

“Watch your steps” – Community mental health professionals’ perspectives on the vocational rehabilitation of people with severe mental illness

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In this qualitative focus group study, Norwegian mental health professionals were ambivalent toward supporting their clients’ work potential. The participants tended to have low expectations towards clients with severe mental illness and their chances in the labor market, write Liv Grethe Kinn and colleagues.

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A fundamental principle in work integration is “that people with disabilities have the right to fully develop their career plans, to have equal opportunities in the employment market, and to have access to the training they need” (Kirsh et al., 2009, p. 392). Correspondingly, there are growing demands for mental health professionals to support their clients in pursuing their own vocational goals (OECD, 2013). The driving forces behind vocational rehabilitation trends come from national and international healthcare policies (Ministry of Labour and Social Inclusion and Ministry of Health and Care services, 2006; Sosial- og helsedirektoratet, 2005; World Health Organization, 2013), research evidence, and people with severe mental illness (SMI) themselves. In a Norwegian context, to promote competitive employment, systems are replacing traditional vocational rehabilitation programs with more effective, evidence-based models such as that of Individual Placement and Support (IPS) (Arbeids- og sosialdepartementet, 2012; OECD, 2013; Spjelkavik, 2012). According to the IPS model (Bond, Drake, & Becker, 2008), front-line staff having access to vocational expertise can stimulate work integration more efficiently. However, within this model, there are many clinical issues to clear up: “How and when should benefits counseling occur? What are the best techniques for developing jobs, supporting people in jobs, and helping them make transitions from one job to another?” (Drake & Bond, 2011, p. 158)

Moreover, it is known that recent efforts to improve employment supports have not generated the desired results. Employment rates for people with severe mental illness in Europe and the United States continue to hover between 9% and 20% (Marwaha & Johnson, 2004; OECD, 2012), while in Norway, “people with SMI have a nine-fold unemployment rate, compared with the national average and more generally” (OECD, 2013, p. 13). The number of persons diagnosed with SMI who are working is even falling (Arbeids- og sosialdepartementet, 2012; Spjelkavik, 2012), while the percentage

of disability caused by mental illness is growing (OECD, 2012, 2013; Øverland, Glozier, Maeland, Aaro, & Mykletun, 2006). Jobs for this population often end quickly or negatively (Spjelkavik, 2012), and the majority of those who are mentally ill who are working tend to be underemployed (Dunn, Wewiorski, & Rogers, 2010; Twamley, Jeste, & Lehman, 2003). Recent reviews of qualitative studies (Blank, Harries, & Reynolds, 2011; Fossey & Harvey, 2010) highlight the importance of understanding vital aspects of helpful relationships in job support from the first person perspective of the person being supported.

What helps and hinders vocational recovery

The most consistently noted individual predictors of job success are employment history, motivation, and self-efficacy (Boardman & Rinaldi, 2013; Catty et al., 2008; Marwaha & Johnson, 2004; Rinaldi et al., 2008). Moreover, it is known that employment status is influenced by illness factors, the area of residence, and the macroeconomic situation in a country, including the local labor market and access to vocational rehabilitation programs (Marwaha et al., 2009). Many studies have investigated the relationship between vocational outcomes and both diagnosis and symptom severity, and the majority have found such indicators to be poor predictors of future work performance (Anthony, 1984; Honey, 2003; Marwaha & Johnson, 2004). However, “the limited literature on skills suggests that work adjustment skills, defined as the ability to get along with people at work, to do the job and to be dependable, are important” (Marwaha & Johnson, 2004, p. 347). Moreover, it has been suggested that “part-time work, symptom management, and the development of coping skills have positive influences on work-related behavior” (Areberg, Bjorkman, & Bejerholm, 2013, p. 590). When clients have been asked what they found helpful in rehabilitation processes, they have mentioned the following factors: positive messages about future potential; self-management strategies for staying well and coping with workplace stress; guidance during the job search; assistance to enable informed choices regarding disclosure; ongoing support from significant others; and feeling connected to others, welcomed, and respected at work (Boyce et al., 2008; Fossey & Harvey, 2010; Johnson et al., 2009; Woodside, Schell, & Allison-Hedges, 2006).

Quite a few studies (Horsfall, Clearly, & Hunt, 2010; Nordt, Rossler, & Lauber, 2006) have investigated professional attitudes toward persons with psychiatric disabilities. For instance, Nordt and colleagues (2006) found “that the better knowledge of mental health professionals and their support of individual rights neither entails fewer stereotypes nor enhances the willingness to closely interact with mentally ill people” (p. 709). It is known that attitudinal and structural factors represent significant barriers to work integration.

People with SMI experience obstacles such as stigma, discrimination, low expectations, and lack of follow-up support (Boardman & Rinaldi, 2013; Garske & Stewart, 1999; Krupa, Kirsh, Cockburn, & Gewurtz, 2009; Secker, Grove, & Seebohm, 2001). Vocational goals are frequently lacking in care plans, work aspirations are often

interpreted as unrealistic, and prejudices limit clients' contact with employers and employment agencies (Marwaha & Johnson, 2004).

It is reported that mental health professionals are frequently less optimistic about work outcomes for people with SMI in comparison to the general public (Horsfall et al., 2010; Nordt et al., 2006). For instance, a survey showed that clinicians believed about two-thirds of their caseloads were either incapable of working or able to perform only voluntary or sheltered work (Marwaha, Balachandra, & Johnson, 2009). The work roles they saw as suitable tended to be low-skilled jobs. Moreover, while clinicians saw helping people into jobs as an essential part of their role, they felt they had limited knowledge about available vocational services (Marwaha, Balachandra, & Johnson, 2009).

Conflicting paradigms

Traditional mental health care assumed that people with SMI have a psychobiological vulnerability toward stress and are unable to work unless they have recovered first (Davidson, 2003). Within this framework, clinicians considered this workability condition to be achieved when a client could function independently (Davidson, Tondora, & Ridgway, 2010). However, during the past decades, recovery-oriented practices have emerged that value first-person accounts, peer support, and empowerment. This vision is based on evidence that people with SMI can cope with distress, live autonomously, and contribute to the community, even while struggling with persisting symptoms. Recovery does not occur in an individual person alone but through ongoing transactions between the individual and his or her environment (Davidson & Roe, 2007; Davidson, Schmutte, Dinzeo, & Andres-Hyman, 2008; Topor, Borg, Di Girolamo, & Davidson, 2009). The term vocational recovery captures how individuals experience regaining roles as workers (Dunn et al., 2010).

Still, there are challenges in the way the recovery vision is being translated into practice (Boutillier, Leamy, Bird, Davidson, Williams, & Slade, 2011). The mental health field appears to be in the grips of conflicting and competing paradigms (Corrigan & McCracken, 2005; Rinaldi et al., 2008). There has long been a biomedical-oriented perspective that uses a "train then place" model, with the expected trajectory being: "The illness is decisive for first care, then treatment, and later on rehabilitation, and possibly vocational rehabilitation" (Bejerholm, Larsson, & Hofgren, 2011, p. 60). The more recent recovery-oriented model is more consistent with the opposing approach of "place then train" as, for example, in the evidence-based approach of Supported Employment (SE). This program does not screen people for work "readiness." Rather, it promotes client placement, including ongoing supported, in-chosen, competitive jobs (Rinaldi, Miller, & Perkins, 2010). However, it remains the case that the majority of clients with SMI do not succeed in the jobs they get (Boardman & Rinaldi, 2013). According to Bond and Kukla (2011), future research should identify characteristics of other sources of vocational support, such as that of mental health professionals. Although this emerging body of research confirms the importance of the relationship

between clients and professionals in clinical services, job support within these services has rarely been studied (Catty et al., 2011). Community mental health professionals are cornerstones of psychiatric care in Norway. It is currently unclear, however, if employment for their clients is a priority within this field. Thus, the aim of this study was to explore the community mental health professionals' views of their clients' work potential and their understanding of local vocational rehabilitation programs.

Methods

Design

Given the objective of this study, the logical choice was a hermeneutic phenomenological framework, which is "useful to achieve a creative dialectic between phenomenological exploration on the one hand, and interpretation and reflexivity on the other" (Binder, Holgersen, & Moltu, 2012, p. 104). Qualitative methodology attempts to understand and account for how humans experience and construct meanings in their ordinary day-to-day lives (Malterud, 2012b). The de-contextualization and re-contextualization of empirical data (Malterud, 2012b) serves as the basis for the analysis applying this framework. Focus groups were selected as the most appropriate method because they can be facilitated group discussions. Therein, people are more likely to feel comfortable talking with others who share similar experiences as a means of exploring sensitive issues (Krueger & Casey, 2009; Malterud, 2012a). Thus, participants are usually selected because of shared social or cultural experiences or shared concern related to the study focus (i.e., caring for persons with mental illness).

Recruitment cities and sampling

Qualitative sampling is concerned with information richness, guided by the sampling methods of appropriateness and adequacy (Malterud, 2012b). Thus, to inform the study, a purposeful sampling approach was used to recruit community mental health professionals working in diverse areas in a larger city on the west coast of Norway. Day rehabilitation programs in the city are not based on a specific service model. Rather, they focus on pre-vocational, social, and daily living skill development. Typically, direct employment services are limited, but program staff may refer clients who are interested in employment to diverse sheltered employment, clubhouse, or supported employment programs.

Participants worked in three diverse services, in varied locations, and with various roles: a) five participants worked in supported housing in two different facilities, b) eight participants served clients at five different activity centers, and c) eight participants worked as case managers in three different locations in community mental health services. In each group, approximately two or three of the participants were colleagues in the same facility. Primarily, the participants served persons diagnosed with bipolar disorder or schizophrenia, but some also mentioned clients who had been diagnosed with less severe mental illnesses, such as depression and social anxiety. Participants were engaged in complex psychosocial interventions. As such, individuals'

development of the skills needed for independent living were facilitated: participating socially, using community resources, managing one's home, education and employment, and managing time.

To capture a range of perspectives, the following inclusion criteria were used for practitioners: 1) having diverse healthcare education, working in varied services, and being in direct contact with clients and 2) having at least three years of experience. Written information and recruitment letters about this study were sent to senior advisors in the community mental health field. These advisors then distributed this information to the leaders of separate services in the city, recommending that interested practitioners contact the first author to partake in the study. Additionally, the first author described the study at a meeting where the leaders of each service were represented. Next, these leaders spread word of this information to potential participants. A total of 22 community mental health practitioners expressed interest in participating by emailing the first author. A written invitation was sent to them. All but one confirmed the invitation; one withdrew.

Participants ranged in age from 30 to 55 years. Years of experience in mental health services ranged from three years to 25 years. The majority of the participants were females ($n = 18$). In the sample of 21 participants, all were staff. Eleven held Bachelor's degrees in social work and two in occupational therapy, and eight held a postgraduate degree in mental health nursing. In terms of occupational position, three of the participants had a leading role within their facilities. Participants working in similar services were grouped together in three homogeneous focus groups, according to the service they covered. For example, informants working in activity centers were grouped together, and so forth.

The Norwegian Social Science Data Service approved the study (project number 24990). The data were secured anonymously; no personal information was collected. The interviewer (first author) had no role or responsibility in these services.

Data collection

Focus groups provide people with the opportunity to interact, discuss, and describe experiences and to cross-examine relevant issues concerning the research question (Krueger & Casey, 2009; Malterud, 2012a). In this 2011 study, the focus group discussions were conducted and audiotaped in a meeting room at the university site (separate from the participants working place) during working hours. Each group session lasted approximately one hour or more. The discussions were guided by the first author (LGK) and were assisted by two co-researchers, one of whom had experienced both mental health issues and being a service user. Both co-researchers facilitated discussions and asked questions during the sessions. Discussions were facilitated by use of an interview guide and included questions concerning participants' experiences and their view of clients' vocational aspirations and work potential. We began groups by posing two broad questions: "Is employment a topic you usually discuss with clients?" and "What is your knowledge of a person's work history?" We

used non-assumptive probes and follow-up questions to encourage participants to elaborate and provide examples from their own experiences and/or the experiences of others they knew, such as: “Can you describe a situation when you assisted a service user to get a job?” or “What is your understanding of local vocational rehabilitation programs when it comes to relevance and availability?” The process of data collection lasted about three weeks. All groups were completed before the transcription phase started.

Analysis

The first author transcribed the audiotaped data verbatim. The first author and one of the co-researchers started the analysis phase shortly after the focus groups were held. The third co-researcher took part in the process of neither analyzing nor reporting the data. Common themes and meanings were identified across the focus groups through a four-step analytic procedure (Malterud, 2012b). Steps 1–3 were conducted separately for each transcript during the analysis. In step 1, the first and second author read the transcriptions of each focus group and separately listed her/his preliminary themes that could elucidate the study aim. In step 2, meaning units were identified, classified, and sorted by codes, potentially related to the previously negotiated themes (Malterud, 2012a). In step 3, the meaning units were transformed into the researcher’s language and were interpreted in light of the text as a whole; abstractions were avoided (Malterud, 2012b).

In step 3, the first author synthesized and transformed meaning units into a summary protocol across each focus group. Empirical data were reduced to a decontextualized selection of meaning units sorted as thematic code groups in first-person format (Malterud, 2012b). In step 4, the data elements were re-contextualized. The first author took the role of a re-narrator and developed an analytic text presenting the most salient content related to the phenomenon grounded in the empirical data, including quotations from each code group (Malterud, 2012b). Interpretations and findings were re- contextualized and validated against the initial complete transcripts (Malterud, 2012b). All the authors reviewed and agreed on the final findings.

Results

Three main themes and one sub-theme emerged from the analysis of the focus group data. They are: (1) viewing service users as vulnerable and not ready for employment, with the discovery of their own lack of beliefs in clients’ vocational potential as a latent barrier; (2) the laying stepping stones by practitioners to everyday life activities, from which clients could be launched into the community and meet new role responsibilities; and (3) displaying skepticism toward the competence of staff in vocational rehabilitation programs. These themes are presented below.

Viewing service users as vulnerable and not ready for employment

Across focus groups, participants reported that they “served” persons at various levels of occupational functioning. Participants explained that several clients had sheltered

jobs with minimum wages, some partook in paid jobs in supported employment, but the majority were unemployed. Participants identified various client-based barriers to competitive employment. Predominantly, they interpreted clients' so-called withdrawal, passivity, and fear avoidance or over-dependency as barriers to employment. As participants said:

Some of our users are like “the sickest of the sick.” It’s basically enough for them living in the community. Many struggle with walking outside, even a few steps, for example to pick up the post.... Therefore, it would be very tricky for them to have a job. ...If clients need individual follow-up, it would be almost impossible.

Moreover, across focus groups systemic barriers were mentioned. As two other participants said, “One has to be quite healthy to fit into the workforce”. “Yes, I wonder if any employer would be willing to hire our clients—I suppose they would prefer more efficient employees. Nowadays, workers have to adapt toward the system—it is not the opposite.” These quotes show that participants felt it was problematic for clients to overcome disruptions related to the illness, stigma, and challenges in a working life. Because participants across the focus groups understood vocational recovery and employment as sensitive topics, job support was not their priority. Apparently, their interventions were mostly focused on care and step-wise approaches to support social inclusion. One participant underlined how she perceived her professional role as a case manager: “I believe that we do incredibly much for them. We follow them to clinicians, to dentists, to activity centers—that’s our regular practice.” Likewise, other participants described their interventions:

We serve some clients; very talented, but they suffer from severe social anxiety. For instance, they cannot use public transport. However, as they refuse to identify as clients, they reject visiting activity centers.... We pick them up at home, and drive them to the activity center—on days when no one else is there. We prepare and eat lunch together with them, and [we] talk. Then, we drive them back home ... so they do not have to worry about transportation.... Yes, this group has been very popular! ... Before, we used to visit individual in their homes—talking about the same problems, repetitively—leading nowhere....

In discussing employed clients' needs, participants expressed that it was challenging and time-consuming to address disruptions related to the illness as well as following job support needs. As some participants said:

Clients' ambivalence is the worst part; one day they want to work and the next: "Oh, I don't really give a shit about getting a job." ...And many do not know their (job) interests. ...Or, if they have a job, they might refuse to go.... And if we happen to ask why, they might not answer, or [they might] become defensive.... There may be thousands of reasons: anxiety or triggers, in or outside the workplace, problems at home.... Therefore, that is my experience—do not put any pressure on them. If you do, they might step back. ...It is all about balancing.

This quotation indicates that participants found it difficult to contain clients' negative work experiences, a necessary component of enabling individuals to learn from their mistakes and stretch their comfort zone. Participants felt that talking about work stressors could provoke clients' mental health problems: "Many users cannot handle stress. ...If we push them too hard, many back off.... Actually, if we did, they could stop coming to the activity center." Besides, some participants described how individuals' work history was a sensitive topic to explore. Thus, they used cautious approaches, as one participant, working with supported housing, said:

Usually, I question clients' job experiences after a while.... When I know the person ... then it's easier to talk about issues like that.Moreover, as I see it, it depends on how long [it has been] since the person had a job; those who worked recently are much keener to talk about work.... However, because their stories often reveal failures at work, there are so many aspects to be aware of.... For instance, some had upsetting outbursts at work, or they were psychotic following social exclusion, and some got fired.

In addition, some participants were concerned about what they understood as their clients' difficulties in dealing with positive feedback or praise at work. As one participant said, "I believe that he would have functioned much better if he hadn't got that job. He couldn't take positive comments about his job skills."

Discovering their own lack of belief in clients' vocational potential as a latent barrier

Across focus groups, some participants evaluated their own stances as possibly posing underlying obstacles to work integration, as is illustrated in the next quotation:

Currently, there is a person (peer) with lived experience working at our activity center. She is doing a really good job. However, at the start, we were very skeptical, thinking she is not one of us (staff). ...Presently, we think the opposite.

This citation shows participants' transformation away from previous self-confessed stigmatizing attitudes toward people with SMI. However, discussions revealed tensions between participants' judgments of their practice regarding stimulating work participation. The following passages show conflicting opinions:

I trust that we do not diminish service users' vocational hopes, but I wonder ... as we typically do not talk about work at activity centers ... are we too cautious? Because I believe that work is very important.... However, our position is to take it one step at a time.

Many service users are not quite "there". ...I mean it would be very hard for them to keep a job. ... In addition, I actually wonder: should we really think employment for everybody? ...I believe if we did, many would panic.... So, we do not talk much about work. ...But, I guess a job specialist would.... What I recommend to clients is social skills training through participation at activity centers. ...Except for younger clients, that could be quite unhelpful. For them, supported employment or supported education would fit much better....

These quotations indicate that the majority of participants focused on social participation, rather than employment, as a foremost goal for their clients. Noticeably, they apparently understood age and persistent illness as important predictors of vocational recovery. Some participants pointed out care plans as a relevant tool to identify individuals' work goals. However, certain concerns about individual plans were also mentioned: "The plan is hidden in a drawer." Moreover, some participants identified lack of information about relevant vocational rehabilitation services as an underlying obstacle. As one participant said, "I have limited understanding of available vocational programs...."

Laying of stepping stones to everyday life activities

Opposing participants' rather pessimistic views as described above, focus group discussions also revealed several participants' hopeful attitudes concerning clients' processes of vocational recovery. "It's an ongoing route. Lots of ambivalence—which can trigger [an] individual's growth: It's a cycle." As one participant said:

I focus on a person's likes—and job interests. Of course, professionals ... are responsible for vocational rehabilitation (i.e., to find relevant jobs), but it is also very much up to us [staff in sheltered homes] to make the right phone calls to the right people at potential work places. Of course, we should primarily assist clients—not control their routes ... toward employment. That's what I actually do: help clients take their first steps.

Participants shared many positive stories about how they strived to facilitate clients' participation in everyday activities through preparation and sharing of meals, focusing on their interests, and facilitation of social events. Participants also repeatedly described activity centers as “stepping stones” to a better life, as exemplified in this next quotation:

At the activity center, we focus on clients' capabilities and interests, not on their problems. We initiate a humorist tone, offering positives and avoiding laying pressure upon them. ...The center is a kind of retreat; we offer enjoyable doings with limited demands. Clients mainly perform hobby activities, and sometimes they have certain duties as a kind of skills or vocational training. ...We are definitely on the support side!

However, this quotation indirectly exposes participants' somewhat pessimistic thoughts about clients' prospects for vocational recovery. The way they spoke about employment shows their doubts about their clients' work readiness or employability. Several participants argued:

For them to get and keep a job would require extensive professional assistance, not only adjustments at the workplace. Who can help them get up in the morning, and what about travelling by bus, alone? So, I am not convinced that employment is a realistic goal for them. Therefore, we do not emphasize employment in our practice. ...I mean—why should everybody necessarily work? ...Of course, I know that recent mental healthcare guidelines and policies emphasize work. However, as I see it, activities of daily living should be valued equal with work ... because many of our clients have wide-ranging shortages when it comes to working. ...For them it is just enough to go to therapy or see welfare consultants once a week. As one of our clients often declares, “I'm so busy with all my therapeutic appointments, I really need a day off to be alone.”

Participants pointed out that they felt many clients defined activity centers as “work,” valuing them as a place to belong that provides daily structure and meaningful activities. By so doing, participants indirectly justified their standpoints about their clients: “Some can work, but some cannot.”

Displaying skepticism toward the competence of vocational rehabilitation staff

Across focus groups, when participants spoke about employed clients, they frequently mentioned concerns about dead-end jobs, the lack of interesting jobs, and insufficient job support from vocational rehab workers. Several participants pointed out that

vocational rehab programs did not understand clients' special needs. As some participants said:

I believe if there were more demands, clients would be more committed. Currently it is more like: "Well, as I have nothing else [pleasant] to do today—I can go to work." So their jobs seem a bit too relaxed. ... Besides, if I ask a client, "How was work today?" he or she often answers, "Well, I haven't been at work. I've been to a program."...I had a client who left a supported job, because he felt that he was not offered challenges. He has tried several vocational rehabilitation programs, but he has not succeeded.

Participants described how some people come into agencies with expectations about employment that may lead to discontent:

Clients tend "to fall between two chairs." ...I had a client—he was in a manic phase. He wanted a real job—to be an auto mechanic—but since he was very unstable during that period, they advised him to apply for a sheltered job. ...But he disliked that. ...Many clients have an aversion against low-skilled jobs like filling screws into a bag or doing catering work.

It is my main impression that clients receive minimal job support from [vocational rehab programs]. As well, the help they are offered tends to be insufficient! ...Most programs ... are concerned with assessing clients' employability. ...Usually, they have to do meaningless tasks, low-skilled and short-term jobs. ...Therefore, I can easily understand why they frequently fall out of these programs!

There were many critical statements across focus groups about how participants experienced vocational rehabilitation staff expertise, as the following mixed passages reveal:

I think that there is a big gap between what [vocational rehab staff] expect of clients ... and how they assess clients' work readiness. They underrate what they actually can accomplish.... Thus, they exclude them. ...It seems that [they] expect clients to be "symptom free"... when they apply for a vocational rehabilitation program!

[Vocational rehab staff] usually prefer to help persons who are not on disability pension. ...Besides, clients who partake in vocational

rehabilitation programs are typically advised to find a placement themselves.... Oh, no, that does not work at all.

Additionally, participants emphasized that clients with higher educational aspirations tended to experience tough challenges in searching for jobs. As one participant said:

[Vocational rehab staff] assessed one of our clients regarding work readiness. They labeled him as "less employable"... and advised him to work only one day a week! However, luckily he ignored those signals ... and recently he fulfilled his exams ... and now he is studying history.

In contrast, some participants underscored that they valued job specialists and their expertise, which the next passage shows:

Recently, we organized a seminar about employment at our activity center, initiated by clients. A job specialist came to provide information about employment options. This meeting came out very positive; it really changed something! In the following weeks, several clients applied for supported employment. Some of them have succeeded in getting a job, but one did not. In addition, that was a downfall for her.... Yes, I have also seen that that job specialist has a super way of assisting people into employment!

Discussion

The aim of this study was to explore community mental health practitioners' views of clients' work potential and their understanding of local vocational rehabilitation programs. The previous section illustrates the complexity of various challenges and strategies experienced by social workers, mental health nurses, and occupational therapists when working with persons diagnosed with severe mental illness in their community. The results may be seen in light of three central aspects, which will be discussed in the following paragraphs.

The first, more positive aspect was this study's finding that participants' valued engagement in meaningful everyday activities as a helpful way of facilitating their clients' recovery. Such pursuits include mingling at activity centers, cooking and eating together, and participating in leisure activities. The participants' beliefs in the health benefits of "balanced" occupations may not be an unexpected finding. Nevertheless, it reinforces the notion that recovery coincides with a person's growing self-realization, a concept which is often reported in the mental health literature. Additionally, according to occupational therapy scholars ([Hammel, 2014](#); [Wilcock, 1999](#)), research has

revealed that personal experience with doing, as well as being and belonging within the atmosphere of doing, enables people to foresee new possible roles to be filled beyond being sick. The statement “you are what you do” emphasizes that not only paid, competitive jobs but also unpaid jobs and even hobbies can positively influence health and well-being ([Kinn, Holgersen, Aas, & Davidson, 2014](#)).

The second aspect of this study was the predominantly pessimistic views the participants held in relation to the vocational potential and job prospects of their clients. They either viewed many of their clients as simply being too disabled to work altogether or they worried that the others would not be able to deal with the pressure and stresses associated with working. As a result, participants primarily advised their clients to remain in activity centers, mainly because these centers could address what they saw as their clients’ primary need for structure within a safe and non-demanding setting. Unfortunately, these findings are not so surprising as some of the main barriers to employment that have been identified in the research to date have been stigma, discrimination, low expectations, and lack of follow-up support by mental health practitioners ([Kinn et al., 2014](#); [Krupa et al., 2009](#); [Marwaha, Balachandra, & Johnson, 2009](#); [Marwaha & Johnson, 2004](#)).

It is known that mental health professionals often lack knowledge about the job market and that their approaches vary. These tendencies cause problematic supports and messages ([Krupa et al., 2009](#)). Mental health service providers tend to “interpret situations from a medical perspective, so that pathology and deficits take prominence over work-related capacities; discourage people with mental illness to take risks in their community lives; and give limited attention to the employment needs of people served” ([Krupa et al., 2009](#), p. 421). It has been revealed that quality consumer-provider relationships and individualized employment services are most instrumental in helping consumers achieve employment goals. Further, a range of environmental barriers exist, including issues related to the service system, entitlement programs, non-human resources, and social stigma ([Henry & Lucca, 2004](#)). As a result, it has been largely left up to persons with mental health conditions who want a job to seek out more recovery-oriented professionals, programs, or persons and/or to find jobs for themselves ([Alverson, Carpenter, & Drake, 2006](#)).

These same issues were identified in a recent a review of work integration efforts in Canada ([Kirsh, Krupa, Cockburn, & Gewurtz, 2010](#)). Five central perspectives were identified in this sphere: “a competency perspective; a citizenship perspective; a workplace health perspective; a perspective focusing on potential, growth, and self-construction; and a community economic development perspective” ([Kirsh et al., 2010](#), p. 1833). According to the review’s authors, the use of a competence perspective entails professionals primarily focusing on the person with mental illness and aims to build self-confidence and abilities at the person’s own pace. In so doing, it suggests that people are not yet “ready” to work (that they lack such work behaviors such as regular attendance, frustration tolerance, and persistent motivation as well as cognitive

capacity and social skills), thereby justifying the need for more pre-employment activities (Kirsh et al., 2010). As the authors comment, “These beliefs lead to a fear that, even in the face of evidence of competence, there is a likelihood that competence may transform into incompetence. In essence, this perspective frames persons with mental illness as ‘damaged goods’” (Kirsh et al., 2010, p. 1838).

Viewing and treating clients as other than “damaged goods” is a challenging postulate that requires concerted effort on the part of mental health practitioners. Their therapeutic relationship between practitioners and their patients may be related to motivation and a sense of optimism about vocational recovery. Notably, although clients’ evaluations of the clinical keyworker relationship do not predict getting a job, it has been demonstrated “they have an indirect impact as they predict the quality of their (clients’) subsequent relationships with the vocational worker, suggesting clinicians may be able to take their relationship with the client into account when assessing suitability for vocational interventions” (Catty et al., 2011, p. 72). Moreover, qualitative research indicates that emotional support, practical assistance, and a client-centered approach are important (Johnson et al., 2009). For instance, with regard to cognitive and emotional support, many persons interviewed about these issues have emphasized “the help they received to stay focused, [the] motivation and encouragement, and [the] developing [of] their confidence” (Johnson et al., 2009, p. 121). As a recent meta-synthesis (Kinn et al., 2014) metaphorically concluded, many people diagnosed with SMI experience working as comparable «to skating on ice.” Ice skaters strive to glide on icy, irregular surfaces on the edge of a blade; people with SMI try to balance on “the edge” of a number of boundaries at work. For persons with SMI to “get off the bench” and “onto the ice” of employment, they may need to be supported in finding and maintaining their balance. This support can be accomplished through a combination of learning new skills and competencies (learning how to skate) and through in vivo assistance from empathic and knowledgeable supporters (being coached while on the ice) (Kinn et al., 2014, p. 125).

The third and last aspect of the study was the participants’ skepticism toward staff expertise in vocational rehabilitation programs. This study’s participants reported that they experienced several of their employed clients receiving insufficient job support. This finding can be interpreted in light of the literature, which argues that supporting work integration, including vocational workers in community mental health teams, is considered critical (Kirsh, Cockburn, & Gewurtz, 2005). However, it is noted that mental health professionals’ attitudes may make it difficult to integrate vocational workers into clinical teams. To adapt to the field’s current paradigm shift to recovery, reviews recommend that mental health professionals (e.g., occupational therapists) “revise their theory and practice critically in order to support the implementation of evidence-based practices in supported employment” (Waghorn, Lloyd, & Clune, 2009, p. 314). Moreover, a recent review (Shepherd, Lockett, Bacon, & Grove, 2012) identified some concrete problems associated with implementing evidence-based supported employment. More specifically, tension existed between job specialists who

advocated real-life outcomes to rehabilitation and clinical staff who tended to assume that symptoms of the illness must be addressed before any functional progress could be made (Shepherd et al., 2012).

Limitation of the study and possible implications

Consistent with the goals and philosophy of qualitative inquiry (Malterud, 2012a, 2012b) the aim of the study was not to offer results that could be widely generalized. Rather, it was to capture important insights based on these practitioners' experiences and beliefs. Further research is recommended to confirm and advance knowledge in this area. Conducting additional focus groups that are more diverse in terms of clients served and geographic location may enhance the transferability and relevance of the study's findings. Discussions in homogeneous focus groups according to professional background would be particularly advantageous. Organizing occupational therapists in one group, psychiatric nurses in a second, and job specialists in a third, for instance, could reveal in-depth insight into mental health professionals' dissimilar and/or similar ideology and practice. Though the sample is limited in this study, the findings are consistent with the existing literature on employment issues for individuals with SMI. For example, stigma and negative attitudes toward clients' work on the part of potential employers as barriers to employment (Garske & Stewart, 1999; Krupa et al., 2009; Marwaha, Balachandra, & Johnson, 2009) and supportive services (Kirsh et al., 2005; Shankar, 2005) as enablers of employment have been reported in the literature.

Conclusion

This study indicates that the mental health professionals interviewed in these focus groups were ambivalent toward supporting their clients' work potential. They primarily viewed their clients as having no chance in the labor market. These findings suggest that to facilitate work integration, mental health professionals should analyze and value clients' occupational narratives, interest, and needs, not only those related to a workplace setting but also those pertaining to the time, use, and activities of daily living (balanced or unbalanced) and particularly those that focus on the activities they find meaningful and that improve their self-esteem and confidence. Moreover, mental health professionals should revise their knowledge base related to guidance from recovery-oriented-research place-then-train models. Job specialists can be seen as necessary change agents, not only for their clients' potential to find a job match in the open labor market but also for mental health professionals' views and attitudes toward the possibilities for their clients' work participation.

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Abstract

“Watch your steps” – Community mental health professionals’ perspectives on the vocational rehabilitation of people with severe mental illness

Community mental health services are expected to focus on vocational recovery. Thus, the aim of this qualitative study was to explore Norwegian mental health professionals’ views of their clients’ potential for working and understanding of local vocational resources. Three focus group discussions with 21 participants, covering supported housing, activity centers, and case management, revealed: (1) viewing clients as vulnerable and not ready for employment and discovering their own lack of belief in their clients’ vocational potential as a latent barrier, (2) laying stepping stones to everyday life activities, from which clients could be launched into the community and meet new role responsibilities, and (3) feeling skepticism toward the competence of vocational rehabilitation staff. This study indicates that mental health professionals interviewed in these focus groups were ambivalent toward supporting clients’ work potential. They primarily viewed their clients as having no chance in the labor market.

Keywords: community mental health services, employment, mental health.

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