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Understanding the Employment Barriers and Support Needs of People Living with Psychosis

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Abstract

This study investigated the employment barriers and support needs of people living with psychosis. A purposive community sample of 137 volunteers drawn from six key stakeholder groups were invited to participate in focus groups and semi-structured individual interviews to elicit their perceptions on the employment barriers and support needs of people living with psychosis. The stakeholder groups included in this study were people with lived experience of schizophrenia or bipolar disorder, carers, health professionals, employers, employment service providers, and community members. Data obtained from 14 focus groups and 31 semi-structured individual interviews were transcribed, imported into NVivo 10, and coded for purposes of thematic analysis. The results of this study revealed that the employment barriers and support needs of people living with psychosis were multiple and diverse. The main employment barriers identified were interpersonal in nature, notably stigma and discrimination. Employment assistance, particularly in the area of job seeking, was the most frequently identified employment support need. The findings of this study suggest that a broad-ranging and collaborative approach is needed across multiple sectors to overcome employment barriers and improve employment outcomes for people living with psychosis. This would include increased public awareness, recovery-oriented health services, effective employment services, training across multiple sectors, and removal of disincentives to work.

Keywords

Unemployment, Psychosis, Qualitative, Focus Groups, Interviews, NVivo, Thematic Analysis

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Understanding the Employment Barriers and Support Needs of People Living with Psychosis

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This study investigated the employment barriers and support needs of people living with psychosis. A purposive community sample of 137 volunteers drawn from six key stakeholder groups were invited to participate in focus groups and semi-structured individual interviews to elicit their perceptions on the employment barriers and support needs of people living with psychosis. The stakeholder groups included in this study were people with lived experience of schizophrenia or bipolar disorder, carers, health professionals, employers, employment service providers, and community members. Data obtained from 14 focus groups and 31 semi-structured individual interviews were transcribed, imported into NVivo 10, and coded for purposes of thematic analysis. The results of this study revealed that the employment barriers and support needs of people living with psychosis were multiple and diverse. The main employment barriers identified were interpersonal in nature, notably stigma and discrimination. Employment assistance, particularly in the area of job seeking, was the most frequently identified employment support need. The findings of this study suggest that a broad-ranging and collaborative approach is needed across multiple sectors to overcome employment barriers and improve employment outcomes for people living with psychosis. This would include increased public awareness, recovery-oriented health services, effective employment services, training across multiple sectors, and removal of disincentives to work. Keywords: Unemployment, Psychosis, Qualitative, Focus Groups, Interviews, NVivo, Thematic Analysis

Employment of people living with psychosis is important in promoting the social and economic inclusion of this marginalised group. It is increasingly apparent that clinical treatment alone is insufficient to ensure a good quality of life for people living with persisting mental health conditions and that more attention needs to be focused on psychosocial rehabilitation, including supporting people to maximise their employment potential. The increasing prominence of the recovery movement over the past decade has focused attention on the importance of living a meaningful and contributing life despite the presence of mental health issues (Brown, 2013). Rather than considering recovery a necessary precursor to work, this approach regards work as a significant stage in the recovery of people living with psychosis (Secker, Grove, & Membry, 2005). Indeed some authors have suggested that meaningful work is integral not only to functional recovery but to clinical recovery as well (Bond et al., 2001; Repper & Perkins, 2003).

Epidemiological studies show that employment rates of people living with severe and persisting mental health conditions are very low, at approximately 20% in Western cultures (Marwaha & Johnson, 2004). In Australia this percentage is much lower than the 53% employment rate for people living with all disability types and the 83% employment rate for people without disability (Australian Bureau of Statistics, 2012).

Previous studies have identified a wide variety of employment barriers associated with psychotic conditions. Several studies have found an association between the severity of psychotic symptoms and employment outcomes (Christenson, 2007; Neuchterlein et al., 2011;

Rosenheck et al., 2006). Whilst psychotic conditions and the effects of anti-psychotic treatment are associated with disruptive symptoms that can be difficult to manage, research indicates that non-clinical factors including demographic factors, racial discrimination, stigma, financial disincentives, models of employment support and employer concerns, also play an important role in determining employment outcomes (Bassett, Lloyd, & Bassett, 2001; Blitz & Mechanic, 2006; Bond, Drake, & Becker, 2008; Olney & Lyle, 2011; Peckham & Muller, 2000; Rosenheck et al., 2006; Waghorn, 2011). Grove, Secker, and Seeborn (2005) suggest that psychological variables such as self-efficacy and goal orientation may be more important than clinical status in determining employability. Social-cultural and economic factors also play an important role. The International Study of Schizophrenia found higher employment rates in some developing countries for individuals living with psychosis. León and León (2007) reported that during a 2-year follow-up period in Columbia, more than two thirds of a cohort of people diagnosed with schizophrenia (68%) were in paid work and 59% had been in full time work for over 2 years. Moreover, for 90% of those who had been working for 12 months, the quality of their work performance was rated positively. This is a superior outcome to employment rates achieved by people living with psychosis in Western countries even with evidence-based disability employment support. Similarly, Srinivasan and Tirupati (2005), in a study of cognition and work functioning among 88 patients diagnosed with chronic schizophrenia in an urban area of India, found 67% were employed, most in mainstream employment. Interestingly, they also found that severity of cognitive symptoms associated with schizophrenia was unrelated to employment outcomes.

Previous studies have investigated the employment-related needs of people living with psychosis. Peckham and Muller (2000) identified the need for better understanding of the employment assistance needs of individuals living with schizophrenia. Since then a substantive body of research has investigated the relative effectiveness of different models of employment support for people living with psychosis. Randomised controlled studies have demonstrated superior employment rates using the Individual Placement and Support (IPS) model of employment support, compared to traditional vocational rehabilitation approaches (Bond, Drake, & Becker, 2008, 2012; Cook et al., 2005). Henry and Lucca (2004) interviewed employment providers to investigate facilitators to employment and found that quality consumer-provider relationships and individualised employment services were the most instrumental factors in assisting consumers achieve their employment goals. Tse and Yeates (2002) identified the importance of “goodness of fit” between individual needs and workplace characteristics. Tse (2004), exploring employer attitudes towards employing people with mental health conditions, identified a number of successful employment support strategies used by employers. Other researchers have identified the need for more support for individuals with psychiatric disabilities to access essential services including transport, education, and training (Blitz & Mechanic, 2006; Neuchterlein et al., 2008). Larson et al. (2011) analysed employment incentives for individuals with psychiatric disabilities and found cognitive factors related to employment commitment to be significantly correlated with employment status.

To date qualitative studies that have investigated employment barriers and support needs of people living with psychosis have used small sample sizes (Bassett, Lloyd, & Bassett, 2001; Peckham & Muller, 2000). Such studies have usually included clients, employment service provider or employers (Henry & Lucca, 2004; Honey, 2004; Larson et al., 2011; Peckham & Muller, 2000; Tse, 2004; Tse & Yeates, 2002). The current study explored the insights and perspectives of a relatively large sample of respondents drawn from 6 different stakeholder groups. Cohen and Cohen (1984), in relation to schizophrenia research, cautioned against generalising results obtained from studies using hospitalised patients with chronic severe symptoms. The current study therefore sought to include client participants residing in the community with varying levels of social and occupational functioning. Whereas qualitative

studies have tended to focus on employment barriers, the present study examined employment barriers and support needs of people living with psychosis.

Method

The first author, a clinical psychologist with extensive experience in the area of employment-related assessments, completed this study in fulfilment of a doctor of philosophy degree at Bond University. The co-authors of this article were involved in the study in the capacity of research supervisors. Dr. Richard Hicks has an extensive background in employment-related research while Dr. Bruce Watt is an experienced clinical and forensic psychologist. Approval was obtained from the Bond University Higher Research Ethics Committee to conduct the study.

The Sample

Based on a review of the literature, six key stakeholder groups were identified whose perceptions were deemed most relevant to the research topic: clients with lived experience of bipolar disorder or schizophrenia, care givers, health professionals, employers, employment service providers, and community members. A purposive sample of 137 participants from these groups was recruited in South East Queensland. Flyers, as approved by the University Ethics Committee, were used to recruit participants from government and non-government organisations. Participants were given a statement explaining the nature and purpose of the study and were required to provide informed written consent to participate and for audio-recording of discussions. Acutely unwell clients were excluded. Table 1 shows the composition of the sample.

Table 1

Composition of Sample: Focus Groups and Interviews

Stakeholder group	No. focus groups	No. group participants	No. interviewees	Total participants	Stakeholder representation
Clients	3	17	8	25	18%
Careers	1	7	2	9	6%
Employers	1	8	3	11	8%
Employment consultants	3	24	3	27	20%
Community members	5	41	5	46	34%
Health professionals	1	9	10	19	14%
Total	14	106	31	137	100%

Note: One community member group consisted of young people aged 18-25 years while another consisted of representatives of community service organisations. It became evident during the course of groups that some participants could be considered members of multiple stakeholder groups.

All participants were required to provide basic demographic information. Figures 1-3 show the demographic characteristics of the sample with respect to age, gender, education, and occupational status. Figure 1 shows the sample included participants aged across the adult life-span. The inclusion of participants aged 80 years or over yielded useful historical information and insights relating to the topic. Relatively more females than males participated within the 20-29 and 50-59 year old age groups.

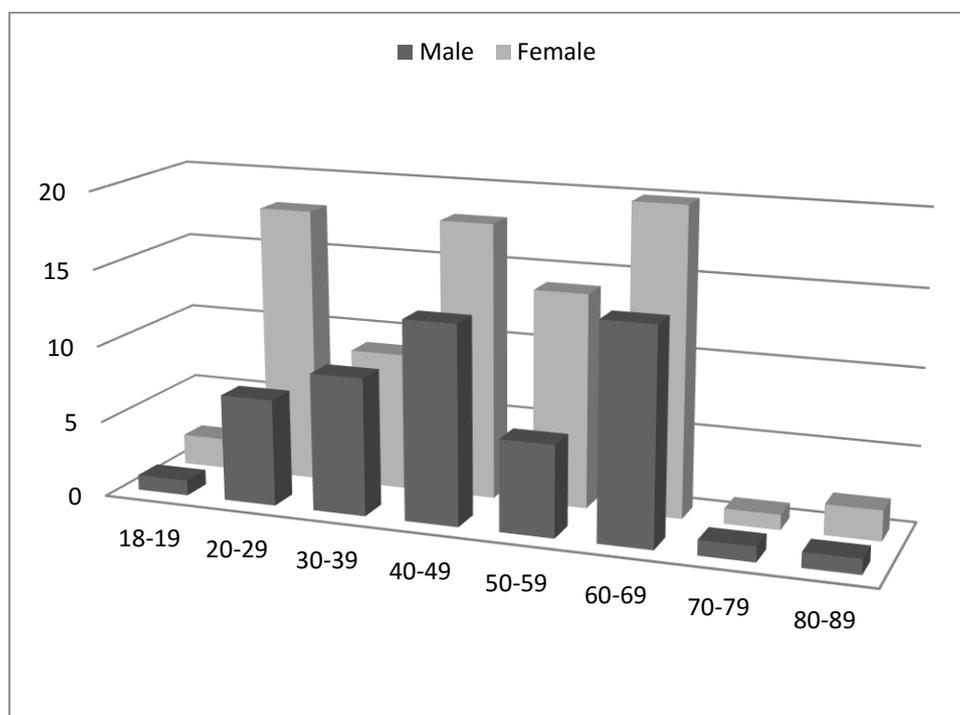


Figure 1. Demographic profile of sample: age group and gender.

The majority of participants (98%) reported having secondary school education and more than half the sample (53%) had undertaken tertiary level study. This is reflected in the occupational status of the sample which included a relatively high percentage of professionals (32.8 %) and community workers (22.6 %).

Focus Groups

Focus groups were selected as a suitable research method to use in community settings, as they encourage synergy of ideas and reduce the role of the researcher, allowing the voice of respondents to be heard (Liamputtong, 2011). Fourteen focus groups were arranged to explore participants' views on the employment barriers and support needs of people living with psychosis. Each focus group comprised 3 to 10 participants belonging to a particular stakeholder group. It was considered that homogenous groups, consisting of people representing the same stakeholder group, would allow for more open and frank discussion on the topic (Krueger & Casey, 2009).

The focus groups were facilitated by an endorsed clinical psychologist. The role of the facilitator was to encourage discussion through the use of minimal encouragers, keep the discussion on track and exercise duty of care. Discussions were recorded using two high sensitivity digital voice recorders and later transcribed.

The questions posed in this study were of a general nature to reduce social acceptability bias and any need for participants to respond in a defensive manner (Kaye, Jans, & Jones,

2011). Bipolar disorder and schizophrenia were chosen as examples of psychotic conditions as it was considered that most participants would have some knowledge of these conditions. Focus groups were asked to respond to two main questions to elicit their views on the employment barriers and support needs:

1. We know that many people who have been diagnosed with schizophrenia or bipolar disorder would like to work in regular paid employment. We also know that the employment rate of people with these conditions is significantly lower than the general population. Why do you think this is the case?
2. What do you think would need to change in order to improve employment outcomes for people who have been diagnosed with schizophrenia or bipolar disorder?

The duration of focus groups was approximately one hour, with half the time allocated to each question.

Individual Interviews

A purposive sample of 31 individuals identified as belonging to each of the different stakeholder groups was recruited from the same geographical catchment area as the focus group participants. The sample included co-workers with experience working alongside a person diagnosed with a psychotic disorder. The following criteria guided recruitment:

- individuals representing demographic characteristics significantly different from those represented in focus groups
- individuals whose availability precluded participation in a focus group
- individuals identified as rich sources of data due to their life experiences (e.g., an employer who had considerable experience employing people diagnosed with a psychotic disorder)
- individuals having experiences different from the general trend (e.g., people with successful careers in spite of psychosis)
- individuals in positions that significantly influence the behaviour and perceptions of others.

The purpose of in-depth interviews was

- to expand the range of people represented in the study
- include exceptional cases in the sample such as people living with psychosis who have fared well in employment
- involve employers who have provided exceptional support
- capture new ideas not already captured in the focus groups
- expand and corroborate ideas expressed in the focus groups
- fill gaps in understanding and test emergent ideas and theory

Individual interviews were approximately one hour in duration and were conducted by the first author who is an endorsed clinical psychologist. All except two interviews, which were conducted via Skype and telephone interview, were conducted face-to-face. All interviews were audio-recorded using a high sensitivity digital voice recorder. Data-gathering continued until a point of saturation was reached, when no new ideas emerged.

Interviews were semi-structured individual interviews. Interviewees were asked to respond to the two main questions posed to the focus groups. In addition a set of questions was developed to tap into the specific interviewee's unique knowledge or experiences and further

explore ideas discussed in focus groups. For example, focus group discussions revealed a need to explore in further depth the effects of antipsychotic medication on work. A question was therefore included in the client semi-structured interview schedule, “Does medication affect your ability to work/study?” Previous research indicates that social security benefits may play an important role in work-related decisions, therefore an additional question was included for client interviewees, “Do social security benefits affect your decisions about work?”

A responsive interviewing style, as described by Rubin and Rubin (2005), was used to elicit relevant information regarding participants’ personal experiences. Spontaneous follow-up questions were asked as necessary to clarify issues raised by the interviewee. Probe questions were used to elicit in-depth information and keep the conversation targeted. An appreciative inquiry approach was used to explore key ingredients of successful work-related experiences (Reed, 2007). This approach poses questions which elicit positive stories. Clients with past work experience were therefore asked the additional question, “Describe the best work situation you have ever been in. Why was it so good? What personal qualities enabled you to achieve this success? What supports around you enabled you to experience success?” Employers were asked, “Have you had any experience in relation to employment of people with schizophrenia or bipolar disorder?,” “Do you have any positive experiences to share?,” “What values on your part enabled this outcome?,” and “Were there others involved in achieving this outcome?”

Data Analysis

Participant demographic data and transcripts of focus groups and interviews were imported into NVivo 10 software (QSR International, 2012). Attribute values (e.g., stakeholder group, age group, education, and occupation) were assigned to all participants to facilitate in-depth analyses (QSR International, 2012b). Transcripts were studied to identify ideas and concepts relevant to the research question. Thematic nodes were created and defined, and relevant sections of text coded to appropriate nodes (QSR International, 2012b). Initially, free nodes were used to store lower order themes. Nodes were progressively organised into a hierarchical structure comprising more general, higher order nodes (parent-nodes) and more specific sub-nodes (child-nodes; Bazeley, 2009). For example, a node named stigma formed a sub-node of the higher order node called interpersonal barriers. During the course of analysis nodes were reviewed and if necessary renamed, node definitions refined, nodes expanded or collapsed, and nodes re-arranged within the hierarchical structure. As the hierarchical node structure evolved, transcripts were revisited several times at different stages in the analysis process, and the contents of existing nodes reviewed to ensure all relevant references were captured in the most appropriate nodes. In-depth analysis consisted of interrogating the data with the use of analytic tools in NVivo 10 such as word search queries, word frequency queries, word trees, and coding queries (QSR International, 2012b). NVivo 10 software was used to generate visualisations of the results including charts and models. The final node hierarchy was used to identify the most frequently referenced employment barriers and support needs.

Rigor

Once the main barrier and support nodes had been identified and defined, academic supervisors were consulted and provided positive feedback on the face validity of the initial hierarchical coding structure. Two focus group participants were invited to code sections of the transcript of a focus group in which they had participated. Their coding was then compared with that of the researcher using the coding comparison query functionality in NVivo 10 (QSR International, 2012b). The results indicated a moderate level of agreement amongst the coders.

The purpose of this comparison was to check inter-coder reliability, but importantly also to assess the clarity of definitions of the emerging nodes and the independence of node categories.

Each transcript was reviewed multiple times at different stages of the project to ensure all references to employment barriers and support needs had been adequately captured and coded to the most appropriate node/s in the evolving node structure. Functionalities of NVivo 10, including word searches, word trees and coding queries, were used to interrogate the data and ensure that all relevant portions of text had been coded to the appropriate nodes (QSR International, 2012b). The use of NVivo 10 software created a searchable record and retrievable audit trail of coding decisions and analyses, thereby promoting transparency and strengthening the trustworthiness and credibility of the findings (Bazeley, 2013; Richards, 2005, Sincovics & Alfonso, 2012).

Several authors have highlighted the potential impacts of the researcher on participant responses in qualitative studies (Barbour & Kitzinger, 2001; Charmaz, 2006; Maxwell, 2005). In this study, the impact of the researcher on participant responses was minimised by maximising the role of participants, allowing groups and interviewees to self-direct the course of discussion as much as possible, and offering only minimal encouragers and prompts if required to remain on topic. It was clear from the amount of discussion and the frank comments provided by members of all stakeholder groups that the goals of the design to reduce defensiveness and social acceptability bias were achieved.

Researcher characteristics may also affect the interpretation of data in qualitative studies. Maxwell (2005) highlighted the importance of self-knowledge as a means to curb researcher bias and suggests that reflective self-analysis constitutes an important means to improve validity of interpretation. Personal reflection formed an important component of this study, with relevant self-observations recorded in the form of memos which were used as an aid to interpretation of the transcribed data.

Maxwell (2005) suggests that respondent validation is the single most important means to exclude misinterpretation of meaning and the perspectives of participants. The researcher presented the main findings of this study to one of the client focus groups, serving as a validity check. There was positive feedback from the group that the findings were consistent with their views on the subject. There were no findings that were disputed by these participants, who provided further corroborative evidence supporting the validity of the findings.

Results

The evolving node structure implied in the processes described above led in due course to the final (presented) node structure. We saw the final hierarchical node structure as providing a useful framework in terms of which to report the findings. Salient results are reported below and illustrated using NVivo models.

Employment Barriers

The main employment barrier themes were broadly categorised as individual, interpersonal, and systemic factors. Individual barriers included references to personal attributes, impacts of the psychotic condition on the individual, and personal circumstances. Interpersonal barriers were defined as factors inherent in interpersonal interactions. Interpersonal factors included references to attitudes, perceptions, beliefs, expectations, emotional reactions, and behaviours pertaining to the employment of people living with psychosis. It included references to knowledge and understanding, stigma and discrimination, workplace management issues, and communication and collaboration. Systemic barriers were conceptualized as broader social issues which impact an individual's ability to find and sustain

employment. Systemic barriers included economic conditions, government policy, ideological factors, and legal issues. As shown in Figure 2, interpersonal barriers were the most frequently referenced barrier in this study.

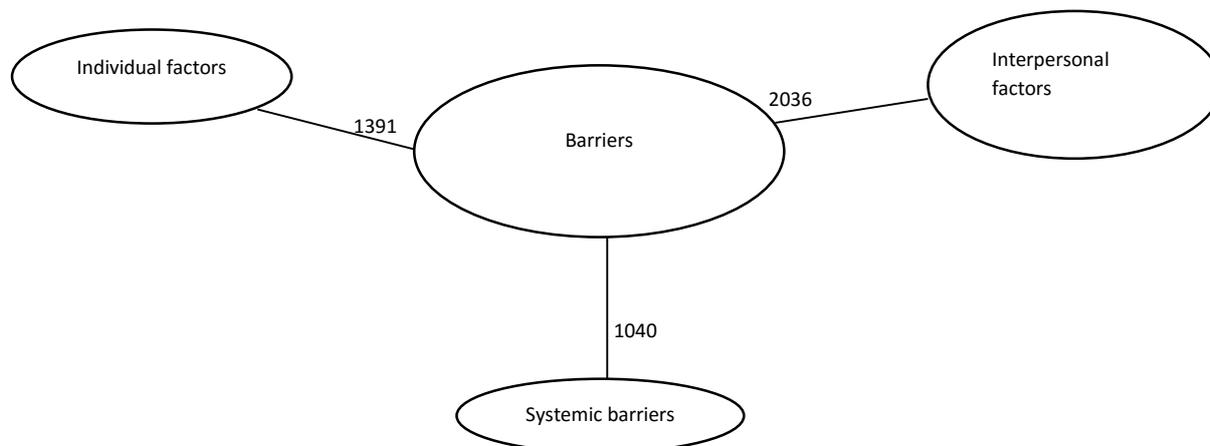


Figure 2. Frequency of references to each of the main barriers to employment

Interpersonal factors. The most frequently referenced interpersonal barriers were stigma (1217 references), discrimination (376 references), lack of knowledge and understanding (359 references), workplace management issue (73 references), and lack of communication and collaboration (20 references). The sum of interpersonal references (2036) exceeds the sum of the references cited in text as some references were coded to the parent node only (interpersonal factors). In relation to stigma one participant commented, “I think the employers, if they knew that one of their prospective employees was going to have a severe mental illness, then stigma would prevent them from gaining that job.” A case manager pointed out that some jobseekers, in an effort to avoid stigma, seek work independently without accessing government funded employment support programs:

...a lot of people want to return to the workplace but they want to do it on their own because they don't want to be labelled with a mental illness going into the workplace. They believe there's that stigma still there so they'll attempt themselves and probably do quite a poor job of trying to get back in the workplace.

Some references reflected internalisation of societal stigma. For example, a peer support worker observed:

... they're afraid of that rejection...if someone knows that person's got schizophrenia then the other people in the workplace are gonna be scared of them, don't want them there...and that is a real thing that still a lot of people don't want those type of people around....so people just think, well, it's easier to stick with staying home or hanging out with friends who also have schizophrenia....

Individual factors. Individual barriers were broadly categorised as impacts of the condition, personal attributes, and personal circumstances. Interestingly, although participants acknowledged the impacts of the condition itself and its treatment on employability this was not the most frequently referenced barrier to employment. Indeed, some client participants

explicitly denied the condition itself was responsible for their employment difficulties. A participant with bipolar disorder in full-time employment said, “I’m still capable of working...there might be something wrong with my mind but there’s nothing wrong with my body so I’m still capable of working.” A participant diagnosed with schizophrenia said, “as long as I’m fit I can pick up timber posts and that with my hand. I’m pretty fit. If you put a bloke out on a property, on a station, there’s farm work. You can pick up timber posts and there’s good money in it.” Another client with schizophrenia said, “My condition definitely hasn’t affected my [ability to work], it’s just my income barriers [social security assets test] that have affected my motivation to do any work, not my condition.”

The most frequently referenced individual barriers were personal attributes (650 references), impacts of the condition (630 references), and personal circumstances (123 references). Personal attributes most referenced as potential barriers to work were motivation, self-management, and self-concept issues. The primary impacts of the condition most frequently identified as barriers to employment were the episodic nature of these conditions, difficulties with social interaction, mood disturbance, and cognitive impacts. Secondary impacts included side-effects of treatment, impact of co-morbidities, effects of stigma on self-confidence, and career disruption. Personal circumstances deemed important barriers to employment included lack of suitable accommodation and lack of family and social supports. An employment consultant remarked,

I think family members can hold people back...like family members who just feel that they don’t have ability to work or aren’t encouraging enough, don’t know how to encourage in the right areas, or aren’t aware of the comments they make. We can have a client we are working with really well and getting motivation but they go home and ask how the meeting’s gone with us and they [can] unravel all that and it can set them back.

Lack of access to public transport was also identified as a potential barrier to employment. A young man with bipolar disorder remarked,

I was doing a [trade] job last year and I had to be at work at 4:30 in the morning and I had to ride my bike from the other side of the xxx down to xxx and I did that for a little bit and then I just threw in the job.

Systemic factors. The most frequently referenced systemic barriers were government policy (675 references), ideological factors (154 references), economic imperatives (142 references), and legal issues (96 references). Ideological factors included references to influences that shape public consciousness regarding employability of people with mental health conditions. It captures references to historical precedents, the role of language, shared beliefs, and media images which perpetuate the status quo. Government policy barriers included references to mental health services (198 references), employment policy (194 references), and social security policy (140 references). An occupational therapist reflected on the role of clinicians in shaping expectations about work:

I don’t know that we give them [consumers] too much hope that they actually *can* work despite those things. I don’t know that that message really gets to them because I think that’s the first hurdle is them believing that they actually can work despite all those things that they are suffering from which are really serious and very, very hard to deal with... (Occupational Therapist).

Aspects of employment policy most frequently referenced were employment services and particularly the efficacy of support provided by employment service providers:

I mean a lot of them, where the patient seems to be on the books, nothing happens for a long time...and then we had some feedback that they [employment service provider] say I don't *have* to work. It seems to be they go and see the employment agency but nothing really comes of it... (Psychiatrist).

You go along there and they always say, "You're not work ready"...this was happening to me all the time. I was going to a place [employment service], they'd keep saying to me, "You're not work ready. Let's change your resume." They kept getting me to do better and better resumes...but the resumes were of a very high standard. And I was saying "*Not work-ready?* Don't you realise that I'm over fifty? I've worked in jobs. Don't you understand that?and when I've worked I've never had problems" (Client with Schizophrenia).

In terms of social security policy, benefits were the most frequently referenced barrier. Participants recognised the importance of social security payments for supporting vulnerable people, however they also commented on the "fine line" between benefits becoming a barrier to employment. The main issues were insufficient incentive for people on social security payments to work, and disincentives such as deductions from payments and loss of entitlements on commencing work.

Employment Support Needs

Support needs identified by participants could be broadly conceptualised in terms of improved employment assistance, culture change, and systemic change. Employment assistance included references to the need for improved employment assistance for people living with psychosis. Culture change incorporated references to the need for improved awareness and positive social attitudes and behaviour towards people living with psychosis. Systemic changes included references to the need for social and government action to improve awareness and promote equal access to sustainable employment for people living with psychosis. It captured references to government policy, legislation, the media, the role of non-government organisations, and research. As shown in Figure 3, employment assistance was the most commonly cited support need (960 references) followed by culture change (597 references) and systemic changes (501 references).

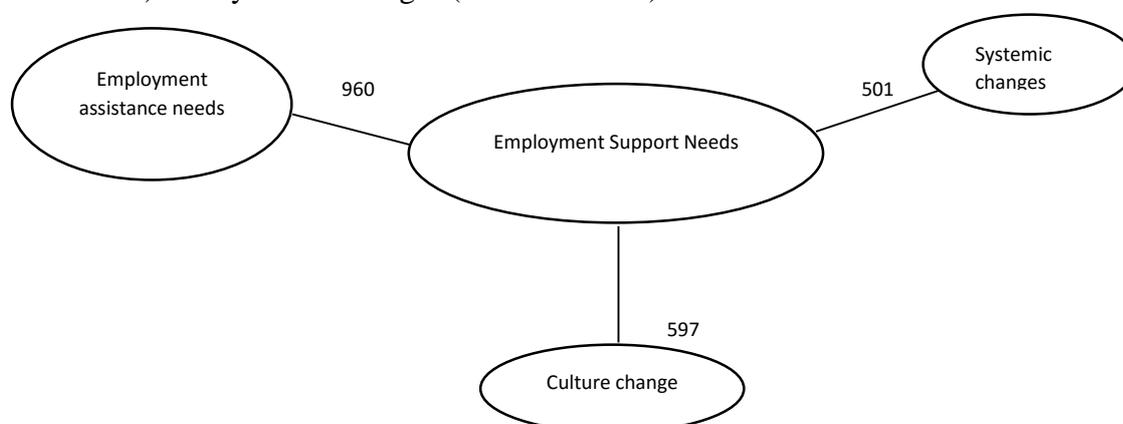


Figure 3. Frequency of references to employment support needs.

Employment assistance needs. The most frequently referenced employment assistance needs were for improvements in the areas of employment services (366 references), workplace support (247 references), self-management skills (172 references), employment support personnel (82 references), and employer needs (78 references). The most commonly referenced employment service need was for job-seeking assistance (130 references). An employment consultant highlighted the need to focus on abilities: "...we're always looking at their weaknesses. We need to look at their strengths." A peer support worker commented:

I think that pretty much they're all capable of working. It just depends on getting the right job at the right hours...it's just about making a good fit between that person and the actual occupation they're going to have.

A client with schizophrenia poignantly stated:

...you got to get a *go* man, you've got to get an employer to give you a *go*. Throw the resume away. Give a bloke a fair go. You don't need to check up on people all the time. Resumes, certificates all this stuff...give a bloke a fair go.

Culture change. The most frequently referenced culture change needs were for more awareness (270 references) and change in societal attitudes and reactions towards people living with psychosis (241 references). A carer remarked:

For me I'd like to see more tolerance of all levels of people but tolerant in every aspect so people can get on with their lives, be productive. We need more productive people in community, we need to turn this economy around, we need to be pulling on board people and be tolerant of their levels of ability.

A carer maintained there is a need for serious mental illness to be accepted and managed on the same level as any other life-threatening illness. Another carer commented on a need "to make the outside people see the person, not their disability, to love the person for who they are and give them respect."

The need for public education (117 references) and more desirable attitudes (102 references) were also major foci of discussion. The media was recognised as an important vehicle for changing public perceptions and attitudes: "I think the biggest issue is the news... how [are] community people...going to help unless they are aware and know they need to change?" (Community Member).

We need to encourage our reporters, our journalists, our media people to look more positively and see how they can promote good mental health (Community Member).

I know this might sound controversial but have TV shows and things like that, or have them integrated into your media...and not portray them as sick people. Portray them as capable individuals that can do work and who can have a normal life, because I think TV is the quickest and easiest way...to [influence] people (Community Member).

There was also wide-spread endorsement of the need for more mental health education in schools. Participants suggested community education needs to commence much earlier, in

schools, to encourage children from an early age to be more understanding and accepting of people with mental health conditions, overcome fear and reduce stigma. Improving employer awareness and management skills were also identified as important areas to address. It was suggested that education should equip employers with skills to manage employees living with psychosis so they can mitigate against any risks and be aware of necessary workplace accommodations, work capacity issues, and stressors to avoid. A community member remarked that “if a situation was to develop, it would only be fair that they [employers] knew what to do or how to handle it.” The need to address employment discrimination was frequently identified:

I just think they [the community] need to stop discriminating against people [living with psychosis] and it’s really unfair the way they’re treating people and really shutting them out from opportunities to earn money, make friends, have some sort of status in society.... (Peer Support Worker).

Systemic change. The main systemic change needs identified related to government policy (421 references). Government policy changes most frequently suggested pertained to mental health policy (145 references), employment policy (120 references), the need for more integrated support (36 references), education policy (35 references) and social security policy (22 references). In relation to mental health policy there was a call for a more positive, optimistic, and recovery-orientated approach with a proactive focus on re-integration into the community:

...you would hope if we were in that future point that it wouldn’t be such a reactive area of care...it would be perhaps a bit more proactive in terms of caring for someone and then integrating them back into the community, as opposed to just caring for them in isolation and out of the community (Community Member).

Carers felt proactive planning needs to occur from the time of diagnosis in order to provide hope and a pathway to recovery:

You have a recovery package straight up front. This is what we need to do to get you back on track and to get you back out into the lifestyle, and there is light at the end of the tunnel. It’s not like, “Sorry about that mate, there’s no hope, you’ll have this forever and, you know, see you later (Carer).

Another carer commented on a need to focus more on flourishing, “...the health system very much thinking how do we get these people to flourish not [just] how do we treat them.”

In relation to employment policy, participants identified the need for appropriate job-seeking support:

I think the government needs to educate the employment agencies in the fact that it’s not a numbers game. Some [jobseekers] do need that extra care and if you give them that extra care they could stay in that job longer because it’s something they do want to do (Ex-employment Service Provider).

Participants also identified the need for employer incentives, mindful workplace management practices, and post-placement support.

... from a business point of view, if I was to go and employ someone with a mental disability over somebody without a mental disability, there'd have to be something in it for me. I'd want something like a tax break or some incentive for the company (Small Business Owner).

Discussion

Through capturing the views of a wide range of stakeholders this study highlighted the wide-ranging employment barriers and support needs of people living with psychosis. The study confirmed many barriers identified in previous research (Bassett, Lloyd, & Bassett, 2001; Blitz & Mechanic, 2006; Bond, Drake, & Becker, 2008; Olney & Lyle, 2011; Peckham & Muller, 2000; Rose et al., 1993; Rosenheck et al., 2006; Schulze & Angermeyer, 2003; Waghorn, 2011). Somewhat surprisingly the most frequently referenced barriers were non-clinical in nature. Although participants affirmed that psychotic disorders have serious symptoms which may disrupt working life, the most frequently identified barriers were interpersonal in nature, notably stigma and discrimination. Importantly, this study provides empirical support for the major role of stigma as a barrier to employment of people living with psychosis. Important systemic factors were also highlighted including deterrents and disincentives to work.

The study identified diverse employment support needs, indicating that a broad-ranging approach is needed to address the large-scale unemployment of people living with psychosis. These changes extend beyond clinical treatment and require collaboration across clinical and non-clinical sectors. While adequate clinical management of psychosis is essential, the findings of this study suggest that to promote vocational recovery a collaborative recovery-oriented approach is needed across multiple sectors. This finding supports the effectiveness of co-ordinated and collaborative approaches to mental health care (Rosenberg & Hickie, 2013).

The most frequently expressed employment support need was for improved employment assistance for people living with psychosis, including appropriate workplace support. This finding supports calls over the past 20 years to improve the quality and efficacy of employment services for people living with psychotic disorders (Rose et al., 1993; Waghorn, 2011).

In addition to the provision of evidence-based employment assistance this study highlights the need to address public stigma, implement recovery-oriented mental health services, provide suitable employment opportunities, improve management training in relation to recruitment and employee support processes, and increase incentives and remove disincentives to work.

Limitations of Study

Although this qualitative study is comparatively large, the sample is purposive rather than randomly selected, therefore further research is needed to generalise the findings. The sample was drawn from metropolitan and regional areas and excluded people living in remote areas where the employment barriers and support needs may differ. A measure of bias may have been introduced due to participants being volunteers whose median age and education were higher than the general population studied (Australian Bureau of Statistics, 2011). This study included relatively few participants with low level educational attainment and in blue collar jobs. Only 8% of the sample consisted of employers. Also, the fact that a particular barrier or support need was referenced less frequently than another, does not necessarily imply that it is less important. For example, only one respondent articulated the need for more research to find effective medications to treat psychotic disorders. Infrequent responses may

also represent valuable insights arising from individuals' unique life experiences. For example, an employer with extensive positive experience employing people with schizophrenia felt that industry workshops would provide the best means to change employer attitudes, while a businessman with experience as a patient advocate recommended online mental health education programs in all workplaces.

Further Research

Further research is needed to corroborate the relative importance of the various employment barriers and support needs identified in this study. Further studies in this area would help elucidate the complex and interactive nature of obstacles faced by individuals living with psychosis who wish to achieve a working life. Research efforts should also focus on investigating the feasibility and effectiveness of measures to overcome employment barriers identified in this study. Several important research questions have received little attention to date. Further studies are needed to examine the relationship between employment status and relapse rates in psychosis and identify factors that mediate this relationship. In particular there is a need to identify workplace factors that may influence employment outcomes among people living with psychosis. Studies of individuals living with psychosis who have successfully recovered a working life might help to elucidate such factors. Empirical studies are also needed to investigate the effectiveness of clinical and non-clinical interventions to improve employment rates among people living with psychosis. Future research investigating attitudes towards employment of people with psychosis should include a more representative sample in terms of education, occupation, and socio-economic status. Future studies should also incorporate a broader range of employers.

Conclusion

It is often assumed that the psychotic condition itself constitutes the main barrier to employment. This study provided evidence to support the view that the most commonly identified barriers are non-clinical in nature, notably stigma and discrimination. The study highlights the many challenges facing governments seeking to support people with psychotic disorders to live a contributing life. These findings indicate that any effort to improve economic participation of people living with psychosis must extend beyond a focus on the individual, to include changing discriminatory attitudes, providing more effective jobseeking and employment support, improving employment opportunities, and creating more work incentives for people receiving social security benefits.

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