16
Past aggression to family	28.9	28	27	21
Present aggression to family	7.9	21	9	14
Past aggression to others	31.6	31	33	22
Present aggression to others	5.3	6	18	9

Long-term unemployed sample

In Spring 2000 there were 36.3 million people of working age in the United Kingdom, of whom 27.0 million were in employment, 7.7 million were economically inactive and 1.6 million were unemployed (ONS, 2001a). Age, qualifications, gender, ethnicity and location all have an impact on the likelihood of becoming unemployed and on the time people spend out of work.

Men are more likely to be unemployed than women, and unemployed for longer. In 2000, 62.5% of the total ILO unemployed were men[12]. However, there are many regional variations. For example, in Manchester in January 1999 only 15% of long-term unemployed were women[13], a similar proportion to the long-term unemployed sample in Manchester.

Young people are much more likely than older people to be unemployed, though older people are more likely to be long term unemployed. Table 20 shows that there were no significant differences in age groups between the sample and Labour Force Survey data (valid Chi-square statistics were not possible for females due to low numbers).

Table 20. Comparison of age groups with Labour Force Survey

	Study sample		*Labour Force Survey*	
	Male $N = 55$	*Female* $N = 7$	*Male*	*Female*
16-19	0	0	5.7	0.0
20-29	14.5	14.3	17.6	22.6
30-39	38.2	28.6	25.8	38.7
40-49	21.8	28.6	22.0	38.7
50-64	25.5	28.6	28.9	0.0

There are also important gender differences in the duration of unemployment. In spring 2000, 34% of unemployed men had been out of work for over one year compared to 19% of unemployed women (ONS, 2001a). Table 21 shows that was no significant difference between the lengths of unemployment between the male survey sample and the Labour Force Survey.

[12] The International Labour Organisation (ILO) definition is recognised as the most reliable measure of unemployment (ONS, 2001a).

[13] Data from Planning Studies, Manchester City Council.

Table 21. Comparison of length of unemployment with Labour Force Survey.

	Study sample		*Labour Force Survey*	
	Male N = 55	*Female* N = 7	*Male*	*Female*
One year but less than two years	52.7	57.1	41.2	32.3
Two years but less than three years	18.2	0	14.7	12.9
Three years or more	29.1	42.9	44.1	16.1

The focus group and interview participants

The following sections give a brief description of the people who participated in the qualitative study under each of the data types. Names have been changed to preserve anonymity.

Focus groups

Three focus groups were conducted with mental health service users in Manchester. All participants were current users of day services, with the majority using day centres. The groups were tape-recorded and data was collected though notes taken at and after each group together with full transcripts from the tapes.

Eight people attended Focus Group 1, though only six people made significant contributions. Daly, Judith, Donal and Geoff were all day centre members, who had attended for several years, and were long-term users of mental health services. None had worked for several years. Daly and Donal were in their thirties, Judith and Geoff were in their fifties. Barbara worked in a sheltered work scheme, working a few days a week in the café at a psychiatric unit. Sandra was working part-time for a user employment project. Both women were in their forties and had used mental health services for over ten years.

Seven people attended Focus Group 2, though six people made significant contributions. Jimmy, Carly and Harry were all day centre members, they had been frequent attendees for several years, and were long-term users of mental health services. None of them had worked for many years. Jimmy and Carly were in their forties and Harry was approaching retirement age. Pete, Simon and Colin were their thirties, had used mental health service users for several years and were currently using a mental health arts based day service.

Eight people attended Focus Group 3. Eddie, Tina, Sally, and Anne were all day centre members who had attended regularly for several years, and were long-term users of mental health services. All were in their late forties and early fifties and had not worked for a long time. Will was in his early thirties and used a mental health arts project, while Philip, Steven and Amy were in their early forties and used a sheltered work scheme.

Interviews
Six in-depth interviews were conducted. The paragraphs below describe the three mental health service users followed by the three long-term unemployed people.

Gary was a white male in his late thirties who lived alone. He had been using mental health services for almost twenty years following a car accident and the death of his father. He had never worked except for a youth training scheme shortly before he became ill. He had attended the day centre for over six years. He had two daughters whom he saw most weeks, but otherwise had very little contact with anyone outside of the day centre. He was interviewed at a day centre.

Anthony was a young, single, white male in his late 20s living at home with his parents. His last job was an order picker at a warehouse. He left that job about a year and half before the interview after becoming ill. He had used mental health services during this time and had a diagnosis of schizophrenia. He was interviewed at home.

Mike was a white male in his mid thirties, living with his partner and two daughters. He had had several jobs, mainly working in factories, though his last job was making pizzas. He first became ill with a psychotic illness over fourteen years ago and continued to work on and off for a few years after. His mental health problems were related to drug misuse. He was interviewed at home.

Bill was a white male in his fifties living with his wife and two adult daughters. He had worked all his life until being made redundant from a support role in the police a few years before the interview. Since then he had had two short-term jobs, the last one over a year ago. He was on his third time as a Jobclub member. He was interviewed at the Jobclub.

Carl was a white male in his mid thirties who lived alone. He had been unemployed for over five years. Before that he had jobs on and off and been in contact with criminal justice system. He had not had a job since a brief episode of treatment by a psychiatrist following the death of his baby daughter, though had not used mental health services for several years.

He had used a Jobclub but only very briefly. He was interviewed following a Jobplan workshop session at a Jobclub.

Matthew was a white male in his late thirties who lived alone. He had not worked for several years. His last job was working in a theatre. He had been in contact with a psychiatrist after the breakdown of his business and relationship, though not for several years. He spent most of his time working on a plot of land growing vegetables and did not consider himself part of mainstream society.

Discussion

It is important that the quantitative data can yield direct comparisons between study groups to answer the research questions. It is also important that generalisations can be drawn from the quantitative data. By contrast the purpose of the qualitative data is to enrich and explain the quantitative data and reveal new insights into the concepts under study. As such it is important that the qualitative data is not just compatible with the quantitative data but can also stand-alone. This discussion also determines the extent to which these conditions are met.

How similar are the two study groups from the survey data?

The two study groups were remarkably similar in terms of demographic variables. The only main difference was that the long-term unemployed sample had a higher proportion of men. This is a reflection of the sampling strategy, which drew the long-term unemployed sample from JSA claimants who are much more likely to be men. Therefore caution must be exercised with respect to gender in the subsequent analysis, particularly to variables more sensitive to gender effects, such as employment history. Also, the small number of long-term unemployed women may invalidate statistical tests when exploring gender differences for this sample.

There were few differences in accommodation, though the mental health service users sample had a higher proportion of owner-occupiers and a lower proportion in private rented housing. This finding will have an impact upon household incomes and financial disincentives to work, as housing costs play a significant role (Giles *et al.*, 1996; Turton, 2001).

There were almost no differences in education, though on inspection the mental health service users were better educated, having more qualifications and at higher levels.

How representative are the study groups from the survey data?

The demographic characteristics of the samples were similar to the populations from which they were drawn. The mean ages of the mental health service users in Manchester and

Tameside were not significantly different (using a t-test) from the mean age in their respective districts, with a mean age of 39.0 years for users in the central Manchester district[14] and 38.6 years in Tameside[15]. The gender distribution of the mental health service users in Manchester was not significantly different to central Manchester (using a t-test). There were no data available for marital status from Manchester's CPA, though comparisons with Tameside's did not reveal any significant differences using a Chi-square test. The ages of the long-term unemployed people had a similar profile to the Labour Force Survey.

However, a comparison with the ethnic profile of each area was difficult due to a lack of reliable data. The Manchester sample had more people from ethnic minority communities than Manchester as a whole, which has 85% white British, 5.5% black and 7% Asian (χ^2 = 14.241, df 3, p = .003). The samples in Tameside were too small for statistical tests, though they were similar to the ethnic profile of Tameside, which has 96% white British and 3% Asian. The samples appear to have fewer people from Asian origins and more black people than in the general population, which reflects the differing service use between ethnic groups (Bird, 1999; Wilson and Francis, 1997).

The sample of mental health service users had very similar characteristics to the typical caseloads of community mental health teams. There appears to be very few differences in age and marital status, though the sample has fewer women. The sample differs in ethnicity, though this is perhaps a more balanced sample than the comparison groups. The main differences occur in accommodation. The lower number of people in supported accommodation and living with others suggests that the study sample is biased towards those more highly functioning individuals living independently in the community.

However, almost all of the mental health service users fell within the Department of Health definition of severe mentally illness. Moreover, the mental health service users sample was similar in terms of severity to typical caseloads of community mental health teams. Indeed, in many respects the sample displayed more severe problems and risks.

The long-term unemployed sample had a very high proportion of men, consistent with local and national statistics. Furthermore, the age profile and lengths of unemployment did not differ significantly from the Labour Force Survey data.

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[14] Data from central Manchester's CPA database of people on enhanced CPA (n = 185), July 2001. No demographic details were available from either north or south Manchester's CPA records.

[15] Data from CPASS annual report, 1999.

How compatible are the survey and qualitative data?

Few demographic details of focus group and interview participants were collected. Based on the information available the qualitative data has similar characteristics to the survey data. There was a similar bias towards men, an age range perhaps slightly older with fewer people from minority ethnic communities. For the mental health service users there was a comparable incidence of severe mental illness. The long-term unemployed people had similarly long duration of unemployment, perhaps longer for the interview participants.

The findings of the qualitative data must be taken in the context within which they were generated. The data is limited in nature, amount and scope. The participants were not representative of mental health service users and long-term unemployed people. Most data came from mental health service users, the majority of participants were either users of day centres and job clubs, and the limited number of long-term unemployed participants were all male. Furthermore, the findings were taken from a limited set of data. Three focus groups, six in-depth interviews and a limited period of participant observation were used to generate the data. However, a further twenty-five people contributed their insights into the matters of this study and their contributions add validity to the findings.

Summary

This section has provided some basic descriptive information about the two study groups. These findings suggest that the samples closely resemble the populations from which they were drawn, and more importantly, that they can be used to represent typical users of mental health services and long-term unemployed people in general living in urban and semi-rural environments.

Perhaps the main finding of this section is that very few differences were found in demographic indicators and key descriptive variables. However, the uneven gender distribution is an important limitation and cannot be ignored in further comparisons between the two groups.

The profile of the survey participants suggests that the data is robust enough to make comparisons between groups, and to generalise, subject to the limitations described. Though limited in many respects, the qualitative data is able to provide insights into the survey findings and illuminates matters of this study not available through the quantitative data.

Section Two: Employment status

> No people or population can be good, intelligent, or happy, except by a rational and natural education and useful employment or occupation. (Robert Owen, 1857)

Employment, and the lack of it, are central to this study. Current employment status has an impact on the health and well-being of an individual. Work histories are important as they can affect current attitudes to work, which can determine who wants to, and is likely, to return to work. This section describes and compares the two study groups in terms of their current employment status and work histories.

Current employment status

As expected most people in both study groups, about 90%, were not working. Slightly more mental health service users (14.1%) than long-term unemployed (9.7%) said they worked, though this was not significant using a Chi-square test.

For the sample of mental health service users there were more men than women on long-term sick (80% and 65% respectively), probably due to longer work histories, and in sheltered work (13% and 4%), which has been noted elsewhere (Schneider, 1997); whereas only women were in employment (4%), retired (12% claiming a pension) and a housewife (8%). For the long-term unemployed sample all women were unemployed compared to 89% of men, with the remaining men were either employed (6%) or in voluntary work (4%). These differences cannot be tested for significance due to a low sample size.

Table 22. Employment status

%	*Mental health service users* *N=71*	*Long-term unemployed* *N=62*
Paid/self-employment	1.4	4.8
Voluntary work	2.8	3.2
Sheltered work	9.9	0.0
Other work	4.2	1.6
Total working	14.1	9.7
Unemployed	0.0	90.3
Long-term sick	74.6	0.0
Housewife/ husband	2.8	0.0
Retired	4.2	0.0
Total not working	85.9	90.3

All but one of the focus group and interview participants were out of work. The only person working was female. The qualitative data revealed interesting insights into how people defined their current employment status. A text search of the qualitative data using the terms, 'work', 'job' and 'employment' found the following perspectives.

> **Sandra.** I work at the moment, I work 16 hours a week and I really enjoy that. [*Focus group 1*]
>
> **Carl.** So it's just little bits like that, just to survive and just get a few little jobs on the side. I know people in the building trade - 'do you want to do a week here, or do a week there?' [*Interview*]
>
> **Philip.** I'd like see us getting paid more for doing our work. [*Focus group 3*]
>
> **Sally.** Most of me work that I do is for the Centre. I have a sale every year, and I do handicrafts at home for it every year. [*Focus group 3*]
>
> **Harry.** I think going to [Day Centre] gives us a job really, you know? [*Focus group 2*]

Each person had a different perspective on work. Sandra had a formal temporary job, whereas Carl's work was very informal, but still with an employer. Philip worked in a sheltered workshop, which is formal but not with an employer. Sally's work was at home making soft furnishings for a sale in a day centre, it was both informal and unofficial. Finally, just going to a day centre was like a job for Harry. What they have in common is that they all felt they were working. This suggests that employment status can be a relative concept and care must be taken when assuming definitions.

Work histories

The summary of work histories, in Table 23, shows that the difference in the number of jobs between groups is significant (χ^2 = 11.27, df 2, p = .004). On average mental health service users had fewer jobs than long-term unemployed (average of 3.0 and 3.8 respectively, t = -2.25, df 131, p = .026; Z = -2.67, p = .007). A greater percentage of mental health service users had had other occupations (supported employment, sheltered work, etc.) than long-term unemployed (40% compared to 20%, χ^2 = 6.45, df 2, p = .04). Apart from these, there were no significant differences between groups for mean lengths of last, longest and best jobs, and social class of last job (see Table 6 in Appendix F).

Social class of last job for the samples differed greatly from the general population, with fewer in social classes I, II and III, and many more in classes IV and V, for both Manchester (χ^2 = 65.63, df 2, p < .001) and Tameside (χ^2 =25.89, df 2, p < .001)[16].

Table 23. Characteristics of employment history

%	*Mental health service users*	*Long-term unemployed*
Number of jobs	*N=71*	*N=62*
None	2.8	3.2
1 to 3	70.4	41.9
4 or more	26.8	54.8
%	*N=71*	*N=62*
Had any job	97.2	96.8
Had full-time job	85.9	91.9
Had other occupation	39.4	19.4
Social class of last job %	*N=71*	*N=61*
I & II	11.3	8.2
III(N) & (M)	29.6	19.7
IV & V	59.2	72.1

Table 24 provides three measures of duration of unemployment. Firstly, mental health service users had a much longer *period since their last paid job* (t = -5.12, df 129.7, p < .001; Z = -5.85, p < .001), with an average of over 9 years compared to 3½ years for long-term unemployed people. Secondly, mental health service users also had a much longer *total period out of work*[17], with a mean of 11 years, accounting for over half of their working life, compared to 6½ years for long-term unemployed (t = -3.75, df 130, p < .001; Z = -4.32, p < .001).

However, when comparing the length of *unemployment before the latest period out of work*, long-term unemployed people had a longer mean duration, though not statistically significant. Indeed, on inspection a higher percentage of long-term unemployed people had previously experienced periods of unemployment (43.5% compared to 31%), and had had more frequent spells out of work, though again not statistically significant. This suggests that the long total period out of work experienced by mental health service users is almost entirely

[16] The social class structure in Manchester, defined by own occupation, was 23.8% in classes I & II, 38.5% in III(N) & III(M), and 25.4% in IV & V. The figures for Tameside were 24.3%, 48.7%, 21.6% respectively. Figures from Department of Health, Compendium of Clinical and Health Indicators 2000, December 2000

[17] Includes all periods not in work, e.g. unemployment, long-term sickness, prison, raising family and as a mature student.

due to the latest period out of work. Indeed, these two variables correlated strongly ($r = .78$, $p < .001$).

The following extracts from interviews and focus groups confirm some of the findings described above. Among the long-term unemployed participants Bill had been in steady work all his life.

> **Bill.** No, I've been in work most of me, me life. [*Interview*]

Whereas Carl had had numerous jobs, periods of unemployment, and time in prison.

> **Carl.** Yes, when I left school I did an apprenticeship - motor mechanics and a course, painting and decorating. And then I had a driving... I used to drive for a bakery delivering bread and picking up monies and things... I've done a bit of boxing, I played professional football for Chester City... I have been in contact with the Police because I've been wheeling and dealing ... And I got in trouble for handling. [*Interview*]

Among the mental health service users, Jimmy, like Bill above, had had a stable work history doing manual work.

> **Jimmy.** ... I have been on the sick for the last five years, and I have done manual work all my life before that... I have worked all my life. [*Focus group 2*]

Whereas Mike had done many jobs, and like Carl, had been in contact with the Police.

> **Mike.** You know, all different stuff, I worked... My sister got me a job at her factory where she worked... And like I worked at, er, Deep Pan Pizza, making pizza and stuff. And I worked in factories - die casting, making metals - and I worked with me father, me father was a plasterer like, erm. Like, I got into the wrong crowd. [*Interview*]

The qualitative data revealed gender differences, with the female mental health service users describing times out of work raising children, part-time working and low paid jobs.

Table 24. Characteristics of unemployment history

	Mental health service users N=71	*Long-term unemployed* N=62
Months since last job	109.0	41.8
S.D.	84.5	66.7
Range	0-360	0-384
Total months out of work (mean)	132.4	76.7
S.D.	86.0	85.7
Median	108	41
Range	0-360	0-384
% of given work history out of work	52.9	30.6
% Unemployed before most recent	31.0	43.5
Mean unemployed	14.0	28.0
S.D.	33.4	56.4
Range	0 - 150	0-279
Spells out of work (%)		
None	1.4	6.5
One	63.4	51.6
Two +	35.2	41.9

Two thirds of mental health service users started their latest period of unemployment *after* their first admission as a psychiatric inpatient. These people worked for an average of 5¼ years after their first admission (S.D. 5.5 years, median 3 years, range 0 – 21 years, N=39). Moreover, 46% of mental health service users had their first admission before they started work in their last job.

So why did mental health service users stop working? Reasons for giving up work are given in Table 25. There were significant differences between the groups (χ^2 = 56.92, df 6, $p < .001$). Most long-term unemployed became unemployed via redundancy or at the end of a temporary contract, whilst most mental health service users left their last job due to health problems. Furthermore, when questioned further reasons such as dismissal, resignation and other were often indirectly a result of poor health.

Table 25. Reasons for leaving last job

%	*Mental health service users* N=67	*Long-term unemployed* N=58
Made redundant	4.5	37.9
Temporary job came to an end	1.5	19.0
Resigned	14.9	12.1
Dismissed	13.4	3.4
Family or personal reasons	4.5	10.3
Health reasons	50.7	3.4
Other	10.4	13.8

In the following extracts from the interviews, two participants describe how they left their last jobs: side-effects of medication and effects of symptoms.

> **Mike.** ... But I got really, really paranoid in that place. And er, the doctor was giving me Depixol injections, Depixol, and they were really not agreeing with me. I was like having muscle spasms and getting rushed into hospital for injections to... I was like stiffening up and all that. But that was the last steady job I had really. [*Interview*]

> **Anthony.** Well, I had hallucinations with a long period of stress and I ended up going into Tameside Hospital, as, eh, I got admitted in there and now I... I... I'm diagnosed schizophrenia.
>
> **Interviewer.** Was this when you were at work?
>
> **Anthony.** Well it started at work.
>
> **Interviewer.** And did you give up work as a result?
>
> **Anthony.** I gave up work, yeah. I left work. [*Interview*]

As with the survey data, long-term unemployed participants spoke of redundancy, while mental health service users had experienced health related problems. The majority of mental health service users became ill before or during their last job, struggled to hold it down and never worked again.

Social mobility

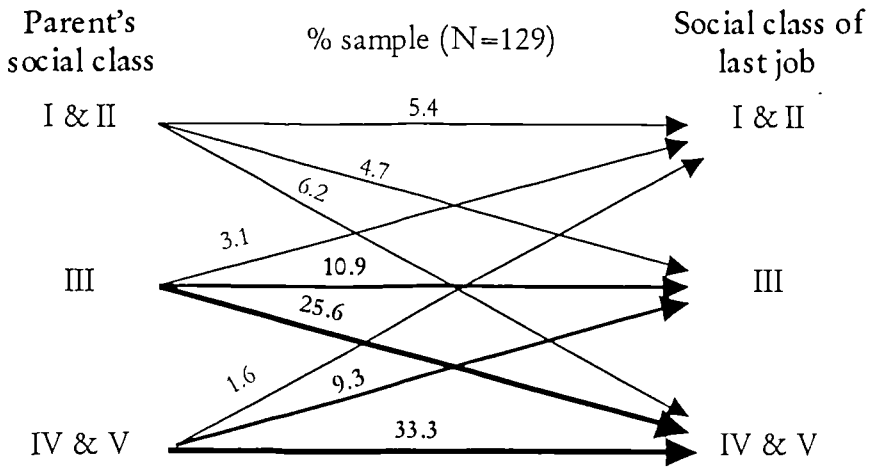
Although there were no significant differences between groups in social class of their last job, when these are compared to parent's social class there appears to have occurred a degree of downward social mobility. The percentage of people whose last job was in social classes I and II had fallen from 16% to 10% and those in class III had fallen from 30% to 25%, whereas those in classes IV and V had risen from 44% to 65% (see Table 7 in Appendix F).

Figure 16 shows that whereas the majority, 50%, were intergenerationally stable (horizontal lines), 37% were downwardly mobile (downward diagonal lines) and just 14% were upwardly mobile (upward diagonal lines).

Data for the general population reveals a reverse trend (Heath and Payne, 2000). Using data from the British Election Surveys (BES) 42% of men and 36% of women in the most recent cohort (born between 1950 and 1959) were upwardly mobile and just 13% of men and 27% of women were downwardly mobile.

For the 'social drift' theory (see Chapter One) to explain the downward social mobility of mental health service users one would expect that those who became ill before taking on their last job would experience downward social mobility, i.e. illness resulted in a job of lower social class. In fact only 23.3% of people who had been admitted *before* getting their last job had downward social mobility, compared to 64.4% for those who had been admitted *after* getting their last job (χ^2 = 9.27, df 1, p = .002). Clearly other factors must explain this.

Figure 16. Social mobility



What factors predict social class of last job? Using the life-course model of occupational attainment (Gershuny and Marsh, 1994) a stepwise linear regression was performed with parent's social class, highest level of education (as a proxy for years of school), months unemployed before last job, and cumulative months non-employed as independent variables. Age was also included since social class from the last job can reproduce age bias, as social class often increases with 'occupational maturity' to a peak at around 35 to 50 years old (Heath and Payne, 2000: 258).

The results showed that 36% of the variance in social class of last job was explained by the age on leaving full-time education, with those with higher levels of education also having a higher social class; 25% of the variance was explained by cumulative length of unemployment, as those with longer unemployment records had lower social class; and 19% by parent's social class. Age and length of latest period of unemployment did not have an effect on social class, with no statistical significance confirmed using one-way ANOVA and Kruskall-Wallace tests. Figure 17 and Figure 18 demonstrate these relationships graphically.

Figure 17. Mean cumulative length of unemployment and social class of last job

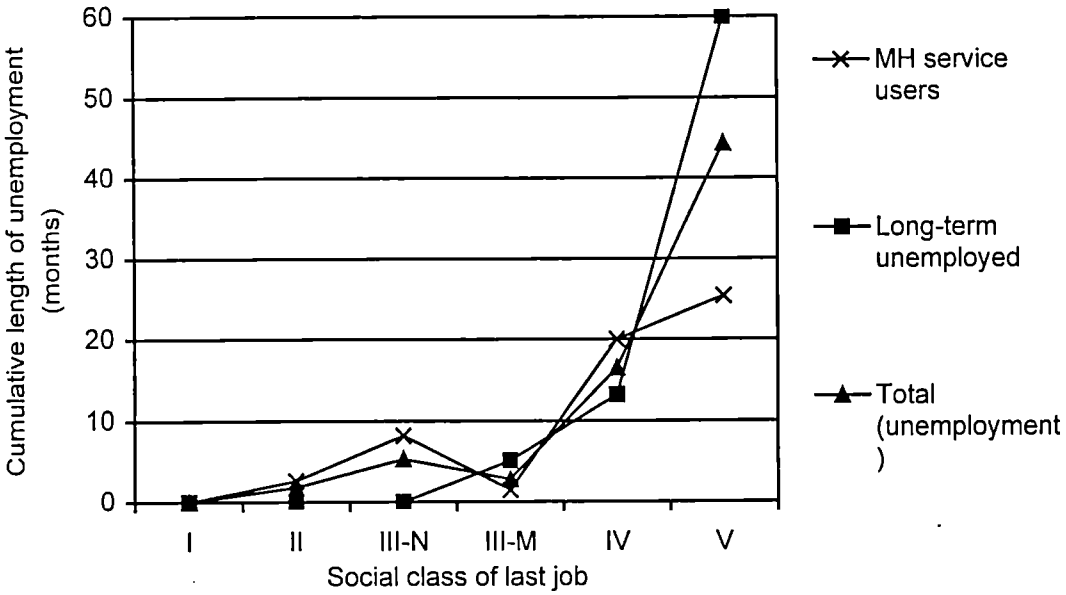
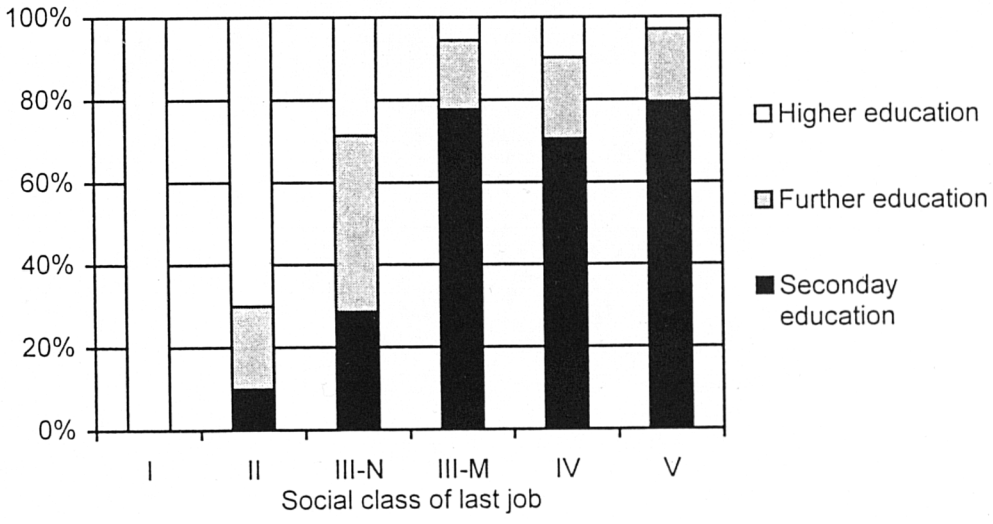


Figure 18. Highest level of education and social class of last job



Discussion

The differences in employment status between the groups are expected and arise from the sampling method, i.e. most long-term unemployed were unemployed and most mental health service users were on long-term sick. A less predictable finding is that no mental health service users were unemployed, defined as claiming JSA. This is likely to be due to the severe mental illness of the sample.

A finding from the qualitative data is that people had different definitions of work. Working could mean paid employment, but it could also mean jobs 'on the side', sheltered work, voluntary work, odd jobs and favours.

There were few differences in work histories between the two groups. Mental health service users had fewer jobs and less unemployment in their employment histories. This could indicate a greater degree of occupational stability, but may also be a function of lower amount of time that mental health service users have spent in work. The qualitative data supported these findings, and found striking similarities in the patterns of work histories. Apart from the length of time since last working, the main differences were not related to the study groups, but rather to the stability of work, gender and age.

The findings suggest that despite quite stable work histories in both groups – people were able to hold down a job for about 6 years on average - mental health service users' work histories are characterised by an exceedingly long period since they last worked. Most mental health service users lost their last job, directly or indirectly, due to health problems and didn't work again.

To explore this finding further one must consider what factors influence the length of unemployment. Evidence suggests that age, gender, qualifications and social class influence the length of time that people spend unemployed. Young people are less likely to have been unemployed for a long period compared with older people, and women are less likely than men to have been unemployed for a long period (ONS, 2001a). Those with no qualifications are the most likely to be unemployed, particularly among men, and those with the highest qualifications are the least likely (ONS, 2001). Indeed, the low educational attainment of both study samples partly explains their unemployment.

The two sets of data also found that both study groups had lower social class than the general population, with most people having had unskilled and manual work. This is an important finding because social class also partly explains current unemployment, as manual

workers are particularly at risk of falling into a cycle of recurrent unemployment (Gershuny and Marsh, 1994).

The downward social mobility is counter to the upward trend in the general population (Heath and Payne, 2000: 262). The 'social drift' theory was proposed to explain this for mental health service users. The findings suggest that this may be the case for just a minority of mental health service users. Indeed, *both* study groups experienced downward social mobility. This phenomenon can be better explained by a lack of qualifications, leading to jobs in lower social class, leading to unemployment.

A key finding is that most mental health service users lost their last job several years *after* their first contact with mental health services. The qualitative data confirmed this finding and revealed for some the struggle of coming to terms with a serious illness while trying to hold down, and eventually losing, their job.

The data on work histories must be viewed with caution as 57% of the whole sample had more than one year missing, and 35% had over three years missing. These missing years were most likely to be caused by inaccurate estimates of time periods and poor recall of time in jobs, unemployed, studying and time in prison. On average mental health service users had 38 months missing and long-term unemployed people had 49 months. As noted by Mowbray *et al.* (1995) more accurate measures of work histories are required.

Section Three: Personal finances

> If 'being poor' once derived its meaning from the condition of being unemployed, today it draws its meaning primarily from the plight of a flawed consumer. This is one difference which truly makes a difference to the way living in poverty is experienced and to the chances and prospects of redemption from its misery. (Bauman, 1998: 1)

The level and type of income are key indicators of poverty, and have been an enduring focus of attention of governments from the first Poor Laws to the present day. A low income is often cited as the main reason for the exclusion from the many opportunities available to the average person. This section goes further by also examining spending which, as highlighted by Bauman, is becoming a key feature in the definition and study of poverty. This section describes and compares the two study groups in terms of sources and levels of income, welfare benefits received, and expenditure by household type.

Income sources and amounts

There were few differences in sources of income between groups. Almost all, about 98%, received welfare benefits and nearly three quarters received Housing Benefit. Very few, less than 7%, had any earnings, and about a quarter had other income, such as partners' earnings, therapeutic earnings, and gifts. Indeed, the breakdown of mean weekly income given in Table 26 shows that welfare and housing benefits make up the majority of income, accounting for 92.1% of total income for mental health service users and 88.7% for the long-term unemployed.

On average mental health service users had higher mean weekly incomes than long-term unemployed ($t = 4.76$, df 123, $p < .001$). The biggest difference was for single people; with mental health service users having an extra £60 per week on average ($t = 6.07$, df 92.6, $p < .001$), almost entirely due to higher welfare benefits payments ($t = 11.12$, df 55.5, $p < .001$). For people living together long-term unemployed people received more housing benefit ($t = -2.81$, df 27.7, $p = .009$), though this is due to a higher percentage of owner-occupiers among mental health service users, therefore not claiming housing benefit.

The most marked differences were between living situations, which are mainly a product of the welfare benefits system. However, the higher 'other' income for people living with a partner is mainly due to a higher percentage having a partners income ($\chi^2 = 19.17$, df 2, $p < .001$) for both groups and to therapeutic earnings ($\chi^2 = 8.14$, df 2, $p = .017$) for mental health service users.

The only other significant differences were a higher percentage of long-term unemployed people who lived alone received gifts ($\chi^2 = 5.98$, df 1, $p = .014$), probably due to having the lowest income of all groups; and a higher percentage of mental health service users received therapeutic earnings ($\chi^2 = 4.03$, df 1, $p = .045$), as they alone are eligible to do so.

Table 26. Weekly Income by living situation

Mean income (£s per week)	*Mental health service users*			*Long-term unemployed*		
	Single people	*Living together*	*All*	*Single people*	*Living together*	*All*
	N=51	*N=19*	*N = 69*	*N=45*	*N=17*	*N = 62*
Welfare Benefits	118.70	131.36	**121.87**	49.83	98.91	**63.29**
S.D.	43.07	71.69	**51.40**	9.49	45.13	**32.96**
Range	0 - 185	50 - 300	**0 - 300**	0 - 81	0 - 172	**0 - 172**
Housing Benefit	29.83	22.67	**27.82**	35.28	49.18	**39.15**
S.D.	32.63	30.53	**31.95**	27.65	22.77	**26.94**
Range	0 - 150	0 - 70	**0 - 150**	0 - 130	0 - 95	**0 - 130**
Other income[18]	7.31	23.19	**10.59**	7.06	11.90	**8.29**
S.D.	20.50	47.71	**28.54**	19.70	21.60	**20.13**
Range	0 - 107.50	0 - 165	**0 - 165**	0 - 100	0 - 76	**0 - 100**
Earnings	3.88	0.00	**2.87**	5.00	3.82	**4.68**
S.D.	17.07	0.00	**14.74**	29.96	15.76	**26.70**
Range	0 – 92.83	0.00	**0 - 92.83**	0 - 200	0 - 65	**0 - 200**
Total income[19]	155.53	185.63	**162.47**	95.24	176.07	**115.45**
S.D.	52.53	62.44	**55.94**	44.15	33.07	**54.40**
Range	41 - 241	75 - 300	**41 - 300**	15 - 307	124 - 226	**15 - 307**

Table 27 shows the weekly incomes adjusted for household size and composition, before housing costs (BHC) and after housing costs (AHC). AHC provides a more realistic picture of disposable income. This was done using an equivalisation technique called the McClements scale (DWP, 2001a), which is used by the government. This means that incomes for all individuals can be compared regardless of household characteristics[20]. Using this method, mental health service users had higher mean incomes than long-term unemployed people before housing costs (BHC, $t = 5.49$, df 125.7, $p < .001$) and after housing costs (AHC, $t = 6.22$, df 109.8, $p < .001$).

[18] The mean figure excludes three cases with mean weekly incomes of over £400, which owing to high income from partners gave a mean other income of £42.88 for mental health service users and £55.01 for long-term unemployed.

[19] Excludes extreme cases described above.

[20] The Households Below Average Income (HBAI) study (DWP, 2001a) uses an income measure that is adjusted, or equivalised, to take into account variations in both the size and composition of the household. This is because a family of several people needs a higher income than a single person in order for both households to enjoy a comparable standard of living. The HBAI equivalence scales take a couple with no children as a reference point. The incomes of larger households are adjusted downwards and the incomes of smaller households adjusted upwards relative to this benchmark.

Table 27. Equivalised weekly incomes.

Income (£s per week)	*Mental health service users*		*Long-term unemployed*	
	BHC	*AHC*	*BHC*	*AHC*
	N = 66	*N = 57*	*N = 62*	*N = 61*
Mean Income	236.19	202.10	153.76	105.10
S.D.	89.54	91.26	80.29	76.84
Median	213.11	196.51	143.44	92.73
Range	67.79 - 434.62	29.73 - 392.12	24.59 - 503.28	22.03 - 472.73

The focus groups and interviews exposed a variety of views on income. A person's living situation appeared more important than the actual level of income. Some mental health service users, such as Jimmy who was single and without children, were quite happy with the money they received.

> **Jimmy.** I think that money works for me. I get enough money, I am quite satisfied with the money I get. If I didn't have it I wouldn't be able to go to places like [the day centre] and Trafford centre for a dinner and things like that you know if I wasn't getting the money you see, or even live where I am doing now, you know. [*Focus group 2*]

Whereas Mike, who had a partner and two children, found it much harder.

> **Mike.** ... It's hard, you know, at birthdays and at Christmas and things like that, you know, it's hard trying to get the money together for me children. I mean, I am on good money at the moment, you know, off the Social, but I don't want to depend on them all me life. [*Interview*]

Although Gary, who was single, also struggled.

> **Gary.** I'm struggling. Struggling, yeah. I'm struggling with money. [*Interview*]

Carl clearly states that the amount of Job Seekers Allowance he receives is not enough.

> **Interviewer.** Do you think it..? It's about £50 a week, isn't it? So you think that's not enough money to be able to live on?
> **Carl.** No, not really... [*Interview*]

However, Carl also supplemented his income with earnings, though these were low and irregular.

> **Carl.** I did little bits of jobs here and there, you know, like friends - I have uncles... And I was doing a couple of days here, money in my hand. Some weeks it might be handy for a month, I might get nowt, and for another couple of months I might get twenty pound a day here, twenty pound there. [*Interview*]

Welfare benefits

The interest here is not to compare groups, as any differences are solely due to sampling method, but rather to explore the characteristics of mental health service users that receive the various benefits and explore any patterns.

Table 28 shows that all mental health service users were in receipt of a disability benefit, with the Disability Living Allowance as the most common followed by Income Support and Incapacity Benefit. There were significant differences between living situations on all disability benefits except Incapacity Benefit, with higher proportions of people living alone in receipt of welfare benefits.

Exploring differences in gender, twice as many men than women were in receipt of Incapacity Benefit (55.6% compared to 23.1%, $\chi^2 = 7.07$, df 1, $p = .008$), while more women than men claimed child benefit (19.2% compared to 2.2%). There were also important differences between age groups, with Income Support claimed mostly by younger people ($\chi^2 = 8.71$, df 2, $p = .013$), DLA claimed by younger middle-aged people ($\chi^2 = 14.80$, df 2, $p = .001$), and Incapacity Benefit claimed mostly by older middle-aged people, though not significant.

There were differences by ethnic group with a higher proportion of white British people than non-white people claiming DLA (87.7% compared to 57.1%, $\chi^2 = 7.02$, df 1, $p = .008$) and Incapacity Benefit (52.6% compared to 7.1%, $\chi^2 = 9.46$, df 1, $p = .002$), while more non-white people claimed Income Support (71.4% compared to 57.9%) though not significant.

There were no significant differences between those claiming and not claiming DLA on the Empowerment Scale, total LSS, M3 or GHQ-12 scores (using independent samples t-test and Mann-Whitney U-test), and for those who had seen a doctor, seen a doctor about nerves or taken medication for nerves in the past year (using Chi-square test), or in mean years since first admission (using independent samples t-test and Mann-Whitney U-test). It is incorrect to assume that the most seriously ill receive higher rates of DLA.

Mental health service users had claimed for longer on average than long-term unemployed (6.7 years compared to 2.3 years, t = 5.43, df 114.4, p < .001), due to the longer length out of work, and an indication of greater benefit dependency. Indeed, there are negative correlations between length of benefit claim and work behaviours and attitudes (n = 114, r = -.31, p = .001).

Table 28. Welfare benefits received by mental health service users

%	*Living alone*	*Living together*	*Living with others*	*All*	*Significance*
	N=40	*N=19*	*N = 12*	*N=71*	*Chi-square*
Income support (for sick person)	75.0	36.8	50	60.6	χ^2 = 8.53, df 2, p = .014
Disability premium	70.0	36.8	33.3	54.9	χ^2 = 8.44, df 2, p = .015
Severe disability premium	42.5	15.8	0.0	28.2	χ^2 = 10.21, df 2, p = .006
Disability Living Allowance	92.5	73.7	58.3	81.7	χ^2 = 8.32, df 2, p = .016
Incapacity Benefit	45.0	42.1	41.7	43.7	ns
SSP	2.5	0.0	0.0	1.4	ns
State Retirement Pension	2.5	0.0	0.0	1.4	ns
Child Benefit	5.0	21.1	0.0	8.5	ns
Lone parent benefit	5.0	0.0	0.0	2.8	ns
Other	5.0	0.0	8.3	4.2	ns

Although most people claimed welfare benefits, many of the interview and focus group participants expressed strong reservations about this.

> Mike. ...I don't want to depend on Social all the time, you know... [*Interview*]

> Carl. ...You can shove the money as far as you can shove it, I don't want that. I don't want to scrounge... It's no good giving me ninety six pounds a fortnight. I can't... I can't survive on it. [*Interview*]

An analysis of the most common benefit Disability Living Allowance (DLA) is given in Table 29. This shows that the most common rates of DLA, for the 58 people who received it, were the higher rate of the mobility component and the middle rate of the care component. Over half of all DLA claims fell into three combinations: middle rate care plus lower rate mobility (20.7%), middle rate care only (19.0%), and higher rate care plus lower rate mobility (15.5%).

Table 29. DLA by component and rates

			Mobility Component			
			None N=25	*Lower rate N=28*	*Higher rate N=5*	*Total N=58*
Care Component	*None*	*N=13*	10.3*	5.2	6.9	22.4
	Lower rate	*N=11*	12.1	6.9	0.0	19.0
	Middle rate	*N=24*	19.0	20.7	1.7	41.4
	Higher rate	*N=10*	1.7	15.5	0.0	17.2
	Total	*N=58*	43.1	48.3	8.6	100.0

*10.3% of DLA claimants gave no details of rates.

The interviews and focus groups reveal the views on DLA. There was a general feeling that DLA had a positive affect on the lives of those who claimed it.

> **Will.** I think you need personal finance. I've only just got DLA, and it changed my life, and, sort of, I started living. But before, like, I was just on income support with not enough money to live.
> **Tina.** ... that can make a difference, that DLA, you know, if it's only a few pounds at the end of the month. It does make a difference and cheer you up. [*Focus group 3*]

Expenditure

Both groups spent most of their money per week on housing, bills and food - 56.1% for mental health service users and 65.8% for long-term unemployed - and spent similar amounts in each expense category in Table 30. Mental health service users spent more per week on clothing ($t = 2.00$, df 123, $p = .047$), tobacco ($t = 4.25$, df 88.0, $p < .001$) and 'other' expenses ($t = 2.20$, df 102.0, $p = .03$). Most of the differences in expenditure were due to living situation. Single mental health service users had a higher mean weekly expenditure ($t = 2.26$, df 71.3, $p = .027$) than single long-term unemployed people. Yet there was no significance difference in mean weekly expenditure for people living together.

Table 30. Weekly expenditure by living situation

Mean expenditure (£s per week)	*Mental health service users*			*Long-term unemployed*		
	Single people	*Living together*	*All*	*Single people*	*Living together*	*All*
	N=49	*N=14*	*N = 64*	*N=44*	*N=17*	*N = 61*
Housing	35.08	42.94	**36.71**	38.65	53.88	**42.90**
Food	21.80	51.79	**28.36**	14.16	53.33	**23.95**
Bills	18.70	35.21	**22.37**	13.53	32.19	**18.43**
Tobacco	15.62	18.23	**16.19**	5.03	9.44	**6.26**
Entertainment	14.41	5.50	**14.80**	14.67	11.91	**13.91**
Clothing	9.70	14.50	**10.69**	4.70	3.53	**4.38**
Transport	3.59	11.18	**5.28**	2.23	3.81	**2.65**
Household goods[21]	2.27	3.21	**2.48**	0.91	1.18	**0.98**
Leisure activities	2.73	3.57	**2.91**	1.66	4.16	**2.34**
Alcohol	4.58	0.71	**3.73**	7.78	3.00	**6.45**
Illicit drugs	3.30	2.14	**3.05**	4.76	2.06	**4.02**
Other items	10.82	3.97	**8.96**	3.99	4.79	**4.22**
Total expenditure	147.11	186.86	**155.80**	110.96	181.85	**129.56**

The main difference was in spending on tobacco. There was no significant difference in the proportions of smokers in each group (63.9% of long-term unemployed people and 71.9% of mental health service users). Yet for those who smoked, mental health service users spent on average £22.52 per week compared to £9.79 for long-term unemployed people ($t = -4.79$, df 65.7, $p < .001$).

The interviews and focus groups confirm these findings. Firstly, that people spent most of their money on essential items. Secondly, that spending on cigarettes was high, particularly among mental health service users.

> **Interviewer.** You can manage on what you get? Or...
>
> **Bill.** Well, just about sort of thing, obviously like now, you do without. [*Interview*]
>
> **Barbara.** Oh, yeah, you don't think of buying new clothes, new things for the house and stuff like that you know, you make do don't you?

[21] Excludes one extreme case of £250 for a single mental health service user.

Judith. Yeah. [*Focus group 3*]

Sally. But you learn to live with it. I've learnt to live within my means. [*Focus group 1*]

Interviewer. So what do you spend your money on?
Anthony. Cigarettes. [*Interview*]

Debt

Table 31 shows high percentages from both groups were in debt. Four people had debts of over £10,000, two from each group. These were excluded from the analysis when calculating the mean debt. There were no significant differences in mean debt between groups, with an average of £803 for mental health service users (6 times weekly income after housing costs) and £1110 for long-term unemployed (nearly 17 times higher than their weekly income after housing costs).

Table 31. Details of debts

%	*Mental health service users* N = 70	*Long-term unemployed* N = 62
With debt	41.4	46.8
With 2 or more	12.9	12.9
	N=26	N=26
Mean debt (£s)	803.13	1,110.23
S.D.	827.99	1,529.84
Range	32 - 3,000	75 - 5,500

Some issues in money management are given in Table 32, with over a third of all people in debt having difficulty in paying it off. Smaller percentages from each group required help to manage their money, though these figures increase for those who have debts to 28.6% for mental health service users and 31.0% for long-term unemployed. Indeed, for those with debts there was a significant correlation between requiring help to manage money and having difficult in paying off debt ($r = .45$, $p < .001$). People who said they have difficulty paying off their debt had a higher mean debt, though not significant.

Those who said that they lacked the money to enjoy everyday life had a lower mean income than those that did not lack the money (£128 per week compared to £184, $t = -3.61$, df 56.7, $p = .001$). A higher percentage of mental health service users than long-term unemployed

people said they did not require any more money (36.8% compared to 18%, $\chi^2 = 5.62$, df 2, p = .018).

Table 32. Money management

%	*Mental health service users*	*Long-term unemployed*
	N=29	*N=28*
Difficulty paying off debt	34.5	39.3
	N=68	*N=62*
Help to manage money	25.0	17.7
Lack money to enjoy everyday life	50.7	82.3
Extra money desired (£s per week)	66.99	106.48
S.D.	98.42	101.24
Range	0 - 500	0 - 400

In the extract from my interview below, Gary, a mental health service user, describes how he gets into debt.

> Gary. I'm struggling. Struggling, yeah. I'm struggling with money. [...] I spend on me bills, buy me dog, buy my food, see me kids weekend, you know, they want money. Then it's gone. Then I'm borrowing. I get myself in debt you know, just to keep myself afloat. Cos I smoke 200 cigarettes a week.

Discussion

Most people from both samples had a low income, with almost all claiming welfare benefits. The definition of 'low' income has always been a source of debate and to some extent has to be arbitrary. A threshold generally adopted to define low income is 60 per cent of median equivalised household disposable income (ONS, 2001a: 107). In 1999/00 this threshold (before housing costs) for the whole population was £142.80[22], with just 8.6% of all households below this figure (DWP, 2001a). This study found that 13.6% of mental health service users and 46.8% of long-term unemployed had incomes below this threshold. These figures are entirely consistent with national norms from the Households Below Average Income (HBAI) series (DWP, 2001a), which found 44% of those not working and 13% of those receipt of disability benefits below the threshold.

[22] In 1999/00 mean net equivalised disposable income (before housing costs) for the whole population (excluding the self-employed) was £338 per week, whilst the median income was £283 (DWP, 2001a).

Another measure of low income is the Council of Europe's decency threshold, which sets a poverty line as 68% of adult mean earnings (Low Pay Unit, 2002). The threshold in April 2000 was £238.68[23]. This measure puts 87.9% of mental health service users and 95.2% of long-term unemployed people with incomes below the poverty line.

The main differences in income levels were products of the social security system. Those living together had higher incomes, as did mental health service users, most of whom claimed disability benefits. Although income levels maybe different between groups, the perception appears as important. This clearly relates to the source of income, the nature of expenditure and past levels of income.

The type of welfare benefit claimed varied with demographic characteristics. It appears that these differences are spilt along traditional gender roles with men claiming contributory benefits, owing to their work records, and women claiming benefits for childcare. Moreover, contributory benefits were claimed by older people and means tested benefits by younger people, again, owing differences in work records. From the qualitative data, many participants expressed negative views about claiming benefits, particularly those that had worked most recently. However, those with DLA felt much better about their finances.

Mental health service users had claimed welfare benefits for longer than long-term unemployed on average. This is a direct result of their longer mean time since their last paid job. In general, people who claimed disability benefits were much more likely to claim for longer than any other type of benefit recipient. The figures for May 2001 found that 75% of all people who had claimed for over 2 years were in the 'sick & disabled group' compared to just 12% in the unemployed group (DWP, 2001b).

For both groups the majority of weekly budget was spent on essential items, such as housing, food and bills. A survey of mental health service users by Hogman and Chapman (1998) also found that, on average, people receiving DLA spent it on four items, of which the most popular were travel, bills, food and clothes. Hogman and Chapman (1998) suggest that the financial support to mental health service users is too low because DLA is intended for personal care and travel expenses, though is often used to meet more basic needs.

Mental health service users spent more than long-term unemployed people, due to their higher incomes, with most (39%) of the difference accounted for by more than double the spending on tobacco. As there was no significant difference in the percentage of those that

[23] Based on mean gross weekly pay of £351 for all adults (ONS, 2001b)

smoked this must be due either to heavier smoking or more expensive tobacco. Indeed, the OPCS Psychiatric Morbidity Survey (Meltzer *et al.*, 1995) found that 74% of those with neurotic disorders and schizophrenia smoked. Moreover, Nelson (2001) reported that people with schizophrenia smoke relatively more than other heavy smokers. However, the qualitative data also suggested that long-term unemployed had more ready access to cheap illicit tobacco, which can be up to £2 a packet cheaper than the usual retail price (BBC, 2001). The interviews and focus groups with mental health service users confirmed these findings, with some providing unsolicited accounts of 'going without' and how spending on tobacco was significant.

There were high incidences of debt, with over 40% from each group owing at least one debt, with a mean debt of several multiples of weekly income and a third of people in debt having difficult in paying them off. Similarly, Hogman and Chapman (1998) found that 38% of mental health service users were in debt. A study of debt among disabled people (Grant, 1995) found that physical and mental health deteriorated due to debt problems and that many had had to cut back on expenditure related to their disability.

As with many studies that have examined the welfare benefits of mental health service users there were some problems in the collection of reliable data; in particular some people were not aware of the benefits (or combination of benefits) they were receiving. Where possible the types of benefits people said they claimed were cross-checked with the amounts received.

Section Four: Health and well-being

> Basically, poorer people are significantly less healthy, both physically and mentally, than richer people. (Pilgrim and Rogers, 1999: 39)

Poor health and well-being are both causes and consequences of unemployment and social exclusion (see Chapter One). This section describes and compares the two study areas and two study groups in terms of their mental distress, physical health and empowerment. This section does not dwell on psychiatric problems (covered by Section One) but rather explores psychological health and general well-being.

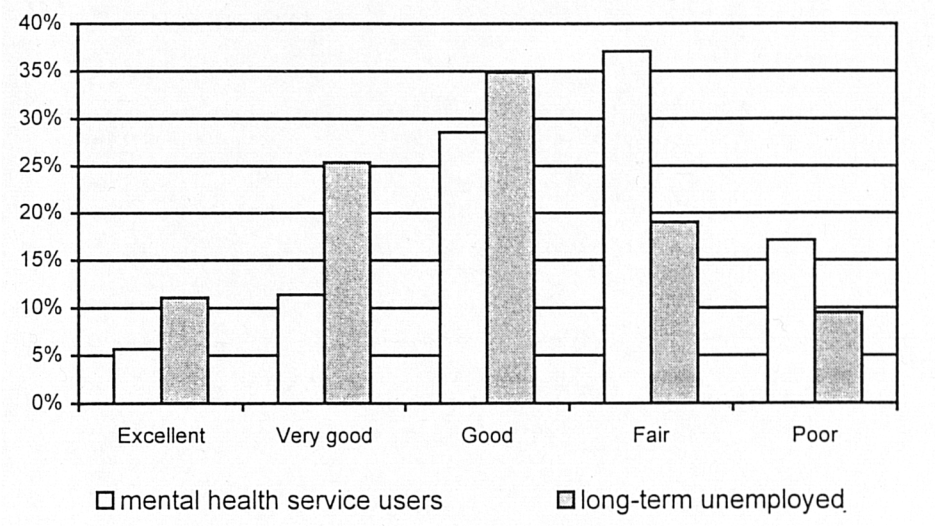
Short Form 12 Health Survey

The SF-12 provides a measure of physical and psychological health. Scores for the SF-12 were not calculated due to the prohibitive costs of the scoring manual and the lack of availability of the scoring algorithm. However, the opening question was used as a measure of general health status, as people's assessment of their own general state of health has been shown to be a good predictor of morbidity and mortality (Department of Health, 1998c).

The difference in general health status between the two study groups, as shown in Figure 19, is significant (χ^2 = 10.40, df 4, p = .034), as 71.4% of long-term unemployed said they had good, very good or excellent health compared to just 45.7% of mental health service users (χ^2 = 9.00, df 1, p = .003).

The percentage of people saying their health was good, very good or excellent declined with age, from 75% for those under 30, to 58% for those 30 to 49, and to 46% for those over 50, though not significantly. There was no significant difference between men and women.

Figure 19. General health status

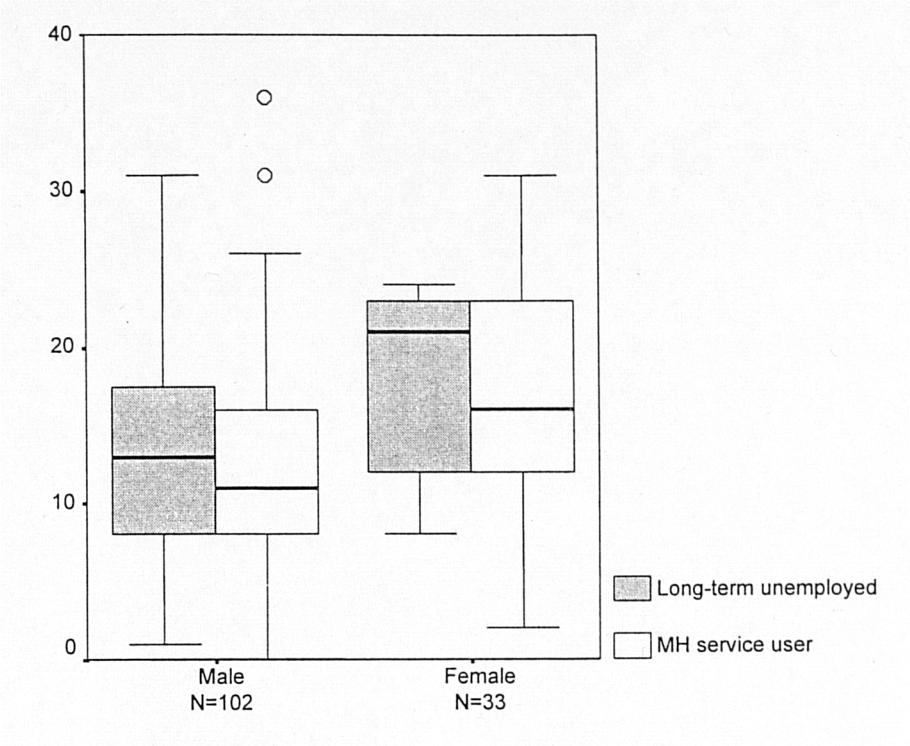


General Health Questionnaire-12

The GHQ-12 is a measure of psychiatric morbidity. The data for the GHQ-12 is presented separately for men and women as there are differences between genders in the general population (Colhoun and Prescott-Clarke, 1994).

Figure 20 shows that mental health service users and long-term unemployed people had similar GHQ-12 scores, with no significant differences (see Table 8 in Appendix F). There were no significant differences between ethnic groups for each gender and no correlation with age. However, there were significant differences in mean GHQ score between age groups for men, with those under 30 scoring higher (5.75, n=12) than those 30 – 49 (2.65, n=68), and 50 plus (2.86, n=20) (F = 4.35, df 101, p = .015), though not for women, possibly due to smaller numbers of women in the sample.

Figure 20. GHQ-12 scores (Likert scoring method)[24]



Empowerment and self-esteem

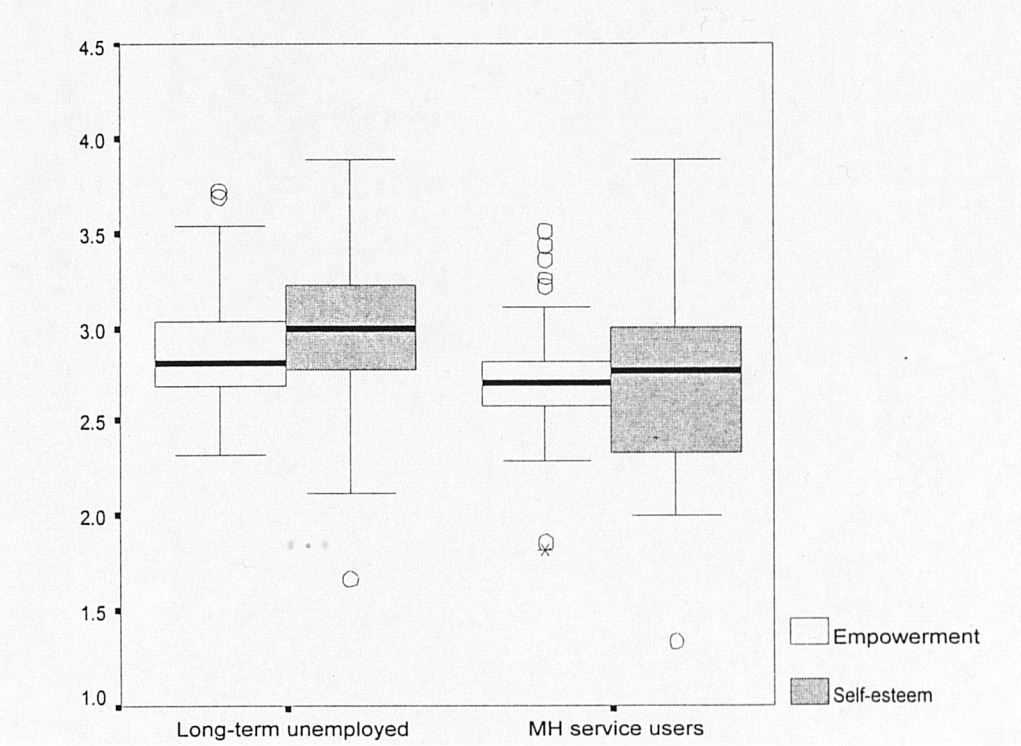
Empowerment and self-esteem are important variables and were measured using the Empowerment Scale (see Chapter Four). Table 33 and Figure 21 shows that long-term unemployed people scored significantly higher than mental health service users on the total Empowerment scale and the Self-esteem, Power, Control and Others subscales. These significant differences were confirmed using a Mann-Whitney U test. Interestingly, there were no significant differences between groups in Manchester. The box plot shows clearly that long-term unemployed people feel more empowered and have higher self-esteem than mental health service users.

[24] The box plot provides a summary based on the median, quartiles, and extreme values. The box represents the interquartile range which contains the 50% of values. The whiskers are lines that extend from the box to the highest and lowest values, excluding outliers. A line across the box indicates the median (SPSS, 1999).

Table 33. Empowerment and self-esteem scores

Mean (S.D.)	*Mental health service users* N=70	*Long-term unemployed* N=62	*Significance*
Empowerment	2.70 (.29)	2.87 (.31)	t = 3.39, df 130, p = .001
Self-esteem	2.75 (.52)	2.95 (.42)	t = 2.42, df 130, p = .017
Power	2.46 (.37)	2.66 (.47)	t = 2.71, df 115.2, p = .008
Activism	3.13 (.32)	3.22 (.41)	ns
Control	2.73 (.41)	2.90 (.46)	t = 2.19, df 127, p = .03
Anger	2.34 (.48)	2.37 (.53)	ns
Others	2.57 (.25)	2.73 (.33)	t = 3.09, df 113.2, p = .002

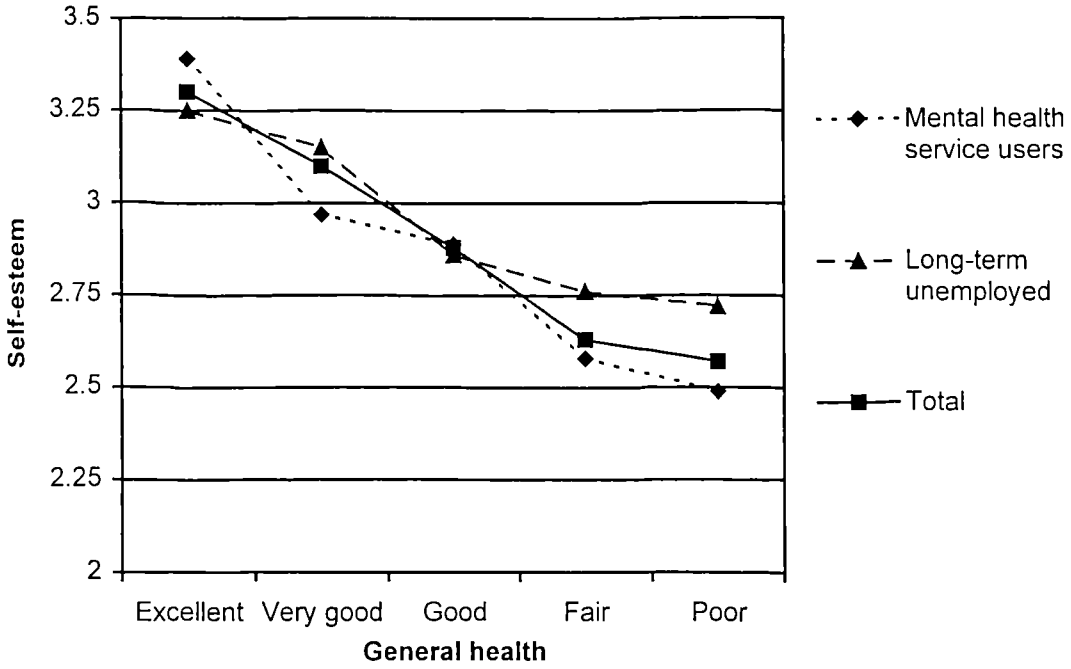
Figure 21. Empowerment and self-esteem scores



There were predictable relationships with health status, with more empowered people having better health; for example Figure 22 shows the relationship between self-esteem and general health. People who said their health was excellent, very good or good had higher mean scores than those who said their health was fair or poor on the empowerment scale (t = 4.28, df 129, p < .001), and self-esteem (t = 4.97, df 129, p < .001) and activism subscales (t = 3.19, df 123.3, p = .002). For men (n = 100), there was a negative correlation between GHQ (Likert scoring method) and Empowerment (r = -.48, p < .001) and self-esteem (r = -.50, p

< .001)[25]. There was a similar pattern for women (n = 32), though only reaching significance for self-esteem (r = .42, p = .015), due to the lower numbers. There was no relationship with M3 score for mental health service users.

Figure 22. Self-esteem and general health



There were also predictable relationships with work histories and education. For mental health service users (n = 70) there was a negative correlation between empowerment and total length of time out of work (r = -.27, p = .026), and for long-term unemployed people (n = 61) there was a negative correlation between total length of unemployment and empowerment (r = -.27, p = .034) and self-esteem (r = -.40, p = .001). Importantly, there were no significant differences between groups in either the empowerment score or the subscales for those who had been out of work for less than five years (using a t-test). Those with qualifications had higher mean scores than those without on the empowerment scale (t = -2.93, df 128, p = .004), self-esteem subscale (t = -2.18, df 128, p = .031), power subscale (t = -3.63, df 128, p < .001) and others subscale (t = -2.92, df 124, p = .004).

The mental health service users sample had a higher mean Empowerment score (p = .001) and a similar self-esteem score compared to those reported by Carpenter *et al.* (2001) in their study of 260 people on the CPA in the UK, which were 2.58 (.30) and 2.73 (.46) respectively.

[25] The correlations with the remaining subscales were also negative and significant, except for anger, but not as strong nor as reliable.

The mean Empowerment score was lower than that reported by the authors of the Empowerment Scale for a sample of 261 users of a self-help programs in the USA (Rogers *et al.*, 1997), with a mean score of 2.94 (S.D. = .32, $p < .001$); lower than a sample of 37 people using mental health self-help groups in the UK (Hatzidimitriadou, 1998) with a mean score of 2.84 ($p < .001$); and was similar to a more severely impaired population of 283 psychiatric outpatients with a mean score of 2.74 (S.D = .34, not significant).

Lancashire Quality of Life Profile (LQoLP)

The study used the subjective quality of life items from the LQoLP on eight life domains – living situation, work, health, leisure, social relations, family relations, legal and safety and finances. In addition to these there were two general well-being items at the beginning and end of the interview. Satisfaction in each domain was rated on a seven point Life Satisfaction Scale (LSS) from 1 'Can't be worse', through 4 'Mixed' to 7 'Can't be better'.

Figure 23 shows the percentages of people satisfied with each life domain (details are given in Table 9 in Appendix F), i.e. those who scored 5 or more on the LSS. The domains with least satisfaction were work and finances for both groups and health for mental health service users. The majority of people in both groups were satisfied with the remaining domains.

Figure 23. Satisfaction with life domains

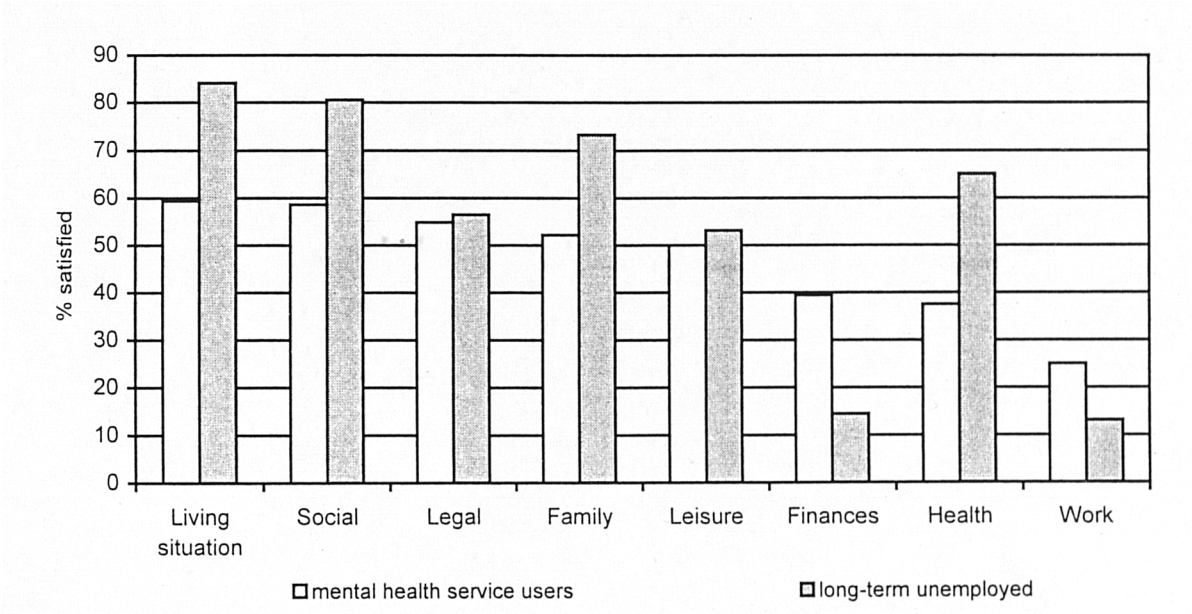


Table 34 shows long-term unemployed people had higher scores than mental health service users on most life domains, reaching significance for general well-being, living situation, family relations, social relations, health and total Life Satisfaction Score (LSS). There were no significant differences on the remaining domains – work, leisure, legal & safety and Cantril's

ladder. There were no significant differences between men and women within each study group.

The only domain on which mental health service users scored higher than long-term unemployed people was satisfaction with finances, though scores for both groups were the lowest of all domains. There was a correlation between satisfaction with finances and present income[26] for the whole sample ($n = 125$, $r = .18$, $p = .048$) and for single people ($n = 95$, $r = .28$, $p = .006$). There was also a stronger negative correlation with the rate of change in income from their last job[27] ($n = 92$, $r = -.32$, $p = .008$) for single people only. In other words, those who experience the larger drops in income, over shorter periods of time, are less satisfied with their finances.

There was a significant difference between ethnic groups only for living situation (ANOVA, $F = 2.92$, $p = .037$), with black people less satisfied than white people, with mean scores of 4.36 and 5.28 respectively ($p = .052$ using Scheffé post hoc test). This is probably due to the lower residential stability described in Section One. Owner-occupiers also had lower satisfaction with living situation ($t = -2.15$, df 127, $p = .033$) than those who rented. This is perhaps due to the financial stress of home ownership whilst living on a low income and the threat of repossession.

[26] Excluding three extreme cases with incomes of over £400 per week, as noted in Table 26.

[27] Calculated as the difference between current income and income from last paid job divided by number of years since last job. This can only be calculated reliably for people living alone as the income from a partner at the time of their last job was not known.

Table 34. Subjective quality of life scores

Mean score (s.d.)	*N*	*Mental health service users*	*N*	*Long-term unemployed*	*Significance*
General well-being	71	4.06 (1.60)	63	4.78 (1.14)	t = -3.05, df 128, p = .003
Work	68	3.91 (1.20)	61	3.94 (1.07)	ns
Leisure	70	4.76 (1.20)	62	4.90 (.82)	ns
Finances	71	3.97 (1.43)	62	3.22 (1.54)	t = 2.92, df 131, p = .004
Living	69	4.88 (1.08)	63	5.59 (.78)	t = -4.38, df 123, p < .001
Legal & safety	71	4.74 (1.04)	62	4.79 (1.28)	ns
Family	69	4.74 (1.31)	60	5.35 (1.11)	t = -2.82, df 127, p = .006
Social	70	4.74 (1.34)	62	5.50 (1.04)	t = - 3.68, df, 127, p < .001
Health	72	4.25 (1.29)	63	5.31 (1.07)	t = -5.12, df 133, p < .001
Cantril's (/100)	71	49.9 (22.0)	62	51.8 (21.3)	ns
TOTAL LSS	68	4.51 (.74)	61	4.98 (.60)	t = -3.98, df 127, p < .001

There were clear and expected relationships between quality of life and health status for both groups, with total quality of life declining with poorer general health ($r = -.48$, $p < .001$) and mental distress (male GHQ-12 Likert scores, $r = -.51$, $p < .001$). Figure 24 shows the relationship between general health and the mean scores of general well-being (ANOVA, $F = 10.80$, $p < .001$), health ($F = 30.74$, $p < .001$), leisure ($F = 4.67$, $p = .002$) and total quality of life ($F = 9.49$, $p < .001$). There were also significant correlations between most domains of quality of life and empowerment and self-esteem (see Table 10 in Appendix F).

Figure 24. Subjective quality of life and general health

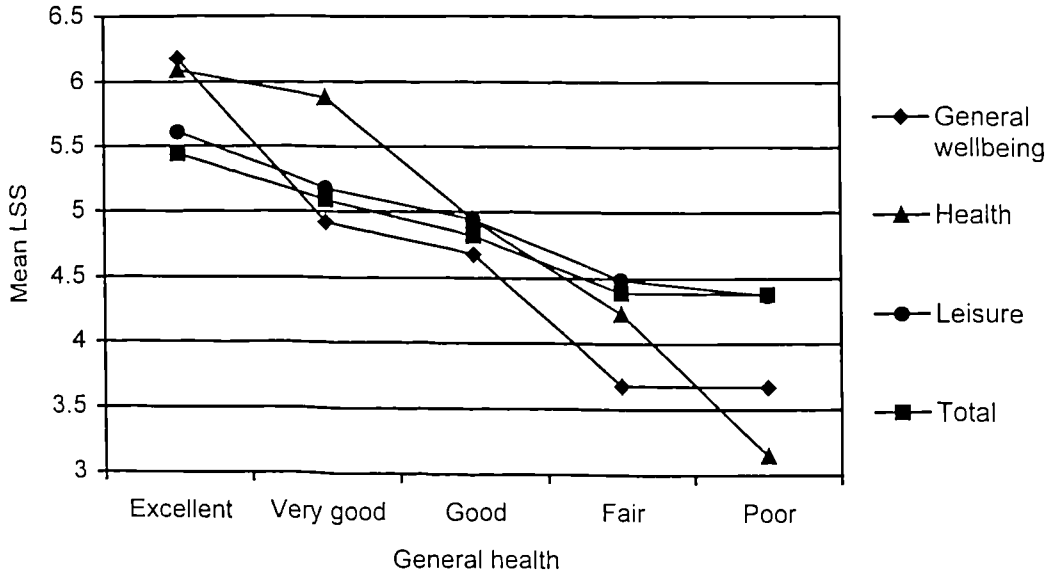
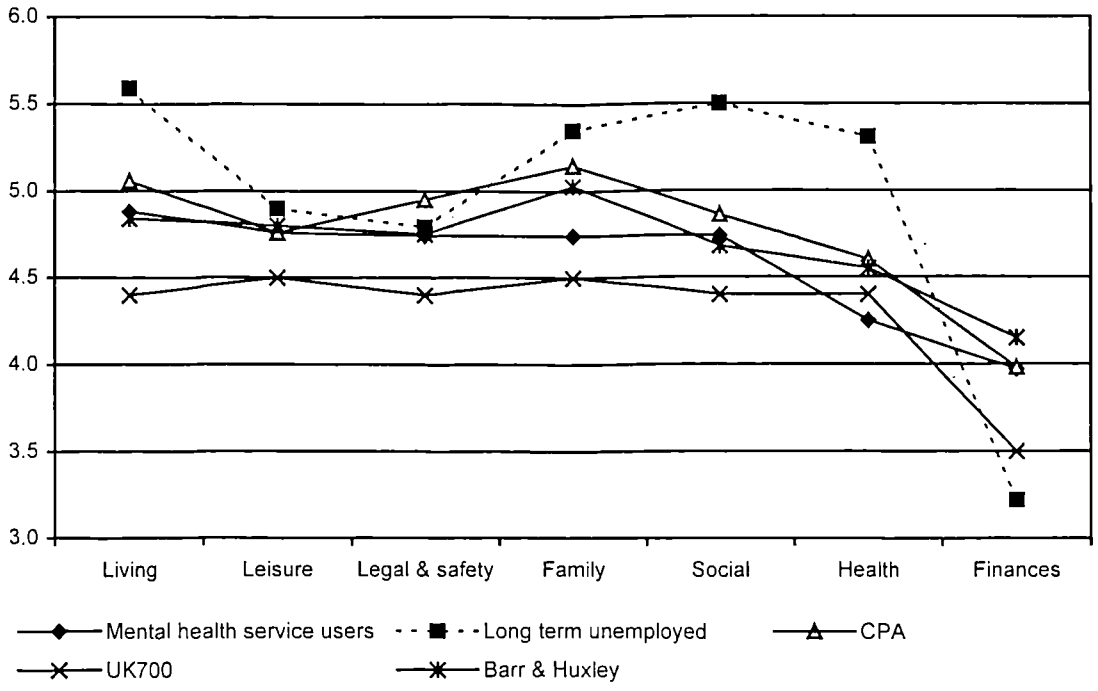


Figure 25 compares mean scores in each life domain of the two study samples with three other samples of mental health service users described earlier (further details are given by Table 11 in Appendix F). Apart from the UK700 sample, which has lower scores across the domains, the mental health service users study sample had very similar characteristics to both the CPA and Barr and Huxley samples. The difference with the UK700 sample could be due to the different demographic characteristics to the other samples. Figure 25 shows that long-term unemployed people have a different profile from people who use mental health service users, with a higher subjective quality of life with respect to living situation, family and social relations and health, though lower satisfaction with finances.

Figure 25. Comparing subjective quality of life



Other health indicators

As expected, a much higher proportion of mental health service users than long-term unemployed people had in the last year seen a doctor for their nerves ($\chi^2 = 87.92$, df 2, $p < .001$), been in hospital for their nerves ($\chi^2 = 19.35$, df 1, $p < .001$) and taken medication for their nerves ($\chi^2 = 115.67$, df 1, $p < .001$). Yet there was no significant difference between groups in the proportions that had seen a doctor for a physical illness (about half) in the last year or had a physical disability (about one fifth). See Table 12 in Appendix F.

Many of the focus group and interview participants from both groups described both mental and physical health problems. The health problems experienced by mental health service users have been well documented (see Chapter One). Anthony highlights the physical health problems associated with being out of work.

> **Anthony.** I am less healthy, because I am not as active as I used to be. I was always on the go when I was working, and now that I am... Now that I am not working I've put, I've put weight on, but that's through my medicine an all... [*Interview*]

Discussion

The long-term unemployed sample regarded themselves as generally more healthy, more empowered and had higher self-esteem than the mental health service users, yet their psychological health was comparable and similar proportions had seen a doctor in the last year.

The general health of long-term unemployed was comparable to that of the of general population of England and in Manchester, where 79% and 70% respectively say their health is excellent, very good or good (Department of Health, 1999c). Mental health service users regarded their health as much worse than these general populations. Both samples had visited their GP less than the general population in England (81%) and in Manchester (86%) (Department of Health, 1999c).

These data show that both study groups had a considerably greater incidence of mental distress than the general population. The Health Survey for England 1994 (Colhoun and Prescott-Clarke, 1994) found that 12% of men and 19% of women scored 4 or more on the GHQ-12. The threshold score of 4 corresponds to the average patient referred to a psychiatrist. The two study samples had about a threefold prevalence of mental distress compared to the general population. Perhaps most the most worrying statistic is the 83% of men under 30 who scored 4 or more compared to just 12% of the general population. However, both samples had similar GHQ scores to those found in other studies of long-term unemployed people (Banks *et al.*, 1980; Gallie *et al.*, 1994; McCabe *et al.*, 1996). Also, research has shown that mental health does not decline with length of unemployment beyond about 3 months, and that mental health is restored upon successful re-employment (Warr and Jackson, 1985).

The empowerment and self-esteem of the mental health service users sample was comparable to that of other samples of severely mentally ill people, whereas the scores for

long-term unemployed people were similar to those of users of mental health self-help programmes. Greater empowerment and self-esteem was found amongst those with better general health, less mental distress, better education and less time out of work. Once again, the detrimental impact of prolonged unemployment, as described in Chapter One, is present in the findings of this study.

The lowest quality of life for both groups was with work, health and finances. This is hardly surprising considering that the sample is made up of people out of work, living on a low income and experiencing health problems. Subjective quality of life is an important indicator of social exclusion and inclusion (Huxley and Thornicroft, 2000). It is notable that satisfaction is lowest in the three key domains that correspond to the main indicators of poverty described in Chapter One.

Long-term unemployed people had a higher subjective quality of life in most life domains, particularly with general well-being, health, living situation, leisure, family and social relations, but not with finances. Higher satisfaction with health and general well-being can be explained by the better health of the long-term unemployed. Higher satisfaction with leisure can also be in part explained by better health, though this will be explored in the next chapter, along with social and family relations.

The higher satisfaction with finances among mental health service users compared to long-term unemployed people was largely due to higher incomes, though exacerbated by the higher relative decrease in income experienced, usually over a shorter period of time, by long-term unemployed people since leaving work. Indeed, the qualitative data presented in the last section shows that many mental health service users were resigned to a life on a low income, whereas long-term unemployed people felt the financial strain more acutely.

Section Five: The extent of social exclusion

This chapter has considered the multidimensional poverty aspect of social exclusion – demographics, accommodation, education, work histories, health and income. This concluding section presents the results from further analysis of the data.

Measuring social exclusion

An index of social exclusion was developed using the variables identified as contributing to social exclusion by the research literature described in Chapter One. That chapter described the social exclusion experienced by mental health service users in terms of economic, social

and health indicators. A range of indicators[28] was chosen from the survey questionnaire to reflect these, which are given in Table 35. A score representing the extent of social exclusion was calculated for each survey respondent. A person scored one point for each of the factors up to a maximum of 15.

Table 35. Indicators of social exclusion

Accommodation	Were living in a workless household
Employment status	Were not working
Work history	Had never worked
	Had been unemployed for over 5 years
Education	Had no qualifications
Social class	Had their last job in social class IV or V
	Had experienced downward social mobility
Finance	Were claiming housing benefit
	Were in debt
Health and well-being	Had fair or poor health
	Scored 4 or more on the GHQ-12
	Scored below 2.75 on the Empowerment Scale
	Scored below 5 on the total LSS of the Lancashire Quality of Life Profile
	Had seen a psychiatrist in the last year
	Had a physical disability

This method provides a unique account of social exclusion faced by mental health service users. Other studies have examined just a subset of these variables, though no other study has used such a combination of indicators and directly compares them with another disadvantaged group.

Results

Table 36 shows that both groups had a mean score of 10. There were no significant differences in mean score using two sample t-test and Mann-Whitney-U test.

[28] The following were originally included but were removed

- Had a weekly income of below half national average. Missing data for 6 cases. Housing Benefit claim is just as good as indicating low income. Plus almost all had incomes below national average earnings.
- Had claimed benefits for over 5 years. Missing data from 9 cases, plus this item duplicated the unemployed for over 5 years item.

Table 36. Social exclusion index

Score (0-15)	*Mental health service users* N = 63	*Long-term unemployed* N = 59
Mean social exclusion score (s.d.)	10.1 (20.4)	10.2 (20.1)
% Score 0 -5	4.8	1.7
% Score 5.1 - 10	57.1	54.2
% Score 10.1 - 15	38.1	44.1

Discussion

From this brief analysis of these variables of social exclusion there were no significant differences between the two study groups. This suggests that the incidence of multiple deprivation are related more to the experience of unemployment than mental health problems.

Yet, we have seen in this chapter that this simple comparison masks the complex and interrelated problems unique to each group. There are both similarities and differences in how each of the key indicators of social exclusion affects the two study groups.

In terms of employment status, the vast majority of both groups were out of work; most had worked, with quite stable work histories, though mostly in low skill jobs. However, the work histories of mental health service users are dominated by very long periods since their last job. This finding is very important and explaining it lies at the heart of this thesis. The qualitative data revealed many explanations, for instance being told they would never work again, crushed confidence, and lack of support, which will be discussed in greater depth in Chapter Eight.

Most of the mental health service users lost their jobs after their first contact with mental health services. It appears from the participants in this study that unemployment is almost an inevitable consequence of severe mental illness. Perhaps with more targeted vocational interventions at an early stage, more people may be able to stay in work or to return back to work soon, and so prevent the long periods out of work.

There were important differences in terms of the income and expenditure of the two study groups. On comparison with national figures, both groups experienced low incomes, particularly for long-term unemployed people. The main source of income was welfare benefits, which was a source of discomfort for many. This was of particular concern for

many mental health service users, although they had higher incomes, they had claimed benefits for a very long time.

The majority of mean weekly expenditure was on essential items, with many people 'going without' many items. Perhaps a consequence of this was a high incidence of debt. These finding concurs with the evidence presented in Chapter One.

In terms of health status, long-term unemployed people had better general health, though both groups had a much higher incidence of mental distress than the general population. The high incidence of mental distress is common amongst unemployed people (See Chapter One). This chapter also highlighted the poor physical health experienced by mental health service users. The lower levels of empowerment and self-esteem among mental health service users can be explained by poorer general health and longer periods out of work. However, low empowerment and self-esteem may be a cause of general poor health and prolong unemployment.

Conclusion

This chapter has examined the nature and extent of multi-deprivation faced by two disadvantaged groups. The extent appears to be similar among both groups, with unemployment as the most significant factor. On closer inspection, the nature of multiple deprivation is different for the two groups. For long-term unemployed people, unemployment appears to impact upon income and mental health. For mental health service users, unemployment has a greater impact upon general health and well-being, such as self-esteem and quality of life, and is more sustained. However, the direction of causality cannot be determined from this cross-sectional data.

These 'static' indicators of social exclusion, such as education, health status, and employment status, are not sufficient to adequately determine the nature and extent of social exclusion. A fuller picture is required that takes into account the extent of social participation and the process factors of social exclusion, such as stigma and discrimination. Chapter Seven will explore the impact of unemployment on day-to-day living and Chapter Eight will examine some of the barriers that prevent re-employment.

Chapter Seven

Findings II: Citizenship and Participation

Introduction

This chapter draws upon the concepts of citizenship and community to describe the nature and extent of social participation, the second dimension of the model of social exclusion introduced in Chapter One. Participation depends upon the relationships between the individual and their communities, characterised by their social relationships, the activities they engage in, and the services they use.

The first indicator of participation is the nature of individuals' social relationships. These are described in Section One using the Social Networks Guide from the survey questionnaire. A second indicator is related to the notions of 'communities of interest' and 'communities of identity', which have evolved to reflect the wider range of opportunities now available for people to interact, organise and gain identity. The study covers two broad communities of identity: mental health service users and long-term unemployed people. A description of what people do and how they interact within their communities is described in Section Two using the Community Activity Profile from the survey questionnaire, the time use diaries, focus groups and interviews.

A more recent addition to the concept of citizenship is the role of consumer. The interest here is in the consumption of public services, and health services in particular. The final section of this chapter considers the use of a range of health, social care and education services, using the CSSRI. The section also examines in greater depth the use of day services for mental health service users and job clubs for long-term unemployed people as a link between consumer, citizen and community.

Section One: Social relationships

A person's social network locates them in their community. Social networks, defined as the size, shape and nature of relationships with others, provide an 'opportunity framework' for meeting the social needs of individuals (Forrester-Jones and Grant, 1997: 2). They form an important link between an individual and society.

This section draws upon data from the Social Networks Guide to describe and compare the two study groups in terms of social network size and membership, together with some key

characteristics of the relationships with network members. The time use diaries, focus groups and interviews complement these findings.

Network size

Network size refers to the number of people regarded as part of an individual's social network. Table 37 shows that on average mental health service users had about 25 members, ranging from 3 to 64. This is over twice as many as for long-term unemployed people, who had about 12 people ($t = 4.56$, df 108.6, $p < .001$). Moreover, 61% of long-term unemployed people had less than 10 members compared to 43% of mental health service users ($\chi^2 = 33.27$, df 5, $p < .001$, see Table 13 in Appendix F).

To explore the factors that may explain this difference a stepwise linear regression was performed on the mental health service users sample, with network size as the dependent variable and independent variables of study area, gender, age, ethnicity, and use of day services. Day service use alone explained 80% of the variance in network size. Indeed, day service users had a mean of 36.5 network members compared to 17.9 for those not using day services ($t = 4.07$, df 64, $p < .001$). Exploring this relationship further a one-way ANOVA ($F = 23.03$, $p < .001$) found that mental health service users who used day services had significantly larger networks than both those not using day services ($p < .001$) and long-term unemployed people ($p < .001$), with no significant difference between the latter two groups (using a post hoc Scheffé test).

For mental health service users, larger network sizes were found for older people ($r = .32$, $p = .008$), white people (ANOVA, $F = 2.93$, $p = .041$), and those living with a partner, though not quite significant (ANOVA, $F = 2.86$, $p = .065$). These relationships can be explained by day service use, as day service users were more likely to be older, white and living with a partner.

For long-term unemployed there were no significant differences in gender, ethnic groups, age groups or marital status. For both groups there were no significant relationships between mean network size and empowerment, quality of life, or GHQ scores. This confirms that number of members is not the most important social network variable.

Table 37. Network size

	Mental health service users			*Long-term unemployed*
	Day service user	*No day services*	*TOTAL*	
	N=57	*N=9*	*N = 66*	*N = 62*
Mean size	36.5	17.9	24.6	11.5
S.D.	20.2	16.4	19.9	12.1
Range	3 - 60	7 - 64	3 - 64	0 - 62

Network membership

Network size alone is too simple a measure in determining the network structure. Network membership provides more insight into the nature of people's relationships. The make-up of individuals' social networks is given in Table 38, using simplified network categories.

From the demographic characteristics presented in the last chapter over half the people in both samples were single and a third were married or cohabiting. The proportions in the UK as a whole are 12% and 73% respectively (Huxley and Thornicroft, 2000).

Mental health service users had a higher mean number of visiting specialists ($t = 10.7$, df 94.3, $p < .001$) and work scheme / day support ($t = 4.82$, df 65.6, $p < .001$), but also more family members ($t = 2.65$, df 126, $p = .009$) and members of clubs and church groups, though not quite significant ($t = 1.88$, df 109.9, $p = .063$).

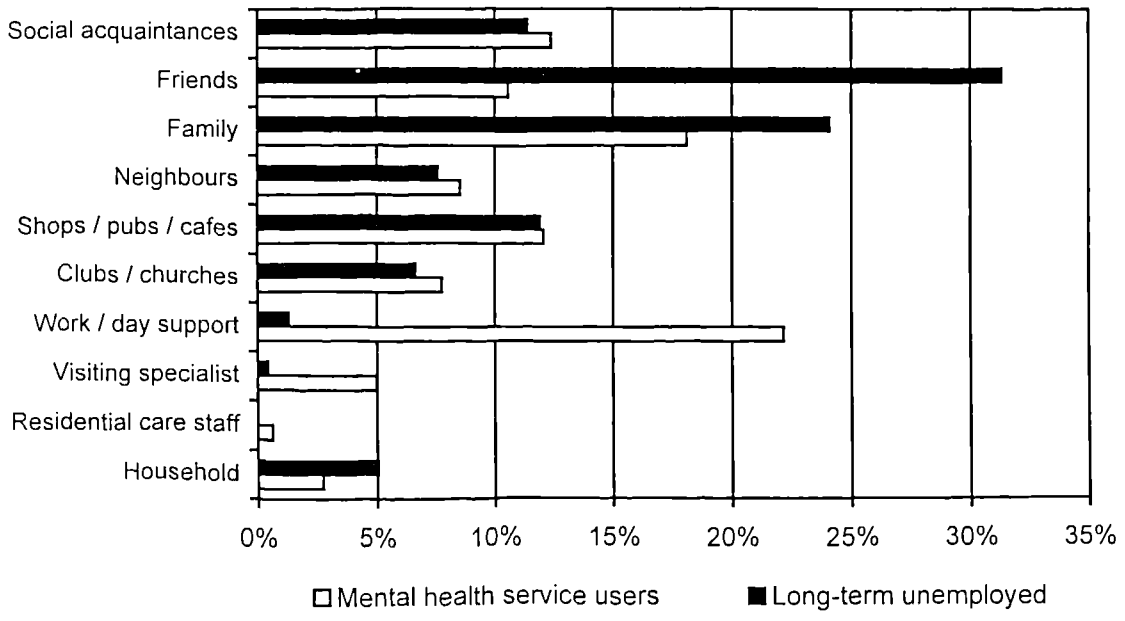
However, these differences can be accounted for by the day service users as there were no significant difference between long-term unemployed and those mental health service users not using day services (one-way ANOVA using post hoc Scheffé test). Not surprisingly, users of mental health day services had a large number of people in work / day support ($t = -3.61$, df 35.9, $p = .001$), than those not using day services.

Table 38. Network membership

Mean number of members	*Mental health service users*			*Long-term unemployed*
	Day service	*No day service*	*TOTAL*	*TOTAL*
	N=24	*N=42*	*N = 66*	*N = 62*
Household	0.8	0.6	0.7	0.6
Residential care staff	0.3	0.1	0.2	0.0
Visiting specialist	1.0	1.3	1.2	0.0
Work / day support	10.7	2.5	5.5	0.2
Clubs / churches	2.0	1.9	1.9	0.8
Shops / pubs / cafes	4.8	2.0	3.0	1.4
Neighbours	3.3	1.4	2.1	0.9
Family	5.9	3.6	4.5	2.8
Friends	2.6	2.6	2.6	3.6
Social acquaintances	5.1	1.9	3.1	1.3

Figure 26 shows the proportion of the social network for each category of network member. On inspection this shows that mental health service users have a smaller percentage of friends and family and a greater percentage of people in work schemes / day support and visiting specialists than long-term unemployed people.

Figure 26. Network membership as a percentage of mean network size for study groups

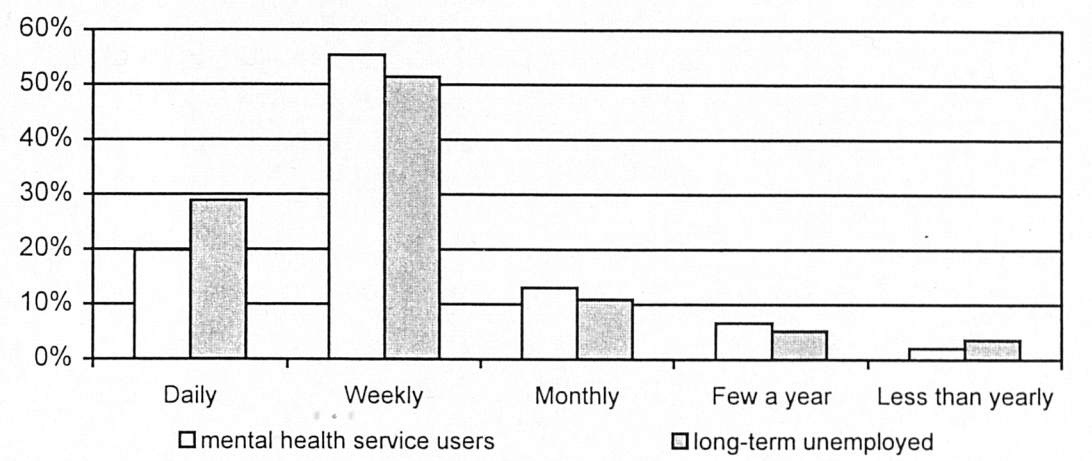


Relationships with network members

In addition to the size and composition of social networks, this section considers the nature of the relationships between individuals and their network.

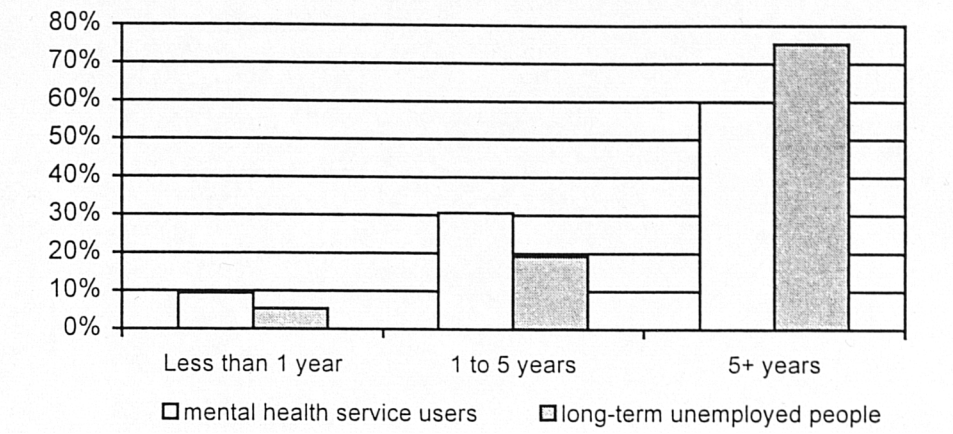
The frequency of contact provides a picture of how often people are in contact with their network, though it should not by construed as a measure of how important these contacts are. Figure 27 shows that long-term unemployed people had a greater proportion of contacts with network members on a daily basis ($t = -2.05$, df 121, $p = .043$). For mental health service users there were positive correlations between the *number* of network members seen on a daily basis and Empowerment score ($r = .31$, p .014), the power subscale ($r = .26$, $p = .037$) and others subscale ($r = .36$, $p = .005$); and between the *percentage* of network members who are seen on a daily basis and Empowerment score ($r = .35$, $p = .005$), and the self-esteem ($r = .26$, $p = 043$), power ($r = .30$, $p = .019$), control ($r = .26$, $p = .041$) and others ($r = .30$, $p = .022$) subscales.

Figure 27. Mean frequency of contact with network members



The length of relationships with network members indicates the stability of the social network. Figure 28 shows that the social networks of both groups were largely comprised of long-term relationships, though mental health service users had a lower proportion of members known for over five years ($t = -2.89$, df 119, $p = .005$), and a greater proportion known for 1 to 5 years ($t = 2.30$, df 119, $p = .023$). For mental health service users there was a weak positive correlation between the *number* of people known for 5 years or more and total LSS ($r = .27$, $p = .036$).

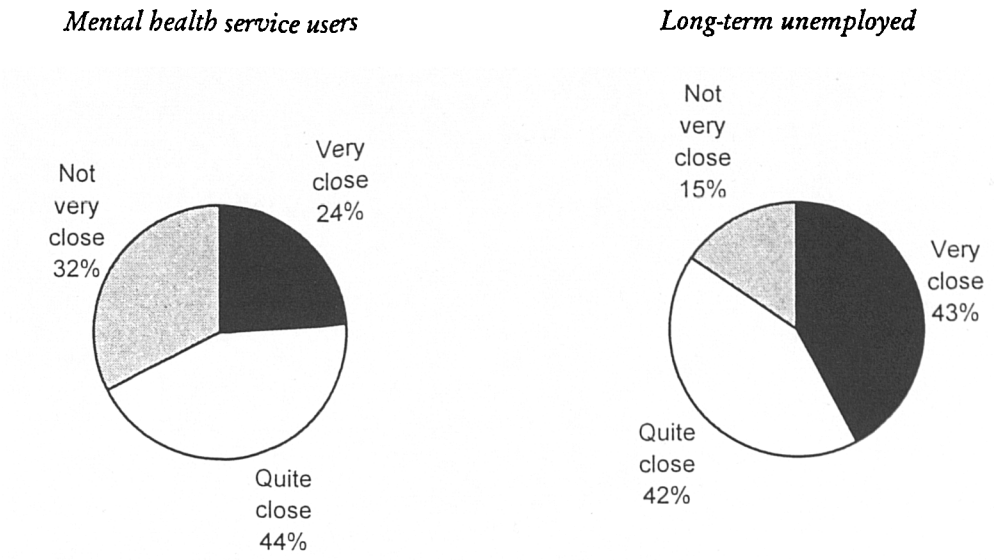
Figure 28. Mean duration of relationship with network members



Closeness to network members is an indication of the importance of relationships. Figure 29 shows that a greater percentage of the relationships that long-term unemployed people had with their network members were 'very close' ($t = -3.39$, df 120, $p = .001$), while mental health service users had a greater proportion ($t = 3.62$, df 107.1, $p < .001$) and number ($t = 4.42$, df 66.4, $p < .001$) who were 'not very close'. Similar proportions had relationships that were 'quite close'. This difference is explained by day services use, as mental health service users who attended day services had a much larger proportion of people that were 'not very close' (41%) than those not using day services and long-term unemployed people (ANOVA, $F = 9.97$, df 2, $p < .001$).

Mental health service users with a higher percentage of people who were 'very close' also scored higher on the power subscale of the Empowerment scale ($r = .34$, $p < .001$). For both groups, there were positive correlations between the Social domain of the Lancashire Quality of Life Profile and the number of friends ($r = .32$, $p < .001$) and the number of network members who were 'very close' ($r = .37$, $p < .001$). There were no significant correlations with GHQ scores for men or women, or with M3 scores for mental health service users. This suggests that closeness affects well-being, but not health.

Figure 29. Closeness to network members



Not all relationships can be assumed to be beneficial. People were asked if their relationship was negative. Both groups had small percentages of their network members who were critical in a nasty way, though long-term unemployed people had a greater proportion (15.4% compared to 9.0%, t = 2.15, df 97.8, p = .034).

Employment status of network members is important as it can determine the potential for material support and influence an individual's chances of returning to work. Similar proportions, about 40%, of social network members were not working. An important finding was that people with a higher percentage of network members out of work also had higher social exclusion scores (r = .27, p = .005).

Friendships

This section also considers the objective quality of life items from the Lancashire Quality of Life Profile related to friendships. Table 39 shows that there were no significant differences between the two groups in the nature of their relationships with friends. A higher percentage of men (47%) than women (28%) said they could manage without friends (χ^2 = 9.08, df 2, p = .011). There were no significant differences when compared to data from a study of mental health work schemes (Schneider, 1997), apart from a higher percentage of the mental health service users sample had a close friend (χ^2 = 8.68, df 1, p = .003).

Comparisons with other social network variables found expected relationships. Those who said they could manage without friends had a lower mean number of friends (1.6 compared to 4.3, t = 2.97, df 77.4, p = .004), and a smaller network size (14.9 compared to 20.9, though not quite significant, p = .057). Those who said they had a close friend had a larger network

size (19.8 compared to 11.1, t = -3.09, df 59.2, p = .002), a greater number of people in shops / pubs / cafés (2.7 compared to 0.1, t = -4.14, df 108.9, p < .001), and a greater number of social acquaintances (2.6 compared to 0.5, t = - 2.32, df 121.8, p = .022). Those who said they had a friend to turn to for help also had a higher number of people who were 'very close' (4.9 compared to 1.7, t = -3.72, df 121.7, p < .001). This indicates that people are a reliable judge of their own friendship status.

Table 39. Nature of friendships

%	*Mental health service users* N=70	*Long-term unemployed* N=62	*Schneider (1997)* N = 157	*Lancashire database* N = 422
Could manage without friends	38.6	46.8	36	61
Had a close friend	80.0	83.9	63	64
Had friend to turn for help if needed	82.9	87.1	75	62
Had visited a friend in past week	55.7	67.7	45	45

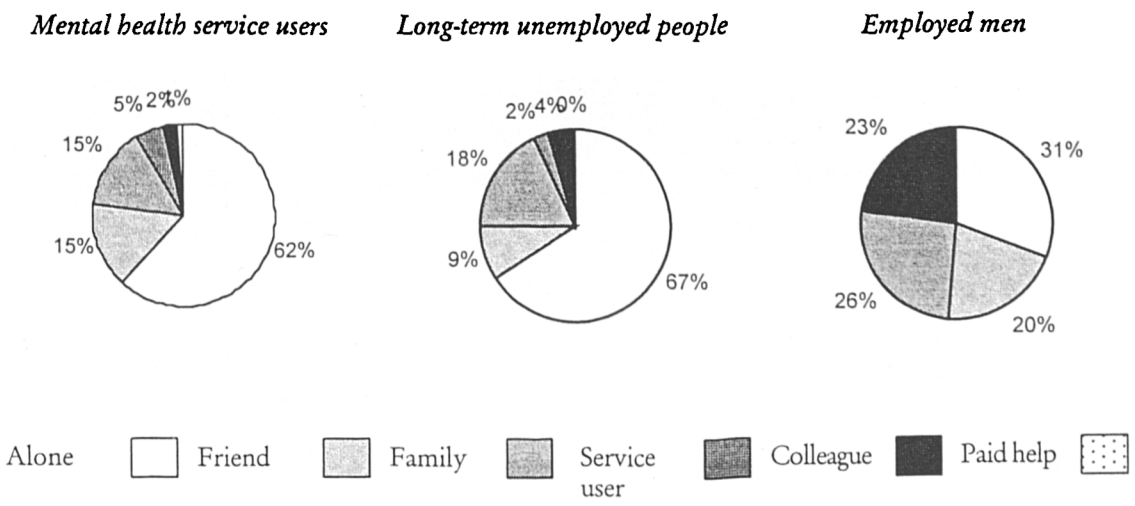
Temporal distribution of network members

The time use diaries provided a novel approach to the study of social networks by estimating the amount of time spent with the various categories of network members. However, this does not provide an indication of the quality of the relationships.

The main finding is that both groups spent about 75% of their time alone. The concept of 'aloneness', however, is a difficult one, as one can be alone amongst others yet not truly alone (Szalai, 1972). The definition used here was largely determined by the individual, though by convention, time sleeping was classed as time alone (Robinson *et al.*, 1972). Figure 30 shows the proportion of time spent with various network members during waking hours for the two study groups. For comparison the third chart is for a sample of employed men from forty four cities in the USA from a major international time use study (Szalai, 1972). The charts clearly show the disproportionate amount of time spent alone by the study groups.

The only significant difference between groups was that mental health service users spent more time during the week with paid help (1.2 hours compared to 20 minutes, Z = -2.34, p = .044). Though it is worth noting that on average a mere 1% of the waking hours of mental health service users are spent with any paid help (though this definition excludes time spent in day centres, classed as with other service users).

Figure 30. Proportion of time spent with network members from time use diaries

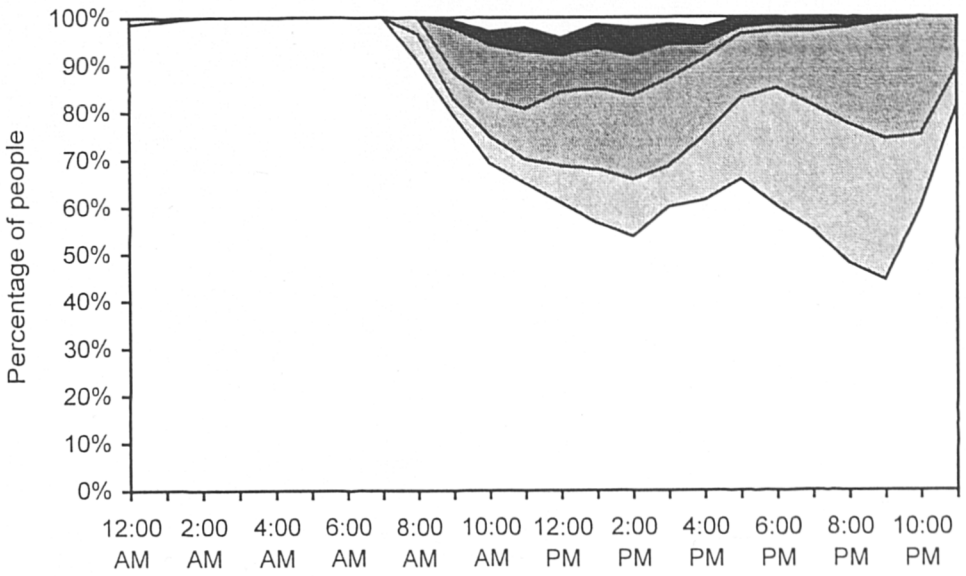


The amount of time spent with network members' changed throughout the day. Figure 31 shows the time spent with network members over a 24-hour period (averaged across seven days). For example, at 2pm 54% of mental health service users were alone, 12% with family, 18% with friends, 9% with other service users, 6% with colleagues, and 2% with paid help.

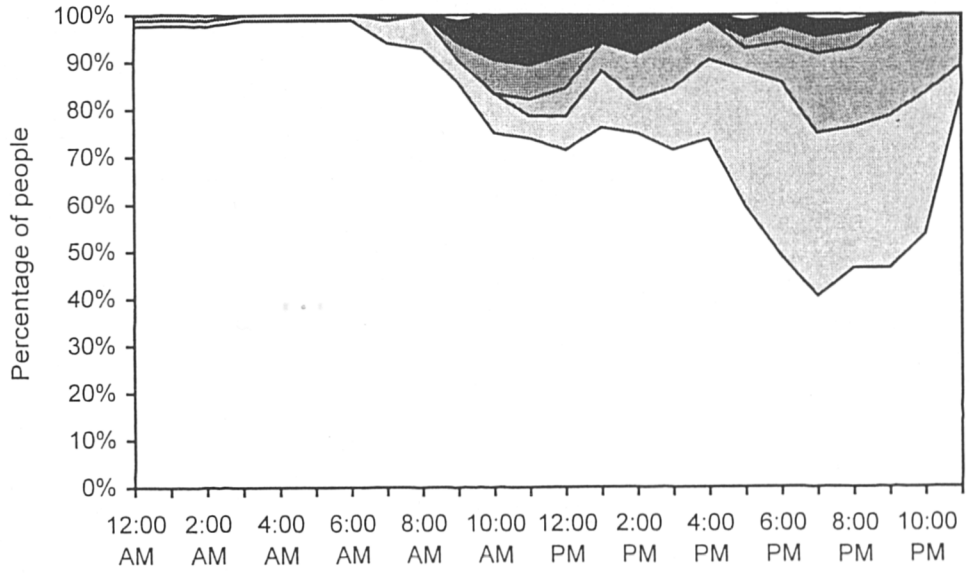
These graphs confirm the large amounts of time spent alone and demonstrate clearly the lack of structure to an average day through lack of work. During the typical working day (9am to 5pm) over 70% of long-term unemployed and over 50% of mental health service users spent time alone. Time with family and friends is more likely to be in the evenings, whereas time with other service users, colleagues and paid help takes place during the day. On inspection long-term unemployed people appear to spend more time during the day alone compared to the evening than mental health service users.

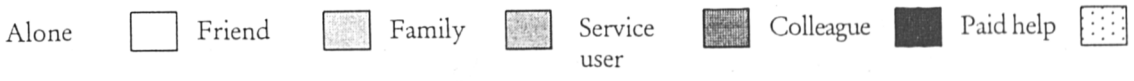
Figure 31. Tiem spent with network members over an average day

Mental health service users



Long-term unemployed people





Social life

The findings from the qualitative data revealed that most participants, though not all, had very poor social lives.

Bill. I don't really know many people, you know I don't go out at night or anything, I don't go drinking or anything like that. [*Interview*]

Judith. ... you know, you go home especially in the summer it's a bloody long evening and Sundays, its horrible, you don't talk to anyone... [*Focus group 3*]

For those who attended day services, the relationships between members were more like associates than friends. This extract shows the limits of the friendships that Anthony had formed with other day hospital members.

Interviewer. How well do you know them? How did you meet them?

Anthony. Well, I just got talking to them. Asking them what they are in there for, I met a couple of mates there. Only a couple. And, err, they told me what they are in for, and I told them what I am in there for and we get on all right. But they are in, like, in the afternoon, so I can only see them for about half-hour to an hour.

Interviewer. Do you not see them outside the day hospital?

Anthony. Err, sometimes, now and again if I bump into them in the street. I don't go out with them at night time or ought like that. [*Interview*]

Which contrasts with his feelings about his prior friendships.

Interviewer. Did you have many friends?

Anthony. Yeah, I had a lot of friends at the time.

Interviewer. Did you go out?

Anthony. I went out to the pub.

Interviewer. So would you say your life was quite busy at that point?

Anthony. Yeah, life was quite busy. Active life it was. [*Interview*]

Many other mental health service users described how they had lost friends since leaving work.

Discussion

Huxley and Thornicroft (2000) suggest that social integration is affected by marital status and type of household. The higher percentage of people living alone is similar to other studies of mental health service users (UK700, 1999), but very different from the general population. For mental health service users there is often a need to live independently to avoid the stresses and potential for relapse that family life can bring (Leff and Vaughan, 1981), though this can also lead to increased isolation (Huxley and Thornicroft, 2000).

The low number of people in the social networks of both study groups resembled those of other studies of people with mental health problems rather than the general population (Bengtsson-Tops and Hansson, 2001; Pattison *et al.*, 1979). For example, the network size of mental health service users was similar to a study of users of self-help groups (Hatzidimitriadou, 1999).

Mental health service users had larger social networks than long-term unemployed people, though most of this difference was due to the larger social networks of those using day services. The focus group and interview data suggest that day service users did know more people, but that these relationships were fairly weak. Indeed, the survey found that mental health service users attending day services had the largest proportion of network members who were 'not very close'.

The membership, frequency of contact, and nature of relationships within networks provide a better picture of their capacity to provide support. Long-term unemployed people had a higher proportion of friends and family in their network, while mental health service users had a higher proportion of people in day services and visiting specialists. Again, these differences were explained by day service use, as mental health service users who did not use day services had a similar membership profile to long-term unemployed people. Moreover, long-term unemployed people and mental health service users not using day services reported similar numbers of 'quite close' and very 'close' members. This suggests that unemployment may be just as significant as mental health problems in explaining the reduced social networks of mental health service users. This supports the weight of evidence that unemployment results in the weakening of social support described in Chapter One.

The findings show the greater impact on well-being of the nature rather than number of relationships. Most contact for both groups were on a weekly basis, though mental health service users had fewer contacts on a daily basis. Daily contact appeared to be important for mental health service users. Those who had daily contact had high empowerment scores and self-esteem, though perhaps those with higher sense of empowerment and self-esteem saw people more often.

Most network members had been known for 5 years or more, though mental health service users knew fewer people for this length of time. Knowing people for a long time is also important for mental health service users. The number of people known for over 5 years correlated with subjective quality of life. Those that had more people who were 'close' also had higher subjective quality of life on the 'social' domain and overall score, and higher self-

esteem. Although few people had critical, negative relationships, these did have a negative impact on subjective quality of life.

These findings provide evidence for the 'stress-buffer' theory of social support (Cassel, 1976), which suggests that better social networks can offer protection from stressful life events (Brown and Harris, 1978), including unemployment.

Over 40% of network members for both groups were out of work. Gallie *et al.* (1994) found a similarly high proportion of other unemployed people in the social networks of unemployed people. They proposed that this directly contributed to the relative weakness of the social support available to them compared to those in employment. Unemployed friends were less likely to be able to offer strong emotional or financial support or help to find a job. Indeed, those who had a greater proportion of network members out of work had poorer general health and higher social exclusion score.

Surprisingly, knowing more people out of work had a small positive effect on empowerment and esteem. This could be due to the relative psychological impact of unemployment, which suggests that unemployment has worse effects for those not surrounded by unemployment. (Jackson and Warr, 1987). In this theory, communities that are surrounded by unemployment have relatively better well-being because they develop greater resilience and find it easier to attribute their lack of job to external responsibility. In the case of this study, perhaps those with a higher proportion of other unemployed people in their network had a mediating effect on their self-esteem – they were less likely to blame themselves.

Most people said they had a close friend, to whom they could turn for help if needed. There were few differences between the two groups in the nature of their relationships with friends, and few differences compared to other studies.

People from both groups spent most of their waking time alone. The analysis over the average day confirmed the large amount of time spent alone, especially during working hours. Most of the time spent with others was during the evening. The qualitative data confirmed that people had poor social lives, especially when compared to the time they were last in work.

A further finding was that mental health service users spent just 1% of their waking hours with paid help (e.g. CPN visits). From these findings the impact of professional intervention must be limited. Community mental health services did not appear to be meeting the social needs of this sample of mental health service users. Moreover, the findings suggest that day

services substitute social contact with friends with social contact with other service users. This may crudely increase the number of contacts, yet does little to address the need for social support. These findings have serious implications for mental health services that wish to promote social inclusion.

This section has provided compelling evidence of the reduced capacity of the social networks of mental health service users and long-term unemployed people to enable social participation. The similarities between the study groups suggests this is most likely to be a function of unemployment than mental health problems, as Gallie *et al.* (1994b) found that unemployed people had reduced sociability and retreated into activities within the household. This link between social network and extent of community participation is explored in the next section.

Section Two: Community activities and social participation

Perhaps as important as the people they know, is what they do. This sections draws upon survey data, time use diaries and qualitative data to describe the lifestyles and social participation of mental health service users and long-term unemployed people. The primary source of information is the survey data taken from the Community Activity Profile (CAP). This data is used to compare the two study groups in terms of the number, frequency and duration of various activities. The CAP was specifically developed for this study to collect information about individuals' use of their time - in work, social, leisure and treatment – during the last four weeks.

The time use diaries were completed by survey participants to reveal more about how people used their time, and also to test the reliability of the CAP. The diaries were completed during the period from March 2000 to February 2001, with a 50/50 split between summer and winter to reduce seasonal variations. Respondents were asked to provide a very brief description of what they were doing for each hour of the day over one week. Diaries were completed by 32 people (45% of sample). Their characteristics are given in Table 40. This shows that there were few differences, either between the two study groups, or between this sub-group and the main sample. The only significant differences were that long-term unemployed time use diary respondents were older than the main sample (47.4 compared to 39.3 years old, $t = -2.68$, df 60, $p = .01$).

In addition to these personal characteristics, there were no significant differences between groups, or with the main sample for social class, living situation, living with children, and accommodation type, Empowerment scale, and length unemployment. Compared to the

main sample, mental health service users who completed a time use diary had a lower mean GHQ score (2.20 compared to 4.37. t = 2.20, df 69, p = .031) and a higher mean score on the Lancashire Quality of Life Profile for living situation (5.25 compared to 4.79, t = -2.02, df 51.6, p = .049), health (4.87 compared to 4.01, t = -2.59, df 69, p = .012) and total LSS (4.80 compared to 4.39, t = -2.13, df 66, p = .037).

Table 40. Characteristics of time use diary respondents

%	*Mental health service users*		*Long-term unemployed*	
	Time use diary N = 20	*Survey sample* N = 71	*Time use diary* N = 12	*Survey sample* N = 62
Female	35	36	8	11
Manchester	80	87	58	68
Non-white	15	21	9	12
Single	60	53	50	43
Married	20	28	33	30
Separated	20	19	17	27
Good to excellent health	55	46	75	71
Age (mean)	41.4	40.9	47.4	40.8

The CAP and time use diaries correlated reasonable well (details are given in Appendix H). The main difference is that the CAP recorded specific activities rather than routine activities such as sleep, eating and personal care. Finally, qualitative data, from interviews, focus groups and participant observation, was used to gain further insights into, and cast new perspectives on, the issues raised.

Types of activity

Each data source revealed a variety of activities. The CAP exposed the range of things that people did with their time, mainly in a structured way. The time use diaries revealed how people spent a whole week, including unstructured activity. And finally, the qualitative data uncovered the different ways in which people responded to the time they had available - some were busy, while other did very little.

The summary of activities from the CAP, in Table 41, shows much similarity in the proportions of people from each group that had taken part in the various categories of activity. The most popular activities for both groups, in terms of percentage taken part, frequency and duration, were 'other' (a range of domestic, home entertainment and hobbies)

and social activities. The next most popular were health & social care and sports for mental health service users and sports and entertainment for long-term unemployed.

Due to the different nature of the variables three tests of significance were used: Chi-square for percent taken part, Mann-Whitney U for frequency, and both Mann-Whitney U and two independent samples t-test for duration. The main differences were that a greater percentage of long-term unemployed did sporting activities ($\chi^2 = 4.51$, df 1, $p = .034$), with greater mean frequency ($Z = -2.17$, $p = .03$) and duration ($t = -2.84$, df 74.1, $p = .006$; $Z = -2.73$, $p = .006$). Whereas a greater percentage of mental health service users took part in religious activities ($\chi^2 = 6.57$, df 1, $p = .01$), with a greater mean frequency ($Z = -2.57$, $p = .01$) and duration ($Z = -2.59$, $p = .01$); and attended health & social care activities ($\chi^2 = 39.72$, df 1, $p < .001$), with a greater mean frequency ($Z = -2.64$, $p < .001$) and duration ($t = 3.72$, df 70.1, $p < .001$; $Z = -6.22$, $p < .001$). There was no significant difference between the groups in the total amount of time spent doing all given activities per month, with about 9 hours per day, with the time remaining assumed to be free time and sleep. There were no significant differences between genders.

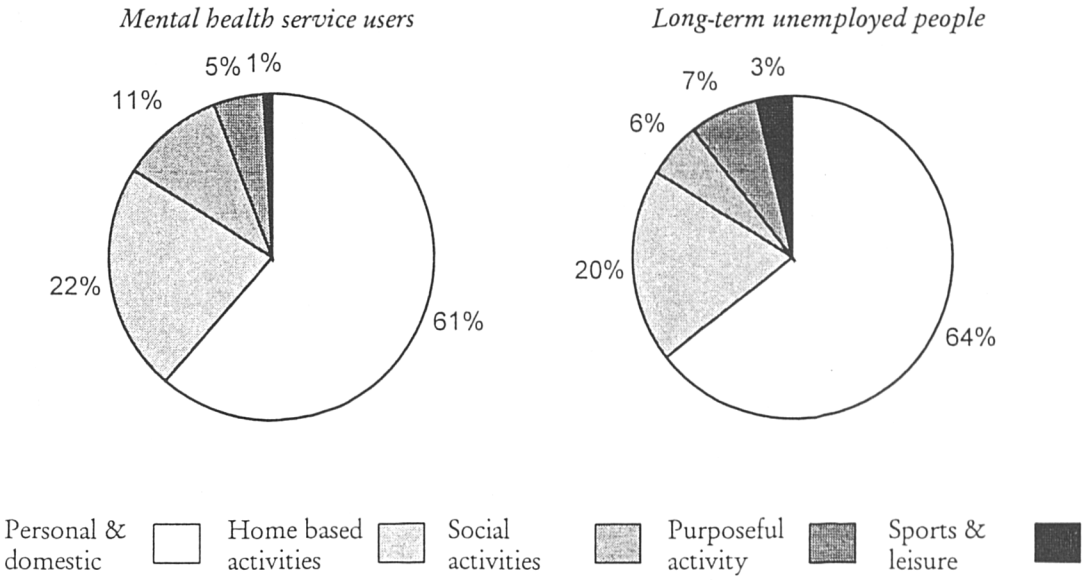
Table 41. Summary of activities

% Taken part, mean frequency (per month) & mean duration (hours per month)		*Mental health service users N=71*			*Long-term unemployed N=62*		
	Range	*%*	*Frequency*	*Duration*	*%*	*Frequency*	*Duration*
Work	0 - 2	21.1	0.27	8.9	17.7	0.23	10.4
Education	0 - 3	18.3	0.27	5.8	16.1	0.16	4.6
Sport	0 - 3	38.0	0.59	4.9	56.5	0.92	16.4
Entertainment	0 - 3	35.2	0.38	1.8	38.7	0.53	3.7
Religion	0 - 2	19.7	0.21	2.1	4.8	0.05	0.25
Health & social care	0 - 5	50.7	0.80	21.8	1.6	0.02	0.13
Social	0 - 3	87.3	1.49	42.5	85.5	1.45	37.4
Other activities	0 - 5	95.8	2.51	177.3	100	2.32	169.6
All activities	0 - 14	98.6	6.52	265.2	100	5.66	242.6
All activities (hours/day)			-	9.5		-	8.7

The time use diaries included the whole range of activities over 24 hours a day for 7 days. Figure 32 shows the proportion of time spent on the various activities. There were very few significant differences between the study groups. About 60% of the week was spent on personal and domestic activities, which included sleep, personal care, meals, home chores,

shopping, rest and travelling. About 20% of the week was spent on home-based activity, such as watching TV, listening to radio or music and reading newspapers. Mental health service users spent slightly more of the week on social activities, such as visiting people and going to a pub. Just a small part of the week was taken up by purposeful activities, such as work, education, day services, job club, looking for jobs, visiting a library. The least amount of time was spent on sporting activities. (See Appendix I for a further details).

Figure 32. Categories of time use over a one week period



The focus groups and interviews emphasised the individual nature of people's activities. They included reading magazines, doing code breakers and crossword puzzles, housework and DIY, going on bus rides and other hobbies, such as keeping tropical fish, needlework, knitting, painting. Although watching TV and listening to the radio were the most popular.

The following sections describe in more detail the categories of activity defined by the CAP questionnaire. For each category the findings from the CAP questionnaire are presented, together with further evidence from the time use diaries and qualitative data.

Work and education

The findings from the CAP in Table 42 show that only a minority of people had taken part in any work and educational activities, with no significant differences between study groups. However, a greater percentage of mental health service users had taken part in 'other' work activities, such as helping family members, (though numbers were too small to calculate valid Chi-square statistics), with a greater mean frequency ($Z = -2.53$, $p = .011$) and duration ($Z = -2.53$, $p = .011$).

Table 42. Work and education activities

% Take part, mean frequency (per week) & mean duration (minutes/week)	*Mental health service users N=71*			*Long-term unemployed N=62*		
	%	*Frequency*	*Duration*	*%*	*Frequency*	*Duration*
Work						
Paid work	7.0	0.15	47	6.5	0.13	65
Voluntary work	8.5	0.14	24	12.9	0.52	92
Other work	9.9	0.34	63	0.0	0.00	0
Education						
Certificated course	12.7	0.20	52	8.1	0.11	22
Non-certificated course	8.5	0.10	18	8.1	0.29	47
Home study	5.6	0.08	17	0.0	0.00	0

The time use diary data found that 25% of mental health service users and 17% of long-term unemployed had done some kind of work activity, such as sheltered work, voluntary work and informal work. Some of the interview participants described the informal work.

> **Carl.** So it's just little bits like that, just to survive and just get a few little jobs on the side. I know people in the building trade 'do you want to do a week here, or do a week there'. It's money in your hands, and like it's, like I say, you have got to go out and look for work. [*Interview*]

This was not confined to long-term unemployed people, mental health service users also did some informal work.

> **Interviewer.** What have you been doing since? Have you been working? Or...
>
> **Mike.** No. Like, now and again, err, a few years ago, I'd, like, help me dad out now and again, you know. If he was, like, busy and that and he wanted a bit of a hand I would just help him out, now and again... Now I can work round friends, you know like, err, maybe, someone will say 'John, will you come and do some cladding in me house?' You know, and err, up the stairs and that, and the living room, and that - cos I can do all that anyway... So I would help around and that you know, just for a bit of extra cash you know. So I've done bits and bobs... [*Interview*]

The time use diary data also found that 67% of long-term unemployed people spent time looking for jobs compared to 15% of mental health service users (χ^2 = 8.88, p = .003), and spent, on average, 4.8 hours during the week compared to just 12 minutes (t = 3.26, p = .008;

Z = -2.40, p = .003). Also, 50% of long-term unemployed spent time studying or in a library compared to just 15% of mental health service users (χ^2 = 4.55, p = .033).

Sports

The CAP found that only a small proportion of people from both groups did any one sporting activity. Table 43 shows that the most popular sporting activities were bar games (snooker, pool, darts, etc.) and swimming for mental health service users; whereas cycling, swimming and football where most popular among long-term unemployed people.

A greater percentage of long-term unemployed people than mental health service users played football (χ^2 = 6.42, df, 1, p = .011), with a greater mean frequency (F = -2.54, p = .011) and duration (Z = -2.57, p = .01); went cycling or running (χ^2 = 6.53, df 1, p = .011), with a greater mean frequency (Z = -2.61, p = .009) and duration (t = -2.56, df 73.2, p = .012; Z = -2.63, p = .009); and did other solo sports, mainly fishing (though numbers were too small for valid Chi-square statistics), with a greater mean frequency (Z = -2.13, p = .033) and duration (Z = -2.13, p = .033). There were no significant differences between groups in those that went swimming, to a gym, played bar games or took part in other team sports. Among the mental health service users, more people who attended day services went to a gym (χ^2 = 3.68, df 1, p = .055) and played snooker (χ^2 = 6.65, df 1, p = .01); mainly because these activities were available.

Long-term unemployed people did more physically demanding sports (i.e. football, swimming, cycling and running), perhaps due to their better general health. Indeed, those who said their health was good, very good or excellent spent more time doing sporting activities than those who said their health was fair or poor (mean of 56 minutes per week compared to 15 minutes, t = 3.09, df 112.3, p = .003). This may also be a reflection of the higher proportion of men in the sample of long-term unemployed people. However, the only difference between genders is that more men (14% compared to none) played football, did it more often and for longer (Z = -2.26, p = .024).

There were no relationships between age and sporting activities, except younger people spent more time playing football (r = -.36, p < .001). Again, this is likely to be related to health, as Chapter Six found that younger people felt healthier.

Table 43. Sporting activities

% Take part, mean frequency (per week) & mean duration (minutes/week)	*Mental health service users N=71*			*Long-term unemployed N=62*		
	%	*Frequency*	*Duration*	*%*	*Frequency*	*Duration*
Football	4.2	0.03	3	17.7	0.29	26
Swim	14.1	0.08	7	17.7	0.16	14
Gym	9.9	0.14	11	6.5	0.14	4
Bar games	15.5	0.20	29	8.1	0.11	22
Cycling / running	7.0	0.21	18	22.6	1.05	114
Other team sports	4.2	0.06	4	4.8	0.13	16
Other solo sports	1.4	0.01	1	9.7	0.21	50

The time use data confirmed these findings. For example, over 33% of long-term unemployed people had taken part in active sports, for an average of over 3 hours a week, compared to just 15% of mental health service users, for an average of 25 minutes a week (though not statistically significant).

The focus groups and interviews confirmed the link between day services and sports activities. Day service users mentioned organised activities such as walking, playing snooker and going to a gym.

> Carly. ... I like coming to this day centre, you know, and mixing with people. That's what I do, I come and play pool and that, you know ...
>
> Anthony. Day hospital? You play pool, you can do art, and you can do crafts... I go to the Gym there, and just work out for about half-hour.

Entertainment and social activities

The breakdown in the types of entertainment and social activities from the CAP are shown in Table 44. The table shows that few people from both groups took part in any organised entertainment. The most popular entertainment for long-term unemployed people was 'other', which mainly included watching football, which they did more often than mental health service users ($Z = -1.99$, $p = .046$) and for longer each week ($t = -2.51$, df 67.7, $p = .014$; $Z = -2.02$, $p = .043$).

There were few significant differences in social activities. Though a greater percentage of mental health service users had visited a friend or relative ($\chi^2 = 6.32$, df 1, $p = .012$), with

greater frequency (Z = -2.19, p = .028) and duration (t = 2.34, df 104.6, p = .021; Z = -2.34, p = .019).

In terms of gender, a greater percentage of men went to a pub (χ^2 = 4.66, df 1, p = .031), with a greater frequency (Z = -2.27, p = .023) and duration (t = 3.71, df 127.4, p < .001; Z = -2.46, p = .014). Men also spent more time in nightclubs (t = 2.15, df 110.0, p = .034). While more women went to a concert (χ^2 = 11.84, df 1, p = .001), with greater frequency (Z = -3.40, p = .001) and duration (t = -2.07, df 42.3, p = .045; Z = -3.40, p = .001).

Table 44. Entertainment and social activities

% Take part, mean frequency (per week) & mean duration (minutes/week)	*Mental health service users N=71*			*Long-term unemployed N=62*		
	%	*Frequency*	*Duration*	*%*	*Frequency*	*Duration*
Entertainment						
Cinema	16.9	0.06	7	12.9	0.05	8
Concert / theatre	8.5	0.03	5	6.5	0.02	3
Nightclub / band	5.6	0.03	11	11.3	0.07	17
Other entertainment	7.0	0.03	4	17.7	0.17	27
Social activities						
Visit	60.5	1.49	383	38.7	1.04	167
Entertain	29.6	0.51	80	37.1	0.91	114
Pub	43.7	0.91	152	56.4	1.07	264
Other	7.0	0.02	22	8.1	0.06	16

A similar pattern of activity was found by the time use diaries, with just 15% of mental health service users and 8% of long-term unemployed going to any organised entertainment. Again, the most popular social activity was visiting other people. A greater proportion of mental health service users paid visits to others (75% compared to 42%, though not quite significant), and spent more hours per week visiting (9 hours compared to 3, t = -2.26, p = .031; Z = -2.06, p = .044).

Health and social care activities

Health and social care activities included services provided by secondary mental health services, such as day centres and groups. This section only applies to mental health service users. The most popular activities were attending a day centre, a sheltered workshop and drop-in.

There were no significant differences between gender, though more men (44%) than women (27%) used any day service. There were no relationships between age and time spent in the various health and social care activities. However, the average age of users of any day service was higher, at 44 years, than those that do not use day services, at 39 years, though not quite reaching statistical significance (t = -1.93, df 69, p = .057).

Table 45. Health and social care activities

% Take part, mean frequency (per week) & mean duration (minutes/week)	*Mental health service users N=71*		
	%	*Frequency*	*Duration*
Day centre	22.5	0.86	180
Drop-in	12.7	0.20	26
Sheltered work	15.5	0.43	87
Group	8.4	0.12	18
Arts & crafts	8.5	0.06	11
Therapy/other	7.0	0.06	5

Just under half (49.3%) of mental health service users had attended some form of health or social care activity. Of those that attended such services, 42.5% had attended more than one service. Table 46 shows that people who used one service (columns) often used another (rows), though reaching significance for only users of day centres and groups (as most groups were arranged by day centres). On inspection, people who used sheltered workshops, drop-ins and arts & crafts activities were more likely to use other activity services, while those that used therapy / other activities used few other formal day services. This finding supports the view that day services create a 'parallel universe' of activities outside of mainstream life, proposed by Chapter Two.

Table 46. Multiple use of health and social care activities for mental health service users

% within service	*Day centre*	*Drop-in*	*Sheltered work*	*Group*	*Arts & crafts*	*Therapy / other*
	N=16	*N=9*	*N=11*	*N=6*	*N=6*	*N=5*
Day centre	-	22.2	27.3	66.7*	16.7	0
Drop-in	12.5	-	27.3	16.7	16.7	20.0
Sheltered work	18.8	33.3	-	33.3	33.3	0
Group	25.0*	11.1	18.2	-	0	0
Arts & crafts	6.3	11.1	18.2	0	-	20.0
Therapy	0	11.1	0	0	16.7	-
No other service	37.4	11.2	9.0	0	16.6	60.0

*χ^2 = 7.31, p = .007, phi = .32, p = .007

Findings from the time use data revealed that both groups spent an insignificant amount of time on health and medical activities, such as appointments. Mental health service users spent 0.6% and long-term unemployed people 0.2% of the week on such activities. However, many more had used day centres and job clubs: 35% of mental health service users had attended a day centre, for a average of 4 hours over the week, and 25% of long-term unemployed had attended a Jobclub, for an average of 1.7 hours over the week. Section three provides further analysis of day service use.

Religious activities

Data from the CAP questionnaire in Table 47 shows that a greater percentage of mental health service users attended a religious service (χ^2 = 9.80, df 1, p = .002), compared to very few long-term unemployed. There were no differences in gender, though those that did attend church tended to be older. A higher percentage of black and minority ethnic people attended a religious service (χ^2 = 4.35, df 1, p = .037).

Other activities

Findings from the CAP (see Table 47) show that by far the most popular activity for both groups was watching TV. The next most popular activity for mental health service users was listening to music, more than twice as popular than with long-term unemployed (χ^2 = 11.88, df 1, p = .001), done more often (Z = -3.38, p = .001), and for longer (t = 2.68, df 118, p = .008; Z = -3.32, p = .001). There were no significant differences between groups in the rest of the activities, apart from a higher percentage of long-term unemployed had taken part in other miscellaneous activity, which included trips, video games, crosswords, gambling and

DIY (χ^2 = 14.06, df 1, p < .001), did them more frequently (Z = -3.72, p < .001) and for longer (Z = -3.51, p < .001; t-test not significant).

There were few differences between genders, though a higher percentage of women than men did domestic activities (gardening, cleaning, cooking, shopping, etc. χ^2 = 11.12, df 1, p = .001), did them more often (Z = -3.80, p < .001) and for longer (t = -3.11, df 36.2, p = .004; Z = -3.81, p < .001).

Table 47. Religious and other activities

% Take part, mean frequency (per week) & mean duration (minutes/week)	*Mental health service users N=71*			*Long-term unemployed N=62*		
	%	*Frequency*	*Duration*	*%*	*Frequency*	*Duration*
Religious						
Service	18.3	0.26	27	1.6	0.03	3
Other	2.8	0.02	4	3.2	0.04	1
Other						
Watch TV	78.9	5.18	1186	87.1	5.23	1479
Listen to music / radio	53.5	3.32	656	24.2	1.48	265
Domestic	32.3	1.64	188	19.3	0.77	108
Read / write	22.5	1.16	186	24.2	1.28	131
Walk	21.1	0.85	60	21.0	1.01	116
Other hobby	15.5	0.61	71	6.4	0.16	28
Miscellaneous	9.9	0.46	312	37.1	2.09	417

Most popular activities

Figure 33 and Figure 34 provide a breakdown in the time spent on the various activities using data from the CAP questionnaire. For both groups just a small number of activities (about 10) made up approximately 75% of the total time spent on activities. Both groups spent nearly half their time watching TV and listening to music or the radio.

Figure 33. Proportion of time spent on activities for mental health service users

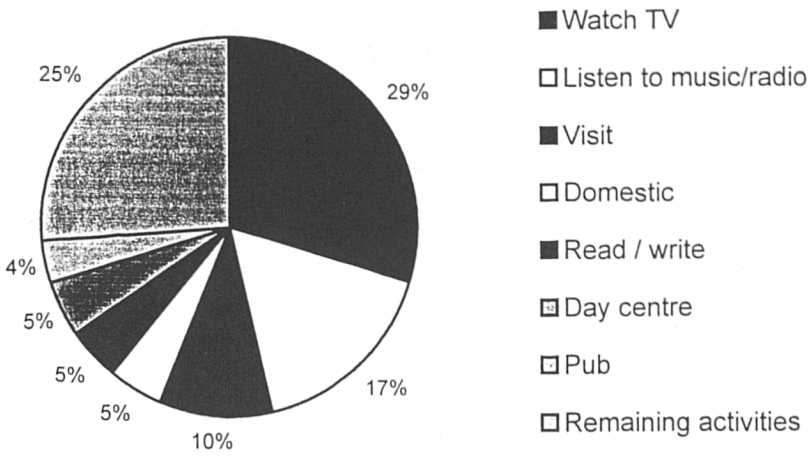
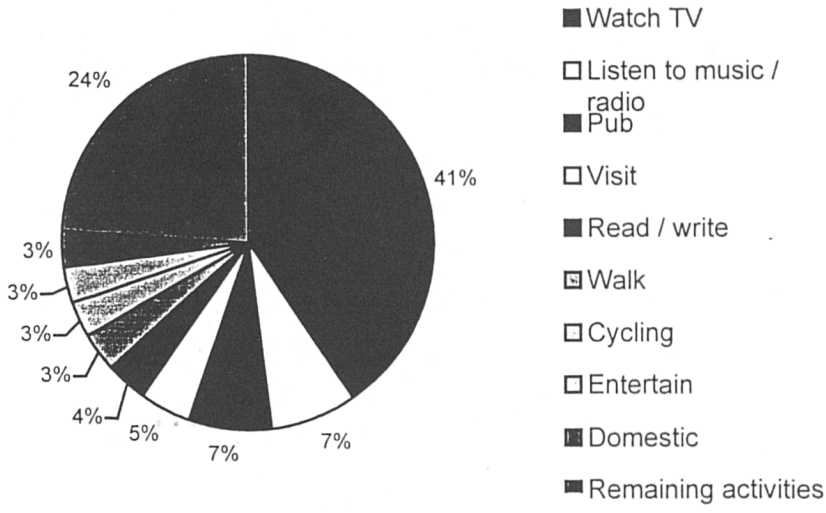


Figure 34. Proportion of time spent on activities for long-term unemployed



These findings were confirmed by the time use diaries. People spent a large proportion of their time sleeping, eating meals, on personal care (washing, bathing, etc.), doing household chores, and shopping. Both groups spent 20% of their waking hours watching TV. On further analysis, mental health service users spent 50% of the productive day (less sleeping, eating meals and personal care) at home watching TV, listening to the radio, reading a newspaper or doing nothing. This figure was 40% for long-term unemployed people. This exposes the high levels of inactivity.

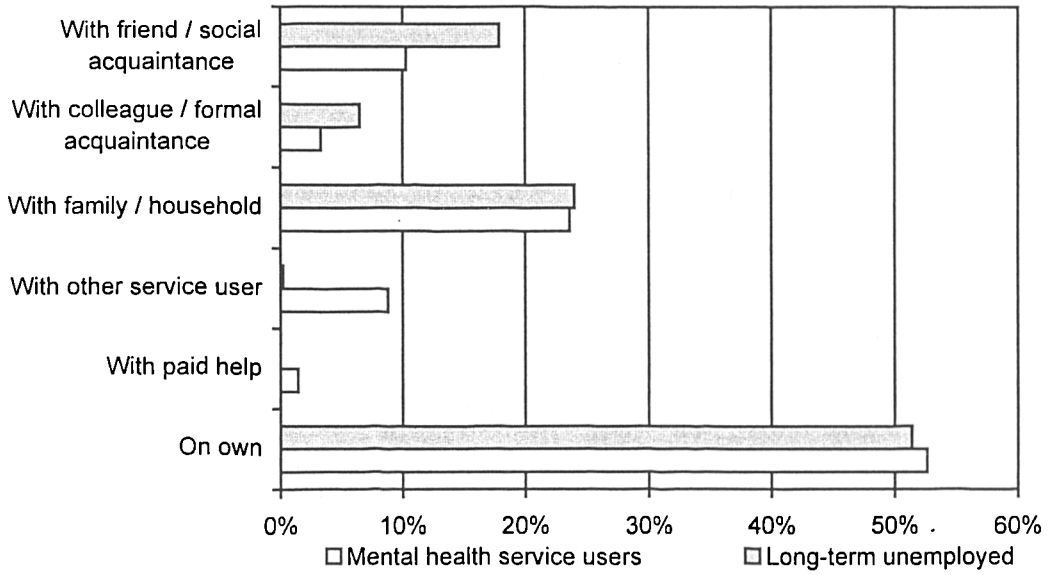
Activities and network members

The findings from the CAP in Figure 35 show that both groups spent the majority of time doing activities alone. Mental health service users spent a greater proportion of time with

other service users (t = 4.27, df 130, p < .001; Z = -5.38, p < .001) and with paid help (Z = -3.85, p < .001), while long-term unemployed spent a higher proportion of time with friends and social acquaintances (t = -2.20, df 130, p = .03). Table 15 in Appendix F gives more details.

Figure 35 shows that time spent with other service users is a substitute for time spent with friends and social acquaintances. This suggests that mental health service users have greater difficulty in making and maintaining friendships.

Figure 35. Proportion of time spent on activities by network members



The greatest differences in time spent on activities by network member were not between groups but between categories of marital status, as shown in Table 48. There were significant differences between marital status in the percentage of time spent doing activities on their own (ANOVA, F = 21.58, p < .001), with family (F = 27.00, p < .001) and with friends (F = 4.81, p = .01). A post hoc Scheffé test found that single and separated / divorced / widowed people spent much more time on their own and less time with family than married people (p < .001), and that single people spent more time with friends than married people (p = .025). Also, younger people spent more of their time with friends (r = -.28, p = .001).

Table 48. Time spent with network members by marital status

	Single / unmarried	*Married / living together*	*Separated / divorced / widowed*
	N=62	*N=39*	*N=31*
On own	57.2	27.6	72.6
With paid help	0.2	1.5	0.9
With other service user	4.0	6.9	3.4
With family / household	13.5	50.4	10.9
With colleague / formal acquaintance	5.7	5.0	2.7
With friend / social acquaintance	19.5	8.5	9.6

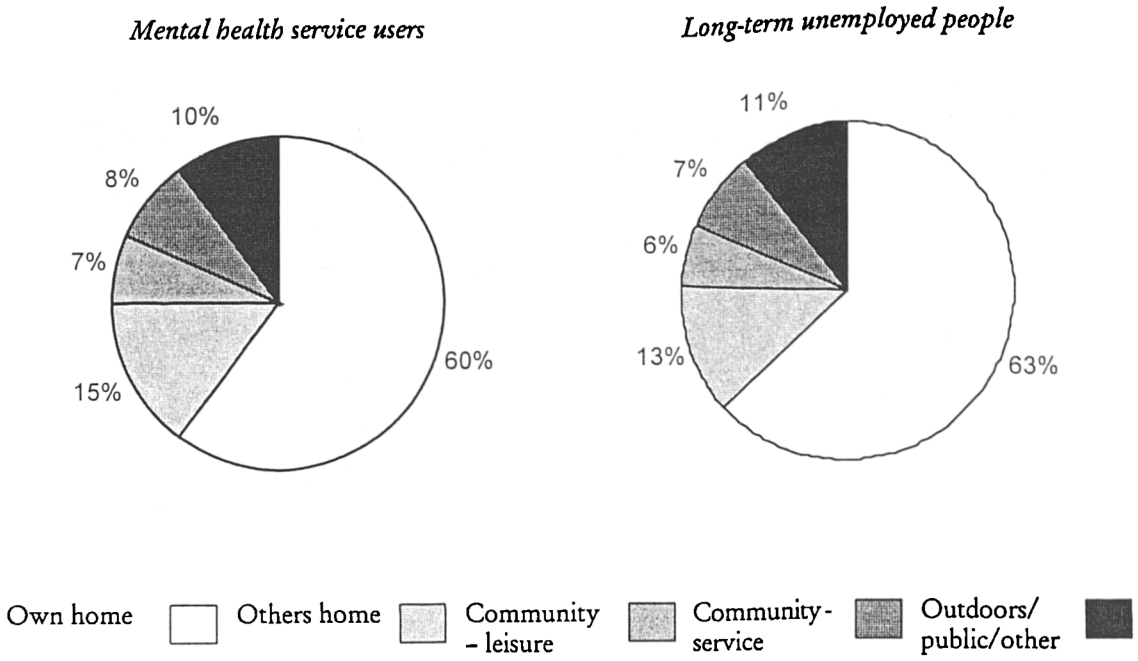
Perhaps more importantly, people who spent more time with colleagues / formal acquaintances ($r = -28$, $p = .002$) and friends / social acquaintances had lower scores on the social exclusion index ($r = -.18$, $p = .047$), whereas people who spend more time alone had higher scores ($r = .21$, $p = .002$). This provides a relationship between social support and social exclusion.

There were few differences between groups in the people who initiated the activities undertaken. A higher percentage of activities were initiated by paid help for mental health service users (11% compared to 1%, $t = 5.39$, $df\ 84.5$, $p < .001$), though the majority, about two thirds, of activities for both groups were initiated by themselves.

Spatial distribution of activities

Results from the time use diary show that the majority of the time during waking hours was spent at home for both groups. Just a quarter of time was spent outside of their own or someone else's home (family or friend). This reveals an interesting spatial dimension to social exclusion, as unemployment leads to the exclusion from public spaces (Kendall, 1999).

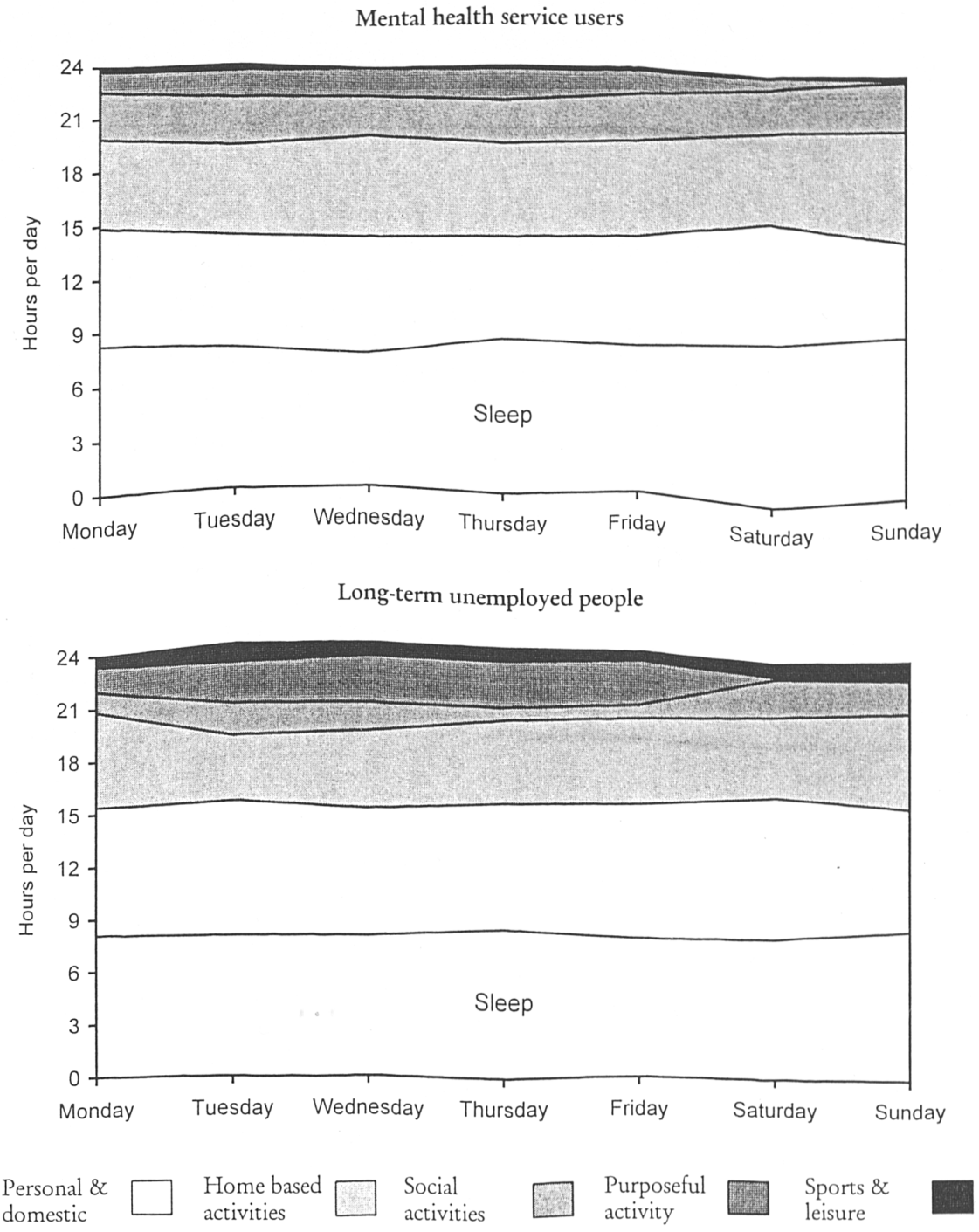
Figure 36. Location of activities.



Temporal distribution of activities

Results from the time use diaries in Figure 37 show how much time was spent on each activity category over the one-week period. The graphs show even more clearly the lack of distinction between weekdays and weekends. These flat lines show the lack of a 'pulse' that characterises the weekly rhythms of life experienced by people in work (Szalai, 1972).

Figure 37. Weekly distribution of activities



A weak 'pulse' was detected for people using job centres, day care services and adult education. Using a single-group repeated measures multivariate analysis of variance the only significant difference in time spent on an activity category over the week was purposeful activity ($F = 3.74$, $p = .014$), as the mean amount of time on these activities significantly reduced at the weekend.

The impact of this lack of time structure was highlighted by the interviews and focus groups. All participants said they had experienced difficulties with living their daily lives, caused by loneliness, lack of structure and lack of a role.

> **Carl.** You just get up, and bored. Personally I get bored.
>
> ...
>
> **Interviewer.** So you don't think, at the moment, that you've got used to living life on the dole?
>
> **Carl.** To be quite honest with you I feel quite useless.
>
> ...
>
> **Interviewer.** What do you feel like when you're idle?
>
> **Carl.** You feel like a piece of shit, for want of a better word. You feel like a nothing, a no man. [*Interview*]

Even those that had structure, such as day service users, said that life after attending was often bleak.

> **Donal.** It's not what you would call a life really. I'd be nice to go somewhere for something to happen. Most people get depressed more in the evenings
>
> **Geoff.** Evenings are all right at home it's just the mornings... Evenings are all right at home I like evenings at home. It's just the passing morning really. [*Focus Group 1*]

Costs of leisure activities

On average mental health service users spent £22 per month on their leisure activities, lower than the £35 spent by long-term unemployed people ($t = -2.06$, $df\ 111$, $p = .042$, excluding the 15% highest spenders[29]). Expenditure on leisure activities was also characterised by many that spent no money at all – 37% of mental health service users and 21% of long-term unemployed. This suggests that a significant proportion used no leisure activities at all, since few facilities are free.

Figure 38 shows that most money was spent on social activities, though the differences between groups were not significant. There were no significant differences between genders, ethnic groups, marital status, and age. It should be remembered that these figures are monthly rather than weekly, which emphasises the low expenditure of unemployed people (ONS, 2001a).

[29] The 11 long-term unemployed and 9 mental health service users who spent more than £150 per month on their activities. Mean monthly spending including this group was £61 for mental health service users and £112 for long-term unemployed.

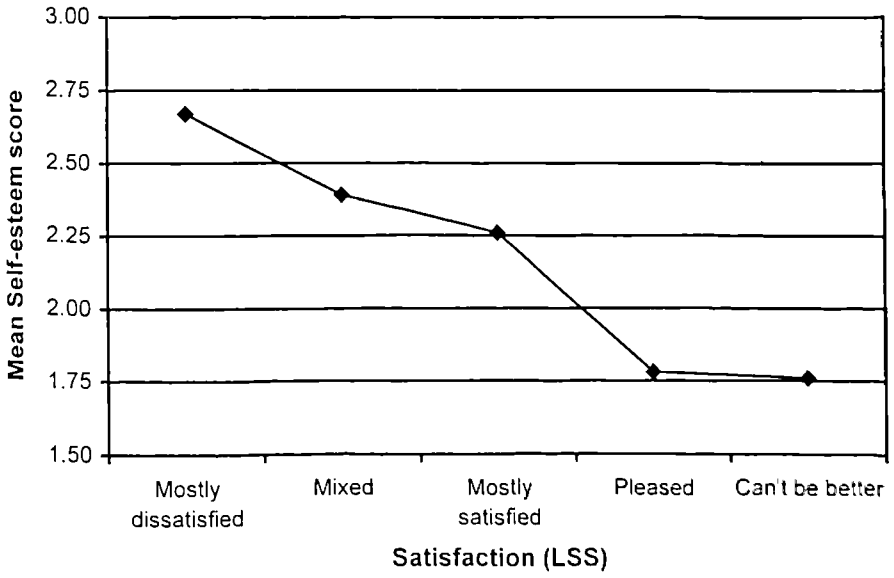
Figure 38. Spending on activities

£s per month	*Mental health service users* N=62	*Long-term unemployed* N=51
Sports	2.25	3.30
Entertainment	2.80	6.04
Social	15.20	22.75
Total	22.08	35.47

Satisfaction with activities

From the CAP there were no significant differences between groups in their satisfaction with the various types of activity. There was a counter intuitive correlation between the total satisfaction with activities and self-esteem (N = 68, r = -.45, p < .001; rho = -.33, p = .005), for mental health service users, though no correlation for long-term unemployed. One would expect *higher* self-esteem scores for those with higher satisfaction. Exploring this relationship further, the only significant correlation by area of activity was with 'other' activities, dominated by TV. Indeed there was a negative correlation between satisfaction with TV and self-esteem (N = 55, r = - .46, p < .001). Though there was no relationship between *time spent* watching TV and *satisfaction* with TV. Figure 39 shows that mean self-esteem score declines with increased satisfaction with TV (one-way ANOVA, F = 3.54, p = .008). So perhaps though people may be satisfied with TV it may not do much for their self esteem, or those with higher self-esteem do not derive as much satisfaction from TV.

Figure 39. Relationship between self-esteem and satisfaction with watching television



There were high proportions from both groups who said they did not have enough to do, with a significantly higher percentage of long-term unemployed (63.9%) than mental health service users (43.3%) (χ^2 = 5.47, df 1, p = .019) saying this. This is an explicit recognition of the emptiness in the lives of the people in this study.

People who said they had enough to do did a higher *number* of activities than those that didn't have enough (6.7 per month compared to 5.6, Z = -2.12, p = .034), and more within each category of activity, reaching significance in entertainment for mental health service users (Z = -1.04, p = .016). However, those that said they didn't have enough to do spent more *time* on activities (69.8 hours per week compared to 57.5, t = -2.14, df 126, p = .035). After an analysis by activity type, this finding was only significant for watching TV. Those that said they did not have enough to do spent more time watching TV (25.6 hours compared to 17.9 hours, t = -2.19, df 113.6, p = .031).

Unsurprisingly, those that said they had enough to do had a higher mean score on the leisure subscale of the LQoLP (5.06 compared to 4.63, t = 2.38, df 126, p = .019; Z = -2.45, p = .006). However, those who said they had enough to do also had a lower mean self-esteem score than those who said they didn't have enough to do (2.04 compared to 2.25, t = -2.34, df 125, p = .021).

Perhaps most importantly, those who had enough to do scored lower on the social exclusion index developed in the last chapter (t = -2.59, df 116, p = .011). Lower social exclusion scores were found for those with a higher number of paid work (r = -.34, p < .001), voluntary work (r = -.26, p = .004), team sports (r = -.25, p = .005) and total number of activities (r = -.28, p = .002). This provides a relationship between the effects of material deprivation and the extent of social participation.

The people who completed the time use diaries were split 50/50 between those who had enough and not enough to do. Those who said they didn't have enough to do watched TV more than those that had enough to do (24 hours compared to 20). Those that said they did have enough to do attended religious services and community meetings for longer over the week (1.4 hours compared to none, t = 3.22, df 15, p = .006) and took part in more work activities (5 hours compared to 30 minutes, t = 2.08, df 15.5, p = .055).

The main feature from the interviews and focus groups was that some people seemed to do a lot of activities, whereas others did very few. This did not seem to relate to whether or not

people went to a day centre or job club. For those that didn't attend a day centre or job club, life was often described as unstructured, with few activities except TV.

> **Interviewer.** Have you done anything? Have you found any structure to your days?
>
> **Mike.** No, just mainly... I like watching the telly and that. I always have this Sky, you know. I watch a lot of football and that... . [*Interview*]

However, for those that did attend day centres and job clubs, these environments did seem to create a time structure to their day, yet revealed the lack of structure outside.

> **Gary.** I come here during the day. I leave about half past three, four o'clock. Go home, take the dog out for a walk. I just sit in. [*Interview*]
>
> **Bill.** Well, err, I get home about one o'clock from here, err [Jobclub]. I get the Evening News on the Tuesday and, err, a Thursday. So, you know, I look through that. I do jobs about the house: anything needs doing, err... I go down to the Job Centre, every now and then sort of thing. [*Interview*]

There were others who attended job clubs and day services and also did a lot outside of the day centre.

> **Amy.** I'm Amy, I also go to [a sheltered workshop]. The things I like doing are going out to the theatre, going out with friends. I'm doing a course in computing and in French. I am also training to be an adviser for the Citizens Advice Bureau. [*Focus group 3*]

Other indicators of citizenship

One of the key indicators of citizenship is taking part in the democratic process. Table 49 shows the percentages of people from the two samples that voted in the last general election (1997 at time of interview) using the survey data. A slightly higher proportion of mental health service users had voted though not statistically significant. People who voted had a higher mean age ($t = 2.84$, df 131, $p = .005$), higher self-esteem ($t = 1.99$, df 130, $p = .049$), had lived at the same address for longer ($t = 3.39$, df 130, $p = .001$), had more qualifications ($t = 3.29$, df 118, $p = .001$), and had a lower social exclusion score ($t = 2.39$, df 120, $p = .018$). This last finding provides a relationship between extent of multiple deprivation and citizenship.

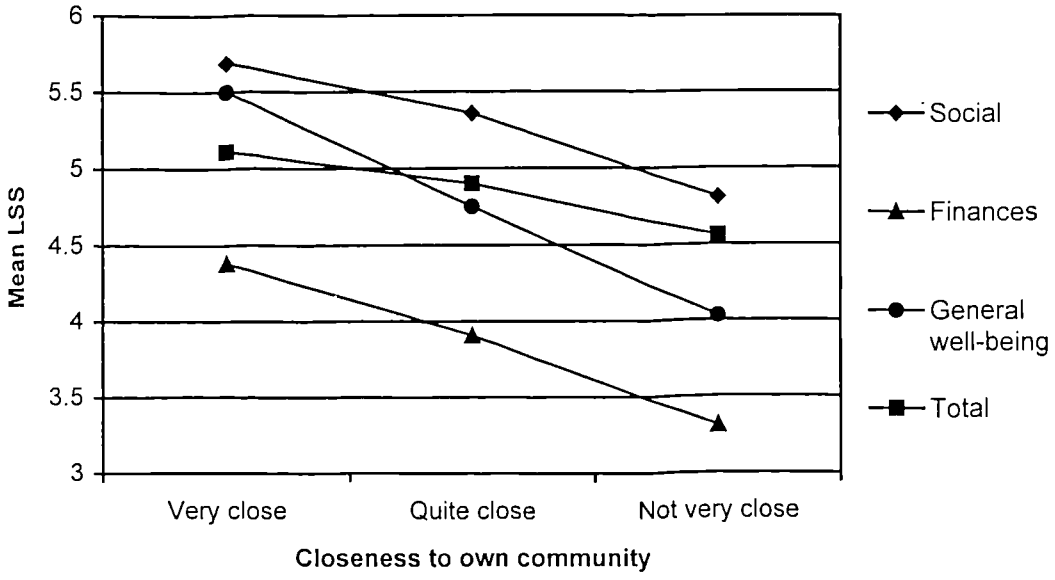
Survey respondents were also asked 'how close do you feel as part of your community?' Table 49 shows a similar distribution of response between the two study groups. Very few felt 'very close' and over half in each group said they were 'not very close'.

Table 49. Other indicators of citizenship

%	*Mental health service users* *N=62*	*Long-term unemployed* *N=71*
Voted in last general election	56.3	43.5
Close to community		
Very close	4.2	8.1
Quite close	45.1	37.1
Not very close	50.7	54.8

There was a clear relationship between subjective quality of life and how close a people felt to their community. Figure 40 shows that a sense of closeness to one's community is associated with higher quality of life in the domains of social life (ANOVA, F = 4.03, p = .02), finances (F = 3.57, p = .031), general well-being (F = 6.31, p = .002) and total LSS score (F = 4.80, p = .01).

Figure 40. The relationship between closeness to own community and quality of life.



Activity levels

This section considers the characteristics of people who are active and inactive. To do so a further analysis of the data using a K-means cluster analysis for 2 clusters was completed (Hartigan, 1975). The cluster variables included the total frequency of activities, to represent regularity of activity; the number of activities, to represent variety; and the proportion of

activities done during the week and during the day, to represent time structure. Table 50 shows the results of this analysis. Cluster 1 is the 'Active' group, who did more activities and which were more structured, and cluster 2 is the larger 'Less active' group. Table 51 shows the characteristics of activity clusters.

Table 50. Cluster variables

Cluster variable	*Cluster 1* *N = 46*	*Cluster 2* *N = 86*	*ANOVA*
Frequency (activities / week)	20	19	Not significant
Number (per week)	6.8	5.8	F = 4.13, df 130, p = .044
% Weekday	35%	10%	F = 57.65, df 130, p < .001
% Day time	56%	11%	F = 329.88, df 130, p < .001

Table 51. Characteristics of clusters

%	*Active* *N = 46*	*Less active* *N = 86*	*Chi-square*
Mental health service users	65.2	46.5	χ^2 = 4.21, df 1, p = .04
Using day service	56.7	25.0	χ^2 = 7.26, df 1, p = .007
Female	41.3	15.1	χ^2 = 11.19, df 1, p = .001
Single	37.0	52.3	ns
Non-white	15.2	17.1	ns
Enough to do	59.1	40.5	χ^2 = 4.02, df 1, p = .045
GHQ 4+	50.0	34.9	ns
Good to excellent health	51.1	61.6	ns
Satisfied with leisure	47.8	53.5	ns
Mean age	42.6	39.9	ns
Mean time spent doing activities (hours / week)			
Watching TV	13.2	27.0	t = 2.41, df 66.2, p = .019
Day centre	3.8	0.4	t = 2.36, df 46.8, p = .023
Domestic activities	4.7	1.3	t = -4.48, df 128.4, p < .001
Reading	0.7	3.8	t = -2.51, df 92.1, p = .014
Time alone	28.0	38.2	t = -1.95, df 124.4, p = .053

The 'Active' cluster is dominated by mental health service users, people using day services, women, and people who feel they have enough to do. The only significant differences in time

spent on the types of activities were that the 'Active' group spent less time watching TV and reading newspapers and more time in day centres and doing domestic activities. The 'Less active' group spent more time doing activities alone. The higher percentage of women in the 'Active' group explains the higher GHQ scores and, perhaps, the domestic activity.

This analysis does not prove that the 'Active' group are coping any better with unemployment than the 'Less active' group. Rather, it could indicate shows that day centres and domestic chores can help to structure people activities, and that watching TV and reading newspapers reduces structure. However, the direction of causality is uncertain, and so it may also indicate that people with more structure are more likely to attend day centres and people with less structure are more likely to watch TV and read newspapers.

Discussion

In this section the two main areas of concern are comparing the level and nature of social participation between the two study groups and between the study groups and the general population. The former allows us to determine the relative impact of unemployment and mental health has on social exclusion. The latter allows us to determine the extent of exclusion experienced by the two study groups.

Comparing mental health service users and long-term unemployed people

The data sources revealed a variety of activities that people from both groups engaged in, though there were very few differences in the amount of participation in the various types of activities. Long-term unemployed people, mainly men, played more active sports while mental health service users attended more religious activities and mental health day services. Both groups spent a very small fraction of their time, about 20%, on any purposeful activity (work, education, etc.) and sports. The most popular activities were watching TV, listening to radio, visiting other people and going to a pub.

There were very few differences in the temporal distribution of activities, with little variation over the typical week. There was a clear lack of the contrast between weekday and weekend activity experienced by those with jobs. Most people spent a large part of their days alone and had a limited social life, which had declined since leaving work. Everybody had low points, times of the day or week when they were bored, lonely and isolated. This demonstrates the negative impact that unemployment can have on social participation and social life.

People with higher scores on the social exclusion index spent more time alone and took part in fewer activities. This suggests that material deprivation has a negative effect on social

support and limits the extent of social participation, though the direction of this relationship cannot be deduced from this data.

Long-term unemployed people spent more on leisure activities despite having lower incomes. This indicates that mental health service users have more difficulties in participating than can be explained by income alone. The lower proportion of time spent with friends is perhaps one reason for this – mental health service users lack people to do activities with. These are explored in the next chapter.

It also seems that mental health services are not addressing this. Mental health service users spent just 1% of their time with paid help and only 11% of the activities were initiated by paid help. This suggests that mental health services have a minimal impact on promoting social inclusion.

The qualitative data suggested that some people had many activities and were busy, while some did very little. The cluster analysis of the survey data revealed two distinct groups. This analysis found that mental health service users, women and people using day services were more active. The inactive group was characterised by more time spent watching TV and time alone.

There was an interesting relationship between self-esteem and satisfaction with TV. Perhaps for those that have enough to do watching TV is beneficial – it is recreational -though not so for those that do not have enough to do, for whom TV is *the* structure. For many TV seems to fill a vacuum in empty lives.

Finally, people who felt close to their community had higher quality of life. This suggests that improvements in quality of life, and hence social inclusion, could be made by helping people to play a role within their communities.

There were several limits to the analysis in this section. Firstly, the CAP and time-use diaries recorded only primary activities. Secondary activities, such as watching TV whilst visiting a friend, were not taken into account in this analysis. Secondly, the total time spent on activities for the CAP amounted to about 9 hours a day. This could indicate lost data and unaccounted for time through poor recall and, though it perhaps indicated the lack of any activity.

A comparison with the general population

This section compares the extent of social participation of the two study groups with data from the general population. The frequency of activity in a given set of activities for the study groups were compared to data from the Household and Community Survey described by

(Gallie *et al.*, 1994). The results, in Table 52, show similar, and sometimes lower, levels of activity compared to the employed, unemployed and non-active (retired, disabled, carers).

Table 52. Comparison of leisure activities

	Mental health service users	*Long-term unemployed*	*Employed*	*Unemployed*	*Non-active*
	N = 71	*N = 62*		*N = 3030*	
Swim	0.14	0.16	0.14	0.12	0.11
Theatre	0.10	0.08	0.05	0.04	0.04
Cinema	0.11	0.11	0.05	0.06	0.03
Pub	0.40	0.49	0.47	0.42	0.33
Church	0.20	0.09	0.15	0.17	0.16
Visit	0.56	0.38	0.55	0.67	0.56
Entertain	0.30	0.33	0.51	0.61	0.54
Garden	0.35	0.25	0.43	0.35	0.43
TV	0.80	0.88	0.97	0.97	0.96
Read book	0.28	0.30	0.80	0.72	0.76
Walk	0.27	0.27	0.56	0.70	0.63
Evening class	0.15	0.15	0.07	0.04	0.05

These findings confirm Gallie *et al.*'s findings that there is little evidence to suggest that the unemployed, and in this case mental health service users, withdraw into inactivity. However, the data presented in this section does reveal that the *patterns* of activity are very different, in particular the amounts of time spent alone and the lack of variation in activity over the week. Moreover, few of the activities considered in this section require the compulsion that is often associated with the benefits of work (Jahoda, 1982).

> What leisure cannot provide, by its very nature, is a sense of compulsion and purpose beyond the pursuit of activity for its own sake. It cannot provide the central core of structure and purpose on which we have come to depend. (Glyptis, 1989: 159)

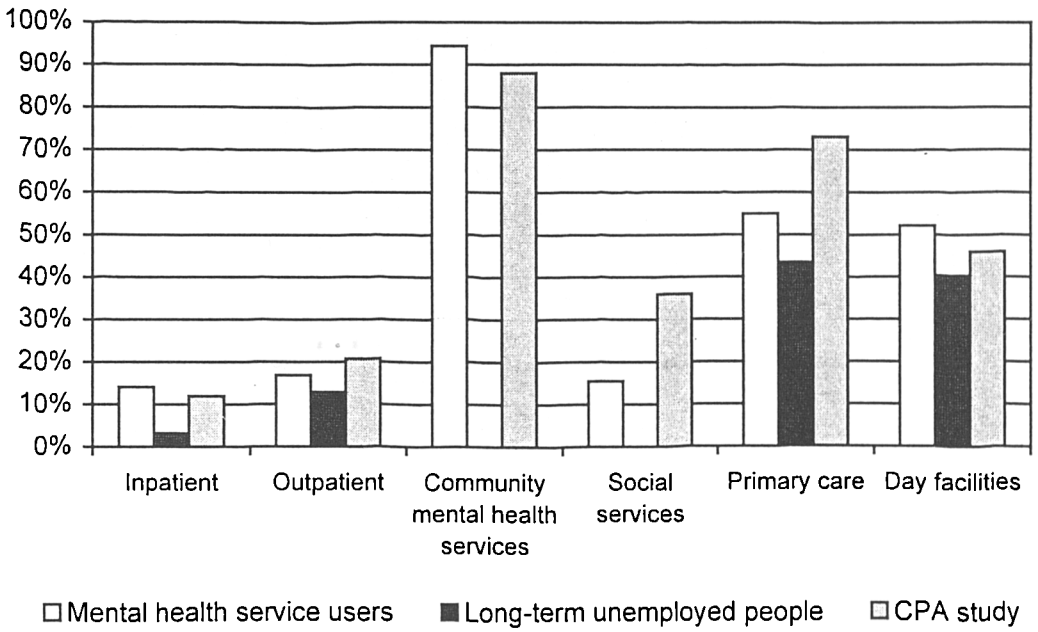
One of the key problems in the analysis of the wealth of data gathered in this study is the paucity of comparative data from other studies. Few other studies have systematically examined the extent of social participation of mental health service users. This data provides a baseline upon which other studies must build.

Section Three: Service use and costs

The use of public services and their associated costs are important as they are another indicator of citizenship. They also allow the examination of the resource implications of the levels of support current provided for both study groups, and the assessment of the financial impact of any proposed changes.

The CSSRI was used to collect detailed information, in a standardised way, about the types and level of services used so that cost estimates can be made. This section provides details of the use of 30 services by people from each study group and the associated costs of these services. These services were examined under six categories – inpatient, outpatient, community services provided the health service, community services provided by local authority social services departments, day facilities and primary care - and are shown in Figure 41. Details of service use within each of these categories is given in Tables 15 to 18 in Appendix F. The use of health and social care services are examined, followed by a more in-depth account of day facilities use from the qualitative data.

Figure 41. Service use of study groups and comparison sample



Use of health and social care services

There were clear and expected differences between groups in their patterns of health and social care service use. A higher percentage of mental health service users had used hospital inpatient services ($\chi^2 = 4.75$, df 1 $p = .029$), community mental health services ($\chi^2 = 113.96$, df 1, $p < .001$) and social services ($\chi^2 = 10.47$, df 1, $p = .001$). The differences in outpatient

and primary care use were small and not significant. For mental health service users there were no significant differences between genders in the use of the six categories of services.

There were differences between age groups and use of health services. All people who had been admitted to an acute psychiatric ward were aged between 30 and 40. People over 50 were more likely to have had outpatient appointments (83.3% compared to none under 30) and used primary care services (83.3% compared to about 50% for younger age groups, $\chi^2 = 8.64$, df 3, $p = .034$).

Surprisingly, general health and well-being did not predict health service use. There were no significant differences in empowerment, self-esteem, M3 scores and general health between users and non-users of the various services.

Compared to the CPA study (Carpenter *et al.*, 2001) the sample of mental health service users had a very similar pattern of service use. This comes as no surprise considering the similarities in personal characteristics described in Chapter Six.

Use of day facilities

Day facilities covered a range of specialist and general day services. Findings from the CSSRI are given in Table 53, which shows that while the overall use of day facilities was similar between groups, the pattern of service use was very different. Mental health service users attended mental health day services and a similar proportion of long-term unemployed attended Jobclubs. This interesting finding is worth greater examination using the qualitative data. The main interest here was to gain a deeper insight into life without work and examine the role of the official environments for the two study groups to use: day centres and job clubs.

Table 53. Use of day activity services

%	*CPA study* N=260	*Mental health service users* N=71	*Long-term unemployed* N=62
TOTAL	46.0	52.1	40.3
NHS day facility	6.2	15.5	0
Day hospital	0	7.0	0
LASSD day facility	6.5	25.4	0
Voluntary day facility	6.2	8.5	0
Sheltered workshop	5.4	8.5	0
Education classes	6.5	12.7	6.5
Jobclub	0	0	33.9

Drawing mainly upon field notes from participant observations in job clubs and day centres, this section compares and contrasts the two environments used by the two study groups. In the absence of work these are the 'official' places to go. These findings are enhanced by the findings from the CSSRI and service level data provided by mental health services in Manchester and Tameside.

The premises

The five job clubs visited were all located in run-down shopping districts, each occupying converted and often cramped office space on the first floor above shops. None of them were well signposted and could only be found with directions. Each had rooms for job club members, an open-door staff room, a quiet room, and a training room.

The three day centres visited were very different from the job clubs. They were located in purpose built local authority buildings in mostly residential areas set apart from shopping districts. Each was clearly signposted. Each day centre had a range of purpose built rooms, (e.g. day room, staff office, kitchen, craft rooms) and gardens.

The people

During the participant observation members of the job clubs were almost exclusively male and mostly in their forties and fifties. Members of day centres were also mainly men, though more mixed than job clubs, and middle aged. Data from the CSSRI and comparative figures for mental health day service users, given in Table 54, confirm these findings. Moreover, a higher proportion of white British people had used day facilities compared to black and minority ethnic people (59.6% compared to 21.4%, $\chi^2 = 6.58$, df 1, $p = .01$).

Table 54. Characteristics of day service users compared to service level data from day services in Manchester and Tameside

%	*Study sample*	*Manchester*	*Tameside*
Age (years)	*N = 27*	*N = 449*	*N = 140*
Under 26	7.4	3.1	5.6
26 - 45	51.9	42.3	48.3
46 +	40.7	54.5	46.2
Male	74.1	60.0	63.0
Female	25.9	40.0	37.0
White	88.9	84.0	96.7
Other	11.1	16.0	3.3

The CSSRI found that day service users had better psychological well-being - a lower percentage of those who had used day facilities (16%) scored over 5 on the GHQ-12 than those who did not user day services (45%, $\chi^2 = 4.55$, df 1, $p = .033$). This may suggest a positive outcome of day care services, though equally, it may mean that these services are not targeted on those most in need.

The relationships that members had with each other, in both environments, were more like colleagues than friends. For example, compare the views of Gary and Anthony, who attended day care services, with Bill, a Jobclub member, who all described in their interviews relationships that were part friendship, part associate, part colleague.

> **Gary.** They are friends when I come in here, but that's as far as it goes, you know. Once you are at home you are there on your own. [*Interview*]
>
> **Anthony.** Yeah, there is a difference, because the friends at the day hospital, they are there to help me, aren't they. They're not friends, they are associates, aren't they. They are there to help me, but when I was working I had friends at work. [*Interview*]
>
> **Interviewer.** Do you get on with them [other Jobclub members]?
>
> **Bill.** Oh yeah, yeah. But I can't remember any I have not got on with. So, I mean, this lot here are okay, so... [*Interview*]

The staff at the day centre and job clubs were predominantly female. Technically, the roles of the staff on job clubs and day centres are very different. In practice, the roles were quite

similar. For example, the day centre staff described their various roles during an initial meeting.

> For just being there
>
> We're like parents
>
> To facilitate groups
>
> We must be approachable
>
> We have a combination of staff to create an atmosphere
>
> We're also cook and cleaner. [*Field notes, 21/11/01*]

In practice the staff had a very 'hands off' role, in which they looked busy yet didn't have that much interaction with members. This short extract illustrates this.

> All the staff (about four of them) were preparing for a fair – rearranging tables, printing off poetry books, organising things to sell. But with just one or two members actually helping them, the rest, over twenty, just sat about in the day room. [*Day Centre, field notes, 29/11/00*]

However, when staff did interact with members they had a strong role. They could change the atmosphere almost immediately, by injecting more life into conversations. Many day centre members said they found the staff very supportive, in a general way, as illustrated by Jimmy, a day centre member.

> **Jimmy.** I think the way that we work with staff [in the day centre] is great, because they are always available, they check up and sort of things like that. [*Focus group 2*]

Similar characteristics were found during observations in the job clubs. For example, one job club leader offered the following when asked about how job clubs are run.

> I operate a very relaxed club, where members can come and look for jobs and complete applications, and such like, in their own time... I think it's important that the atmosphere is quite sociable as, well, where else have they got to go? They'd be stuck at home all day. [*Jobclub, field notes, 27/9/00*]

During observations at a job club a similar social and supportive role was evident.

> When she came into the room, the job club worker seemed to create a centre of attention among the men. Conversation was lifted. She created topics to talk about and group 'banter', whereas when left to themselves the men spoke quietly, intermittently, in small groups. [*Jobclub, field notes, 23/9/00*]

In both day centres and job clubs the staff had a low profile, in both cases their main role appeared to create a relaxed atmosphere – almost like hosts – and in both cases staff provided stimuli for conversation.

The purpose

The purpose, or reasons why people attend day centres and job clubs have obvious differences. People are referred from community mental health teams to attend a day centre to provide structure to their day and an opportunity to socialise. On face value, long-term unemployed people are referred from Job Centres to attend a job club to find work.

In practice there were many similarities in the purpose of the two environments. Although some do use the Jobclub to successfully find work, many, mainly longer-term unemployed people use it for the same purpose as the day centre. Observations revealed that the main purpose of both environments was to provide a venue for a social club. Compare the descriptions of day centre activities with those of a Jobclub.

> Another man, in a wheelchair, had come for eight years and liked the company. He said 'I know lots of faces, some names, but only a few to talk to at length' and to play games 'scrabble and chess are popular'. He said drop-ins fill the gaps in his day and provided a place to socialise as he doesn't like being on his own. [*Day Centre, field notes, 20/12/00*]

> It's a social club for men really. Men, unless they go to the pub they don't meet other people... Jobclub is informal and full of banter - people like it to talk about the news... It's warm and there's people to socialise with... If it was called 'mens' social club' no-one would turn-up. People who want to work will find it, others come to socialise and mix with others, they also get to know things from others. [*Interview with Jobclub leader, field notes, 12/9/00*]

Some members also came for less specific reasons –for 'something to do' or 'to keep active'.

> A man, Danny, sat down for a chat. He said that he came 'now and again when there's nowt else to do.' He helps his wife with housework, but goes to pub or here to 'get me from under my wife's feet.' [*Day Centre, field notes, 4/12/00*]

> One man was discussed by the staff when we went out for a smoke. The Jobclub leader said 'He doesn't want a job, but he comes here every day. He drops off his kid at school and comes here. I'm not sure why. For something to do, I suppose.' [*Jobclub, field notes, 27/9/00*]

A self-help function -to be with people with similar issues –was also found.

> Eddie [...] I like coming to the centre, I find it secure here, with friends, we're all the similar sort of boat, and I know all the people here. [*Focus Group 3*]

> **Bill.** Well it's mainly just looking for jobs, but you know, err, it's obviously the people here are in the same predicament as myself, you know, looking for a job... [*Interview*]

Despite their obvious differences the observations found that most people attended day centres and job clubs to be with others, get out of the house, and find comfort and support in the company of people in a similar situation.

The activities

In theory, the activities of these two environments should be very different: Jobclubs are for job search activity and day centres are for group work and social activities. In practice, the observed activities of the day centre and job clubs were very similar.

People attended day centres and jobclubs to be in the company of others. For some this meant chatting, for others just being in the same room seemed sufficient. The tempo of the days was slow, regulated by the making and drinking of tea and coffee, smoking cigarettes and taking part in unstructured activity such as reading newspapers and playing board games, as shown by the two extracts below.

> The rear lounge filled up through the morning, from four people when I arrived at nine thirty to over twelve when I left at eleven thirty. Some people smoked, some just sat, P told me some jokes, and, as the room filled up, separate conversations took place. [*Day Centre, field notes, 29/11/00*]

> The men sat around a large table in the middle of the room that had piles of newspapers at its centre. Some read newspapers, others talked in small groups and some just sat there in silence. Job search activity – looking at vacancies on the wall, writing a letter or making a phone call, were infrequent, a slow pulse to the day – was interspersed in the longer periods of chatting, sitting in silence, making and drinking teas and coffees and going outside for a smoke. [*Jobclub, field notes, 23/9/00*]

Some members had more structured activities by helping staff with some light duties.

> Some of the members appeared to have 'jobs' in the job club ... He collected the post and took it to the post box each day ... Another member was asked to make teas and coffees for me and the staff. [*Job Club, field notes, 22/9/00*]

> One of the members was helping [the staff] by making teas, coffees and toast... [*Day Centre, field notes, 4/12/00*]

Others seemed disconnected from the activities around them, and were there simply to be somewhere.

> One man in particular kept appearing on the landing to look at the post in the out tray, and then would look at the posters and job adverts on the wall. He did this repeatedly in an aimless fashion, moving from room to room, throughout the day. [*Jobclub, field notes, 22/9/00*]

> A man was walking around the tables for most of the morning, seemingly without purpose. Activity continued around him as if he wasn't there. [*Day Centre, field notes, 4/12/00*]

The environment

Perhaps the main characteristic feature of both environments, as made explicit by the staff, was the informality. This was evidenced by a lack of time structure and expectations, coupled with freedom and use of first name terms. The observation notes referred time and again to the café/social club/pub environment, with music playing, jokes told, quiet people, quiet times, lots of smoking and drinking tea/coffee. The following extracts compare the atmosphere in a day centre with that in a job club.

> During this time several other people had arrived. Each person was greeted by their first name by other members... Music played continuously.... As I sat talking to Ian, I looked around the room - at people sat on their own drinking tea and coffee, at the others chatting at some tables, and at the noise and activity in the kitchen – I really felt I was in a café... [*Day centre, field notes, 4/12/00*]

> A radio was playing modern pop music from a local commercial radio station throughout the morning... During my time there Adrian had been completing a job application. I'm not sure if it was the novelty of my presence, but not much work happened and very little job searching. But there was a lot of chatting. [*Jobclub, field notes, 27/9/00*]

As discussed earlier, friendly relationships can evolve naturally within this environment for those that want them. The drawback of this 'club' feeling is that it can exclude new members, which has an impact on drop-out rates.

Both job clubs and day centres experienced high drop out rates. For example, service level data from mental health services in Tameside found that only 50% of people referred day centres actually attended and 20% of those who chose not to return did so after their initial visit (Turton and Ferguson, 1999). Moreover, 35% of appointments to the psychiatric day hospital failed to be kept, and a mere 26% of people referred to the sheltered workshop had taken up their place. From the CSSRI, 22.7% of non-day service users had previously used day facilities. This shows that nearly a quarter of day service users had dropped out within three months.

The reasons for this can be found in the words of those that have attended and chosen not to, and also from the experiences of those that continue to attend. Firstly, some said the environment intimidated them, as several current day centre members who left immediately after their first visit said they returned later with a friend.

> **Gary.** I was a bit thingy at first, you know, scared, cos I didn't know anyone at all. I did come and I left. Then I met someone at the hospital and I could start coming back. [*Interview*]

Some took one look at the people and didn't want to be associated with them.

> When Anne came the first time she said 'I walked straight back out of the door. I didn't want to spend time with them.' [*Day Centre, field notes, 4/12/00*]

Whilst others said they got bored.

> **Mike.** That was, err, that was four months ago. I used to go up on a Friday for a few hours and play football and that with five-a-side. I used to go up there. I got bored with that though. [*Interview*]
>
> **Interviewer.** Why do you think people don't come to [the day centre]?
>
> **Carly.** It can get boring. [*Focus Group 2*]

Service Costs

Table 55 shows clearly that costs are much higher for mental health service users than long-term unemployed people, almost twenty times higher. This is not surprising considering the higher service use, and of services with higher costs, especially of specialist services. The highest costs for mental health service users were community mental health services and inpatient services. Day facilities form the third highest cost.

For mental health service users there was a significant correlation between medication costs and M3 score ($N = 37$, $r = .39$, $p = .018$) and a relationship with age: people under 30 had a mean cost of £35.29 per week compared to £25.12 for 30 to 49 year olds and £5.36 for over 50s (ANOVA, $F = 5.40$, $p = .007$). People with higher M3 scores were more likely to be taking anti-psychotic medication, and in particular, younger people were more likely to be taking the more expensive atypical anti-psychotic medication.

For mental health service users, there were no significant difference in costs between those using and not using day services, except of course, the cost of day facilities ($t = -6.29$, df 27.0, $p < .001$). The additional cost of using day services was £49.60 per person per week, or £2580 per year.

Table 55. Weekly health and service costs

£ per week	*Mental health service users* N = 71	*Long-term unemployed people* N = 62	*CPA* N = 260
Inpatient	56.23	2.51	18.08
S.D.	188.79	13.94	93.22
Outpatient	3.69	0.87	3.82
S.D.	15.91	2.48	1.15
Day facilities	29.39	4.29	24.05
S.D.	45.86	7.90	53.43
Community mental health	65.26	0	37.76
S.D.	78.95	0	59.91
Social Services	7.69	0	7.26
S.D.	29.04	0	16.29
Primary care	4.27	2.00	7.46
S.D.	11.24	13.02	19.83
Total service costs	167.18	10.63	112.10
S.D.	239.57	19.06	152.80
Medication costs	22.47	0.32	-
S.D.	22.87	1.19	-
Total costs	190.15	10.96	-
S.D.	243.55	19.20	-

Discussion

In terms of service use there were many differences between study groups in the levels, patterns and costs of service use -mental health service users had far higher levels of service use at much greater cost.

Perhaps of greater interest to this study is the use of day facilities. The total use of day facility was comparable for both groups, though the types of facility were greatly different. Mental health service users used mental health day services and long-term unemployed used Jobclubs.

On face value, there are few similarities between a job club, where long-term unemployed people go to help them find work, and a day centre, where disabled people go who feel they cannot work. However, in practice they serve a similar purpose, attract similar types of people, who do similar types of activities and create a similar 'social club' environment. Though, many differences cannot be ignored, for example members get a meal at the day centre and some activities, like trips out, are organised.

Day facilities constitute a significant cost to mental health services. However, access to these services is problematic. Firstly, only a minority of mental health service users are regular attenders. For example, service level data from Tameside showed that only 10% of eligible people used day services (Turton and Ferguson, 1999). Daily use figures showed that each day just 27 people attended the two day centres, leaving over 670 people on the enhanced CPA with no statutory day service support. Section Two revealed how bleak the daily lives of many mental health service users are and the associated impact on well-being. Day care services are failing the majority of mental health service users.

Secondly, of those that do get referred, the majority of people leave soon afterwards due to intimidation, stigma and boredom. Also day services attract few younger people and people from minority ethnic groups. This is due to the 'parallel universe' of day care services, with their lack of stimulation, lack of variety and lack activities that are relevant to the lives of many mental health service users. Indeed, day services appear to add nothing more to the lives of mental health service users than additional weak relationships and some structure.

The role of day services is called into question by these findings. It appears that day services are not targeted on those with poorer health. For those that do attend, the environment is not dissimilar to other social environments, such as cafés. Yet mental health services provide these environments at a cost of over £2,500 per person per year.

Conclusion

This chapter has examined the social life, community participation and services use of mental health service users and long-term unemployed people. The findings were drawn from survey data, time use diaries, focus groups and interviews.

The picture that emerges about the social life of mental health service users and long-term unemployed people are strikingly similar. It is one characterised by small social networks, little contact on a daily basis, and a high proportion of network members out of work. Both groups spent most of their waking time alone and expressed particular times when they were most lonely. As noted by Gallie *et al.* (1994: 263) with reference to unemployed people: these impoverished social networks lock people into their situation of social exclusion.

This situation has been described by the limited involvement in community activities. Most people took part in activities that incurred little or no cost and did them alone. The lack of purposeful activity resulted in little variety over a typical week. TV and radio were often the substitute.

The relationship between material deprivation, social networks and social participation has been explored. An explanation for this relationship is that unemployment, low income and poor health limit social networks which in turn provide a restricted 'opportunity framework' for community participation. Day care services were developed as a mechanism to address this problem for mental health service users.

Chapter Two argued that day care services we an outmoded concept. The empirical evidence presented here supports this view. Traditional day care services provided a limited range of opportunities to a limited range of people, and leave the vast majority of mental health service users to live a sparse existence characterised by few social contacts and limited participation in community activities.

The next chapter provides a further analysis of the data and examines the relationships between the individual and their aspirations, the barriers they face and the supports required.

Chapter Eight

Findings III: Aspirations and Barriers to Inclusion

Introduction

This chapter uses a mixture of qualitative and quantitative data to explore the aspirations and barriers to inclusion for mental health service users and long-term unemployed people. To do so the chapter is organised in the following four sections.

Desired Activities. The activities people would like to do.

Barriers faced. The barriers they faced.

Supports desired. The further supports desired.

Labour Market attachment. How close people are to work

Section One considers explores who wants to work and why, and also examines the desire for activities other than work. Together, these form people's aspirations for inclusion – their own self-defined notion of inclusion.

The previous two chapters described the material deprivation and lack of social participation experienced by the two study groups. Sections Two and Three considers the other dynamic elements of social exclusion, the barriers that prevent people achieving their aspirations and the supports required to overcome these.

Finally, Section Four introduces the concept of labour market attachment: how ready a person is to get a job. This is used to determine the characteristics of those people who are most likely to return to work and those people who are not.

Section One: Desired activities

The interviews and focus groups found that by far the most desired activity was work. Some people expressed the specific types of work they wanted while others said they just wanted a job. Outside of work, very few mentioned other specific activities, whilst others said they wanted just to do something, anything. This section explores the desired activities given by participants and the motivations for wanting them. It is structured around the qualitative data, though is mainly illustrated by the survey findings.

The desire to work

Everyone who participated in the interviews and focus groups had a view on work, most expressed a desire to work. The survey also found high proportions from both groups who wanted to work. Table 56 shows the proportion of people from each group who would like to work and saw themselves working in the future. A higher percentage of long-term unemployed people than mental health service users said they wanted to work (χ^2 = 9.74, df 1, p = .002), saw themselves working in one year (χ^2 = 29.24, df 1, p < .001), saw themselves working in three years (χ^2 = 16.40, df 1, p < .001), and ever see themselves doing any work in future (χ^2 = 10.24, df 1, p = .001). Women were more likely to see themselves ever working again (χ^2 = 4.14, df 1, p = .042).

The differences between groups can be explained by the longer duration out of work experienced by mental health service users. Those who did not want to work had had a longer mean duration out of work (143 months compared to 93, t = -2.43, df 69, p = .018).

Table 56. Desire to work

%	*Mental health service users*			*Long-term unemployed*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
	N=45	*N=26*	*N=71*	*N=54*	*N=7*	*N=61*
Want to work	66.7	69.2	67.6	90.7	85.7	90.2
See self working in 1 year	31.1	42.3	35.2	81.5	85.7	82.0
See self working in 3 years	46.7	61.5	52.1	85.2	85.7	85.2
Ever see self doing some work	66.7	88.5	74.6	94.4	100.0	95.1
Yes to any one statement	77.8	88.5	81.7	96.3	100.0	96.7

The reasons for wanting to work

The interview and focus group participants expressed many reasons why they wanted to work. Firstly, some felt that work could bring structure to their life.

> Simon. Working through the day, it gives you certain times to do things at. It's gives you purpose in your life. You can carry all them into you're social life. You know, you're up at certain times, you're at work at certain times, you come home have you tea at certain times. [*Focus group 2*]

Others were motivated to earn money and be independent.

> **Eddie** Make their own way, not have your money coming off the Government. [*Focus group 3*]

The influence of family and to provide for them was a common and powerful incentive.

> **Interviewer.** So, in summing up, what do you think are the main, the main things that could improve your quality of life?
>
> **Mike.** Erm, try and get back to work and get in err, you know, and having the money to give the children everything and that. [*Interview*]

Some also referred to respect and self-esteem.

> **Carl.** [...] I'm doing it for me, for my self esteem, for me, for my pride - if you lose your pride you haven't got a thing. [*Interview*]

A common motivation to work, particularly for the younger mental health service users was a desire to return to 'normal' and being part of society. This had an underlying desire for recovery, to 'get well'

> **Donal.** I've gone through all the mental problems, taking the tablets and everything, but now I am getting over all of it, and I would just like to see for myself like what I'd be like in work. If I had a chance like... [*Focus group 1*]
>
> **Eddie.** If you went to the pub, sort of thing, you would feel like more integrated with society, more a part of society, because you are doing a bit of work within society. You're not excluded. [*Focus Group 3*]

Though this return to normality is also felt by long-term unemployed men of a similar age.

> **Carl.** I just wanna be an earner, I just want to be a Mr Average, getting up at nine to five and just working... I want to get a job because I want to be independent. [*Interview*]

Even those that didn't want work said they suffered without it.

> **Jimmy**. Yes, yes, because I think to be at work, you know I have worked all my life, and you lose something by not being at work.
>
> **Harry**. You feel dead degraded, don't you? [*Focus group 2*]

The last words on this topic are given by Anthony, who neatly summarises why he wants to work and rounds it up with the desire to 'have a life' –perhaps the most simple definition of social inclusion.

> **Anthony.** It [work] gets me back into society again. It, it... you have got your own money, you know what I mean, you are earning your own money. You can do more things when your working. You have got more life, more of a life, you have got a work life and you have got an home life an' all, instead of just an home life, being bored. If you are working you are meeting different people and you get to have work mates and all that, and go out for a drink with your work mates, can't you. And it's, what do you call it, generally have a life. [*Interview*]

Attitudes to work

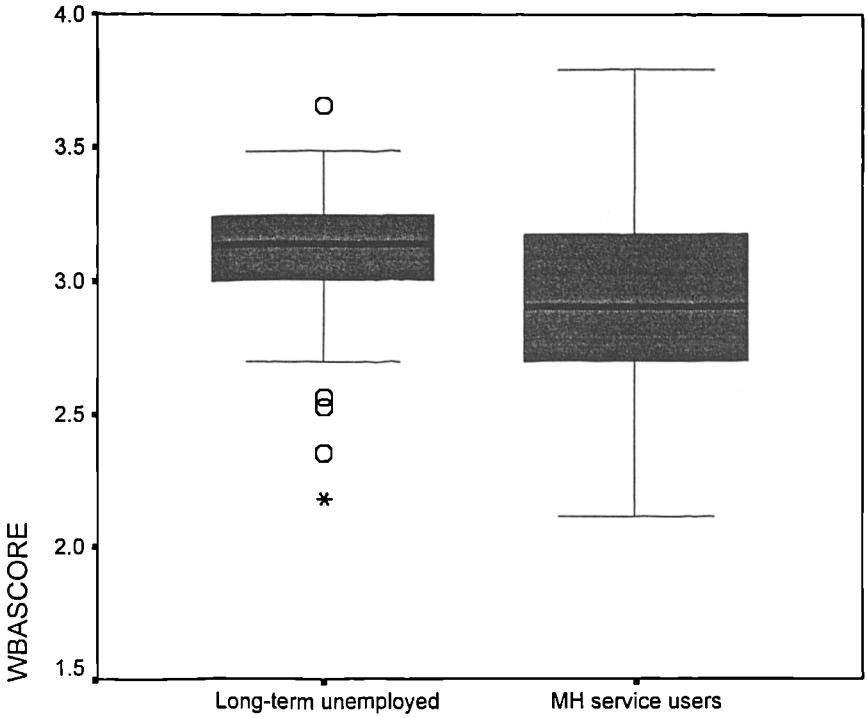
Another approach to assessing attitudes to work was the Work Behaviours and Attitudes Scale (WBAS) used in the survey questionnaire. The WBAS measures attitudes and feelings towards work, co-workers, and supervisors and provide an assessment of personal performance and capability. The scale consists of 29 items answered on a four-point scale, and has three subscales: work pride and independence, work anxiety and work performance.

Table 57 shows that long-term unemployed had a higher mean score on the total WBAS (t = -3.19, df 119.6, p = .002) and the Pride and Independence subscale (t = -3.34, df 128, p = .001). Figure 42 shows the distribution in WBAS scores. There were no significant difference in mean scores on demographic variables, except those with qualifications had a higher mean WBAS score (t = -2.13, df 128, p = .035).

Table 57. Work Behaviours and Attitudes Scale

Scale (1-4) *Mean (S.D.)*	*Mental health service users* *N = 68*	*Long-term unemployed* *N = 62*
WBAS score	2.92 (.38)	3.10 (.26)
Pride	2.81 (.48)	3.07 (.38)
Anxiety	2.72 (.64)	2.89 (.64)
% WBAS 3+	41.2	79.0

Figure 42. WBAS scores[30]



Those who said they wanted to work had a higher mean score on the WBAS (t = -3.36, df 36.6, p = .002) and work pride subscale (t = -3.68, df 36.3, p = .001). As fewer mental health service users said they wanted to work, this may explain the differences in work attitudes. However, taking only those who said they wanted to work the long-term unemployed still had a higher mean score on the WBAS (t = -2.31, df 95.1, p = .023) and work pride subscale (t = -2.43, df 112, p = .017) than mental health service users, though this was not significant when comparing the two study groups in Manchester.

The impact of social exclusion on attitudes to work was also evident. Those with higher social exclusion scores had lower attitudes to work (r = -.37, p < .001), controlling for study group. There was also negative correlation between the WBAS score and most recent time out of work (r = -.26, p = .004) and total time out of work (r = -.28, p = .001). Again, this may also explain some of the difference in WBAS scores between groups as mental health service users have spent on average a longer duration out of work. Those with more unemployed social network members had a lower WBAS score (r = -.21, p = .026).

[30] The box plot provides a summary based on the median, quartiles, and extreme values. The box represents the interquartile range which contains the 50% of values. The whiskers are lines that extend from the box to the highest and lowest values, excluding outliers. A line across the box indicates the median (SPSS, 1999).

The second measure of work attitudes was a response to the statement 'If I had as much money as I needed I would still like a job' (Warr, 1982). 68% of long-term unemployed and 67% of mental health service users either agreed or agreed strongly. Both study groups had a strong commitment to work.

Those who agreed with the statement were more likely to say they wanted to work (χ^2 = 17.75, df 1, p < .001), had higher scores on the WBAS (t = -3.77, df 126, p < .001) and Work Pride and Independence subscale (t = -4.61, df 126, p < .001), and had spent less time out of work (t = 2.08, df 128, p = .04). There was no significant difference in weekly income and satisfaction with finances between those who agreed and those that disagreed with the statement. The desire to work is independent of current income.

Work desired

For those that said they wanted to work, the survey questionnaire asked for details about the type of work desired. People who want to work in occupations with plenty of jobs are more likely to do so. The results are given in Table 58. The differences between the two groups were significant (χ^2 = 26.24, df 3, p < .001). A greater percentage of long-term unemployed wanted a full-time job and self-employment, and a greater percentage of mental health service users wanted a part-time job or voluntary work. None wanted sheltered work, although 10.6% of the mental health service users wanted to work part-time (under 16 hours), and so remain on benefits, compared to just 2.7% of long-term unemployed.

These differences are partly a result of gender bias in the samples, as men mostly wanted full-time work, whereas many women wanted part-time. However, the desire for part-time work among mental health service users is real as 33.3% of male mental health service users wanted part-time work compared to just 4% of long-term unemployed men.

Table 58. Type of work wanted

%	*Mental health service users*			*Long-term unemployed*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
	N=30	*N=20*	*N=50*	*N=50*	*N=6*	*N=56*
Full-time employment	63.3	5.0	40.0	80.0	66.7	78.6
Part-time employment	33.3	55.0	42.0	4.0	16.7	5.4
Self-employment	0.0	20.0	8.0	14.0	16.7	14.3
Voluntary work	3.3	20.0	10.0	2.0	0.0	1.8

Table 59 shows the reservation wages of the two groups. The reservation wage is the minimum wage that a person would consider working for. A higher proportion of mental health service users wanted to work for no pay, whereas a higher proportion of long-term unemployed were prepared to work for less than the National Minimum Wage[31]. Excluding the 14.6% of mental health service users who did not want a wage and two outlying cases of over £20 per hour, there were no significant differences in mean reservation wage between groups or genders. It is most likely that those mental health service users who wanted no wage were concerned about losing welfare benefits. It is clear that both groups have not 'priced themselves' out of the labour market and have modest aspirations for earnings.

Table 59. Reservation wage (£s per hour)

%	*Mental health service users* N = 48	*Long-term unemployed* N = 56
No wage	14.6	0.0
Up to £3.69	6.3	14.3
£3.70+	79.2	85.7
(£/hour)	*N = 40*	*N = 55*
Mean reservation wage	5.85	5.29
S.D.	2.92	1.63

Labour market flexibility

The survey included questions about labour market flexibility using the dimensions proposed by Gallie *et al.* (1994). Those with greater flexibility are more likely to get work. Table 60 shows that there were no significant differences, though perhaps the higher percentage of long-term unemployed that would consider retraining could be due to their lower levels of qualifications. Both groups are slightly more flexible than the unemployed in the study by Gallie *et al.* (1994), where 45% would consider retraining and 40% would move area.

Table 60. Labour market flexibility.

%	*Mental health service users* N = 55	*Long-term unemployed* N = 57
Take anything going	20.0	19.3
Consider retraining to get a job	52.7	70.2
Move area for a suitable job	30.9	40.4

[31] At 1999/2000 level (Low Pay Commission, 1998).

However, for those who said they wanted to work, 16.1% of mental health service users had looked for work within the last four weeks compared to 91.2% of long-term unemployed (χ^2 = 64.23, df 1, p < .001).

Leisure activities

The CAP also asked whether people wanted to do any more activities than they were currently engaged in. Table 61 shows that the majority of people in both groups wanted to do other non-work activities. Sporting activities were the most desired activities for both groups, followed by social activities and holidays.

There were no significant differences between groups, except a greater proportion of mental health service users said they wanted to read (χ^2 = 5.49, df 1, p = .019) and drive (χ^2 = 6.45, df 1, p = .011). These are perhaps due to the side-effects of medication. It should be noted the very small percentage, less than 2%, of mental health service users who wanted to do health & social care activities, i.e. mental health day services.

Table 61. Activities wanted

%	*Mental health service users* *N = 71*	*Long-term unemployed* *N = 62*
Any activity	63.4	51.6
Sports	32.4	22.6
Social	16.9	14.5
Entertainment	11.3	14.5
Education & training	8.5	11.3
Religious	1.4	0.0
Health & social care	1.4	0.0
Other	50.8	16.1
Others		
Holiday	15.5	11.3
Drive	9.9	0.0
Read	8.5	0.0
Hobby	5.6	1.6
Miscellaneous	11.3	3.2

Table 62 shows that a friend or social acquaintance was the preferred companion for the desired activities. The only significant difference between groups was that a higher percentage of mental health service users wanted to do their activities on their own (χ^2 = 4.71, df 1, p =

.03). Note that very small percentages of mental health service users wanted to do their activities with paid help and other service users.

Table 62. People with whom to do desired activities

Mean number	*Mental health service users*			*Long-term unemployed*		
	Manchester	*Tameside*	*TOTAL*	*Manchester*	*Tameside*	*TOTAL*
	N=62	*N=9*	*N = 71*	*N=42*	*N=20*	*N = 62*
With friend / informal acquaintance	29.0	33.3	29.6	28.6	25.0	27.4
On own	24.2	22.2	23.9	11.9	5.0	9.7
With colleague / formal acquaintance	14.5	11.1	14.1	21.4	5.0	16.1
With family	8.1	11.1	8.5	11.9	10.0	11.3
With paid help	1.6	11.1	2.8	0.0	0.0	0.0
With service users	3.2	0.0	2.8	0.0	0.0	0.0
With anyone	1.6	0.0	1.4	0.0	0.0	0.0

During the interviews it was difficult to get people to say what they specifically wanted to do other than work and training. The lack of ideas for specific activities outside of work was particularly true for long-term unemployed men. The participants expressed a desire to have a better social life, especially those who had little or no social contact such as Gary.

> **Interviewer.** Would you prefer it if you knew people outside of the Day Centre?
>
> **Gary.** Well, I would like to have friends here that come round and see me, and I could go round and see them. But I can't see it happening. [*Interview*]

Others wanted more social activities, such as evenings out.

> **Judith.** Yeah, social evenings and things like that. You know, you might have one mate but you just get bored to death just two of you trying to... You do, don't you. [*Focus Group 1*]

Having a relationship was also seen as important

> **Anthony.** I would like to get a girlfriend. Once me life's back in order. [*Interview*]

The interviews and focus group participants confirmed the survey finding about the desire to go on holiday and trips.

> **Donal.** I've never been on holiday in my life. [*Focus Group 1*]

The survey found that few mental health service users who wanted to do health & social care activities. However, for those already engaged in such activities many expressed the desire for more of the same – more hours, more activities and more staff in day services. The following statements illustrate this.

> **Judith.** Well, I think definitely longer hours.
>
> **Barbara.** Your life isn't nine 'till five is it?
>
> **Interviewer.** More hours of what?
>
> **Barbara.** Like centres and places we can go... [*Focus group 1*]

Discussion

By far the most desired activity was work. Work was wanted for many reasons - the structure to life, to meet family commitments, for self-respect – though the underlying reason was to return to normality, be independent and socially included. It appears that work is indeed the preferred route to inclusion.

There were some important differences in the desire to work. A higher percentage of long-term unemployed people than mental health service users wanted to return to work. Long-term unemployed people also had more positive work attitudes. These differences can be explained by the longer periods that mental health service users have spent since last working. Chapter Six saw the work histories of mental health service users dominated by very long periods since their last job. This main difference is likely to cause fewer mental health service users to want to work and to have more negative work attitudes, as illustrated below.

> **Jimmy.** Coming back to what you were saying, I can see at my age, and I have been on the sick for the last five years, and I have done manual work all my life before that, nobody is going to be interested. [*Focus group 2*]
>
> **Steven.** I have been out of work so long, so many years, you know. [*Focus Group 3*]

More timely interventions may be the most effective means of preventing the social exclusion of mental health service users. With an average of nearly six years between the first contact with mental health services and job loss experienced in this study, mental health services have ample time to intervene.

The WBAS has been shown to be a significant predictor of work expectations and future work status (Mowbray *et al.*, 1995). For mental health service users the mean WBAS scores were not significantly different from the US sample described by Harris *et al.* (1993), where

they found a mean score of 2.94 (S.D. = 0.40), a mean work pride score of 2.82 (S.D = 0.50), and a mean score of 3 for mental health service users in employment.

To estimate the proportions of people who are most likely to return to work a threshold score of 3 on the WBAS was chosen. These data suggest that 40% of mental health service users and 80% of long-term unemployed are most likely to get a job. The figure of 40% concurs with the proportions of mental health service users who gain work through supported employment in the US (see Chapter Three).

However, positive attitudes to work alone do not result in employment. Gallie *et al.* (1994) found very little distinction between the attitudes to work of employed and unemployed people. The factors that seemed to promote re-employment were the availability of certain types of work, resources within the household to facilitate job search and better qualifications.

There has been an increase in the availability of part-time work, which was the preference of mental health service users and women in particular. This suggests that mental health service users have a better chance of finding the work they want. Moreover, since more women than men saw themselves working again, then perhaps female mental health service users are most likely to return to work. This concurs with the OPCS survey of psychiatric morbidity (Meltzer *et al.*, 1995c), which found that women with mental health problems are more likely to be in employment.

As for pay expectations, most people had realistic reservation wages at about £5 or £6. This is at odds with the low wages earned by mental health service users who work (AfSE, 2000). Both groups also demonstrated greater labour market flexibility than a comparative sample of unemployed people in a study by Gallie *et al.* (1994).

In terms of resources to find work, Chapter Seven found that most people had very limited social networks and many members out of work. Chapter Six also found that most people had few qualifications. Both these militate against finding a job. Indeed, the findings revealed that those who know more people out of work also have lower attitudes to work.

There were large differences in the number of people looking for work – 16% of mental health service users compared to over 90% of long-term unemployed people. This difference may be partly due to the smaller percentages of mental health service users who want work and their lower work attitudes. However, there could also be an impact on job search of welfare benefit rules. The income for unemployed people is dependent on their availability to

work and active job search, while the income for mental health service users is dependent on their unavailability to work. The effect is more likely to be due to the wider range of barriers such as stigma and discrimination, which are considered below.

Other desired activities included education and social activities, though many struggled to know what to do outside of work, especially long-term unemployed people. This reinforces the central role of work in what people consider a 'normal' life and be socially included. The findings have negative implications for mental health day services as very few mental health service users desired day service activities or activities with other service users.

Section Two: Barriers faced

> Social inclusion must come down to somewhere to live, something to do, someone to love. It's that simple - and as complicated – as that. There are all kinds of barriers to people with mental health problems having those three things. (Charles Fraser, Inquiry witness, in Dunn, 1999: 23)

A picture is emerging of two groups of people with very little to do and a keen desire to work. Therefore it comes as no surprise that the majority of the focus group discussions and interviews focused on the barriers participants said they faced. This section describes the main barriers to work and leisure activities using survey data, with a special focus on the three main barriers to inclusion for mental health service users: lack of money, poor health, stigma and discrimination.

The range of barriers

The survey participants completed the Barriers to Work Checklist (see Chapter Five). Table 63 shows the percentages of those who either agreed or strongly agreed with the checklist statements. Both groups were very concerned with losing their benefits. Mental health service users were also concerned with requiring extra support and not being well enough, whilst long-term unemployed people felt that 'jobs don't pay enough to live on' and believed that 'there were not enough jobs'.

Mental health service users had a lower score on the Barriers to Work Scale, representing greater perceived barriers to work. Those who said they had a good or fairly good chance of getting a job had a significantly higher score ($t = -3.75$, df 58, $p < .001$). This scale also correlated well with the WBAS ($r = .54$, $p < .001$).

Table 63. Barriers to work checklist

% Agree with barriers statements	*Mental health service users* N = 67	*Long-term unemployed* N = 62	*Difference*
If I got a job I may lose my benefits.	88.4	56.5	χ^2 = 17.03, df 1, p < .001
I would need extra support to hold down a job.	64.2	22.6	χ^2 = 22.60, df 1, p < .001
I'm not well enough to work.	61.8	8.1	χ^2 = 40.52, df 1, p < .001
No one would employ me.	54.4	19.4	χ^2 = 16.97, df 1, p < .001
If I got a job my health would suffer.	50.0	8.1	χ^2 = 27.18, df 1, p < .001
Jobs don't pay enough to live on.	46.4	61.3	ns
There aren't enough jobs.	46.3	41.9	ns
I don't have the right skills to get a job.	43.5	35.5	ns
I have difficulty communicating.	31.9	11.3	χ^2 = 8.04, df 1, p = .005
I can't get a job because I'm looking after my family.	9.0	1.6	ns
Mean Barriers to Work Score (1-5)	2.89	3.53	t = -6.27, df 127, p < .001
S.D.	0.55	0.61	

The CAP also included questions about the reasons why people were not doing the leisure activities they wanted to do. Table 64 shows that the single main barrier to activities for both groups was lack of money. The remaining barriers given by long-term unemployed were too varied to list here. However, problems with health, motivation and concentration / medication were the main barriers to mental health service users. There were no significant differences between genders, age groups, or living situation.

Table 64. Barriers to desired activities

Mean number	*Mental health service users* N = 71	*Long-term unemployed* N = 62
Lack of money	31.0	38.7
Nothing in my area	7.0	4.8
Nobody to go with	7.0	1.6
Health problems	26.8	3.2
Other barriers	38.0	17.7
Motivation	15.5	3.2
Concentration / medication	8.5	0.0
Not enough time	7.0	1.6

The following sections examine in more depth the barriers to inclusion for mental health service users.

Welfare benefits system

The focus groups and interviews confirmed that the welfare benefits system was one of the main barriers to work.

> **Donal.** I think that's [the benefits system] the main problem, really isn't it? There is so much to lose out on. [*Focus group 1*]

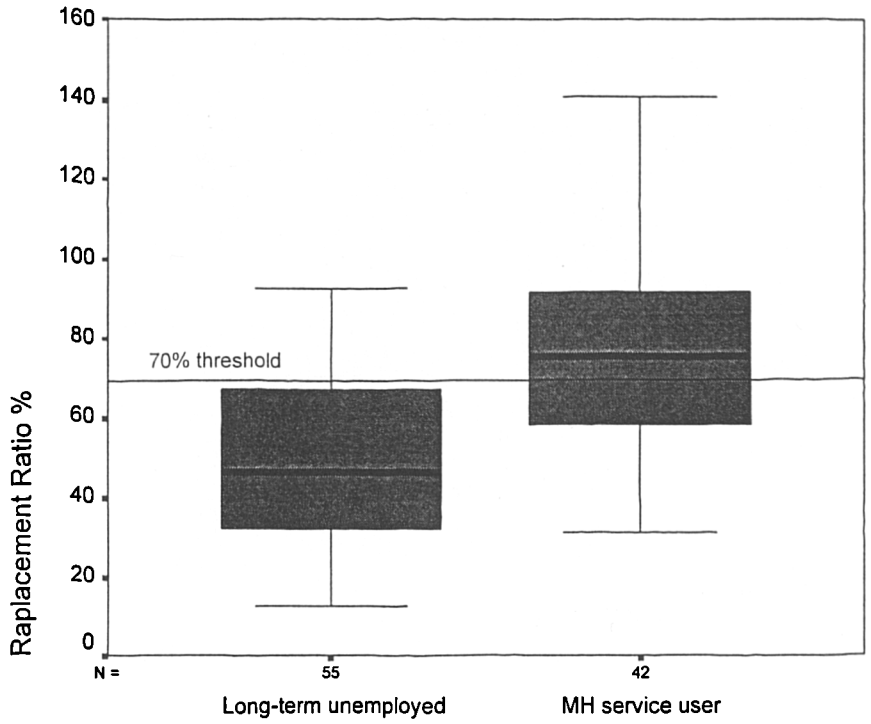
There was the problem of the unemployment trap: coming off benefits and getting into work that pays enough.

> **Carl.** ... I am gonna need two hundred pound plus, because I am gonna have to, err, pay for my children's... CSA is gonna be on my back, I've got Poll Tax, Council Tax, Rent, got my bills, my water rates. [*Interview*]

The replacement ratios (RRs) were calculated using the survey data. The RR is the ratio of income out of work compared to wages in work (see Chapter Four). The income in work was calculated by multiplying the individuals' reservation wage with the preferred number of hours. Calculations of Working Families Tax Credit and Disabled Persons Tax Credit, Housing Benefit and Council Tax benefit were made using Mancalc 2000 (Ferret Information Systems, 2000). The income out of work was taken from the information given by the participants.

Figure 43 shows the range of values for the replacement ratios. RRs over 70% represent a significant level of unemployment trap (HM Treasury 1997). Those with RRS over 100% are financially worse off in work. This shows that mental health service users had greater financial barriers to work than long-term unemployed people. The mean RR for mental health service users was 75% compared to 48% for long-term unemployed people ($t = 5.88$, df 58, $p < .001$). 71.2% of long-term unemployed people had a RR below 70%, compared to just 28.8% of mental health service users ($\chi^2 = 12.87$, df 1, $p < .001$). This suggests that over 70% face a significant financial barrier to work.

Figure 43. Replacement Ratios



Higher replacement rates were found for women (t = -2.87, df 95, p = .005), people with children (t = -2.71, df 56.5, p = .009), people with a permanent partner (t = -2.29, df 95, p = .024), and those receiving Housing Benefit (t = -2.34, df 95, p = .022). A step-wise multiple regression found that, together, study group, living with children and claiming Housing Benefit accounted for 43% of the variance in replacement rates. Living situation can seriously affect the chances of working, as found in Chapter Four.

For mental health service users there are also problems with therapeutic earnings (now called 'permitted work', see Appendix A), which in the example below, limit Philip in the amount he can earn.

> **Philip.** DSS could be a bit more supportive. They say you can only earn £15 a week, work therapy, but, you know... I have had it put my way, where I have lost £2 - £4 because DSS saying you are only allowed £15 a week. But I got offered more work in the way of working for the shop, or working whatever, and I can't do it because DSS say you are only allowed to earn £15. [*Focus group 3*]

The complexity of the rules also resulted in problems, particularly the lack of flexibility to start and stop work.

> **Jimmy.** ... It's like so many new rules and regulations coming up... How many people know about the other benefits you can get? It is so complicated, you know. [*Focus group 2*]

> There is a lack of flexibility in the benefits system. Each time you get and lose a job you have to sign on and off. [*Interview with Jobclub leader, field notes*]

The complex rules also have an affect on some people's mental health.

> **Will.** Once you have been diagnosed with a mental illness things should become easier when it comes to benefits and stuff like that. Because I have spent nearly five to six years going backwards and forwards to the Benefits Agency without any support workers or anything. I was doing it on my own, and the stress of going into these places and just trying to get money you are entitled to... the Government should make it easier on your mind, it just perpetuates mental illness... [*Focus group 3*]

The complex rules and lack of understanding can also lead to fears about what could happen to peoples' incomes.

> Finance is a major disincentive for even part-time or college. Dealing with Benefits Agency puts people off, they don't even want to look at it. They know of examples of this, for example their partner was affected by benefits when going to work. [*Staff focus group*]

Despite the many financial problems associated with work some people said they would deal with the financial consequences just so that they can work. This shows that financial considerations are not always paramount.

> **Interviewer.** ... Do you think money is going to be a problem again?
>
> **Mike.** Well, it will be anyway, to get on in life... But you have got to do it, haven't you, you know... And the same with me sister and her husband, like, they have always worked. But they haven't got any money anyway, it's still hard when you are working, you know. [*Interview*]

Work skills and training

A key problem, for both mental health service users and long-term unemployed people, was a lack of skills. Barbara, an older member of the day centre, felt the technology had moved on.

> **Barbara.** For me, like, working in an office environment and having a couple of years off, and, now technology has improved that's a barrier as well. Going back, you know, everything has moved on so much. [*Focus group 1*]

The Jobplan and Jobclub leaders all identified poor basic skills as a main problem with the return to work for long-term unemployed people.

Another barrier were the negative perceptions of the workplace. Below, Steven describes some of his experience of trying to return to the workplace, which, to him, seems like a high pressure environment.

> **Steven.** And people always want you to be able to take pressure jobs as well. Because every time I've gone for a job in the past, not every job, but even a job making pizzas at Pizza Hut, they say can you work under pressure. What do you say 'No, I want to go home', you say, 'Yeah, course you can, course I can'. It's just bloody mad when you get there you don't get a break all day, things like that, you know... [*Focus group 3*]

Lack of money

The focus groups and interviews gained further insight into the problems with finance. A lack of money prevented people from doing things in general.

> **Interviewer.** So, many of things that we have talked about like the things you enjoy doing, things you'd like to do... .
>
> **Judith.** Yeah, you can't really afford to do them! Well it's a dream isn't it? It's all a dream. [*Focus group 1*]

But also specifically, such as in Gary's case who cannot take his children on holiday.

> **Gary.** I'd like to go on holiday with me kids - well, take them away for a week. But I can see that never happening.
>
> **Interviewer.** Why is that?
>
> **Gary.** Because of my money situation. [*Interview*]

Others mentioned problems with paying for fees and materials for college courses.

Mental health service users linked the lack of money directly to their mental state.

> **Tina.** But, you know, in the Winter, if I haven't got the £5 to get a taxi there and back to my friends, I won't go out, I'm stuck in me house, through no fault of my own. But, as I say, it's changed it a bit, and I can afford to do it, you know. It does help.
>
> **Interviewer.** Amy, were you going to say something about that?
>
> **Amy.** Erm, it does help to have a social life and if you can't afford to have one it does tend to make you quite depressed. [*Focus group 3*]

While for others there was an indirect effect. For example, one mental health service user was unable to go mountain bike riding as he did not own a bike. However, to save up and go on a ride he would have to stay in more, which made him feel more depressed.

Others talked about a more general dissatisfaction with money. This was often due to the higher costs of being unwell. In the following example, Gary described how he spent money on eating in cafés rather than cooking, and the stress this causes.

> **Gary.** It [money] worries me. Like, I can't cook for myself, cos if I do if I put somat on, or I try to do somat, I go in the living room and forget about it. It'll either be burned or I've ruined it. Me memory is not all that good. [*Interview*]

Health problems

Health problems were referred to many times by focus groups and interviewees, particularly by mental health service users. Mental and physical health problems, and the side-effects of medication all played a role in preventing people from doing what they wanted.

Mental health

Not surprisingly, the mental health service users mentioned many difficulties associated with their mental health, such as concentration, stress, paranoia, panic attacks, etc. The following extracts illustrate these. For example, Gary did not see himself working again because of his concentration.

> **Gary.** No, no. No. I don't think my concentration would enable me to work. My concentration wouldn't be any good to work. [*Interview*]

A common message from interviewees and focus groups was the desire not to experience too much pressure. Here Eddie would like to do things, but to maintain a balance.

> **Eddie** To me its like, I could do with some things to do, but not too many things because it would do the same to me, it would make me ill pretty surely, its too much.
>
> **Interviewer.** Too much pressure?
>
> **Eddie** Yeah, it's like a balancing act... .like something to do so you don't go depressed, but too not much that you end up where it makes you ill that way, you know? [*Focus group 3*]

Another common problem experienced by mental health service users was paranoia. Both John and Anthony, below, have experienced these feelings and do not desire to put themselves in those situations again.

> **Mike.** Erm. Well it's hard to be working around people, you know, who I don't know and that. And I get paranoid and things like that. Like I was working at a die cast place on Ancoats Street, a good few years ago, I would say about eight years ago, and err... [*Interview*]

> **Anthony.** Well, I only go to the pub every now and again. I go out during the day, because I am scared at the night time, I get paranoid. So, err, if anyone's in the pub at the time I'll have a game of pool with them, talk to them, socialize, but I very rarely go out. [*Interview*]

A common concern amongst the mental health service users was the fluctuating nature of their illness.

> **Judith.** And a lot of it is being tied though, isn't it, you know. You don't always feel the same so, you know, some days you could get there, some days you can't - you don't know from one day to the next. [*Focus group 1*]

Motivation is another problem, though attributable to many reasons. Here Gary links it to his lack of confidence and self-esteem.

> **Interviewer.** But is it your motivation that stops you?
>
> **Gary.** Yeah, it is, yeah. Myself, you know, I have got no confidence, you know. I have got no self-esteem and stuff like that. [*Interview*]

Confidence was also a problem. Sally below wished to avoid new public situations, whilst Sandra mentioned her anxiety over job applications.

> **Sally.** I have no confidence. Although I could always find out how to go about it, but I have no confidence in actually going to the college where there will be probably teenagers, and that's the bit I don't fancy about it. [*Focus group 3*]

> **Sandra.** I find things like my actual confidence in myself, not having the confidence to fill in the forms and not fluff up the interview, you know, with anxiety ... [*Focus group 1*]

Mike speaks for many of the mental health service users that mentioned mental health problems: that there is an uncertainty over how they would react in certain situations. Most did take the personal risks associated with a return to work, college or other public spaces for fear of becoming ill again: an emotional gaoler.

> **Mike.** But I don't know, yeah, yeah, I don't know how I would react. I don't know how I would be, at a college; I don't know how I would react, whether I would be ill again or whatever. [*Interview*]

Despite an individual's ability to cope with their mental health problems, Carly notes below that the presence of a medical record may also be a barrier to work.

> **Carly.** [...] I cannot see any employer in the world that's going to say I will take that person as opposed to a person that has got a clean medical history and that hasn't got any history of this [mental illness]. [*Focus group 2*]

Side-effects of medication
The side-effect of weight gain had an impact on some participants' social life.

> **Interviewer.** [...] You have sort of explained you are doing less things than you did before you became ill...
>
> **Gary.** Yeah, yeah. What I found, when I started taking medication I was nine and a half stone. But it's like, when I was taking medication it put me weight right up. It's made me breathless; it's sort of slowed me right down.
>
> **Interviewer.** And this had an affect on your friendships?
>
> **Gary.** Yeah, it makes me feel like I don't like myself. I'm ugly and fat, you know, and I can't get anyone. All people are talking about me and I get paranoid. [*Interview*]

Medication can also cause tiredness that can affect early starts, while others could not drive due to medication. The side effects of medication also create barriers.

> **Sandra.** My short-term memory has been damaged now because of treatments I have had. So I find I have got to keep diaries, to write everything down, erm, sometimes I do not know what day it is, I do not know what month, you know, so if I do see a paper, erm. So, it is difficult when your memory is affected. [*Focus group 1*]

Physical illness
Physical illness was mentioned as well as mental illness. In this following extract from a focus group physical illness was mentioned before any other barrier.

> **Interviewer.** What are the barriers then? What are the kind of things that you felt are holding you back or are holding you back?
>
> **Sandra.** Illness... .
>
> **Judith.** Yeah, physical illness... [*Focus group 1*]

Stigma and Discrimination
The two most talked about barriers were stigma and discrimination. Although related there is a difference between the two; where stigma is the fear of being treat differently, as illustrated by Carly.

> **Carly.** It's like a fear of standing out from the crowd, you know, you get labelled as different. [*Focus group 2*]

And discrimination is the experience of being treat differently, as described by Colin.

> **Colin.** It's not the same language, you do get treat differently with mental illness. [*Focus group 2*]

In practice, and in the words of the participants, they are interrelated and interchangeable. The following sections highlight the main themes: from specific examples of discrimination, through poor treatment by family and friends, to more general experiences about the fears of disclosure and the wider attitudes of the public.

The experience of discrimination

One example of discrimination, cited by each of the three focus groups independently, was the poor treatment by some bus drivers when using their bus pass. Participants from all three focus groups mentioned independently the types poor treatment, such as insults and not stopping. It became apparent that this poor treatment is not aimed at mental health service users themselves, but rather highlights a key feature about mental illness: that there is no visible sign of disability.

> **Eddie** They don't realize you've got serious problems. To them they look at you, in the summertime I've got a suntan, you know, I look really well, they haven't got a clue about death, about suicide. But to bus drivers, you know, it's like you have got some kind of free gift and you are not having to pay like the rest of the people, they don't understand you are attending the hospital... [*Focus group 3*]

The main theme of this section is that such poor treatment, the actual experiences of discrimination, affects future behaviour. Those who have been discriminated against then try to avoid further poor treatment by withdrawing from social participation. Hence discrimination fuels stigma and stigma fuels social exclusion. Donal describes this knock-on effect.

> **Donal.** It does knock you out a bit. You get that attitude from a bus driver, he is supposed to be a public servant and you expect more from people. [*Focus group 1*]

Many past experiences of discrimination were related to employment. For example, Anne felt she was forced to leave her job, despite feeling she had coped well.

> **Anne.** Well I'm a schizophrenic and I worked most of the time, but if I was very bad I used to take time off and I worked there eleven years.
>
> **Interviewer.** Where was that?
>
> **Anne.** At X. And they started giving me... annoyance, you know, upsetting me and that, I think they wanted to get rid of me. Anyway I've given me notice in haven't I?
>
> **Amy.** Mmmmm.

Anne. But I coped with it for a long time, and I wasn't too bad, but with staying home, I got worse. Do you understand?

Interviewer. Being at home made things worse?

Anne. Yes, and I ended up in hospital. [*Focus group 3*]

In the following example Sally's employers found out about her illness and sacked her. Like Anne this precipitated a worsening of her condition.

Sally. Well, I worked on school dinners when my kids were little, and I worked there for six months and I was getting on fine, nothing happened. Then came the crunch, I had to fill in a medical, which everybody had to do. Once that went back and it came back, 'not suitable', yet I'd done the job for six months, and they didn't examine me or nothing.

Interviewer. Did you lose the job?

Sally. They just found out that I had a breakdown and that was it.

Tina. It's like taboo isn't it?

Sally. And that made me ill, I was all right until then. [*Focus group 1*]

Again, these experiences have knock-on effects on behaviour. For example, the discussion below shows that people are afraid of telling employers about their illness.

Judith. What I think one of the biggest barriers is telling them [employers] that you have got a mental health problem.

Interviewer. So you are concerned that if you had told somebody, your employer, that you had told them you were diagnosed with some mental health problems, then they would do what? What do you think they would do?

Sandra. Well, I don't think I would have had the jobs.

Judith. No.

Geoff. They would turn you down wouldn't they?

Sandra. I have applied for a pile of jobs, so I don't think I would have got the jobs in the first place if they'd have known what I suffer with... [*Focus group 1*]

And the knock-on effects can stop others from even applying for jobs, as they feel they will be rejected.

> **Donal.** They ask about your mental health as well, that's also on the application forms. I know if I put some of the things down I know I would not get the job. [*Focus group 1*]

Discrimination prevented some from even looking for jobs, which explains the low proportion of mental health service users who look for work. Philip and Steven were told they'd never work again. Although this happened several years ago, they indeed had never worked again.

> **Philip.** I went to, err, the Employment Exchange on, err, Wilmslow Road, you know the one opposite the Four in Hand?... That was a couple of years ago, and she said I'd never work again, the girl.
>
> **Steven.** They said that to me. I've had that said to me...
>
> **Philip.** That you'll never work again?
>
> **Steven.** By the Job Centre, yeah.
>
> **Interviewer.** Why would they say that?
>
> **Philip.** I don't know. She asked me what I wanted to do, I said 'Well I'll do anything'. She asked me if I had any mental illness, I said I was schizophrenic. She said 'Oh, you won't be able to work again'. [*Focus group 3*]

As well as direct experiences, some participants mentioned other people's experiences having an affect on their behaviour and limiting their lives. In the example below, Sandra will avoid social situations because of other peoples' experiences of discrimination.

> **Sandra.** I have experienced other people who they know has got mental health and I've seen what they have gone through. So I know damn well that, you know, I'm not going to put myself in the same situation. [*Focus group 1*]

Family and friends

A recurrent source of discrimination and feelings of stigma was, surprisingly, among family and friends. These were taken as a yardstick for the responses that others in the wider community may have. In the first example Carly describes her sons reactions, while Sally cannot even tell her daughter.

> **Carly.** I do find there is a stigma attached to it. You know, if you admit having a mental health problem there is still a stigma attached to it. Even with family and friends. [*Focus group 2*]
>
> **Sally.** I mean, my daughter doesn't even know that I suffer from schizophrenia, and she's 30 year old now and she doesn't know. [*Focus group 3*]

In the second example, Harry describes verbal abuse and the resulting fear of disclosure to a future partner.

> **Interviewer.** You were saying about admitting to a mental health problem. What are people's reactions?
>
> **Harry.** There's people that turn round and say I'm a nutter and things like that, you know. I'm a nutter and things like that, you know, just...
>
> **Interviewer.** Who said that to you?
>
> **Harry.** Well, people when they've been out and socializing with people who are not in hospital or not in a Day Centres then I get that, you know. And if I have a girlfriend I am frightened of admitting that I am like that, you know. I find that I don't want to be rejected. The system I am in at the moment I don't get rejected because everybody is more or less the same as me, you see. [*Focus group 2*]

This is another example of how the experience of discrimination, in this case verbal abuse, resulted in stigma that limited future opportunities. In Harry's case, he wanted a partner but restricted life to safe places like the day centre.

In the following example, Pete reveals his strategy for partial disclosure to friends, so that he can keep them, based on his past experience.

> **Pete.** When my mates come round to the house and things like that they know I'm ill but they don't know what's going on, you know what I mean? The looks people give you when you tell them. [*Focus group 3*]

Otherwise, as Gary describes below, people lose friends after becoming ill.

> **Interviewer.** Did you have many friends before you became ill?
>
> **Gary.** Well, I used to, yeah, yeah. I had people who I went to school and grew up with, and a few others I went out for a drink with and... you know.
>
> **Interviewer.** And what has happened after you getting ill to explain that?
>
> **Gary.** They just all drifted away, one by one: 'I'm going here' or 'I'm watching this' or 'I'll catch you next week' or 'I'll see you tomorrow' and tomorrow never comes, you know, full of promises. [*Interview*]

Disclosure, concealment and safety in numbers

Many participants said they were reluctant to discuss their mental health problems with other people in the wider community due to their negative experiences with families, friends and employers. The discussion below between Simon and Jimmy illustrates how disclosure to new people could pose a problem. Simon described to whom and when he may disclose his

mental health problems, Jimmy highlighted the dangers of getting it wrong and being labelled.

> **Simon.** Maybe, round close friends and people you know, they wouldn't treat you differently...
>
> **Jimmy.** Yeah, yeah.
>
> **Simon.** But if you are meeting people for the first time...
>
> **Jimmy.** Obviously you've got to be...
>
> **Simon.** You can't disclose your mental health to all and sundry. You've got to be selective in the first place.
>
> **Jimmy.** Obviously you've got to be selective, yeah, but you're tarred with the same brush... [*Focus group 2*]

In the example below, Sally, who said she had yet to tell her daughter she had schizophrenia, had a stricter policy: never tell anyone. Later in the focus group Sally reveals her coping strategy: she never mentions schizophrenia, but uses a different language.

> **Sally.** I just say a nervous breakdown, that's my word for it. [*Focus group 3*]

Anne and Eddie illustrate the fear of telling people about their diagnosis of schizophrenia because of the uncertainty of what the reaction might be. Eddie is clearly influenced by the poor understanding of mental illness.

> **Anne.** You don't want to tell them you're a schizophrenic because you don't know what their reactions are going to be.
>
> **Eddie** I would crack up and kill them, that's what they'd think! [laughs] [*Focus group 3*]

The feelings of stigma, fuelled by experiences of discrimination, provide good reasons for mental health service users to seek 'safe' environments, either in a centre or in a group. Pete's example is an example of 'safety in numbers', and like Carly's introduction, this is about not standing out in a crowd.

> **Pete.** We went out to, err, we were on a photography group. We all went down to town together to a camera shop, the three of us. We would never have tried doing that on our own. [*Focus group 2*]

The down side of this desire for 'safety' is the experience of Tina, who has experienced a kind of stigma by association with the day centre.

> **Tina.** Can I tell you what problem I have? Years ago I used to think, you know, I hope no-one sees me coming in here, because, I know, a couple of times they say, 'Oh, I've seen you going in there to go to work' and I just say 'Oh'. Because, when I say 'No, I go here', they say, 'Well you look all right to me. There's nothing wrong with you, why do you go there?' And, you know, it's as if you have got to explain to them.... they want to know the detail. I get a lot of that.

Poor understanding of mental illness

The main reason for not disclosing mental health problems was due to the fear of a negative reaction caused by a lack of understanding.

> **Amy.** You could go and meet people and they'd accept you for who you are, but if you were to tell them that you have a mental illness, that's when you get rejected. [*Focus group 3*]

Steven provides another example of a lack of understanding. In his case friends that avoid the truth because they can't cope with the word schizophrenia.

> **Steven.** People say, 'Well it's just depression, isn't it?' They don't want to know if you're schizophrenic, you're friends even. They can't cope with the fact that you're schizophrenic. [*Focus group 3*]

This poor understanding of mental illness was often seen from the negative public perceptions of mentally ill people in general, such as the caricature of the mad axe man.

> **Sandra.** But to a lot of people mental health is still people running amock with a knife. You know what I mean, isn't it? You know, mention mental health and we are all funny monsters... [*Focus group 1*]

But, also the negative perceptions of schizophrenia in particular.

> **Eddie** It's the worse, I think personally, it's the worst one you can have labelled, schizophrenia. Because society, from my point of view - I don't know what other people think - is that they have got imaginations of they're stabbers, the go out axing people... Because that's the media, the media have told them, that certain people do that, that's schizophrenic. [*Focus group 3*]

These public perceptions were seen to be fuelled by the way the media handles mental illness.

> **Pete.** It's like with the media as well, when you read bits in the paper they always give a negative view of mental illness.
>
> **Harry.** That's right, yes.
>
> **Interviewer.** And you think that reflects upon yourselves?
>
> **Carly.** Well, it reflects on everybody. [*Focus group 3*]

In summary, mental health service users often conceal their illness and avoid situations where it may be raised. They did this because they felt, and from past experience they know, they will be treat differently, and be discriminated against. They felt this discrimination comes as a result of the poor understanding of mental health. Here, the participants have made a link between public attitudes and their withdrawal from social participation, into social exclusion.

Services

Rather than helping, mental health service users said that some services created barriers. For example, people said they were referred to day services on a seemingly ad hoc basis, as illustrated by Sandra below.

> **Sandra.** ... I've been suffering for ten years, but during that ten years I have never been referred anywhere. I didn't even know about this place, you know. [*Focus group 1*]

Once 'inside' a day service, members felt they had little choices between services. Indeed, during each of the three focus groups, where people from different day services were brought together, there was a very limited understanding about what happens in other services.

Another barrier was a way *out* of day services and into work. Here Donal wanted to have a go at working and wanted day service staff to tell him more about getting a job.

> **Donal.** They haven't got that far really, have they? You come here and you have some discussions going on about going back to employment, like, they haven't got any much good to say. We need to know more about it. [*Focus group 1*]

Moreover, Donal went on to say that he has been discouraged from work by staff.

> **Donal.** Yeah, I'd like to have a try, but some people say you shouldn't do it, you do that because social services or doctors... [*Focus group 1*]

This was reinforced during the staff focus group where day services staff recognised their own low expectations of mental health service users acted as a barrier to work. Also the staff focus group identified information between services as another problem. Mental health service users also raised this issue. In particular they highlighted the lack of continuity as a barrier to getting the right nature and level of support.

Discussion

Mental health service users felt they faced more barriers to work than long-term unemployed people. The greatest perceived barrier to work was the financial disincentives and administrative complexities of welfare benefits, as described in Chapter Four. Almost 90% of

mental health service users thought they would lose their benefits if they returned to work. On further analysis, mental health service users faced *actual* financial barriers to work, with over 70% facing a significant level of unemployment trap. However, it is encouraging that the numbers with an *actual* barrier were not as numerous as those with a *perceived* barrier: 64% of people who thought they would lose their benefits would actually be better off in work. The unemployment trap was greater for families and those claiming Housing Benefit.

The perceived barriers for mental health service users were mainly individual (health and support), whereas long-term unemployed people felt they faced more societal (pay and availability of jobs). This suggests more hope for mental health service users than long-term unemployed people, provided adequate support can be given.

Other barriers to work included poor skills and poor work history. These are well-documented problems facing many unemployed people (Gallie *et al.*, 1994). The lack of money was also a practical barrier to an active social life and leisure activities. Health problems, both physical and mental, also limited activity.

Mental health service users described their experiences of discrimination: at work, using services and by family and friends. These negative experiences, coupled with the poor public understanding of mental health and negative portrayal in the media, resulted in feelings of stigma. The feelings of stigma limited peoples' behaviour, creating internal barriers that stopped people looking for work, using public facilities or forming new friendships. The limited opportunities available were the 'safe' environments of day services, though which in turn exacerbated the feelings of stigma. This is perhaps the key 'process' factor in understanding social exclusion among mental health service users. Discrimination by others acts to exclude people, whereas stigma results in self exclusion. The latter would not exist without the former.

Section Three: Supports desired

This section examines the nature of supports that people felt they required to overcome the barriers they faced and achieve the activities they desired. This section uses survey data, together with interview and focus group notes to first examine the support people had received, then explore the supports people felt they needed.

Support to find work

For those who said they wanted to work, survey participants were asked about the supports they had received over the last year. Table 65 shows that more long-term unemployed people received help to find work than mental health service users ($\chi^2 = 4.78$, df 1, $p = .029$). Most

of the difference appears due to more long-term unemployed using job centres and job clubs, with mental health service users using more non-mainstream support such as mental health work schemes, CPNs and day centre staff. No responses were given for either DEAs or occupational therapists. For mental health service users, more men than women received help, with 48.5% and 22.7% respectively (χ^2 = 3.71, df 1, p = .05).

Table 65. Support received to find work

%	*Mental health service users* *N = 55*	*Long-term unemployed* *N = 56*
Received any help to get work?	38.2	58.9
Job centre	5.2	23.7
Jobplan / Job Club	0.0	27.1
Careers officer	1.7	0.0
New Deal personal advisor	0.0	1.7
Mental health work scheme	13.8	0.0
College	6.9	10.2
Social worker	1.7	0.0
CPN	3.4	0.0
Staff at day centre	3.4	0.0
Other	6.9	10.2

Survey participants who wanted to work were also asked what services they would like to receive. Overall, 76% of mental health service users and 68% of long-term unemployed people said they wanted additional help. Table 66 shows that the most popular forms of support were those designed to help people get a paid job. The only significant differences between the types of support desired between the two study groups was a higher percentage of mental health service users wanting help with health problems (χ^2 = 10.56, df 1, p = .001). This may not be a surprising finding, yet only a third of mental health service users wanted help with health problems to get back to work, which is perhaps lower than expected. It is, however, unexpected that there were few differences between the two groups.

There were differences between genders. For mental health service users a higher proportion of men wanted help to find a paid job (χ^2 = 10.28, df 1, p = .001), work experience in paid work (χ^2 = 5.84, df 1, p = .016), careers advice and guidance (χ^2 = 4.87, df 1, p = .027), and help to keep a paid job (χ^2 = 4.87, df 1, p = .027).

Many of the supports desired by participants were the direct opposite of barriers, for example more money would overcome the lack of money. The following sections use interview and focus group data to describe the additional supports which could overcome barriers to desired activity.

Table 66. Support desired to find work

%	*Mental health service users* *N = 58*	*Long-term unemployed* *N = 59*
Help to find a paid job	43.1	28.8
Work experience in paid work	36.2	35.6
Further education or training	36.2	30.5
Help with health problems	34.5	6.8
Training on job finding skills	32.8	22.0
Careers advice and guidance	29.3	22.0
Help to keep a paid job	29.3	18.6
Work experience on benefits	25.9	18.6
Benefits advice	24.1	18.6
Help / advice on self-employment	19.0	18.6
Help with childcare / dependents	1.7	5.1
Other kind of help	13.8	5.1

Improvements to Services

There were several suggestions for improving services. Firstly, for mental health service users, receiving an appropriate level of support to suit need was identified, for example when at work. The support given should be both practical, as in Gary's case.

> **Gary.** I wouldn't mind people coming out and helping me sort me flat out. It needs decorating, I could decorate at one time but I can't do it, now it's an effort. [*Interview*]

And emotional as illustrated by Steven's experience at college.

> **Steven.** I found the counselling by the college staff - there was a counsellor at the college I go to -helped me last year when I was starting on this course. I had had a lot of time off, because I didn't feel well. The other reason was I couldn't always make it on time to the class, like I was late all the time. So I had a chat with the counsellor, you know, she was great she was really good and that was sorted, you know. She spoke to the teacher and we had a chat, you know. [*Focus group 3*]

One of the main themes for support was motivation and encouragement, for example to get people into work.

Philip. I think a lot more could be done, you know. You could be encouraged to get work and get support you know, you know what I mean like... [*Focus group 3*]

The importance of better social networks that could bring better opportunities to take part in activities was mentioned.

Gary. I would like company, you know. I would like people to, err, get me into things, cos if you have got somebody else there, you've got to do things, if you go with them. It's, sort of like, you're doing it then, whereas if it was just you there you are not doing it, you think, 'oh, I'll leave that until tomorrow' It just builds up. [*Interview*]

The timing of the support should be flexible to suit personal situations, such as evening appointments. A solution from staff was to increase the choice available to mental health service users and provide more opportunities. The staff members also noted that mental health service users rather than staff must value these opportunities.

Mental health service users wished to learn from others to improve services: from service users who have a better understanding of mental health problems. They also wanted new services, such as complementary therapies and more holistic treatments, which also have the effect of empowering users.

Finally, perhaps the main issue to overcome barriers was an adequate income. The support required was access to good welfare rights advice.

Eddie To be included in Society you do need money. [*Focus group 3*]

Here, Will talks about how his life changed after getting Disability Living Allowance.

Interviewer. What things that you are doing now with DLA that you weren't doing before?

Will. It was just, erm, being able to go to the shops and get some dinner in the afternoon, go to town and get some tapes and CDs, you know, just little things like that. It's not that much but it's a difference.

Interviewer. Not having to be very careful with your money?

Will. Yeah, just being able to go on an impulse and buy something.

Eddie Same here, I got DLA. It changed me quite considerably, at times I got trapped in me flat, I couldn't go on the busses, frightened of going out. I get the £14 odd, [...] and that way you can afford to get a taxi, you know, £2.50 to the hospital or to here, so it does make your life more complete.

> **Tina.** But that DLA certainly helps and it gives you a boost in yourself, you know. Depending on what you getting, but it does help, you know. It stops you from staying in and getting institutionalised and worrying. [*Focus group 3*]

Improvements to the wider social environment

In addition to support services participants also wished to create a better social environment, particularly related to raising awareness of mental health issues. For example Sandra identifies education as a solution and Judith raises the issue that mental health problems are common, yet are poorly understood

> **Sandra.** Because one in three people suffer it in their lifetime and it is still such a bone of contention, isn't it?
>
> **Judith.** Yeah, make people understand. Like understanding if you have got a plaster on your arm, they can see that. You know what I mean? [*Focus group 1*]

A practical example is that people wanted the 'normal' opportunities in colleges but taught by people with an understanding of mental illness. This also applied to the workplace, where employers had an understanding of mental health problems and the effect on productivity.

Discussion

Supports to overcome barriers faced have been presented. A key finding is that 43% of mental health service users who wished to work also wanted help to find a paid job. This further reinforces the clear desire to get back to work for a substantial proportion of mental health service users and points to high demand for supported employment services.

However, current resource allocation suggests that adequate help is not being given to people with mental health problems in the UK. Chapter Two identified the lack of supported employment programmes that are specifically tailored to the needs of people with mental health problems. Chapter Three described the effectiveness of those vocational rehabilitation programmes that focus on competitive employment outcomes. Chapter Four outlined the main barriers to employment and demonstrated how supported employment and generous earnings disregards have helped many mental health service users in the US get a job. These findings clearly suggest the need for reform the welfare benefits system and to develop supported employment services in the UK.

In this study fewer mental health service users than long-term unemployed people had received help to get work. Though there were few differences in the amounts or types of support desired. Despite more women mental health service users wanting work, and having better attitudes to work, they had received less support to find work. Does this indicate that

mental health service users discriminate against women when it comes to work? It may also be due to the greater demand from men, who wanted more supports than women.

Improvements to mental health services were suggested, such as an appropriate level of practical and emotional support, given when most needed, by people with a good understanding of mental health problems. Mental health service users wanted more encouragement to try a wider range of relevant, appropriate and meaningful activities.

For those who did not wish to try employment money, and in particular access to DLA, was valued. Access to an adequate income is necessary for mental health service users to be able to participate in the wider society. However, it is not sufficient, additional supports –both practical and emotional –are required to help mental health service users participate more effectively. Improvements to the wider social environment were also suggested, to raise awareness of mental health problems, for example in colleges, and to make the workplace more accommodating.

Section Four: Labour market attachment

There are some important differences between the two study groups in the activities they desired and the barriers they face. However, these are not sufficient to separate these into two distinct groups. Mental health service users and long-term unemployed share many characteristics in terms of their aspirations for and barriers to work. This section provides a further analysis of the data to determine the characteristics that bind people with similar attachment to the labour market.

Predicting a return to work

Perhaps the simplest method of determining labour market attachment is an individual's desire to work. Chapter Three introduced the factors that may predict a person's return to work. This suggested that there are complex and conflicting accounts of who will return to work. Even though it is difficult to predict exactly who will go back to work, we cannot allocate the level and nature of resources to tackling the problem if we don't try. This section describes a cluster analysis technique using the variables identified in the literature that are associated with an increased chance of returning to work.

Cluster analysis

A hierarchical cluster technique was used with Ward's method (Ward, 1963) and squared Euclidean distance on interval data. A K-means cluster analysis for 3 clusters using an iterative technique was also used, which confirmed these results (Hartigan, 1975). The variables used in the cluster analysis were WBAS, Pride and Independence subscale, barriers

to work checklist score, number of qualifications, number of jobs, and total length out of work.

The cluster analysis revealed three groups based on the key indicators of labour market attachment. Table 67 shows the results for each variable, with significant differences between clusters on all but number of qualifications. The largest cluster has a stronger labour market attachment, and is characterised by higher work attitudes, lower barriers to work, more qualifications, more jobs, and less time spent out of work. These people are, perhaps, most likely to return to work.

Table 67. Labour market attachment clusters

	Strong N=57	*Medium* N=40	*Weak* N=26	*Total* N=123	*Significance* ANOVA
% Sample	46.3%	32.5%	21.1%	100.0%	
WBAS	3.12	2.92	2.87	3.00	F = 7.2, df 122, p = .001
Pride	3.07	2.81	2.82	2.93	F = 5.2, df 122, p = .007
Barriers to work checklist	3.6	3.1	2.9	3.3	F = 16.3, df 122, p < .001
Number of qualifications	1.6	1.3	0.8	1.3	F = 2.4, df 122, p = .098
Number of jobs	4.1	3.2	2.7	3.5	F = 4.6, df 122, p = .012
Length out of work	29	111	248	102	F = 445.4, df 122, p < .001

Characteristics of clusters

Table 68 shows the characteristics of people in each of these clusters. People with the strongest labour market attachment are less likely to use mental health services and live in Manchester, and are more likely to be male, want to work, be better off in their preferred employment, younger, more satisfied with their health, felt more empowered, have lower financial barriers to work, and have a shorter period of recent unemployment.

The three distinct clusters which differ systematically in their work attachment were also compared on the index of social exclusion. The significant differences held here as well. These findings demonstrate a clear association between social exclusion and work attachment. This is striking because many of these components of social exclusion, related to housing, income, health and well-being, were not directly related to work.

A surprising finding was the high service costs associated with the 'strong' group (using Kruskall Wallace test). This may suggest that greater cost saving could be made by effectively supporting this group into employment. Indeed, in a cost-benefit study of supported employment Clark *et al.* (1996) found a negative correlation between employment and

services use and concluded that employment opportunities could be increased for people with mental health problems without increasing costs.

Table 68. Characteristics of labour market attachment clusters

%	*Strong* *N=57*	*Medium* *N=40*	*Weak* *N=26*	*Total* *N=123*	*Significance* *Chi-square*
Mental health service users	23	73	77	50	χ^2 = 32.5, df 2, p < .001
Male	83	80	58	76	χ^2 = 6.5, df 2, p = .039
Manchester	68	80	92	77	χ^2 = 6.1, df 2, p = .049
Wants to work	91	70	58	77	χ^2 = 12.9, df 2, p .002
Ever want to work	96	80	65	84	χ^2 = 13.9, df 2, p = .001
Out of work 5 years +	0	67	77	38	χ^2 = 66.3, df 2, p < .001
RR < 70%	68	59	35	60	χ^2 = 5.6, df 2, p = .06
Better off in work	78	61	44	67	χ^2 =7.2, df 2, p = .028
Active cluster	38	41	55	45	ns
Mean					*ANOVA*
Age (years)	39	41	46	41	F = 4.5, df 122, p = .013
Months since last job	22	76	183	74	F = 73.8, df 122, p < .00
*Replacement Ratio***	52%	65%	79%	61%	F = 9.44, df 93, p < .001
*Years on benefits***	1.8	6.1	9.2	4.6	F = 27.6, df 112, p < .00
Health LSS	5.0	4.7	4.2	4.8	F = 4.0, df 122, p = .021
*Years since first admission**	4.9	11.7	17.0	12.3	F = 8.0, df 51, p = .001
*Length of residence (months)**	43	136	88	101	F = 3.5, df 59, p = .038
Empowerment Scale	2.86	2.75	2.68	2.79	F = 3.7, df 121, p = .029
*Network members out of work***	4.6	10.2	7.8	6.9	F = 4.9, df 105, p = .009
Hours per week with friends	11.0	6.4	4.7	8.2	F = 2.9, df 122, p = .056
Number of sports activities per week	1.0	0.7	0.4	0.8	F = 3.2, df 122, p = .046
*Service costs per week**	271	113	108	141	χ^2 = 11.14, df 2. p = .004
*Social Exclusion Index***	9.6	10.1	11.2	10.0	F = 4.3, df 114, p = .017

*Mental health service users only. **Sample is less than N = 123

Support required by cluster

Table 69 shows the types of support required by people in each of the three clusters. Interestingly it appears that those with a stronger labour market attachment do not require as much help as those classed as 'medium', who want a job but clearly need much help to do so. Those with a weak attachment do not feel that they require much help at all, a reflection that getting a job is not a priority for these people.

There were no significant differences between levels of labour market attachment in use of services, however it is important to note that just 31% of those with a strong attachment had used mental health day facilities compared to 61% of those with medium and weak attachment. This confirms that use of day services does not promote labour market attachment.

Table 69. Support required for each cluster

%	*Strong* N=57	*Medium* N=40	*Weak* N=26	*Total* N=123	*Significance*
Careers advice and guidance	19	38	12	24	χ^2 = 7.0, df 2, p = .031
Benefits advice	18	30	4	19	χ^2 = 7.2, df 2, p = .028
Training on job finding skills	25	38	4	24	χ^2 = 9.7, df 2, p = .008
Work experience in paid work	37	43	8	33	χ^2 = 9.6, df 2, p = .008
Help to find a paid job	26	50	15	32	χ^2 = 10.2, df 2, p = .006
Help to keep a paid job	19	33	8	21	χ^2 = 6.9, df 2, p = .049

Figure 44 shows the proportions of the study groups in the three clusters. Supports required are given according to the level of labour market attachment. This chart has important implications for the research evidence on supported employment. Chapter Three found that many supported employment programmes achieved competitive employment rates for about 50% of their users. This analysis suggests that for a typical caseload of a community mental health team, the proportion that could achieve competitive employment is more likely to be 50% of the 70% with 'strong' and 'medium' attachment. This implies that a more conservative estimate of 35% of mental health service users could successfully find and keep a job. This is nevertheless much greater than the current employment rate of 5–10%.

Figure 44. Proportions of study groups requiring three levels of support to achieve social inclusion

Discussion

This section suggests the hypothesis is not proven, as there were indeed significant differences in labour market attachment and mental health status between the two study groups. However, the results did reveal that the desire to work is more a function of other factors of social exclusion than mental health status.

Welfare benefits regulations suggest that long-term unemployed people are fit and ready for work, while mental health service users are disable and not capable of work. This study has shown a more complex picture. It appears that about 20% of mental health service users are ready for work, while about 30% of long-term unemployed are not. The results also show that around a further 50% of mental health service users would like further help to engage in work activities.

The findings reveal that 35% of this sample could achieve competitive employment if high quality supported employment programme was available and adequate provision was made within the welfare benefits system. As over 90% were unemployed, this suggests that the current allocation of resources for vocational rehabilitation did not reflect the true demand. Mental health service users in this sample were not given sufficient support to get a job.

This analysis also throws up the question of how to promote the social inclusion for the remaining 65% of mental health service users; some who still wish to work, and others who

do not wish to work. For the former group, we may need to revisit sheltered employment, such as social firms and user-run enterprises.

For the latter group, the solution may lie in the small percentage of long-term unemployed who do not wish to work, and in the many others who do not work - 25% of the adult working population - together with the rising numbers of retired people. A work-based society needs to accommodate this substantial part of the population. Other means of inclusion that go beyond the ideal of career must be sought. These issues are taken up in the concluding chapter.

Conclusion

This chapter has examined the aspirations and barriers to inclusion of mental health service users and long-term unemployed people. It is clear that work is the route of choice into social inclusion. The findings suggest that over two thirds of mental health service users want to work and that about 35-40% could do so. It is the very long periods out of work that seem to reduce the chances of ever returning and increase the problems associated with unemployment described in the previous two chapters. Mental health services need to intervene much sooner to aid a return to work.

No one, it seems, chooses to want to go to a day centre or want to do things with other mental health service users. As was shown in Chapter Two, the reality is often that this is the only option available. A shift in resource allocation is required to match the support to the aspirations and abilities of service users.

The chapter also considered the barriers to inclusion that people faced, both real and perceived. The most significant barrier faced by mental health service users was the financial disincentives of the benefits system, though almost 30% did not face a significant unemployment trap if they claimed all the benefits to which they were entitled. The main barrier to the engagement in other community activities was the lack of money.

Perhaps the underlying barriers to inclusion for mental health service users were discrimination and stigma that resulted in withdrawal from social participation.

Together, these barriers bring a dynamic component to the concept of social exclusion. This suggests that the routes to inclusion must also be dynamic in nature. The final chapter considers how to promote social inclusion for mental health service users.

CHAPTER NINE

Conclusions and Recommendations

Introduction

Social exclusion and inclusion, citizenship and participation, stigma and discrimination: these are contested terms that are difficult to define and measure. Yet these are the concerns that most affect the lives of people with mental health problems. The importance of this study lies in the importance of these concerns. This study is significant because it provides a comprehensive attempt to define, operationalise and measure social exclusion among people with mental health problems.

The purpose of this thesis is to examine the barriers to social inclusion for people with mental health problems. To do so it explored the relationships between long-term unemployment, social exclusion and mental health and provides:

- A description of how people with mental health problems and long-term unemployed live with unemployment;
- A comparison of the similarities in the problems faced by these two groups; and
- An account of the needs for work, leisure and social activities for these two groups.

The following sections assemble the main arguments and summarise the key findings to support these aims, before turning to the question of how to overcome the barriers to inclusion.

Evidence from the background chapters

Each of the background chapters presents theoretical arguments and empirical evidence to provide an original contribution to this important field.

Main conclusions and original contributions

Chapter One established the importance of the concept of social exclusion in contemporary social policy and defined it using the following three dimensions.

- Multiple deprivation, based on the concept of relative deprivation, and using indicators, such as unemployment, low income, and poor health.
- Relational poverty, based on the severed relationships from civic and social life.
- Dynamics, or the process of social exclusion, characterised by stigma and discrimination.

Chapter One provides the first comprehensive attempt to define social exclusion among people with mental health problems. This definition was used to argue that social exclusion is *the* primary problem facing mental health service users.

Chapter Two charted the development of day care services in their attempt to tackle the problems of social exclusion faced by mental health service users. This provided a comprehensive account that draws together three main strands of mental health service provision: day hospitals and partial hospitalisation programmes, with their focus on treatment; day centres and sheltered workshops, whose main purpose is rehabilitation; and supported employment programmes and their emphasis on promoting social inclusion through work. The chapter argues that the focus of day care services has shifted from the treatment of mental illness to the promotion of social inclusion.

Chapter Three used empirical evidence to confirm this argument. In particular, the key features that help mental health service users to get, keep and benefit from a job were identified. It is clear from the evidence that supported employment is the most effective means of promoting social inclusion, yet such services are relatively underdeveloped in the UK.

Chapter Four provided an original analysis of the social security systems in the UK and the US to argue that the welfare benefit system is the main barrier to promoting social inclusion. The chapter concludes that the UK benefits system is the main reason for the lower employment rate of mental health service users in the UK compared to parts of the US with supported employment programmes. The benefits system has therefore limited mental health services in the UK from developing supported employment programmes.

Limitations of the evidence

The research evidence has substantial limitations. There are many claims in the literature that people with mental health problems are socially excluded. Yet there are very few studies in the field of mental health that have defined, operationalised and measured social exclusion. Most of the evidence came from disparate and often methodologically flawed sources. The widespread unemployment of mental health service users is now well established, though often based on point prevalence estimates that ignore the long-term nature of unemployment. The main income studies used postal surveys of ill defined samples with limited reliability about the types of welfare benefits claimed. Most social network studies examined the impact on clinical rather than socio-economic outcomes. The gaps in the evidence are numerous. For example, there are no comprehensive studies about how mental

health service users spend their time, their voting patterns, nor engagement in community activities.

The evidence on day care services is also limited. There are problems in defining day care, as described in Chapter Two, with no consensus about their purpose or who they are for, which translates into problems in measuring their effectiveness. There are also gaps in the literature, which is dominated by two areas. The first considers day hospitals and partial hospitalisation, largely conducted by psychiatrists in the UK and US, studied from a medical perspective. The second examines the effectiveness of supported employment programmes at achieving paid competitive employment, almost exclusively by US researchers. There is very little research evidence on other forms of day care services, for example drop-ins, user-run services and arts based projects. Moreover, most research on the topic comes from a programme perspective, rather than being grounded in the day to day experiences and aspirations of service users.

Finally, the evidence presented about the welfare benefits system also has limitations. There have been few attempts to examine the impact of social security policy on the social exclusion of mental health service users nor on the development of mental health services. Chapter Four begins to fill this gap by providing details of *typical* case studies and *idealised* budget constraints. But this does not explore the *actual* budget constraints of a representative sample of mental health service users nor assesses the extent of the problem.

Evidence from the research study

The research study reported in Chapters Five through Eight presented empirical evidence designed to redress these gaps in our understanding of mental health, long-term unemployment and social exclusion. The contributions to current knowledge made by this study are considered below. But first, this section examines the original features of the research methodology.

Research methodology

The research study used an inclusive methodology to generate a comprehensive account of the social exclusion faced by mental health service users and long-term unemployed people, together with their aspirations and obstacles to inclusion.

There are two novel features about the research methodology. Firstly, the study compared the lives of mental health service users with long-term unemployed people. Very few studies of people with mental health problems have used a comparison group without mental health problems. Yet comparisons drawn with the 'well' general population would make normative assumptions about how mental health service users lives *should* be, rather than how they *are*.

Such comparisons would be unfair and at odds with a social model of disability. It is clear from the research literature that the lives of mental health service users are characterised by long-term unemployment. The comparison made here to people without mental health problems, who also experience long-term unemployment, provides an original insight into the relationship between mental health, unemployment and social exclusion.

Secondly, the study used a unique combination of methods -a survey, time use diary, focus groups and interviews -to measure social exclusion. The survey questionnaire allowed standardised and reliable research instruments to directly compare the demographics, health status, personal finances, social networks, community activities, and labour market attachment of mental health service users and long-term unemployed people. The time use diary provided details of the spatial and temporal relationship between individuals and their communities. The focus groups and interviews gave a detailed picture of people's aspirations and obstacles to inclusion. In summary, Table 70 shows how the combination of methods enabled the measurement of social exclusion.

Table 70. Measuring social exclusion

	Method of measurement			
Dimension	*Survey questionnaire*	*Time use diary*	*Focus groups, Interviews*	*Participant observation*
Static factors: Multiple deprivation	✓			
Relational factors: Citizenship and participation	✓	✓	✓	✓
Process factors: Stigma and discrimination			✓	

The analysis first considered the contribution from each method. It was particularly important for the validity of the qualitative data that it each could 'stand alone'. The data from each method was then analysed with reference to other methods. This resulted, for example, in qualitative data providing insights into the quantitative data in Chapter Six, and vice versa in Chapter Eight. This method of triangulation enhances the validity of the study (Bryman, 1988).

Important and original research findings

What original contributions does the research study provide? Each of the three findings chapters revealed important results. This section draws together the key findings under the three dimensions of social exclusion developed by this thesis.

Multiple deprivation

The study groups experience the kind of deprivation described in Chapter One: long-term unemployment, low income and poor health. The most important finding is that the *level* of deprivation is similar for people with mental health problems and for long-term unemployed people. This suggests that it is the experience of unemployment that has the largest impact on the lives of both groups.

However, the *nature* of this deprivation differs. For long-term unemployed people, unemployment appears to impact most upon income and mental health. This concurs with the deprivation (Jahoda, 1982) and financial stress theories of unemployment. For mental health service users, unemployment has a greater impact upon general health and well-being, such as self-esteem and quality of life, and is more long-term. For example, mental health service users have higher incomes, but live on these low incomes for much longer. This suggests a much more complex experience of deprivation that cannot be explained without examining how people cope with life without work.

Citizenship and participation

Both study groups also experience the problems of small social networks, few or no contacts on a daily basis, and a high proportion of network members out of work. Most people take part in activities that incurred little or no cost and do them alone. The lack of purposeful activity results in almost no variety over a typical week. The findings suggest that multiple deprivation limits social networks which in turn provides a restricted 'opportunity framework' for community participation.

Day care services were developed for mental health service users partly as a mechanism to address this lack of participation. The findings suggest that traditional day care services provide a limited range of opportunities to a limited range of people, and leave the vast majority of mental health service users to live a sparse existence characterised by few social contacts and limited participation in community activities. Day centres appear to re-create the environments found in other areas of social life – social clubs, pubs and cafés – yet at significant cost to mental health services.

Stigma and discrimination

Before considering the barriers to inclusion for mental health service users, Chapter Eight sought to derive a definition of inclusion from the study groups rather than imposing normative views. The findings suggest that over two thirds of mental health service users want to work and that about 40% can get a job. Over 60% want to do more leisure activities,

half of these want to do sports. No one includes traditional day centres, or activities with other service users, in their aspirations.

The very long periods out of work seem to reduce the chances of mental health service users ever returning to employment and increase the problems associated with unemployment. This is attributed to the financial disincentives of the benefits system, the most significant barrier to work, which was found to be a perceived barrier for 90% and an actual barrier for 70% of mental health service users. A further, undoubted barrier to inclusion for mental health service users is that of discrimination and associated stigma. Mental health service users withdraw from participation in economic and social life for fear of unfair treatment. These barriers are summarised in Table 71.

Table 71. Barriers to inclusion for mental health service users

Type of barrier	*Nature of barrier*	*Extent of barrier*
Barriers to looking for work (Only 16% looking for work.)	Perceptions of the benefits system	Over 88% of survey participants felt they would be worse off in work.
	Stigma and health problems	Over 60% have a fear of rejection and/or relapse.
Barriers to getting a job. (90% not working.)	Financial disincentives	70% face a significant unemployment trap
	Discrimination	54% felt no one would employ them. Poor employer attitudes described by participants are backed up by recent evidence[32].
	Lack of qualifications and poor work history	Average length of unemployment was over 9 years. 40% have no qualifications.
	Lack of effective support	The provision of supported employment is inadequate to meet demand.
Barriers to community participation (80% without purposeful activity.)	Limited social networks	Most have small networks with few friends.
	Lack of money	Persistent low incomes. Over 30% lack money to participate.
	Stigma	Participants feared reactions to their diagnosis. People spent 75% of time alone.
	Lack of support	Support from mental health represents just 1% of time.

The dynamic nature of these barriers suggests that the routes to inclusion must also be dynamic in nature. Before these are explored, the limitations of the research study are considered.

[32] An evaluation of the ONE service, the merger between the Benefits Agency and Employment Service now called Jobcentre Plus (see Appendix A), found that just 37% of employers said they would employ people with a mental illness, compared to 62% who would take on a physically disabled person, 78% for long-term unemployed people and 88% for lone parents (DWP, 2001c).

Limits of the research study

The research study used a unique combination of research methods to explore a difficult concept using a novel research design. The results from this study provide valuable insights into important areas, though some limitations should be noted.

The similar demographic profiles of the survey participants suggest that the data is robust enough to make comparisons between these groups, and to represent typical users of mental health services and long-term unemployed people living in urban and semi-rural environments. However, the samples were not randomly selected and therefore may be subject to unknown bias. Yet, the difference between research based on random samples and convenience samples is not as great as is often implied (Bryman and Cramer, 1997).

Further limitations were due to the sample size, which was relatively small. This limited tests of significance, particularly when making comparisons within the study groups, such as gender and ethnicity. This means that further differences and relationships could exist. However, the risks of using data from a US sample for the power calculation were not realised.

There was also an uneven gender distribution. This is a particular weakness considering the important relationships between genders, such as employment, domestic work and social relationships.

In addition, the study was limited by its cross-sectional nature. This does not allow inferences to be made about direction of causality where associations are detected. The study has illuminated some important relationships, yet is not able to disentangle cause and effect.

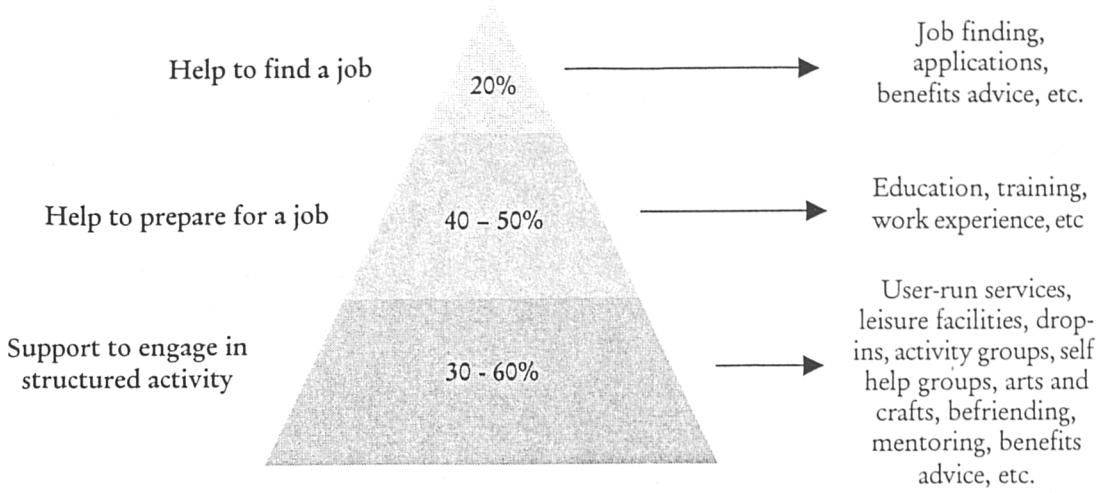
Finally, the study used participants living in urban and semi-rural districts of a large city in the North West of England. The generalisability to other parts of the country is limited by the structure and composition of the local economy, services and community.

Recommendations

> As long as those at the bottom of society have some economic, social or cultural function to perform in the rest of society, they cannot be totally excluded. (Gans 1993: 330)

This study has confirmed that the best route to inclusion is through work. But social inclusion is not just a matter of people getting a job. Inclusion for mental health service users means creating a complex web of support –emotional and practical. The pyramid in Figure 45 illustrates the nature and range of supports required suggested by the findings from this study. The policy and research recommendations are given below.

Figure 45. Pyramid of support to promote social inclusion of mental health service users



Employment

The findings reveal that over two thirds of mental health service users want to work. Using a conservative estimate, about 20% of mental health service users are ready, willing and able to get a job, and a further 40-50% require additional support to achieve their occupational outcome. The majority want to work in open competitive employment, though some also want voluntary work or some kind of sheltered work, such as in social firms and user-run enterprises.

Additional support is required to enable people to get, keep and benefit from work. Chapter Three found that the most effective way to obtain jobs for people with mental health problems is supported employment. This means rapid placement into a paid job with on-going support rather than segregated prevocational training. Outcomes are improved if jobs match individual preferences and accommodations in the workplace are made. The integration of vocational and clinical services in one agency is more effective than providing these services separately. Moreover, these findings suggest that employment interventions should be made at the earliest opportunity following initial contact with mental health services to minimise the damaging effects of long-term unemployment.

It is clear from these findings that the resource allocation for supported employment is not sufficient to meet the demand. Mental health services should invest in supported employment programmes for people with mental health problems.

There is also demand for alternative forms of employment, such as social firms and user-run enterprises. However, there are gaps in the evidence about the effectiveness of these models.

Further research is required into the potential for social firms and user-run enterprises to promote social inclusion.

The welfare benefits system provides a major obstacle to the development of supported employment programmes and the employment of mental health service users. If the government wish to create a more inclusive society, with employment opportunities for all, then they must go further than the recent changes to the tax and benefit system. As recommended by Social Security Advisory Committee (1997), a fundamental review of the system of benefits for disabled people is required. This should take into account the changes that have been proposed by other commentators (All Party Mental Health Group, 1997; Davis and Betteridge, 1997; DIG, 1997, Thornton *et al.*, 1997) such as increasing earnings disregards, good quality welfare rights advice, and a review of Housing Benefit (Simons, 1998). Until such changes occur, people with mental health problems will continue to be marginalised from the labour market by a benefits system that was not designed to accommodate their return to work.

Other routes to inclusion

This study revealed that just 20% of mental health service users were engaged in purposeful activity. Over 63% wanted more activities, such as sports, leisure and hobbies. The majority of mental health service users had poor quality social networks and had limited participation in community activities. The findings suggest that at least a third of mental health service users require other means of achieving inclusion. This could be much higher if those who want to work do not achieve it.

Traditional day care services are not a solution to meet this need. Instead of achieving the ideal of integration, the practice of traditional day care services has exacerbated exclusion. Day centres and sheltered workshops are outmoded – rooted in the exclusionary principles of the asylum –and there is no longer demand for them by mental health service users.

The damaging effects of unemployment and inactivity and the under-use of day care services suggest that alternative definitions of inclusion are required that do not involve employment (Coulton, 1996). The solutions are two-fold: developing *communities of interest* and forming *communities of identity*, introduced in Chapter One.

Communities of interest

Communities of interest are groups of people who share mutual interests and activities, such as clubs, groups and societies. There are a number of measures required to increase participation in these communities.

There must be measures to promote individual's capacity to join pre-existing communities of interest. This requires the support from mental health services to access the wide range of mainstream opportunities. Examples of support to promote participation were proposed by mental health service users in this study: community mental health teams need to provide an adequate level of practical and emotional support to achieve community participation; and they need to have access to an adequate income. The requirements for the enhanced CPA provide a structure for this to occur.

Measures are also required to develop community capacity to enable mental health service users to participate in community life. This is a particular priority for mental health service users who live in poor communities where few opportunities may exist. Mental health services need to become part of the wider community development and anti-poverty agenda and use their resources to develop inclusive communities, via initiatives such as the Neighbourhood Renewal Fund, New Deal for Communities and the Single Regeneration Budget. After all, people with mental health problems are members of these geographic communities and have the capacity to contribute. Primary Care Trusts could provide the mechanism to bridge the gaps between secondary mental health services, regeneration and primary care (Barnes and Wilkinson, 2002).

Examples of how these measures can be achieved in practice are given in recent reports such as *Working for Inclusion* (Bates, 2002) and *Strategies for Living* (Faulkner and Layzell, 2000). Some examples are summarised below.

- Supported access to community activities. For example Gibb (2002) describes the work of *Mainstream* and role of *bridge-builders* who develop links with groups and organisations and support mental health service users to access them. Turton (1998) describes a similar voluntary sector project working with people with severe mental illness who are reluctant to engage with mental health services. Turton and Ferguson (1999) describe how this can occur within an integrated mental health service. A further example includes supported education described in Chapter Two.
- Local Exchange and Trading Systems are community barter networks where members exchange goods and services using a local currency. Originating in Canada there are now over 400 systems in the UK (Gosling, 1997). Manley (1999) describes the use of LETS by mental health service users to gain work opportunities and access to services, such as complementary therapies, without the pressures of formal employment and financial problems of the welfare benefits system.

- Community timebanks (Boyle and Reed, 2002) allow mental health service users to volunteer their skills in return for credits with which they can 'buy' the skills of others. This is similar to LETS but with time as the unit of currency. Both are based on the concept of the reciprocal exchange of labour (Sik, 1988).
- Community café projects and healthy living initiatives. Wilson (2002) describes the opening of a cyber café in Merton that provides Internet access and opportunities to socialise, as well as offering training and work experience. The New Opportunities Fund provides mental health services with opportunities to develop social, leisure and complementary health opportunities alongside other community groups.

Just as attempts at combating 'nimby' campaigns have resulted in successful housing projects (Repper et al, 1997), further research is required on how mental health services can work with communities of interest – clubs, faith communities, volunteering, libraries, sports and exercise – to help service users access these opportunities.

Further measures are required to reduce stigma and discrimination. Stigma is now recognised as the greatest problem facing mental health service users by the World Psychiatric Association (Sayce, 2002). Sayce reports some of the stigma campaigns and their mixed impact (Sayce, 2000; 2002). She concludes that a focus on rights is required and the use of legislation to ensure better treatment of people with mental health problems.

Communities of identity

People with mental health problems form a community of identity. Simple notions of integration ignore that mental health service users have particular issues and concerns. But this should not be about grouping together people with a common illness, but rather recognising the diversity of experiences that people wish to share: such as age, ethnicity, sexuality, religion, survival of abuse, and alcohol and drug dependency. The development of self help / mutual aid groups, along-side the measures recommended above, should ensure that people have access to peer support (Hatzidimitriadou, 1999) without the further exclusion created by day care services. For example, Torrey *et al.* (1995, 1998) describe how consumer-run services have complemented the development of supported employment after the closure of traditional day treatment programmes.

Empowerment is now an important matter for mental health services. In addition to measures such as employment, community participation and self-help, the involvement of users in the planning and delivery of services is a further way to promote empowerment and inclusion. The 'user movement' in the UK has grown rapidly since the 1980s

(Hatzidimitriadou, 1999; Pilgrim and Rogers, 1999) with users now involved in commissioning services, staff training, the delivery of care (Perkins *et al.*, 1997), and evaluation (Rose, 2001). Further research is required to determine how effective these innovations are in improving the quality of mental health services and promoting the social inclusion of service users.

Conclusion

This study has ventured into new territory, conceptually and methodologically, yet has returned with familiar results. It comes as no surprise that the lives of mental health service users are often characterised by long-term unemployment, persistent low incomes, poor general health and well-being, restricted social networks and limited participation in community life. Because these conditions are tolerated, and perhaps even maintained by mental health services, these problems are considered a natural consequence of mental illness. Yet this study found similar problems of social exclusion are also faced by long-term unemployed people without a psychiatric diagnosis. This suggests that the primary problems faced by mental health service users are largely due to unemployment.

There is cause for hope. There are examples where mental health service users have created opportunities for themselves – though work, education and hobbies, although these successes have often been in spite of widespread discrimination and lack of support from mental health services. There are also examples where mental health services can develop more inclusive services –supported employment, social firms, user-run enterprises, self-help. But promoting social inclusion should not be an optional addition. Every form of mental health service – from acute care (Repper and Perkins, 2002) to assertive outreach teams - needs to be driven by the aspirations of their users.

Mental health services are wasting energies and resources maintaining their users in poverty and social exclusion. They are also wasting service users lives. For treatment and care to be effective against the debilitating effects of social exclusion then mental health services must develop more inclusive practice. This means supporting their users to achieve their aspirations for inclusion and promoting the role of users within service planning and delivery. Mental health services also need to form partnerships with local groups and organisations to develop the capacity of the communities in which their users live to become more inclusive.

The social exclusion of mental health service users presents complex and fundamental problems, and social inclusion sets a challenging agenda for mental health services. This thesis recasts the problems faced by service users as social exclusion, illustrates what that

means in their day-to-day lives, and points the way towards overcoming the barriers to inclusion.

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APPENDIX A

UK policy and social exclusion

This appendix provides a description of UK social policy responses to the problems of social exclusion. These policies are examined with particular reference to mental health.

Social Exclusion Unit

The work of the SEU is based on developing policy initiatives and recommendations for action in five key areas that cover the 'most excluded' in society (SEU, 2001a). These are:

- Truancy and school exclusion
- Rough sleeping
- Neighbourhood renewal
- Teenage pregnancy
- Opportunities for 16-18 year olds not in education, employment or training

The SEU works by bringing together a wide range of experts – from within government, plus representatives from local authorities, probation service, police, business, faith communities and the voluntary sector – in cross-cutting groups. Though the SEU has yet to consider mhsu as one of the 'most excluded' groups.

A major piece of work for the SEU resulted in the National Strategy for Neighbourhood Renewal (SEU, 1998, 2001: 74) that aims to

> To improve outcomes on worklessness, crime, health, skills, and housing and the physicalenvironment – delivering on national and local targets; and
>
> to narrow the gap between the poorest neighbourhoods and the rest of the country.

The responsibility for this has now passed to the Department for Transport and the Regions.

Opportunity for All

The agenda to tackle social exclusion does not lie exclusively with the SEU. The Government published *Opportunity for All*, their strategy for tackling poverty and social exclusion (DSS, 1999a). The important policy initiatives relevant here were:

- The New Deal national welfare to work programmes

- The national minimum wage
- A range of health initiatives

These initiatives are covered separately below. This report recognizes the link between mental health and social exclusion.

> Mental health problems are a key barrier to social inclusion, and are a major cause of poor physical health, disability and mortality. Disadvantaged people are at particular risk of suffering poor mental health; more contemplate suicide and more actually commit suicide than people who are better off. People with mental illness have increased sickness absence, change jobs more often and are more likely to be unemployed. (DSS, 1999a: 105)

The action to be taken on mental health described in the report included:

- Developing mental health promotion strategies in schools, workplaces and prisons.
- Developing NHS Direct
- Developing the National Service Framework (NSF) for Mental health.

Of these measures the NSF is the most concrete step, as the first is contained within the NSF and the second is not mental health specific. The NSF is described below.

The New Deal

Perhaps the central plank of government policy to tackle social exclusion is the New Deal. The New Deal is designed to assist a range of targeted groups back to work. These groups include young people (18-24) who have been out of work for 6 months, adults (25-59) who have been out of work for two years, over 50s who have been on any benefit for 6 months, disabled people and lone parents. The New Deal is compulsory for the first two groups and members must enter the relevant programme. The programmes differ for each group but there are features common to all, such as some form of training, job search assistance, or subsidized employment.

The New Deal for Disable People (NDDP) provides measures to help people with disabilities and those with long standing illness get back to into the labour market or remain in work. The programme has four key elements (ES, 1998). There are currently 20 one year 'innovative schemes' designed to test ways of helping people move into or remain in work. Disabled People have access to personal advisors to co-ordinate services and advise clients. The NDDP has been introduced in addition to the measures previously introduced for people with disabilities, such as Disability Employment Advisors (DEAs) who are based in

Employment Service jobcentres as part of the Disability Service Team (formerly know as Placement Assessment and Counbcelling Teams, PACT).

So far, the various pilot schemes for the NDDP has attracted few participants and the many difficulties surrounding the work potential of those on incapacity benefit remain to be addressed (Nickell and Quintini, 2001).

The application of a national programme may restrict locally tailored, innovative and creative solutions, and may provide scare opportunities for people with mental health problems. People with mental health problems who wish to re-enter the labour market have particular need. The history of the development of generic employment services for disabled people has shown that people with mental health problems gain little benefit from such services. For example, the concept of supported employment has been promoted in the UK for some time by the DfEE via the Support Placement Scheme. Though just 6.2% of the 21,840 places provided by the SPS in 1995/6 were taken by people with mental health problems (Honey and Williams, 1998).

National Minimum Wage

The National Minimum Wage was introduced at £3.60 per hour for adults in April 1999 rising to £3.70 in October 2000 and £4.10 in October 2001. Young persons have a lower rate. Nickell and Quintini (2001) report that the numbers affected by the minimum wage were up to 7 or 8 percent of the work-force, of whom 70% were women and three-quarters of those were part-time. They argue that the minimum wage is too low to have had a significant impact on the pay prospects of low skill men most of whom are in work at pay rates above the statutory minimum. For example, 40 hours per week at the minimum rate will yield a mere £164, which is below 50% of the national average wage (National Statistics, 2001).

In the UK a recent study into the impact of the national Minimum Wage on disabled people found 86% of people with mental health problems working for less than 16 hours, and 72% earning £15 per week or less (AfSE, 2000). Similar results were found in a national survey of supported employment (Beyer *et al.*, 1996). It seems that few people with mental health problems even get to earn the minimum wage.

Disabled Persons Tax Credit

The Disabled Persons Tax Credit (DPTC) replaced Disability Working Allowance (DWA) October 1999. DWA only encouraged a few hundred into work (Rowlingson and Berthoud, 1996). The main criticisms were its complex rules, loss of disability benefits if the job didn't

work out, and the lack of awareness about the benefit (Zarb *et al.*, 1996). The DPTC is designed to remedy some of these criticisms, though its rules remain almost the same. DPTC can be paid through the wage packet and is designed to be more generous than DWA by reducing the rate at which benefit is withdraw from 70% to 55% of earnings and increasing the earnings thresholds on which payments are calculated (HM Treasury, 1997).

In a study that examined the financial impact of DPTC Turton (2001) found that although the benefit was more generous than its predecessor, the effect of Housing Benefit eliminated any positive gains. Turton (2001) concluded that there were few circumstances were people with mental health problems would be better off in work at the minimum wage.

This has been confirmed by examining official data. Kirby and Riley (2001) reported that on average less than six per cent of sick and disabled people moved to another benefit or left benefit altogether. The take-up of DPTC jobs was very low, with less than 0.2 per cent of people moving to a DPTC job per quarter since 1999. This seems to echo the problems of DWA.

Permitted work

From April 2002, permitted work rules apply to people who are disabled and on benefits including Incapacity Benefit and Income Support. This replaces the former 'therapeutic earnings' rules. These rules effectively introduce a disregard of £66 per week in 'supported work'. This earnings allowance approximates to 16 hours per week at the national minimum wage. It is not time limited for people on the enhanced CPA of the National Service Framework in Mental Health, people employed by Social Firms via Support Centres, people in touch with a care co-ordinator of employment development officer or who have had a social services assessment, and people in sheltered workshops or who work as part of a hospital treatment programme.

However, for those on Income Support and Housing Benefit, the majority of mental health service users, the £20 per week earnings disregard – the 'Permitted Work Lower Limit. Also, work will be limited to just six months for those not meeting the eligibility for non-time limited work.

Extended linking rules

A new linking rule was introduced in October 1998, which means that former claimants of long-term incapacity benefits who lose a job within one year of taking it will be able to return to Incapacity Benefit at the former rate. The 16-hour limit on voluntary work was also

abolished. These two rules are a positive step for mental health service users who wish to work.

Jobcentre plus

As part of the 'New Contract for Welfare' the government has brought together the Employment Service and Benefits Agency and other welfare providers in a 'single work-focused gateway' (DSS, 1998). This service, known as ONE, has been piloted in 12 areas since 1999 (Kirby and Riley, 2001). All new claimants have access to a personal advisor to guide them through their options on work, benefits, tax credits, training, housing and other government services in one place. The aim of the services is to focus more on work rather than the payment of benefits. Attendance is now mandatory for those claiming Job Seekers Allowance, but is still optional for disabled people. ONE pilots will be absorbed into the national roll-out of Jobcentre Plus.

An evaluation of the ONE pilot sites examined outcomes for three groups: people on jobseekers allowance, disabled people and lone parents (Kirby and Riley, 2001). They found the results do not suggest that ONE changed labour market transitions for sick and disabled people.

Disability Discrimination Act and Disability Rights Commission

The Disability Discrimination Act (1995) aims to tackle discrimination on the grounds of disability. Part II (Employment Provision) applies to organisations employing 15 people or more and makes it unlawful to treat a disabled person less favourably. An employer has a duty to make 'reasonable adjustments' to the work environment to accommodate any substantial disadvantage experienced by a disabled person. An example may include altering the working hours of a person with mental health problems who is sometimes away from work due to their disability.

More recently, the Disability Rights Commission has also been established to protect, enforce and promote the rights of people with disabilities and strengthen the provisions of the Disability Discrimination Act (DDA).

The limitations of the DDA are twofold. The definition of disability used adopts a more medical than social model of disability, which explicitly excludes mental illness other than 'clinically well-recognised illness' and those who have been, or likely to be, 'disabled' for over 12 months (Sayce, 2000). The scope of the DDA is also more limited than the ADA, as it does not prohibit medical examinations before job offer, outlaw questions about disability on application forms, nor cover discrimination in education (Sayce, 2000).

Mental health policy

The National Service Framework for Mental Health (Department of Health, 1999a) sets out national standards for the development of mental health services for working age adults together with evidence based service models and interventions. The aim of standard one is:

> To ensure health and social services promote mental health and reduce the discrimination and social exclusion associated with mental health problems.

The NSF recognizes the significance of the relationship between mental health and social exclusion. Specific measures include public education campaigns, as a way of reducing stigma, together with a range of initiatives described as

> healthy schools, healthy workplaces, healthy neighbourhoods and other settings, using programmes to improve understanding of the factors which affect mental health. (Department of Health, 1999a: 20)

However, there are no concrete measures to ensure the social inclusion of people with mental health problems. The NSF does make reference to other policies that can assist

> Moreover, a range of Government policies will also support this National Service Framework. Social exclusion can both cause and come from mental health problems. Initiatives designed to promote social inclusion - for example, Sure Start, Welfare to Work, New Deal for Communities and the work of the Social Exclusion Unit - will all strengthen the promotion of mental health and individual well-being, and reduce discrimination against people with mental health problems. (Department of Health, 1999a: 12)

However, we have seen in the foregoing examples that these policies will have, at best, a minimal positive impact on people with mental health problems.

Standard four brings a little more hope to people with severe and enduring mental health problems. This standard aims to 'ensure that every person with severe mental illness receives the range of mental health services they need' (p41), which must be written down in a care plan. The NSF integrates care management and the Care Programme Approach (CPA) with two levels of CPA. For those on the enhanced CPA the written care plan must include:

- Action needed for employment, education or training or another occupation
- Arrangements needed for an adequate income
- Arrangements to promote independence and sustain social contact, including therapeutic leisure activity

However, the NSF cites just two examples of employment projects, and no other interventions to promote social inclusion. Furthermore, the NSF does not seem sure about

whose responsibility this should be. Current mental health policy clearly recognises employment as one of the outcomes of mental health care. Modernising Mental Health Services (Department of Health, 1998a) states that for many people with a mental disorder, the best outcome will be to obtain and sustain meaningful work. The document states that is an objective of the welfare state, but there is no mention of the health service's responsibility to provide any specialist support. Instead, it is the responsibility of local authorities. Modernising Social Services (Department of Health, 1998b) states that

> Employment is one of the most powerful pathways to independence, and our National Policy Guidance reminds councils of their responsibility to help service users and carers of working age work where possible.

Social Service Departments are urged to work with other departments to implement the government's Welfare to Work Policy, including Employment Service, the Benefits Agency and other welfare providers. The co-ordination of all these agencies has been facilitated by the Joint Implementation Plans (Welfare to Work), which were drawn up in each local authority area for April 2001.

There remains a lack of clarity over which government department should take responsibility for promoting work for people with mental health problems. If work is treatment, then the responsibility must fall with the health service. If employment is the desired outcome then the employment service seems best placed. Yet, this is also a matter of welfare and so the task of social security.

Appendix B

Questionnaire

Social Inclusion Survey

This study is being carried out by Neil Turton at the University of Durham.

What is this survey?

This is a survey of how included you feel in your community. To do so the interview will ask questions about the following areas of life:

- **You and your health**. This will ask about where you live, your health and how much control you feel you have over your life.
- **Work, education and training**. This will ask about your qualifications, work experience, future work expectations and your views about work.
- **Social and leisure activities**. This will ask about the things you do and what you would like to do.
- **People you know**. This will ask about who you know and your relationships with them.
- **Money and the services you use**. This will ask about your income and expenditure and the health services you use.

The survey will be used to gain a better understanding of what it is like to be out of work for a long time with mental health difficulties and to discover better ways of helping people gain what they want from life.

Who will see my answers?

The information you give is totally confidential. No one will see your answers. The information you give will be collected together with the questionnaires from other people. A computer will be used to analyse the data and look for general themes and common views. Individuals will not be able to be identified from this information.

Completing the questionnaire

Please answer the questions on the following pages. Don't forget that your answers will remain confidential. We are not at all interested in identifying you personally, rather we are interested in the group of people we are studying.

For office use only

Date ☐☐/☐☐/☐☐ **Start time** ☐☐:☐☐

Id No ☐☐☐☐☐☐ 366 **Interviewer's Initials** ☐☐☐

SECTION ONE – ABOUT YOU

A1. Date of Birth d d | m m | y y

A2. Gender **Male** ☐ **Female** ☐

A3. What is your marital status?

Single / unmarried	☐	Divorced	☐
Married / with permanent partner	☐	Widow / Widower	☐
Separated	☐	Not known	☐

A4. What is your ethnic group?

African	☐	Irish	☐
Afro-Caribbean	☐	East European	☐
Bangladeshi	☐	White British	☐
Black British	☐	British Asian	☐
Chinese	☐	Mixed	☐
East African Asian	☐	Other Black	☐
Indian	☐	Other White	☐
Pakistani	☐	Don't know	☐

A5. Country of birth ☐

A6. First Language

National Language	☐
Other language (gut having **good** knowledge of national language)	☐
Other language (but having **poor** or **no** knowledge of national language)	☐

A7. Please give the nature of your parent's occupations

Father _____ ☐ *Card 9*

Mother _____ ☐ *Card 9*

A8. What is your usual/normal living situation now?

Living alone (+ / - children)	☐	Living with other relatives	☐
Living with husband or wife (+ / - children)	☐	Living with others	☐
Living together as a couple (+ / - children)	☐	Not known	☐
Living with parents	☐		

A9. What kind of accommodation is it?

Homeless / roofless	☐	Bungalow	☐
Caravan	☐	Hostel	☐
Flat	☐	Lodgings	☐
Terraced house	☐	Other (please state)	☐
Semi-detached house	☐		
Detached house	☐		

A10. Type of ownership?

Owner occupier ☐ Privately rented ☐ Housing Association/Local Authority ☐

If you live in domestic accommodation:

A11. How many rooms are in this accommodation? ☐

A12. How many of these are bedrooms? ☐

A13. How many other people live here? ☐

A14. Do your family live there too? ☐

A15. How many children (under the age of 18) live here? ☐

A16. Please give ages of children _____

A17. How long have you lived here? ☐☐ **Years** ☐☐ **Months**

A18. If less than 3 months, then please indicate previous type of accommodation *(choose a type from A8 - 10 above)*

A19. Please give post code district

How satisfied are you with:

A20. The living arrangements here? *Card 3*

A21. The amount of independence you have here? *Card 3*

A22. The amount of influence you have here? *Card 3*

A23. Living with the people who you do? *Card 3*

A24. The amount of privacy you have here? *Card 3*

A25. The prospect of living here for a long time? *Card 3*

A26. The prospect of returning to live in hospital? *(if applicable)* *Card 3*

A27. Comments.

SECTION TWO – ABOUT YOUR HEALTH & GENERAL WELL-BEING

B1. Can you tell me how you feel about your life as a whole today? ☐ *Card 3*

General Health Questionnaire

We should like to know if you have had any medical complaints and how your health has been in general **over the past few weeks**. Please answer ALL the questions on the following pages by crossing the answer you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you answer ALL the questions.

Have you recently:

B2.	Been able to concentrate on whatever you're doing?	☐ Better than usual	☐ Same as usual	☐ Less than usual	☐ Much less than usual
B3.	Lost much sleep over worry?	☐ Not at all	☐ No more than usual	☐ Rather more than usual	☐ Much more than usual
B4.	Felt that you are playing a useful part in things?	☐ More so than usual	☐ Same as usual	☐ Less useful than usual	☐ Much less than usual
B5.	Felt capable of making decisions about things?	☐ More so than usual	☐ Same as usual	☐ Less capable than usual	☐ Much less capable
B6.	Felt constantly under strain?	☐ Not at all	☐ No more than usual	☐ Rather more than usual	☐ Much more than usual
B7.	Felt you couldn't overcome your difficulties?	☐ Not at all	☐ No more than usual	☐ Rather more than usual	☐ Much more than usual
B8.	Been able to enjoy your normal day-to-day activities?	☐ More so than usual	☐ Same as usual	☐ Less so than usual	☐ Much less than usual

B9. Been able to face up to your problems?	☐ More so than usual	☐ Same as usual	☐ Less able than usual	☐ Much less able
B10. Been feeling unhappy and depressed?	☐ Not at all	☐ No more than usual	☐ Rather more than usual	☐ Much more than usual
B11. Been losing confidence in yourself?	☐ Not at all	☐ No more than usual	☐ Rather more than usual	☐ Much more than usual
B12. Been thinking of yourself as a worthless person?	☐ Not at all	☐ No more than usual	☐ Rather more than usual	☐ Much more than usual
B13. Been feeling reasonably happy, all things considered?	☐ More so than usual	☐ About same as usual	☐ Less so than usual	☐ Much less than usual

During the <u>past year</u> have you:

	YES	NO	DON'T KNOW
C1. Seen a doctor for a physical illness?	☐	☐	☐
C2. Seen a doctor for your nerves?	☐	☐	☐
C3. Been in hospital for your nerves?	☐	☐	☐
C4. Do you take medication for your nerves?	☐	☐	☐
C5. Do you have any physical disability which affects your mobility?	☐	☐	☐

C6. How old were you when you were first admitted to a psychiatric hospital / ward (if appropriate)? ☐☐ **years old**

How satisfied are you with:

C7. Your general state of health?	☐	*Card 3*
C9. How often you see a doctor?	☐	*Card 3*
C10. Your nervous well-being?	☐	*Card 3*

Your health in general - The SF-12 Health Survey

Please answer every question. Some questions may look like others, but each one is different. Please take time to read and answer each question carefully by crossing the box that best represents your response.

D1. In general, would you say your general health is:

☐	☐	☐	☐	☐
Excellent	**Very Good**	**Good**	**Fair**	**Poor**

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	YES, limited a lot.	**YES, limited a little**	**NO, not limited at all**
D2. **Moderate** activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	☐	☐	☐
D3. Climbing **several** flights of stairs.	☐	☐	☐

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	YES	**NO**
D4. **Accomplished less** than you like.	☐	☐
D5. Were limited in the kind of work or other activities.	☐	☐

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	YES	**NO**
D6. **Accomplished less** than you would like.	☐	☐
D7. Didn't do work or other activities as **carefully** as usual.	☐	☐

D8. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

☐	☐	☐	☐	☐
Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**

These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks** ...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
D9. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
D10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
D11. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

D12. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

☐	☐	☐	☐	☐
All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**

D13. Comments.

Making Decisions

Below are several statements relating to one's perspective on life and with having to make decisions. Please put a **X** in the box which is closest to how you feel about the statement. Please indicate how you feel now. First impressions are usually the best. Do not spend a lot of time on any one question. Please be honest with yourself so that your answers reflect your true feelings.

Please answer all the questions by crossing the box that best describes how you feel now. Please cross only <u>one</u> box per question.

	Strongly disagree	Disagree	Agree	Strongly agree
E1. I can usually determine what will happen in my life.	☐	☐	☐	☐
E2. I am only limited by what *I* think is possible.	☐	☐	☐	☐
E3. People have more power if they join together as a group.	☐	☐	☐	☐
E4. Getting angry about something never helps.	☐	☐	☐	☐
E5. I have a positive attitude towards myself.	☐	☐	☐	☐
E6. I am usually confident about the decisions I make.	☐	☐	☐	☐
E7. People have no right to get angry just because they don't like something.	☐	☐	☐	☐
E8. Most of the misfortunes in my life were due to bad luck.	☐	☐	☐	☐

	Strongly disagree	Disagree	Agree	Strongly agree
E9. I see myself as a capable person.	☐	☐	☐	☐
E10. "Making waves" never gets you anywhere.	☐	☐	☐	☐
E11. People working together can have an effect on their community.	☐	☐	☐	☐
E12. I am often able to overcome barriers.	☐	☐	☐	☐
E13. I am generally optimistic about the future	☐	☐	☐	☐
E14. When I make plans, I am almost certain to make them work.	☐	☐	☐	☐
E15. Getting angry about something is often the first step towards changing it.	☐	☐	☐	☐
E16. Usually I feel alone.	☐	☐	☐	☐
E17. Experts are in the best position to decide what people should do or learn.	☐	☐	☐	☐
E18. I am able to do things as well as most other people.	☐	☐	☐	☐

	Strongly disagree	Disagree	Agree	Strongly agree
E19. I generally accomplish what I set out to do.	☐	☐	☐	☐
E20. People should try to live their lives the way they want to.	☐	☐	☐	☐
E21. You can't fight the council or the government.	☐	☐	☐	☐
E22. I feel powerless most of the time.	☐	☐	☐	☐
E23. When I am unsure about something, I usually go along with the rest of the group.	☐	☐	☐	☐
E24. I feel I am a person of worth, at least on an equal basis with others.	☐	☐	☐	☐
E25. People have the right to make their own decisions, even if they are bad ones.	☐	☐	☐	☐
E26. I feel I have a number of good qualities.	☐	☐	☐	☐
E27. Very often a problem can be solved by taking action.	☐	☐	☐	☐
E28. Working with others in my community can help to change things for the better.	☐	☐	☐	☐

SECTION THREE – ABOUT YOUR WORK, EDUCATION AND UNEMPLOYMENT

The following questions will ask about your work history and education.

F1. Are you working currently? YES ☐ NO ☐

F2. What is/was your current or last job? *(include paid and unpaid)*

Job title	Hours per week	Type (card 6)	How long for? (Months/yrs)	Occupation (card 7)	Industry (card 8)	Class (card 9)
_____	☐☐	☐	☐☐	☐	☐	☐

F3. How much do / did you earn per week (gross)? £ ☐☐☐•☐☐

How satisfied are you with:

F4. Your current or last job? ☐ *Card 3*

F5. Being unemployed (no paid job) or retired? *(If appropriate)* ☐ *Card 3*

F6. The amount of money you make? (*from work*) ☐ *Card 3*

F7. How long ago did you leave your last paid job? ☐ **Yrs** ☐ **Mths**

F8. What was the reason for leaving this paid job? ☐ *Card 10*

What jobs have you done in the past? *(Please work back over time. Include periods of unemployment)*

Job title	Type (card 6)	How long for? (Years)	Occupation (card 7)	Industry (card 8)
F9. _____	☐	☐☐	☐	☐
F10. _____	☐	☐☐	☐	☐
F11. _____	☐	☐☐	☐	☐
F12. _____	☐	☐☐	☐	☐
F13. _____	☐	☐☐	☐	☐
F14. _____	☐	☐☐	☐	☐

Job title	Type (card 6)	How long for? (Years)	Occupation (card 7)	Industry (card 8)
F15. _____				
F16. _____				
F17. _____				

F18. What was your best job? ☐ *put question number of job in box*

F19. What is your highest level of education?

Primary education or less	☐	Higher education	☐
Secondary education	☐	Other general education	☐
Tertiary/further education	☐	Not known	☐

F20. At what age did you finish continuous full-time education? ☐

F21. Which qualifications do you have, starting with the highest first.
Enter codes from card 11 in the boxes below.

F22. Are you currently studying towards any qualifications? YES ☐ **NO** ☐

*If **NO** then go to G1, If **YES** please give details.*

Course title	The type of qualification (see card 11)	The main place you do this education or training? (see card 12)
_____	☐	☐

The next questions are about looking for work

G1.	Do you want to work? *(Any type of work)*	**YES**	☐	**NO**	☐
G2.	Do you see yourself working in one years time?	**YES**	☐	**NO**	☐
G3.	Do you see yourself working in three years time?	**YES**	☐	**NO**	☐
G4.	Do you ever see yourself doing any work?	**YES**	☐	**NO**	☐

If NO to all then go to G27.

G5. What type of work would you like?

Give job title and comments

	Type (card 6)	Occupation (card 7)	Industry (card 8)

G6. What would you like about this work?

G7. How many hours per week would you like to work? **Hours**

G8. What is the minimum hourly wage would work for? £ • ou

G9. How long would you be prepared to travel to work? **Minutes**

G10. When was the last time you looked for a job? **Weeks ago**

G11. What was the last job you applied for?

Job title and comments	Get it? *(y/n)*	Type *(card 6)*	Occupation *(card 7)*	Industry *(card 8)*

G12. Would you be prepared to take anything going? **YES** **NO**

G13. Have you seriously considered re-training in order to get a job? **YES** **NO**

G14. Would you be prepared to move if a suitable job came up in another area **YES** **NO**

G15. Could you start work within the next 2 weeks? **YES** **NO**

G16. Have you looked for work within the last 4 weeks? **YES** **NO**

*If **NO** to then go to **G24**.*

G17. How long have you been looking for work? ☐☐☐ **Weeks.**

During the last four weeks...

G18. How many job applications have you made? ☐☐☐

G19. How many interviews have you been offered? ☐☐

G20. How many interviews have you attended? ☐☐

G21. How many job offers have you had? ☐☐

G22. What job search methods have you used? *(tick boxes that apply)*

Job centre / job club	Newspaper / Jobs paper	Agency	Contact with employers	Social contacts	None	Other
☐	☐	☐	☐	☐	☐	☐

G23. What do think your prospects are of finding work?

Very poor	Fairly poor	Even	Fairly good	Very good
☐	☐	☐	☐	☐

G24. In the last year have you received any advice, information, training or support to help you get work? YES ☐ NO ☐

If **YES**, who or where was this help from? *(please tick as many as apply)*

DEA at Job Centre	☐	At college	☐
Other at Job Centre	☐	Social Worker	☐
Careers Officer	☐	CPN (Community Psychiatric Nurse)	☐
New Deal personal advisor	☐	OT (Occupational Therapist)	☐
Employment advisor at voluntary organisation *(Please specify below)*	☐	Staff at Day Centre	☐
		Other *(Please specify below)*	☐

☐

G25. Was this help enough? YES ☐ NO ☐

G26. What further help would you need to get and keep the kind of work you want? *(Please tick as many as apply and indicate the most important for you)*

Careers advice and counselling	☐	Help to find a paid job	☐
Benefits advice	☐	Help to keep a paid job	☐
Training on job finding skills	☐	Help / advice on self-employment	☐
Further education or training	☐	Help with childcare / dependents	☐
Work experience in paid work	☐	Help with health problems	☐
Work experience on benefits	☐	Other kind of help (please specify)	☐

_____

About the barriers to work

G27. How strongly do you agree with the following statements?

	Strongly Agree	Agree	Don't mind	Disagree	Strongly disagree
a) "I'm not well enough to work."	☐	☐	☐	☐	☐
b) "There aren't enough jobs."	☐	☐	☐	☐	☐
c) "If I got a job I may lose my benefits."	☐	☐	☐	☐	☐
d) "No one would employ me."	☐	☐	☐	☐	☐
e) "Jobs don't pay enough to live on."	☐	☐	☐	☐	☐
f) "If I got a job my health would suffer."	☐	☐	☐	☐	☐
g) "I don't have the right skills to get a job."	☐	☐	☐	☐	☐
h) "I would need extra support to hold down a job."	☐	☐	☐	☐	☐
i) "I can't get a job because I'm looking after my family."	☐	☐	☐	☐	☐
j) "I have difficulty communicating."	☐	☐	☐	☐	☐
k) "If I had as much money as I needed I would still like a job."	☐	☐	☐	☐	☐

Work Behaviours and Attitudes

Below are several statements about working. Please put a X in the box which is closest to how you feel about the statement. As you answer remember to think about your current or last job? (including voluntary work and work experience if necessary)

Please answer ALL questions as best you can.

	Exactly like me	Mostly like me	A bit like me	Not at all like me
G1. I like to talk about work with my friends.	☐	☐	☐	☐
G2. Quite often I stay home from work.	☐	☐	☐	☐
G3. I get very upset with myself when I make mistakes at work.	☐	☐	☐	☐
G4. Usually I am on time for work.	☐	☐	☐	☐
G5. It's OK for my boss to tell me that I did my job wrong.	☐	☐	☐	☐
G6. I am able to do difficult tasks.	☐	☐	☐	☐
G7. Having a job makes my life better.	☐	☐	☐	☐
G8. Looking for a job makes me nervous.	☐	☐	☐	☐
G9. I talk easily with my boss.	☐	☐	☐	☐

	Exactly like me	Mostly like me	A bit like me	Not at all like me
G10. I cannot do difficult tasks.	☐	☐	☐	☐
G11. I like doing the same work over and over again.	☐	☐	☐	☐
G12. I make friends at work easily.	☐	☐	☐	☐
G13. I can work at a task for only a short time.	☐	☐	☐	☐
G14. I am eager to work.	☐	☐	☐	☐
G15. I do not like being closely supervised.	☐	☐	☐	☐
G16. I know that I do good work.	☐	☐	☐	☐
G17. I worry that my work is not good enough.	☐	☐	☐	☐
G18. I need help to do most tasks.	☐	☐	☐	☐
G19. I do not like changing tasks.	☐	☐	☐	☐

	Exactly like me	Mostly like me	A bit like me	Not at all like me
G20. I set high standards of work for myself.	☐	☐	☐	☐
G21. I listen and follow instructions well.	☐	☐	☐	☐
G22. I worry about losing my job.	☐	☐	☐	☐
G23. I don't mind when my boss tells me that I did a poor job.	☐	☐	☐	☐
G24. I can find a job myself.	☐	☐	☐	☐
G25. I am responsible and reliable.	☐	☐	☐	☐
G26. I feel nervous at work.	☐	☐	☐	☐
G27. I don't care about how good a job I do.	☐	☐	☐	☐
G28. I have good attitudes towards people in charge.	☐	☐	☐	☐
G29. I like being on my own at work.	☐	☐	☐	☐

G30. Comments (write on reverse)

SECTION FOUR – ABOUT THE ACTIVITIES YOU DO

What sort of activities did you do last month?

Please complete the following questions using the instructions provided.

H1. Do you do any **work**? This may include full or part-time, paid or unpaid.

Activity	Frequency (per month)	Duration (mins/hrs)	Days & time	With who?	Initiated by	Satisfied	More / less	Cost
a) _____								
b) _____								

Did you do any **education and training courses**? These may include any courses at a college, NVQs, evening classes, literacy classes.

Activity	Frequency (per month)	Duration (mins/hrs)	Days & time	With who?	Initiated by	Satisfied	More / less	Cost
c) _____								
d) _____								

What **sporting activities** did you currently do? These may include swimming, playing a sport, gym, cycling, etc.

Activity	Frequency (per month)	Duration (mins/hrs)	Days & time	With who?	Initiated by	Satisfied	More / less	Cost
e) _____								
f) _____								
g) _____								

Did you go to any organised **entertainment?** These may include going out to see a band, a nightclub, disco, comedy club, the theatre, cinema, concert, etc.

Activity	Frequency (per month)	Duration (mins/hrs)	Days & time	With who?	Initiated by	Satisfied	More / less	Cost
h) _____								
i) _____								
j) _____								

Did you take part in any organised **religious activities?** These may include going to services, meetings, etc.

Activity	Frequency (per month)	Duration (mins/hrs)	Days & time	With who?	Initiated by	Satisfied	More / less	Cost
k) _____								
l) _____								

What **health / social care activities** did you attend? These may include day hospital, day centre, voluntary sector day facility, social club, treatment, etc.

Activity	Frequency (per month)	Duration (mins/hrs)	Days & time	With who?	Initiated by	Satisfied	More / less	Cost
m) _____								
n) _____								
o) _____								

What **social activities** did you do? These may include paying a social visit, having someone round, cooking a meal, going out to a pub or club.

Activity	Frequency (per month)	Duration (mins/hrs)	Days & time	With who?	Initiated by	Satisfied	More / less	Cost
p) _____								
q) _____								
r) _____								

What **other activities** did you do that you haven't mentioned? E.g. walking, watching television, listening to radio or music, reading, gardening, housework.

Activity	Frequency (per month)	Duration (mins/hrs)	Days & time	With who?	Initiated by	Satisfied	More / less	Cost
s) _____								
t) _____								
u) _____								
v) _____								
w) _____								

		YES	NO
H2.	Would you give up any of these activities if offered a chance to work? (especially day time activities)	☐	☐

If YES, which ones? ☐

	Enough	Not enough	Too much	Don't know
H3. Have you enough, not enough or too much to do during the day?	☐	☐	☐	☐

How strongly do you agree with the following statements.

		Strongly Agree	Agree	Don't mind	Disagree	Strongly disagree
H4.	"It costs too much to do the things I want to do."	☐	☐	☐	☐	☐
H5.	"There's not much to do on evenings and weekends."	☐	☐	☐	☐	☐
H6.	"There are not enough local places where I can go."	☐	☐	☐	☐	☐

H7. What do you like most about the things you do?

H8. What do you dislike most about the things you do?

How satisfied are you with: *use card 3*

H9. The amount of pleasure you get from things you do at home? ☐

H10. The amount of pleasure you get from things you do outside your home? ☐

H11. The pleasure you get from radio or TV? ☐

About the things you would like to do

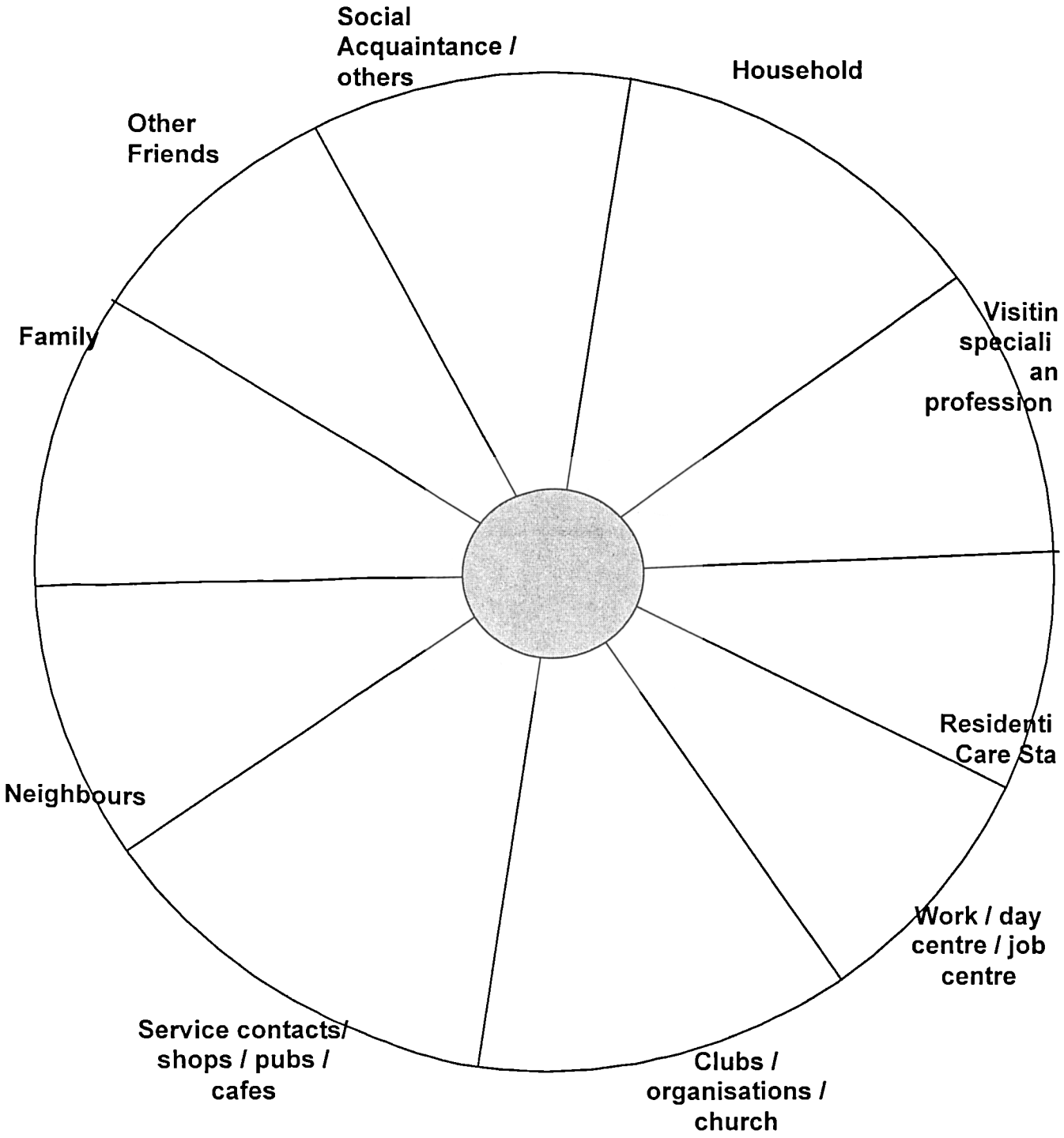
H12. What things would you **like to do** with you time but don't currently do? Please consider work, education and training, sports, leisure, entertainment, etc.

Activity	Frequency	With who?	Main barrier	
a) _____	☐☐	☐	☐	_____
b) _____	☐☐	☐	☐	_____
c) _____	☐☐	☐	☐	_____
d) _____	☐☐	☐	☐	_____
e) _____	☐☐	☐	☐	_____
f) _____	☐☐	☐	☐	_____
g) _____	☐☐	☐	☐	_____
h) _____	☐☐	☐	☐	_____

H13. What could help to overcome these barriers? E.g. Do you required any support?

SECTION FIVE – ABOUT THE PEOPLE YOU KNOW

Please put your name in the centre of the circle below. Think about each adult person you know and write their initials in the segment according to how you know them, e.g. a friend, family member, etc.



I1.	Initials	Area of life	Closeness	How Often?	How Long Known?	Out of work?	Critical
a)							
b)							
c)							
d)							
e)							
f)							
g)							
h)							
i)							
j)							
k)							
l)							
m)							
n)							
o)							
p)							
q)							
r)							

I2. How many children do you have? ☐☐

	YES	NO	DON'T KNOW
I3. In the past year have there been any times when you would have liked to have participated in family activities but were unable?	☐	☐	☐

How satisfied are you with:

I4. Your family in general? ☐ *Card 3*

I5. The amount of contact you have with your relatives? ☐ *Card 3*

I6. Your marriage? (if applicable) ☐ *Card 3*

People differ in how much friendship they need.

	YES	NO	DON'T KNOW
I7. Would you say that you are the sort of person who could manage without friends?	☐	☐	☐
I8. Do you have anyone who you would call a "close friend" (i.e. someone who knows you very well)?	☐	☐	☐
I9. Do you have a friend to whom you could turn for help if you needed it?	☐	☐	☐
I10. In the past week have you visited a friend?	☐	☐	☐

How satisfied are you with:

I11. The way that you get on with other people? ☐ *Use card 3*

I12. The number of friends you have? ☐ *Use card 3*

I13. Comments

SECTION SIX – ABOUT YOU AND YOUR MONEY

J1. Do you receive any state benefits? (*please tick boxes that apply*).

	You	P		You	P
JSA (income based)			Statutory Sick Pay		
JSA (contributory)			Housing Benefit		
Income Support (for sick person)			Council Tax benefit		
• Plus disability premium			State retirement pension		
• Plus severe disability premium			Child benefit		
Disability Living Allowance			Family Credit		
• Care component (L, M or H)			Lone parent benefit		
• Mobility component (L or H)			DPTC/DWA		
Attendance Allowance			New Deal		
Incapacity Benefit			Other (please state)		

J2. For how long have you claimed these benefits? | | | |

J3. What was <u>your</u> cash and non-cash Income last week?

INCOME SOURCES	AMOUNT (£s per week)
Earnings (gross or net?)	•
State benefits	•
Housing Benefit	•
Gifts	•
Loans	•
Illicit activities	•
Other (specify)	•
	•
TOTAL INCOME	•

J4. What was your expenditure last week?

ITEMS OF EXPENDITURE	AMOUNT (£s)					
Housing (rent or mortgage?)				•		
Bills						
Food				•		
Transport				•		
Entertainment				•		
Clothing and foorwear				•		
Household goods				•		
Leisure activities				•		
Alcohol				•		
Illicit drugs				•		
Tobacco				•		
Others (specify)				•		
				•		
TOTAL EXPENDITURE				•		

J5. Do you owe any debts at the moment?

To whom do you owe?	AMOUNT (£s)					
				•		
				•		
				•		
				•		

J6. Are you having difficulty in paying off your debts? YES ☐ NO ☐

J7. Do you normally need help to manage your your money? YES ☐ NO ☐

J8. Have you recently earned money through any activity you have not metioned? **YES** ☐ **NO** ☐

(e.g. prizes, buy & selling, work, etc.)

How much did you earn? ☐

J9. In the past year, have you been turned down for any state benefits for which you have applied? **YES** ☐ **NO** ☐ **DON'T KNOW** ☐

J10. About how much more money per week do you need to be able to live as you would wish? £☐☐☐•☐☐

J11. During the past year, have you ever lacked the money to enjoy everyday life? **YES** ☐ **NO** ☐ **DON'T KNOW** ☐

How satisfied are you with:

J12. How well off you are financially? ☐ *Card 3*

J13. The amount of money you have to spend on enjoyment? ☐ *Card 3*

SECTION SEVEN – ABOUT THE SERVICES YOU USE

K1. What inpatient services have you used over the last 3 months?
(Please enter 0 if service has not been used)

Service	Name of facility	No. of admissions	Total no of inpatient days
General medical ward			
Emergency/crisis centre			
Long stay ward			
Acute psychiatric ward			
Psychiatric rehabilitation ward			
Specialist assessment and/or treatment facility			
Secure/semi secure unit			
Special hospital (e.g. Rampton)			
Other (describe)			
Other (describe)			

K2. What outpatient services have you used over the last 3 months?
(Please enter 0 if service has not been used)

Service	Name of facility	Unit of measurement	Total no. received
Psychiatric outpatient visit		Appointment	
Special unit outpatient visit		Appointment	
Other hospital outpatient visit (incl. A & E)		Appointment	
Day hospital (excl. regular day activities)		Days attended	
Other (describe)			
Other (describe)			
Other (describe)			

K3. What day activity services have you used over the last 3 months?
(Please enter 0 if service has not been used)

Service	Name of facility	No. of attendances	Average duration of attendance (hours)
Community mental health centre			
NHS day activity facility			
LASSD day activity facility			
Vol. Org. day activity centre			
Social club			
Sheltered workshop			
Education classes			
Other (describe)			
Other (describe)			

K4. What community care services have you used over the last 3 months?
(Do not include services provided by staff if in an accommodation facility)

Please enter the relevant numbers in the **Provider sector** box

1=NHS 2=Social Services Department 3=Voluntary organisation 4=Private

Service	Provider sector	Total no. of contacts	Average contact time (mins.)
CPA key worker			
Care Manager			
Community mental health team member			
Other (describe)			
Other (describe)			

K5. Excluding contact with the professionals and team members noted previously, what other community care services have you used over the last 3 months? *(Do not include services provided by staff if in an accommodation facility). Please tick 'D' if service delivered in own home. Use 'Other' rows if BOTH domiciliary and other locations apply.*

Please enter the relevant numbers in the **Provider sector** box

1=NHS 2=Social Services Department 3=Voluntary organisation 4=Private

Service	Provider sector	D	Total no. of contacts	Average contact time (mins.)
Psychiatry consultant				
Psychiatry senior registrar				
Psychologist				
Community psychiatric nurse				
Other nursing services				
Social worker				
Occupational therapist				
Physiotherapist				
Speech therapist				
Chiropodist				
Individual counselling/therapy				
Group counselling/therapy				
Home help/home care worker				
Outreach worker/family support				
General practitioner				
Dentist				
Optician				
Other (describe)				
Other (describe)				

FOR CODER'S USE ONLY

Service code	Mins per week				Cost per min						
									•		
									•		
									•		
									•		
									•		
									•		
									•		
									•		
									•		
									•		
									•		

K6. Over the last 3 months, have you been in contact with the **criminal justice services**? (police, courts, probation, etc.) **YES** ☐ **NO** ☐

If YES, how many contacts with the police? (Contact = interview or stay of some hours, but not overnight) contacts ☐

How many nights spent in a police cell or prison? nights ☐☐

How many psychiatric assessments whilst in custody? assessments ☐

How many (criminal or civil) court appearances? Criminal ☐ Civil ☐

Apart from the above, how many time have been detained in police custody or prison? Police custody ☐ prison ☐u

How satisfied are you with:

K7. Your general personal safety? ☐ *Use card 3*

K8. The safety of this neighbourhood? ☐ *Use card 3*

K9. Did you vote at the last general election? **YES** ☐ **NO** ☐

K10. Do you have a current driving licence? **YES** ☐ **NO** ☐

K11. Please list below use of <u>any</u> drugs taken over the last <u>one</u> month.

Name of drug	**Dosage** (if known)	**Dosage frequency** (Times per day)	**Depot** (Y/N)

K12. What is your medication prescribed for?

SECTION EIGHT – ABOUT YOUR LIFE IN GENERAL

L1. How close do you feel as part of your community?

Very Close ☐ Quite close ☐ Not very close ☐

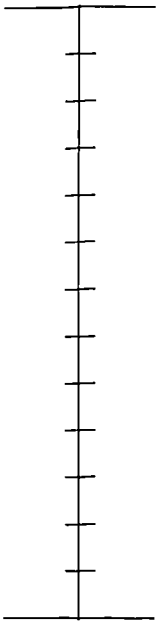
During the course of this interview, you and I have discussed many of the conditions of your life and how you feel about them. Might we try and sum them up now?

L2. Can you tell me how you feel about your life as a whole? ☐ *Card 3*

L3. This is a picture of a ladder. I would like you to imagine that the bottom of the ladder represents the very worst outcome which you could expect to have had in life. The top represents the very best possible outcome you could have expected. Can you please mark (X) where on this ladder you would put your life at present?

Best possible outcome

Best



Worst

Worst possible outcome

L4. How happy has your life been overall?

1. Very Happy
2. Pretty happy
3. Not happy
4. Don't know

☐

L5. Can you name anything(s) which would improve your quality of life?
(tick the ares of life you would most like to improve)

Health	☐	
Work	☐	
Leisure	☐	
People	☐	
Money	☐	
Services	☐	
Other	☐	

L6. Any other comments?

L7. We would like to repeat the interviews in about one years time. Can I contact you again to repeat the interview next year?

YES / NO

What is the best way to contact you?

Telephone ☐ Number?

Letter ☐ Address?

L8. Would you be prepared to complete a simple diary of what you do for one week?

YES / NO

If YES, give time budget and write ID number

Finish time ☐☐ ☐☐

Interviewers Comments

Before filing this questionnaire or proceeding to the next interview, would you please complete the following section while your impressions of both the interviewee and the setting for the interview are still fresh in your memory

How long did the interview take? ☐ **minutes**

How reliable or unreliable do you think the client's responses were?

☐ Very reliable ☐ Generally reliable ☐ Generally unreliable ☐ Very unreliable

Any other comments?

APPENDIX C

Unit Costs used in costing methodology

PSSRU (2000) source	*Unit*	*Unit cost*
INPATIENT		
Generic hospital cost	*day*	£ 223.00
Accident & emergency	*day*	£ 282.00
Acute NHS hospital service (mh)	*day*	£ 144.00
Voluntary sector residential care (staffed) hostel (mental health)	*week*	£ 295.00
OUTPATIENT		
Outpatient attendance (mental health)	*Appointment*	£ 107.00
Dermatology outpatient appointment	*Appointment*	£ 53.00
A&E outpatient	*Appointment*	£ 65.00
Generic outpatient appointment	*Appointment*	£ 68.00
Haematology outpatient appointment	*Appointment*	£ 54.00
Generic outpatient appointment	*Appointment*	£ 68.00
Day hospital attendance	*Day*	£ 62.00
Surgery outpatient appointment	*Appointment*	£ 58.00
COMMUNITY MENTAL HEALTH SERVICES		
Consultant psychiatrist (including qualifications)	*Contact hour*	£ 254.00
Clinical psychologist	*Contact hour*	£ 61.00
Clinical psychologist (home visit)	*Contact hour*	£ 62.08
Community mental health team member (Key worker)	*Contact hour*	£ 55.00
Social worker (adult)	*Contact hour*	£ 83.00
CPN (at clinic with qualifications)	*Contact hour*	£ 67.00
LASSD Home care worker	*Contact hour*	£ 10.10
DAY ACTIVITY		
NHS Trust day care	*Hour*	£ 8.33
LASSD day care	*Hour*	£ 5.67
LASSD day care (minus capital costs)	*Hour*	£ 3.65
Vol. Org. day care	*Hour*	£ 5.67
Vol. Org. day care	*Hour*	£ 5.67
Vol. Org. day care (minus capital costs)	*Hour*	£ 3.62
Sheltered work scheme	*Hour*	£ 6.40
Community mental health team member	*Contact hour*	£ 55.00
LASSD Home care worker	*Contact hour*	£ 10.10

PSSRU (2000) source	*Unit*	*Unit cost*	
Higher education	*Hour*	£	4.95
Adult education	*Hour*	£	1.85
Further education	*Hour*	£	3.71
PRIMARY CARE			
GP (including direct care staff costs and qualifications)	*Contact hour*	£	1.96
GP (Home visit)	*Contact hour*	£	3.06
Practice nurse (at clinic)	*Contact hour*	£	21.00
Chiropodist clinic visit	*visit*	£	9.00
Counselling services in Primary Medical Care	*Contact hour*	£	26.60
Dentist	*Contact minute*	£	0.43
Optician	*Contact minute*	£	0.66

APPENDIX D

Scale reliability

			95% confidence level	
Scale	*Items*	*Alpha*	*Lower CL*	*Upper CL*
GHQ-12 (N=135)	12	0.92	0.90	0.94
M3 (N=38)	20	0.62	0.42	0.77
Empowerment Scale (N=128)	28	0.85	0.81	0.88
Self-esteem	9	0.88	0.85	0.91
Power	8	0.70	0.61	0.77
Activism	6	0.72	0.64	0.79
Control	4	0.55	0.42	0.67
Anger	4	0.56	0.42	0.67
Other sub-scales	15	0.66	0.57	0.74
WBAS (N=130)	29	0.75	0.68	0.80
Pride	16	0.77	0.70	0.82
Anxiety	5	0.56	0.43	0.67
Performance	6	0.46	0.30	0.59
LQoLP				
Total LSS (N=109)	24	0.84	0.79	0.88
Accommodation (N=128)	6*	0.77	0.66	0.86
Health (N=134)	3	0.77	0.69	0.83
Work (N=121)	2**	-0.29	-0.85	0.10
Leisure (N=130)	3*	0.68	0.57	0.77
Family (N=129)	2	0.55	0.36	0.68
Social (N=132)	2	0.80	0.71	0.86
Finance (N=133)	2	0.76	0.66	0.83
Safety (N=133)	2	0.63	0.49	0.74
General well-being (N=133)	2	0.77	0.67	0.83
Barriers to work (N=124)	10	0.78	0.72	0.83

*excludes optional item.

**excludes item on satisfaction with amount of money made through work.

APPENDIX E

Node structure

Free node
Blurred boundaries

Tree nodes
(1) /Do Now

(1 1) /Do Now/Inside

(1 1 1) /Do Now/Inside/premises

(1 1 2) /Do Now/Inside/people

(1 1 3) /Do Now/Inside/Activities

(1 1 4) /Do Now/Inside/environment

(1 1 5) /Do Now/Inside/staff

(1 1 6) /Do Now/Inside/role

(1 1 7) /Do Now/Inside/Day centre politics

(1 2) /Do Now/Outside

(1 2 1) /Do Now/Outside/On own

(1 2 2) /Do Now/Outside/With others

(1 2 4) /Do Now/Outside/Low points

(1 2 6) /Do Now/Outside/Informal economy

(1 2 7) /Do Now/Outside/Social life

(2) /Want to do

(2 1) /Want to do/Specific

(2 1 1) /Want to do/Specific/Work

(2 1 2) /Want to do/Specific/education

(2 1 4) /Want to do/Specific/Leisure

(2 1 5) /Want to do/Specific/Social life

(2 2) /Want to do/General

(2 3) /Want to do/Don't know

(2 4) /Want to do/Reasons for change

(3) /Barriers

(3 1) /Barriers/Finance

(3 1 1) /Barriers/Finance/lack of money

(3 1 2) /Barriers/Finance/welfare benefits

(3 2) /Barriers/Health

(3 2 1) /Barriers/Health/physical

(3 2 2) /Barriers/Health/mental

(3 2 3) /Barriers/Health/medication

(3 3) /Barriers/Discrimination

(3 3 1) /Barriers/Discrimination/bus pass

(3 3 2) /Barriers/Discrimination/family & friends

(3 3 3) /Barriers/Discrimination/Services & employers

(3 3 4) /Barriers/Discrimination/Others experience

(3 4) /Barriers/Stigma

(3 4 1) /Barriers/Stigma/reactions

(3 4 2) /Barriers/Stigma/employers

(3 4 3) /Barriers/Stigma/public perceptions

(3 4 4) /Barriers/Stigma/labels

(3 4 5) /Barriers/Stigma/media

(3 5) /Barriers/Services

(3 5 1) /Barriers/Services/lack of information

(3 5 2) /Barriers/Services/referrals

(3 5 3) /Barriers/Services/GPs

(3 5 4) /Barriers/Services/resources

(3 5 5) /Barriers/Services/Discouragement

(3 6) /Barriers/Work related

(3 6 1) /Barriers/Work related/age

(3 6 2) /Barriers/Work related/illness

(3 6 3) /Barriers/Work related/skills

(3 6 4) /Barriers/Work related/Work place

(4) /Solutions

(4 1) /Solutions/Services

(4 1 1) /Solutions/Services/Continuity of care

(4 1 2) /Solutions/Services/Flexible to suit

(4 1 3) /Solutions/Services/training & education

(4 1 4) /Solutions/Services/learn from others

(4 1 5) /Solutions/Services/Communication

(4 1 6) /Solutions/Services/Appropriate levels of support

(4 1 7) /Solutions/Services/Motivate & encourage

(4 1 1) /Solutions/Services/New services

(4 1 9) /Solutions/Services/Money

(4 3) /Solutions/Improve environment

(4 3 1) /Solutions/Improve environment/Better understanding

(4 3 2) /Solutions/Improve environment/Work

(5) /History

(5 1) /History/Reason for leaving last job

(5 2) /History/Reasons for illness

(5 3) /History/Crime

(5 4) /History/Family background

(5 5) /History/Before

APPENDIX F

Further quantitative data

Table 1. Ethnicity

	Mental health service users			*Long-term unemployed*		
	Manchester	*Tameside*	*Total*	*Manchester*	*Tameside*	*Total*
	N=63	*N=9*	*N=72*	*N=42*	*N=21*	*N=63*
African	1.6	0	1.4	2.4	0.0	1.6
Black British	7.9	0	6.9	0.0	0.0	0.0
Indian	3.2	0	2.8	0.0	0.0	0.0
Pakistani	0	0	0	2.4	0.0	1.6
Irish	1.6	0	1.4	0.0	0.0	0.0
East European	0	0	0	4.8	0.0	3.2
White British	76.2	100	79.2	76.2	95.2	82.5
British Asian	0	0	0	4.8	0.0	3.2
Mixed	1.6	0	1.4	0.0	0.0	0.0
Other Black	4.8	0	4.2	0.0	0.0	0.0
Other White	3.2	0	2.8	0.0	4.8	1.6
Don't know	0	0	0	9.5	0.0	6.3

Table 2. Marital status

	Mental health service users			*Long-term unemployed*		
%	*Manchester*	*Tameside*	*Total*	*Manchester*	*Tameside*	*Total*
	N=63	*N=9*	*N=72*	*N=42*	*N=21*	*N=63*
Single / unmarried	52.4	55.6	52.8	38.1	52.4	42.9
Married / with partner	27	33.3	27.8	28.6	33.3	30.2
Separated	4.8	0	4.2	11.9	4.8	9.5
Divorced	14.3	11.1	13.9	21.4	9.5	17.5
Widowed	1.6	0	1.4	0	0	0

Table 3. Social class of parents

%	*Mental health service users*			*Long-term unemployed*		
	Manchester	*Tameside*	*Total*	*Manchester*	*Tameside*	*Total*
	N=63	*N=9*	*N=72*	*N=42*	*N=21*	*N=63*
I Professional	8.2	11.1	8.6	7.3	9.5	8.1
II Managerial & technical	9.8	0.0	8.6	7.3	14.3	9.7
III-N Skilled non-manual	14.8	22.2	15.7	12.2	19.0	14.5
III-M Skilled - manual	26.2	22.2	25.7	29.3	9.5	22.6
IV Partly skilled	31.1	33.3	31.4	36.6	42.9	38.7
V Unskilled	9.8	11.1	10.0	7.3	4.8	6.5

Table 4. Living situation

%	*Mental health service users*			*Long-term unemployed*		
	Manchester	*Tameside*	*Total*	*Manchester*	*Tameside*	*Total*
	N=63	*N=9*	*N=72*	*N=42*	*N=21*	*N=63*
Alone	57.1	55.6	56.9	57.1	47.6	54.0
With partner	20.6	22.2	20.8	19.0	28.6	22.2
Living together	4.8	11.1	5.6	4.8	4.8	4.8
With parents	11.1	11.1	11.1	11.9	9.5	11.1
With other relatives	3.2	0.0	2.8	2.4	0.0	1.6
With others	3.2	0.0	2.8	4.8	9.5	6.3
With children	15.9	11.1	15.3	23.8	23.8	23.8

Table 5. Type of accommodation

%	*Mental health service users*			*Long-term unemployed*		
	Manchester	*Tameside*	*Total*	*Manchester*	*Tameside*	*Total*
	N=63	*N=9*	*N=72*	*N=42*	*N=21*	*N=63*
Owner occupier	28.6	11.1	26.4	9.8	4.8	8.1
Privately rented	9.5	11.1	9.7	12.2	38.1	21.0
Housing Assoc. /Local Auth.	61.9	77.8	63.9	78.0	57.1	71.0

Table 6. Lengths of jobs

%	*Mental health service users*			*Long-term unemployed*		
	Manchester	*Tameside*	*Total*	*Manchester*	*Tameside*	*Total*
Length of longest job	75.8	97.5	78.6	79.6	130.3	102.0
S.D.	92.3	85.8	91.2	79.6	98.1	87.4
	N=55	*N=9*	*N=67*	*N=40*	*N=20*	*N=60*
Length of last job	53.1	80.9	56.8	42.5	47.7	44.2
S.D.	76.8	98.3	79.8	61.1	62.0	60.9
	N=55	*N=9*	*N=64*	*N=40*	*N=20*	*N=60*
Length of best job (months)	73.9	86.8	75.7	66.6	79.0	70.8
S.D.	92.3	85.3	111.9	73.4	95.1	80.7

Table 7. Social Mobility

%		*Parent's social class*			
		I & II *N=21*	*III* *N=51*	*IV & V* *N=57*	*Total* *N=129*
Social class of last job	*I & II*	33.3	7.8	3.5	**10.1**
	III	28.6	27.5	21.1	**24.8**
	IV & V	38.1	64.7	75.4	**65.1**

Kendall's tau-b = .26, r = .28, $p < .001$

Table 8. GHQ-12 scores for men and women

%	*Male*			*Female*		
	Mental health service users	*Long-term unemployed*	*Total*	*Mental health service users*	*Long-term unemployed*	*Total*
	N=46	*N=56*	*N = 102*	*N=26*	*N=7*	*N = 33*
Likert score	12.83	13.18	13.02	16.58	17.57	16.79
S.D.	7.25	7.16	7.17	8.19	6.68	7.81
GHQ score	2.91	3.18	3.06	5.19	5.43	5.24
S.D.	3.62	3.40	3.49	3.82	4.50	3.90
% score 3+	30.4	39.6	35.1	66.7	57.1	64.5
% score 4+	30.4	33.9	32.4	61.5	57.1	60.6
% score 5+	28.3	28.6	28.4	46.2	57.1	48.5

Table 9. Satisfaction levels with life domains

	Mental health service users			*Long-term unemployed*		
% Satisfied	*Manchester*	*Tameside*	*TOTAL*	*Manchester*	*Tameside*	*TOTAL*
Work	27.1	11.1	25.0	9.8	20.0	13.1
Leisure	49.2	55.6	50.0	40.5	80.0	53.2
Finances	41.9	22.2	39.4	14.3	15.0	14.5
Living	61.7	44.4	59.4	83.3	85.7	84.1
Legal & safety	59.7	22.2	54.9	54.8	60.0	56.5
Family	53.3	44.4	52.2	75.0	70.0	73.3
Social	62.3	33.3	58.6	78.6	85.0	80.6
Health	38.1	33.3	37.5	66.7	61.9	65.1

Table 10. Correlations between subjective quality of life and empowerment and self-esteem

	Empowerment	*Self-esteem*
General well-being 1	$r = .51, p < .001$	$r = .55, p < .001$
Leisure	$r = .31, p < .001$	$r = .38, p < .001$
Living	$r = .24, p = .007$	$r = .19, p = .031$
Legal & safety	ns	$r = .23, p = .009$
Family	$r = .24, p = .007$	$r = .33, p < .001$
Social	$r = .37, p < .001$	$r = .44, p < .001$
Health	$r = .46, p < .001$	$r = .57, p < .001$
General well-being 2	$r = .50, p < .001$	$r = .58, p < .001$
Cantril's (/100)	$r = .50, p < .001$	$r = .51, p < .001$
TOTAL LSS	$r = .46, p < .001$	$r = .52, p < .001$

Table 11. Comparing subjective quality of life

Mean score	*Mental health service users* *N ˜ 70*	*Long-term unemployed* *N ˜ 60*	*CPA* *N = 260*	*UK700* *N = 708*	*Barr & Huxley* *N ˜ 60*
General well-being 1	4.06	4.78	4.33	N/a	N/a
Work	3.91	3.94	4.83	3.60	4.31
Leisure	4.76	4.90	4.76	4.50	4.80
Religion	-	-	4.87	4.90	4.80
Finances	3.97	3.22	3.98	3.50	4.15
Living	4.88	5.59	5.06	4.40	4.84
Legal & safety	4.74	4.79	4.95	4.40	4.75
Family	4.74	5.35	5.15	4.50	5.03
Social	4.74	5.50	4.86	4.40	4.68
Health	4.25	5.31	4.60	4.40	4.55
General well-being 2	4.13	4.74	4.38	4.30	4.30
Cantril's (/100)	49.9	51.8	53.30	N/a	N/a
TOTAL LSS	4.51	4.98	4.79	N/a	4.69

Table 12. Other health indicators

% in last year	*Mental health service users*			*Long-term unemployed*		
	Manchester *N=63*	*Tameside* *N=9*	*Total* *N=72*	*Manchester* *N=42*	*Tameside* *N=21*	*Total* *N=63*
Seen doctor for physical illness	55.6	44.4	54.2	45.2	47.6	46.0
Seen doctor for nerves	92.1	88.9	91.7	16.7	4.8	12.7
Been in hospital for nerves	25.4	33.3	26.4	0.0	0.0	0.0
Taken medication for nerves	96.8	100.0	97.2	7.1	0.0	4.8
Has physical disability	25.4	11.1	23.6	9.5	28.6	15.9

Table 13. Network size

	Mental health service users			*Long-term unemployed*		
	Manchester	*Tameside*	*TOTAL*	*Manchester*	*Tameside*	*TOTAL*
	N=57	*N=9*	*N = 66*	*N=42*	*N=20*	*N = 62*
% with size						
None	0	0	0	0	10	3.2
1 to 5	5.3	11.1	6.1	33.3	30	32.3
6 to 10	33.3	55.6	36.4	28.6	20	25.8
11 to 20	7.0	22.2	9.1	25.6	25	25.8
21 to 40	29.8	0.0	25.8	7.1	10	8.1
41 plus	25.6	11.1	22.7	4.8	5	4.8

Table 14. Network membership

Mean number of members	*Mental health service users*			*Long-term unemployed*		
	Manchester	*Tameside*	*TOTAL*	*Manchester*	*Tameside*	*TOTAL*
	N=57	*N=9*	*N = 66*	*N=42*	*N=20*	*N = 62*
Household	0.7	0.6	0.7	0.5	0.7	0.6
Residential care staff	0.2	0.0	0.2	0.0	0.0	0.0
Visiting specialist	1.3	1.1	1.2	0.1	0.0	0.0
Work / day support	5.9	2.7	5.5	0.2	0.1	0.2
Clubs / churches	2.1	1.0	1.9	0.8	0.7	0.8
Shops / pubs / cafes	3.3	0.9	3.0	1.2	1.7	1.4
Neighbours	2.2	1.2	2.1	0.7	1.3	0.9
Family	4.7	3.0	4.5	3.0	2.4	2.8
Friends	2.7	2.2	2.6	3.9	3.0	3.6
Social acquaintances	3.5	0.1	3.1	1.4	1.2	1.3

Table 15. Frequency and duration of activities and percentage of time spent with network members

Mean frequency (per week) & mean duration (minutes/week), % of total time	*Mental health service users N=71*			*Long-term unemployed N=62*		
	Frequency	*Duration*	*%*	*Frequency*	*Duration*	*%*
On own	2.72	2206	52.6	2.10	1899	51.4
With paid help	0.27	20	1.4	0.00	0	0.0
With other service user	0.68	304	8.8	0.02	6	0.2
With family / household	1.20	948	23.6	1.27	880	24.0
With colleague / formal acquaintance	0.38	128	3.3	0.45	229	6.5
With friend / social acquaintance	1.28	372	10.3	1.84	624	17.9

Table 16. Use of hospital services

%	*CPA*	*Mental health service users*			*Long-term unemployed*		
		M/chester	*T/side*	*Total*	*M/chester*	*T/side*	*Total*
	N=260	*N=62*	*N=9*	*N=71*	*N=42*	*N=20*	*N=62*
INPATIENT	22.0	12.9	22.0	14.1	2.4	5.0	3.2
Medical ward	3.8	1.6	0	1.4	0	5.0	1.6
Emergency / crisis centre	0	0	0	0	2.4	0	1.6
Acute psychiatric ward	5.4	11.3	22.2	12.7	0	0	0
Crisis hostel	0	1.6	0	1.4	0	0	0
OUTPATIENT	65.0	17.7	11.1	16.9	9.5	20.0	12.9
Special unit	3.1	0	0	0	2.4	0	1.6
A&E	0	14.5	0	12.7	4.8	15.0	8.1
Other	17.7	3.2	11.1	4.2	2.4	5.0	3.2

Table 17. Use of community mental health care services

%	CPA	Mental health service users		
		Manchester	Tameside	Total
	N=260	N=62	N=9	N=71
HEALTH	88.0	93.5	100	94.4
Psychiatric outpatient	49.2	66.1	66.7	66.2
Consultant psychiatrist	13.1	4.8	22.2	7.0
Psychologist	3.8	12.9	0	11.3
Therapist / counselling	2.7	8.1	0	7.0
CPN	4.2	3.2	0	2.8
CPA key worker	36.5	66.7	77.8	69.0
CMHT member	5.4	27.4	0	23.9
Other	0	12.9	0	11.3
SOCIAL SERVICES	36.0	14.5	22.2	15.5
Care manager	13.3	11.3	22.2	12.7
Social worker	6.2	3.2	0	2.8
Home care	7.3	1.6	0	1.4

Table 18. Use of primary care services

%	CPA	Mental health service users			Long-term unemployed		
		M/chester	T/side	Total	M/chester	T/side	Total
	N=260	N=62	N=9	N=71	N=42	N=20	N=62
PRIMARY CARE	73.0	54.8	55.6	54.9	42.9	45.0	43.5
GP	39.2	38.7	44.4	39.4	21.4	35.0	25.8
Nurse	10.4	4.8	0	4.2	0	0	0
Chiropodist	8.5	3.2	0	2.8	0	0	0
Dentist	21.2	16.1	11.1	15.5	28.6	20.0	25.8
Optician	13.5	12.9	0	11.3	9.5	0	6.5

APPENDIX G

NSF definition of severe mental illness

Severe mental illness was defined by the working group as follows:

- there must be a mental disorder as designated by a mental health professional (psychiatrist, mental health nurse, clinical psychologist, occupational therapist or mental health social worker) **and either**

- there must have been a score of 4 (very severe problem) on at least one, or a score of 3 (moderately severe problem) on at least two, of the HoNOS items 1-10 (excluding item 5 'physical illness or disability problems') during the previous six months **or**

- there must have been a significant level of service usage over the past five years as shown by:

    - a total of six months in a psychiatric ward or day hospital, or
    - three admissions to hospital or day hospital, or
    - six months of psychiatric community care involving more than one worker or the perceived need for such care if unavailable or refused.

(Department of Health, 1999: 126)

APPENDIX H

A comparison between the CAP questionnaire and time use diary

A total of 32 people completed both time use diary (TUD) and the CAP questionnaire. Comparisons were made for the coded activities (Table 1) and the people with whom activities were taken part (Table 2). Both parametric and non-parametric tests were used. Just 6 significant differences between the mean hours per week were found by each method and just 6 items that did not correlate significantly.

The CAP questionnaire under reported the amount of time spent doing household tasks, reading (dominated by newspapers), resting and sleeping, and attending church and other meetings, perhaps due to poor recall. The CAP questionnaire also under reported the amount of time people spend on their own. However, when time spent resting was taken out of the time use diary calculation this difference disappeared. The CAP questionnaire did not pick up time doing nothing. The CAP also under reported time spent with paid help, though this was due to people not including time spent with home help in the CAP questionnaire. Finally, the CAP under reported the amount of time people spent with their friends, which may be due to people being with friends but not doing any activity.

Table 1. Comparisons between time use diary and CAP questionnaire by activity type

Hours per week	*TUD*	*CAP*	*Difference*	*Correlation*
Work	2.72	2.56	ns	r = .66, p < .001
Study	0.97	1.53	ns	ns
Household	15.97	6.97	Z = -3.99, p < .001	
Religious / meetings	0.72	0.27	Z = -2.11, p = .035	
Radio / music	8.63	10.33	ns	r = .65, p < .001
TV	22.03	19.55	ns	r = .59, p = .001
Read	4.1	2.37	Z = -2.04, p = .042	
Visit	6.84	7.15	ns	r = .42, p = .016
Entertain	1.09	1.6	ns	ns
Active sports	1.38	1.38	ns	r = .42, p = .016
Outdoors / walk	1.81	1.69	ns	r = .35, p = .05
Pub / club	3.13	3.28	ns	r = .73, p < .001
Entertainment	0.84	0.88	ns	ns
Rest / sleep	90.67	104.42	Z = -2.72, p = .007	ns
Other leisure	1.43	3.3	ns	r = .42, p = .022
*Day care**	4	3.34	ns	r = .81, p < .001

Table 2. Comparisons between time use diary and CAP questionnaire by people

Hours per week	*TUD*	*CAP*	*Difference*	*Correlation*
Alone	127.84	35.54	t = 17.35, df 31, p < .001	r = .52, p = .002
Alone (less rest)	39.81	35.54	ns	r = .68, p < .001
Paid help	0.88	0.05	Z = -3.14, p = .002	ns
Service users	4.19	2.76	ns	r = .63, p < .001
Service users*	5.1	4.41	ns	r = .75, p < .001
Family	17.56	17.7	ns	r = .55, p = .001
Colleagues	3.44	3.94	ns	r = .6, p < .001
Friends	14.09	7.77	t = 2.08, df 31, p = .046	ns

*Mental health service users only

APPENDIX I

Time use diary data

	Mh service users		Long-term unemployed			
	% Take part	Hours per week	% Take par	Hours per week	chi stat	diff
Sleeping	100.0	59.5	100.0	56.3		
Watching TV	100.0	21.7	100.0	22.7		
Eating / meals	90.0	9.3	100.0	14.7		
Personal care	90.0	9.0	91.7	7.3		
Radio / music	65.0	11.1	41.7	4.5		
Home chores	65.0	5.6	58.3	6.7		
Visiting	75.0	9.2	41.7	3.0	$\chi^2=3.56, p=.05$	$t=-2.26, p=.031$; $Z=-2.06, p=.044$
Errands / shopping	90.0	5.8	83.3	5.9		
Resting / nothing	70.0	6.7	50.0	4.4		
Reading/newspapers	65.0	4.8	66.7	5.8		
Pub / club	45.0	5.7	41.7	3.3		
Other domestic/DIY	35.0	1.6	41.7	4.9		
Travelling	65.0	3.0	66.7	3.0		
Day care / job club	35.0	4.0	25.0	1.7		
Work	25.0	2.8	16.7	2.7		
Job search	15.0	0.2	66.7	4.8	$\chi^2=8.88, p=.00$	$t=3.26, p=.008$; $Z=-2.40, p=.003$
Outdoors	20.0	2.0	33.3	1.6		
Active sports	10.0	0.4	33.3	3.1		
Child care	15.0	0.4	25.0	2.8		
Other leisure	25.0	0.8	33.3	2.3		
Conversation	25.0	1.3	33.3	1.5		
Study / library	15.0	0.2	50.0	2.3	$\chi^2=4.55, p=.03$	$Z=-2.51, p=.048$
Entertaining	35.0	0.9	25.0	1.4		
Health / medical	50.0	1.0	8.3	0.3	$\chi^2=5.77, p=.01$	
Religion / meetings	30.0	1.0	8.3	0.3		
Entertainment	15.0	0.5	8.3	0.7		
Cultural events	10.0	0.3	8.3	0.2		
TOTAL	12.8	108.6	12.6	111.8		