Workers’ perspectives on self-directing mainstream return to work following acute mental illness: Reflections on partnerships

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Abstract. Objective: To examine barriers and facilitators influencing self-direction of return to mainstream work following acute mental illness.

Participants: Five individuals who had attempted return to mainstream work following acute mental illness.

Methods: In depth, semi-structured qualitative interviews with the five participants selected through purposive sampling.

Results: The three main themes related to the workers’ self-direction of their return to work experience were (a) worker self-management, (b) workers’ ‘personal’ partnerships and (c) workplace partnerships.

Conclusion: Personal and workplace partnerships are integral to supporting workers as they take ownership of their full potential and self-direct return to mainstream work.

Keywords: Mental illness, return to work, self-direction, partnerships

1. Introduction

The incidence of mental illness in the workplace is expected to become the leading cause of work disability in the world by 2020 [32]. In Canada, this trend has prompted concerns about the human and economic costs of increasing levels of mental illness [5], and productivity losses related to mental illness are estimated to be about $17.7 billion annually [21]. Although reducing costs may be desirable, workers returning to work following acute mental illness face complex challenges both in terms of personal recovery and in regaining competence at work [4]. Inherent challenges are etched with growing expectations of worker self-responsibility which are reflected in the shifting mental health paradigms toward self-empowerment and recovery rather than symptom management [2, 23]. The nature of partnerships between workers and providers of vocational services are also changing [6]. Collectively, these trends represent a progression toward more self-direction in the return-to-work (RTW) process by recovering workers as they take on a leading role in making decisions, setting goals, and managing the steps in the service process.

Still, theoretical underpinnings of client self-direction are in their infancy. Programs addressing the self-management of chronic conditions including depression provide some insight into the activities that an individual must undertake in order to self-direct recov-
ery [28,29]. These include the means to access needed resources, carry out medically related behaviors, enhance self-efficacy in engaging in needed behaviors, and ensure proficiency in problem solving [1]. Bandura [3] elaborated on the integral role of self-efficacy in driving self-management, citing the need for consideration of the individual’s perception of the potential gap between abilities and expectations and the need to assure a best fit between the two. This reinforces the need for an individualized approach to the factors impacting an individual’s ability to engage in a self-directed process in an efficacious manner. Unfortunately, research and specific approaches to self-direction are noticeably lacking in the literature.

Most studies of self-direction and RTW following acute mental illness address employer and management perspectives rather than those of the worker. Dominance of the medical model and difficulties attaining a clear picture of worker-perceived barriers and facilitators to self-directing RTW may be contributing factors [4]. Based on a systematic review of effective workplace practices in RTW that included worker perspectives [14] seven principles for successful RTW have been identified. These included the workplaces’ commitment to health and safety, availability of modified work, modification without disadvantage to others, training of supervisors, early and considerate contact with the worker, the existence of a RTW coordinator and employee consented communication between the health care providers and the employer regarding workplace demands. However, none of the studies in the systematic reviews included workers who were consumers of mental health services.

While the viewpoint of people with mental illness is a missing piece of the puzzle, a few studies have delved into workplace interventions found to influence RTW outcomes positively for workers with mental illness [13,19]. Krupa [19] identified employment interventions that improved employment outcomes for all workers with mental illness which included (a) early identification of mental illness and diagnosis, (b) treatment and access to evidence-based psychological treatments such as cognitive therapy, (c) client-centered assessment and planning, (d) coping skills training including disclosure management, work hardening, reasonable job accommodations, and (e) social network development. The existing disconnects between the myriad of workplace interventions available and corresponding utilization by professionals and workers were also noted.

Additional studies that address the personal skills and characteristics required to self-navigate while partnering with all stakeholders provide evidence that perspectives of those with mental illness are beginning to be addressed more closely in the literature [17,27]. Krupa et al. [20] examined the influence of stigma in the domain of employment and identified the complexities of managing disclosure of mental health issues. Kirsh [17] investigated personal empowerment skills and environmental supports and identified three themes in the data that influenced the process of work integration from a consumer perspective, (1) work as meaningful to consumers, (2) the impact of the workplace milieu on job satisfaction and tenure, and (3) the importance of communicative supervisor and co-worker relationships. Co-worker and manager relationships with the worker were noted to impact worker self-esteem and quality of work life. In some cases, ability to maintain the job was a testament of the value of partnerships in the workplace. Workers faced difficulties disclosing information related to health, and requesting needed accommodations, and their decision making was influenced by the workplace climate.

Studies based in a supported employment setting provide the closest parallel examination of self-direction itself. Shaw and colleagues investigated worker self-direction in vocational rehabilitation settings [25–27] and suggested that a complex array of factors impacts both consumers and their vocational rehabilitation providers. Facilitators to self-direction included the external support system, and positive consumer and provider factors, while barriers included bureaucracy, accessing and acquiring resources, service provider actions, personal limitations and barriers related to the disability [27]. The lack of participants with distinct mental health issues, the differences in setting, and the focus on finding work rather than returning to work may limit the application of these findings to workers in mainstream environments.

The importance of multi-stakeholder collaborations or partnerships in successful self-direction is underscored [12], as is the need for effective communication among the stakeholders at all levels including individual, group and organizational interactions [9,13]. While collaborations are crucial, the diverse and sometimes conflicting paradigms of the potential stakeholders compound worker challenges in the RTW process. For example, the business paradigm of the employer, the health promotion perspective of the provider, and the cost of care focus of the insurer can interact to create formidable pathways for the worker to navigate. Shaw and Polatajko [24] examined critical collaborations in the RTW process. Building on the Occupation Compe-
tence Model (OCM) [22] they developed an organizational framework of the complex issues related to worker competence. The framework enables the characteristics contributing to a work disability to be categorized and used to inform strategies for successful RTW. Subsequently, Hatchard [15] utilized the OCM to inform the development of a user-friendly process to guide stakeholders in supporting worker self-navigation.

The scant research on self-direction in RTW following acute mental illness in a mainstream work environment prompted this research. Cohesive collaborations and partnerships among multiple stakeholders are indicated, but the means to organize and execute these in order to optimize self-direction on the part of the returning worker is not clear. More information on the consumer perspective of barriers and facilitators to self-directing RTW would help all stakeholders create more effective partnerships with workers. The objective of this pilot study was to examine the barriers and facilitators impacting self-direction in return to work for individuals following acute mental illness.

2. Method

2.1. Design

This research project utilized qualitative methodology to enable the researchers to describe and seek to understand how study participants experienced their return to mainstream work following acute mental illness. Use of such methodology enables each participant to be “viewed as if with a wide-angled lens, enabling a deeper understanding of the interrelationships between them and their complex social and physical environments” [30, pp. 5–6]. Within this paradigm an interpretative, phenomenological approach was chosen because it “acknowledges that a person’s ‘life world’ is a social, cultural and historical product, as well as a pole of individual subjectivity” [11, p. 720].

2.2. Participant sampling

This research was conducted in partnership with a private psychiatry practice in British Columbia, Canada. The practice has a combined focus on individual intervention and psychiatric research and their clientele frequently undertake the challenge of mainstream work. Individuals between the ages of eighteen and sixty-five who had experienced acute mental illness that had resulted in time off work and had attempted a RTW in a mainstream workplace were considered. Those who had experienced mental illness secondary to a physical illness, or exhibited a thought disorder or personality disorder were excluded as these variables were seen as potentially creating unique RTW issues.

The psychiatry practice’s administrative assistant distributed the recruitment package to all potential participants in the practice after ethics approval was received from the University of British Columbia Behavioural Research Ethics Board. Participants in the study were fully apprised of the methods, aims, risks, benefits, and limitations of the study and provided written consent.

Once underway in selecting participants from the consenting respondents, we followed a process of choosing subsequent participants who could best speak to the emerging codes and categories. As Fossey et al. [11] point out qualitative sampling requires the selection of those who can “best inform the study” (p. 726). Sampling and data analysis occurred concurrently as described by Coyne [10].

The final research participants included four females and one male ranging in age from thirty-five to sixty-two. One of the participants had a diagnosis of bipolar mood disorder, two had recurrent depression, one had recurrent depression and post-traumatic stress disorder (PTSD) and one had a single episode depression and PTSD.

They included a health care professional, a financial sector employee, two health and human services workers and a government sector employee. Three were union employees while two did not belong to unions and time off work ranged from 3 to 24 months. Four participants had returned to their previous jobs when interviewed. One participant discussed returning to a former job, but at the time of the interview was off work and contemplating long term disability. Two people had had one previous RTW following mental illness; three had not experienced RTW previously. None of the participants had involvement with vocational rehabilitation providers.

2.3. Data collection

In-depth, semi-structured interviews with the five participants were conducted by the first researcher. One participant was interviewed twice. This participant had provided one of the first interviews in the study. Because the participant was a particularly good informant, demonstrating self-awareness and having reflected upon and integrated the personal journey, we returned
to this person to do a formal member check of data, and to obtain further description to illuminate and refine themes near the end of the study. Each interview was approximately 90 minutes and was audiotaped, later transcribed verbatim then analyzed. In order to promote consistency, a working definition of the term ‘self-direction’ was explained verbally to each participant at the start of the interview. Self-direction was described as participating in planning the RTW, in accessing needed resources and in following through with needed actions not referring to working in isolation as the term might imply. The initial interview questions are shown in Table 1. Probing questions were guided by the literature and the interviewer’s experience and explored personal strategies used by participants in their RTW, as well as their perceptions of workplace and societal factors impacting their ability to self-direct the RTW process. Interview questions were expanded and refined and new questions added to explore areas of interest in greater detail subsequent to each interview.

2.4. Data analysis

Data analysis began after the first interview to facilitate exploration of emerging ideas as the interviews progressed [11]. It involved line by line coding of interview transcripts using constant comparative methods. This process involved identifying similarities and differences across data which allowed the researchers to make analytical distinctions [8]. The participants’ perspectives on issues relating to worker self-direction of RTW following acute mental illness were identified. Open coding [7] was used to address initial data and established units of meaning which closely described the data at hand. For example, actions and events in the data were defined using the participants’ own words. Higher level categories were created by grouping initial codes together according to similarities. Common categories were grouped together to form themes based on analytic decisions made by the researcher. During the data analysis process, categories progressed from initial codes which were more concrete to themes which became more abstract. Categories having little support were eliminated. Memo writing [8] was used throughout the process to analyze ideas about codes, categories and themes. Diagramming [8] was also used to examine data through visual representations of categories and themes and their connections.

2.5. Ensuring qualitative rigor

The credibility of the study was supported through (a) audiotaping and verbatim transcription of the interview data, (b) provision of direct quotes from the subjects, (c) the use of field notes to record researcher observations, (d) source triangulation from five subjects (including transcripts, field notes, analytical memos, and diagrams), (e) formal member checking of the findings with two participants, (f) peer review by the university program faculty and peers at the stages of project development and defense of findings, and (g) review of the data collection and analysis by the project supervisor (second author). The dependability of the study was supported through use of an analytic diary to provide an audit trail. Raw data, field notes and the analysis are available for confirmability of results.

Principles of reflexivity [30] were used to promote clarity of the researchers’ position. The first author’s positionality was based on fifteen years’ experience as an occupational therapist in mental health settings. This included two years in a private practice involved in return to work intervention. She has also personally experienced RTW following acute mental illness on two occasions. Personal perspective was further developed through involvement in related qualitative research projects [15,16]. The second and third authors had clinical occupational therapy experience in mental health and experience in qualitative research. They were able to bring a perspective that was more removed and based on clinical and research orientations. The

| Table 1
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<thead>
<tr>
<th>Semi-Structured Interview Guide: Sample Questions (Barriers and Facilitators)</th>
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<tr>
<td>1. How was your experience with your recent challenge of return to work?</td>
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<tr>
<td>Probes: What were the greatest challenges?</td>
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<tr>
<td>What parts (if any) did you find easy or straightforward?</td>
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<tr>
<td>2. Were there any things (routines) at home or at work that affected your success in returning to work?</td>
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<tr>
<td>Probes: Were there any things you did at home to make the transition easier?</td>
</tr>
<tr>
<td>What were some things you did at work to make the transition easier?</td>
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<tr>
<td>Did you have any difficulties in making your needs known during these stages?</td>
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<tr>
<td>At home? At work?</td>
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<tr>
<td>Are there aspects of your work activities that have made your return to work difficult?</td>
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<tr>
<td>Any other ideas of things that might have been helpful?</td>
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first author’s closeness in positionality aided the researcher through her understanding of the system and her empathy with the participants’ experiences. She acknowledged assumptions at the outset of the study arising from awareness of existing models of RTW and also from perceived personal benefits of education in managing RTW. These assumptions were countered through use of field notes, member checking and review by the second author. A broad based perspective resulted and therefore the researcher’s positionality is viewed as positively influencing the trustworthiness of the results of the study.

3. Findings and interpretations

The three themes identified relating to the participants’ experiences of self-directing their RTW were worker self-management, the worker’s personal partnerships, and workplace partnerships.

3.1. The worker: Managing self

Participants described qualities that they viewed as important in facing the challenges of RTW. Many of these qualities focused on behaviors related to self-management of mental health. These included cognitively processing information, exploring implications and purposefully executing needed actions to improve lifestyle and health. Participants described self-management strategies and their limitations.

3.1.1. Self-acceptance

Participants discussed a tendency to strive for self-awareness, illness awareness and understanding of needs through self-reflection. They perceived progression toward self-awareness to be challenging:

“Well, accepting that you’re not well is really, really hard and I go through this every once in a while. I realize I’m not well and I can’t do everything that I used to do. When you accept that, life is so much easier.”

Strategies to enhance self-awareness were noted. For example, self-reflection was seen as a useful strategy. “I talked about how I felt [in the journal] and then I talked about my positives”... as was openness to considering the advice of others, “you shouldn’t be doing work on your own time”. Strategies to promote self-awareness also promoted self-acceptance.

Accessing personal strength was integral to managing RTW for participants. All subjects expressed motivation to return to work, often tempered with caution. For example, one participant stated “I was really itching to go back, but I didn’t want to go back too quickly and not be ready.” Two participants indicated a conscious adjustment toward a more positive outlook, “I just wanted to go back with a better attitude”. Others noted that personal strength was used to reconnect with co-workers “I went in a few days ahead and said hi to everybody... That was what I needed to do.” In acknowledging the onus of responsibility required to progress with RTW, the participants accepted the need to draw upon personal strength, adjust attitudes as needed and reconnect with co-workers. Participants felt that self-acceptance aided in these efforts.

Self-acceptance for participants was not always easy. They frequently cited personal barriers to moving forward included the experience of disempowerment and of lowered self-esteem. Four participants described experiencing self-doubt and concern about work performance during the early parts of RTW. Acceptance of these uncertainties helped in putting the early days of RTW in perspective: “After having a mental illness it was daunting to go back to a job, even a job I’ve done for 10 years and know well... I felt a little bit like a deer in the headlights.” Some subjects were sensitive to the reactions of others to their return: “How are they going to think of me and are they going to look at me different?”

Participants described the need to take assertive action to move forward despite these barriers. This underscored the inherent strength required to be successful: “I have come so far and I think I’m handling myself better...I’m outwardly projecting that I’m good and I’m strong... sometimes I just get frustrated...whether that’s coping with it or not, I’m not sure, I think to a certain extent it is.” Participants noted that taking assertive action included addressing the issues of disclosure of mental illness in the workplace. Several indicated openness toward disclosing. While decisions regarding disclosure varied, participants felt that self-directing related choices and actions was empowering.

3.1.2. Managing lifestyle and health

Participants described part of ‘managing self’ as ‘managing lifestyle and health’. They noted that lifestyle factors contributed to their physical and mental health prior to going on leave from work: “You’re running here and running there and trying to get to work...you’re just getting overwhelmed with everything.” Participants recognized that if lifestyle factors
3.2. The worker’s personal partnerships: aging the self and to enhancing self-direction during lifestyle and health as contributing positively to man-to work]. Participants saw conscious management of regimes was cited as key to regaining health and sustaining a level of wellness required to work. One participant stated that “I honestly think that the medication helped me get to the point where [I could return to work]”. Participants saw conscious management of lifestyle and health as contributing positively to managing the self and to enhancing self-direction during RTW.

3.2. Relationships form the foundation of their RTW.

The second theme that emerged related to participants’ personal partnerships, or those individuals outside the workplace who influenced the participant’s recovery and/or RTW. While a strong support system was described as key to successful RTW, participants soundly noted instances when the realities of life rocked their support system and challenged the security of their RTW.

3.2.1. Relationships form the foundation

Participants expressed gratitude when describing the importance of encouragement from family members, significant others and their psychiatrist in recovering health, returning to work and monitoring ongoing stressors. One stated: “She [wife] was always organizing me here and there. A lot of the time, I was just staring out the window. She’d try to get me motivated.” One participant simply stated “my family has been amazing” and another “[my friend] got me through one of my depressions. She talked to me... every single night.”

Participants described guidance by the psychiatrist as key in supporting self-direction in RTW. None of the participants was receiving the services of rehabilitation professional. All described their psychiatrist’s services as extending beyond medical intervention. Such involvement included guiding RTW plans and discussing work stressors: “We were talking about people at work and their attitudes toward things and how they treated you. He tried to point out the importance of being up front with them, discuss what’s bothering you.” Assisting with family stressors was also common: “Marital relations... that was affected quite a bit so we talked about that also.” One participant described a key contribution of the psychiatrist as intervening during difficulties with an insurance company: “When you’re in this fog at first, it’s hard to keep all that straight... psychiatrist was good at helping me do the forms in a timely manner.” Participants expressed that the psychiatrist provided a level of expertise that assisted them in regaining the foothold required to self-navigate.

3.2.2. Realities challenge personal partnerships

While a positive external support system was seen as key to successful RTW, participants acknowledged that the realities of their life situation external to the workplace sometimes weakened their base of support. The challenge of coordinating work schedules with family life was a common experience for participants. They also noted the challenges of parenting and home management responsibilities: “Schedule. yeah, it’s tricky to maintain that... you don’t see your kids for three or four days at a time” [and] “When they’re [children] at school, I’m home... when I come back they’re sleeping”.

Participants presented the necessity of caring for family members and extended family during periods of illness as creating a tipping point between managing work and not managing work. One participant stated: “Actually, it was, my husband was going through a hard time and so that put me more stress at work.” Another described the cumulative impact of long term caregiving: “Once she [wife] started getting better, that’s when I let my guard down. It was a lot of stress.” At times, decisions about when to RTW were based on the demands of supporting the family and not on optimal timing for RTW related to health status: “I had to be strong mentally and physically so I just challenged myself.” “It’s like we ‘have’ to do this, I ‘have’ to do this... I wasn’t ready for work, this month, no.” “I have to... because of money.” The realities of participants’ lives outside the workplace sometimes eroded their feelings of having a strong base of support. Family stresses at times impacted participants’ illness and made contemplation of RTW unfeasible. One participant stated “This is the worst thing... to live like someone’s keeping you [in] depression.” At times the weightiness and immediacy of such realities discouraged workers in their self-direction of RTW.
3.3. Workplace partnerships: Relationships and demands

The complexities of relationships involving both workplace leadership and co-workers influenced self-direction in the RTW process for participants. They saw the levels of support from managers and co-workers as key factors to their success. They also noted that perceived lack of support, criticism or conflict influenced their ability to manage workplace demands and self-direct the RTW process. Participants discussed the availability and utility of workplace accommodations as well as factors relating to the real demands inherent in the mainstream workplace.

3.3.1. Workplace leadership

Managers displayed varying levels of support and awareness of mental health issues, according to participants. They saw the manager relationship as a key influence on their ability to successfully self-direct their RTW – an influence which could be positive or negative.

One participant described the manager relationship as making the difference between returning and not returning to work: “If [return] would have just tumbled down... I wouldn’t be there right now, and I’d be gone.” Participants consistently described support from management as important to promoting self-direction in the RTW process: “[working full time hours] wasn’t that hard for me once I knew what the reaction of my manager would be. I guess [knowing manager’s reaction] was the biggest thing so once I got there it wasn’t hard at all.” Participants described attitudes of effective managers, for example: “tolerance, respect, the fact that mental illness doesn’t mean you’re stupid or you’re lazy of that you can’t do the job as effectively as you do... that you’re not crazy.”

Teamwork and communication with management promoted self-direction and successful RTW according to participants. “If I found I was getting overwhelmed, I would know to go to my manager or to one of the other girls and ask for help... we’ve had meetings... we’ve talked about it... we have to be a team player.” The manager was seen as a direct support, but also as key to fostering foundations within the workplace on an ongoing basis: “I can see other places where there wasn’t this kind of team work, where there be a certain amount of dissention... Definitely if that was going on, that would be a major source of stress.”

Criticism and lack of support from managers or employers had a powerful effect on participants’ ability to sustain a RTW. “Then [after two weeks of graduated RTW] I got a call at home from the manager saying that my orientation was over... I think that [shortening orientation] came from other staff who started to resent... you know, she’s working.” Participants viewed such lack of support as impacting their confidence to move forward with the RTW: “... after being berated so much in those meetings [with manager about performance], I could see how I was slipping in self-esteem.” While some sought assistance with perceived injustices from a union, the impact of this resource was not conclusive. While participants described unsupportive management as a threat to RTW success, many participants shared positive experiences with management and RTW.

3.3.2. The power of co-workers

All participants described the support of their co-workers as a factor that assisted them in returning to their former workplace. Co-worker actions appreciated by the participants ranged from conveying a welcoming attitude... “Just make that person feel good coming back, to understand”, to assisting in rebuilding co-worker connections “just opening lines of communication, sort of almost like a liaison between myself and other members of the team”, and partnering in work activities “she gave me a full hand, right, and that spirit, made me like ok.” Several participants shared poignant experiences originating from the negative actions of a single co-worker:

“Yeah, I was thinking, I’m not ready for work or I have to go home. No this is not for me, but when the person is changed, the partner was changed I was feeling normal, like I can work, this is my place.”

Co-workers were seen as playing an important role both collectively and as individuals in fostering the self-direction of their colleagues through their contributions to supportive work environments.

3.3.3. Responding to work demands

Participants noted the importance of a comfortable fit between work schedule (pre and post RTW) and worker health needs. All saw having some control over the pace and difficulty level of the RTW as helpful: “First of all, I didn’t have to deal with clients when I first went back. My manager made it easier on me to just process paper work and that.” Three participants described the importance of familiarity with both the workplace and the nature of work as supporting a manageable starting point: “If I was starting a new job I would have been
terrified or a lot more stressed.” They consistently described the experience of self-directing their RTW by drawing upon ingrained skills.

While acknowledging the importance of a manageable starting place, the participants also provided forthright opinions of the need for mainstream workers to shoulder required work responsibilities. “I guess it [employer’s tolerance] all depends because if people if they have a job, they need to do it.” Another stated “if you want to get back out there and get back in the work force you have to learn how to do it.” The influence of job accommodations on the worker’s ability to remain back at work was not clear. One worker indicated the complexity mainstream workers could face in seeking accommodations: “Next thing you know you’re working steady days, but you’re not really in a role you would prefer to be. It’s a career limiting move as well. It just gives you a bad reputation.”

The participants clearly valued workable and familiar starting points in resuming work. While a workable schedule and control over pace and difficulty of work contributed to the worker’s ability to self-direct their RTW, daunting realities of the mainstream workplace diminished their sense of self-direction at times. A manageable fit between recovery of function to meet the demands of the mainstream workplace and the availability of workplace accommodations influenced participants’ sense of ability to self-direct their RTW.

4. Discussion

Findings from this study identified participants’ perspectives on the barriers and facilitators to self-direction in the RTW process. The main themes addressed worker self-management, workplace partnerships, and relationships and demands within the work environment. Personal factors such as self-acceptance and managing health and lifestyle, and environmental factors such as personal support, workplace leadership, co-worker interactions and work demands were identified consistently within these themes.

While studies addressing the perspectives of individuals returning to mainstream work following acute mental illness are limited, some findings are similar to those in our study. Kirsh [17] looked at workplace meaning experienced by mainstream workers who had been previously hospitalized for mental illness. Similar to our study, Kirsh’s participants described the importance of workplace milieu, having solid partnerships, including a communicative supervisor, and positive coworker relationships as key to successful reintegration to mainstream work. A further study by Kirsh et al. [18] echoes the findings of our study in stating that successful transitions into productive work in the mainstream for people with varied disabilities require resources and supports at the individual level, but also within the workplace and societal levels. Kru-pa [19] suggests that a long term investment from physicians in learning about the nature and scope of employment interventions is necessary to improve RTW outcomes. Our participants described such an investment from their psychiatrist as beneficial in supporting self-direction in RTW.

Kirsh et al. [18] also called for professional intervention that was not time limited to support the maintenance of work during the period in which concomitant problem solving and personal insights are developed. However, the rapidly rising rates of mental health related work disability [32] are likely to strain existing resources and to confound potential studies of their utility. These issues underscore the need to understand what sort of education would best support self-navigation of return to mainstream work. The related need for workplace structures to prevent mental illness and support mental health [12,13,19] follows, as addressed in the formulation of solid workplace partnerships.

Our findings also relate to studies of worker self-direction within the supported employment literature. Shaw et al.’s [25] exploratory study of self-direction of consumers looking for work in supported employment environments found similar key facilitators. For example, self-direction was assisted by workers’ ability to draw upon inherent strengths, by opportunities to build or regain confidence, by enhanced self-direction, and by support of family and significant others. While both sets of workers acknowledged personal challenges in their journeys, Shaw et al.’s supported employment group cited lack of developed functional skills and self-confidence as their main challenges, whereas our mainstream group discussed the need to regain and access existing personal strengths and work abilities. The co-worker and manager influences emerging in our study were not cited by participants in Shaw et al.’s study which showed vocational rehabilitation providers as key facilitators of worker self-direction. The participants in our study were not linked with vocational rehabilitation services but indicated that their psychiatrist addressed similar issues. The lack of involvement of vocational rehabilitation partners in our mainstream study may indicate a notable gap in service provision influencing self-direction. A second study by Wood-
side examined a sample of mental health consumers in a supported employment environment [31] and further reinforced the need for workers to take responsibility for their mental health including medication management. This corresponds to our findings regarding the importance of personal health management. The supported employment literature underscores integral facilitators to navigating vocational recovery, but does not represent the unique challenges inherent in self-directing mainstream RTW.

Probing the workers’ experiences of the RTW period itself was an innovative perspective of this study. Scrutiny of specific RTW experiences was facilitated by the fact that all participants discussed RTW with their previous employers. The participants responded to the questioning of this finite period in their lives with reflections on vivid, frequently grave, memories. They described the temerity often required to move forward and the intensity of their processing at the personal level. The actions of particular individuals, both positive and negative, resonated as having been key to the outcome of the RTW which stresses the high value of effective, positive workplace partnerships. Some workers’ stories of feeling forced to move forward in the face of residual illness, the unmetered realities of the workplace, and concomitant personal life challenges illustrated the make or break undertones of the timeframe examined. The participants had the involvement of a common psychiatrist who provided consistent expertise during recovery, RTW and beyond – a resource often not available to individuals attempting to shoulder the challenges of RTW following acute mental illness. The snapshot presented here tells participants’ stories of this most vulnerable period. It highlights the immediacy of returning workers’ need for resources and strategies to assist the RTW process.

The central limitation of this study involves the scope possible for a graduate student project that had to be carried out within a restricted period of time. This related to several aspects of the study. We only interviewed five participants. While we found that this provided rich data supporting the themes presented in this paper, we found we could not collect enough data in the allotted time to formulate themes related to some other issues suggested by participants. Trends in research data related to stigma, the need for increased tolerance toward mental illness in the workplace, and needed educational resources; these issues warrant further investigation. Also, because of the small sample size, we cannot be sure whether certain personal characteristics influenced participants’ perceived experience. It seemed that the themes presented here were still relevant to participants regardless of gender and recentness of RTW; however we would need to interview more people to be sure of this. The limited time frame of the study also only allowed us to do formal member checks with two study participants. Allowing all participants to review categories and themes and provide feedback would have further enhanced the credibility of the study results.

Clearly, the understanding of barriers and facilitators influencing return to mainstream work from the workers’ perspective is in the early stages. The findings of this pilot study align with previous studies in beginning to describe the personal, workplace and societal influences on mainstream RTW. Needed professional resources to support the journey are unclear, as is a model to direct the related worker driven processes. Further research is required to specifically address these integral foundations.

Implications for future research include the need to explore educational needs and develop educational strategies for returning workers in order to promote development of effective workplace partnerships. Whether the education should be centered on the worker or the employer or both is in question. Focus groups composed of similar samples of workers would shed light on these evolving issues and help to build foundations for the needed partnerships to execute innovations.

5. Conclusion

The perspectives of mainstream workers with mental illness enhance understanding of the issues that can influence an individual’s ability to take ownership of directing RTW following acute mental illness. Clearly, individuals facing this challenge acknowledge self-management of health, coupled with solid external support systems, as integral to the process. Workplace factors such as strong partnerships with co-workers and managers temper potential barriers during the reintegration period and allow time for the worker to assimilate work demands. A workplace climate of tolerance and understanding of mental illness can help workers navigate this complex picture.

The growing fallout of lost productivity, not only for the impacted workers, but for their workplaces, families and communities, is a societal issue. The resources that would make a difference need to be at the forefront. Meanwhile, the overall message resonating from the participants in the study appear worthy of attention.
Seemingly simple actions, whether positive or negative, have the potential to impact deeply on the lives of others. Partnerships that form workplace foundations offer professional resource continuity and acknowledge a journey of recovery. Such partnerships are integral to workers as they strive to take ownership of their full potential.

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References


