Health Promoting Employment Interventions for Unemployed Men in the United States:
A Scoping Review of the Literature

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Abstract

While the economy and unemployment rates in the United States have improved since The Great Recession, there are still millions of individuals searching for employment and untold others that have removed themselves from the job search until opportunities return or new opportunities are established. Men’s health disparities are tied to the social determinants of health, many of which are inextricably linked with employment status. A scoping review of the existing quantitative and qualitative literature was conducted to determine the breadth of research focusing on employment interventions for unemployed men in the U.S. that have also included a measure of health or health-related behavior. Studies meeting inclusion criteria were reviewed and entered into tables for narrative analysis in accordance with a methodological framework proposed by Arksey & O’Malley (2005). Results show that existing research has been restricted to pilot studies addressing single health conditions or health behaviors and fail to address chronic health and co-morbid conditions. Recommendations for future research are provided and limitations of the current review are presented.

Key words: Unemployment, Intervention, Men, Scoping Review, and United States
Background

While the current unemployment rate in the United States (U.S.) of 5.5 percent (8.7 million people) is a marked improvement from previous years, the post-Great Recession unemployment rate for adult men of 5.2% remains higher than that of adult women at 4.9 percent (Bureau of Labor Statistics, 2015). From the Bureau of Labor and Statistics, Boushey (2009) reported that from the beginning of The Great Recession in December 2007 to July 2009, 74.2% of all jobs lost were those of men largely due to the volume of losses in construction and manufacturing. Wessel (2014) reported that in the U.S. more than one in six males between the ages of 18 and 54 years old are currently unemployed, for a total of 10.4 million men. Recently, the New York Times, CBS New, and the Kaiser Family Foundation have collaborated on work examining the unemployed male worker in the U.S. Results from large-scale polling have been interwoven with individual case studies, providing a unique lens from which to view the problem. Findings from their nationwide polls have indicated that for every 100 men between the ages of 25 and 54, 90% have had a full-time job at one point in their lives; 64% want a job; 48% say that health problems or disability is a major reason they are not working; 43% say that not working has been bad on their mental health, 34% have been convicted of a crime, and 17% say their physical health is poor (Hamel, Firth, & Brodie, 2014). These poll results suggest that nearly half of all men between 25 and 54 who are unemployed directly relate their unemployment status to a physical health problem or disability (Hamel, Firth, & Brodie, 2014). Additionally, many respondents from these polls identified unemployment as having a negative impact on their mental health.

Research on the health consequences of unemployment on men has been limited due to
methodological issues, minimal agreement on the definition of unemployment and its potential direction/s of effect or association pertaining to health, as well as the inherent difficulties with examining a complex phenomenon in a prospective fashion (Mossakowski, 2009). This said, health disparities have been and continue to be recognized issues, though progress in addressing health disparities related to men’s health has been slow, especially as it pertains to the health of specific subsets, such as African American and Hispanic men (Thorpe, Richard, Bowie, LaVeist, & Gaskin, 2013; Kaiser Family Foundation, 2012). Limitations and arguably frustrations led Thorpe et al. (2013) to assert that “there needs to be an Office of Men’s Health in the Department of Health and Human Services similar to the Office of Women’s Health…” and that focusing on men’s health “is one viable way to increase overall population health” (p. 206).

While an Office of Men’s Health in the Department of Health and Human Services could serve to better coordinate research and advocacy efforts, more timely intervention is needed to combat the negative health effects of unemployment on men in the U.S. As Baker et al. (2013) stated, “Clearly, the best way to address the negative health sequelae of unemployment is to create meaningful jobs that provide a living wage” (p. 255). Recognizing a need to allocate additional resources to addressing long-term unemployment, President Obama has encouraged employers, communities, and federal agencies to better coordinate their efforts and create best practices for successfully engaging and employing the unemployed (White House, 2014). To this end, one hundred and seventy million dollars in Department of Labor grants were allocated to support established partnerships to connect the unemployed to jobs in fields that are currently in-demand (White House, 2014).

Employment interventions are options for better preparing individuals to identify and seek out employment, as well as work to develop “soft skills” to better manage communication
with others, manage stress, and be in a position to succeed when opportunities for meaningful employment return/present themselves (Hergenrather, Geishecker, & Rhodes, 2013).

Employment, more specifically employment in a non-hazardous environment that provides a living wage and adequate benefits can be considered the origin of multiple social determinants of health (Marmot et al., 2008). Given this it can easily be argued that the involuntarily unemployed are at risk for health conditions, if they do not already exist, or remain at greater risk of further decompensation and/or exacerbation if not successfully re-connected to employment and the benefits often associated with it, such as social support and status, health benefits facilitating access to healthcare, and stability (Marmot et al., 2008). Given this, employment/working as opposed to simply one’s functional status must be considered as a key health outcome for those receiving care and perhaps the ultimate goal of care provision for those of working age. As such, any intervention that focuses on increasing employment or the employability of the unemployed must also consider the health of its participants for it to be of lasting benefit and reasonable return on investment. The purpose of this paper is to identify and better understand what health promoting employment interventions have been established to serve unemployed men in the U.S.

**Justification for a Scoping Review of the Literature**

A scoping review was employed for this project, as such a review allows for an extraction “of a diverse body of evidence giving it meaning and significance that is both developmental and intellectually creative” (Davis, Drey, Gould, 2009, p. 1386). Support for the scoping review as an approach in its own right has been building in nursing research over the past several years, with the bulk of momentum originating in the United Kingdom (Arksey & O’Malley, 2005; Davis, Drey, & Gould, 2009). Systematic reviews still garner favor for directing evidence-based
practice; however, where the objectives are to identify the type and quantity of research conducted in an area (as is the case here), rather than to assess the quality of or synthesize study findings, scoping reviews are appropriate (Davis, Drey, and Gould, 2009; Thomas, Menon, Boruff, Rodriguez, & Ahmed, 2014). As presented in Davis, Drey, and Gould (2009), the National Institute for Health Research (NIHR) Service Delivery and Organisation Research and Development Programme (SDO) in the United Kingdom has “spear headed the scoping movement through academically robust and practically relevant studies…” (p. 1387). As noted by the SDO, scoping reviews are particularly useful when the goals are to:

1. Identify the scope of work conducted, or working definitions or conceptual boundaries of a topic area,

2. Outline what is already known and identify gaps in existing research; or to conduct

3. a conceptual analysis, which may include the “mapping” of existing empirical evidence to describe and interpret issues that will inform future research and development opportunities.

These key concepts serve as strengths of the scoping review when utilized for examining a broad and multifaceted topic, such as health promoting employment interventions for unemployed men in the United States. For the reasons cited above, having a better understanding of the extent to which research has been conducted on this complex topic is needed. Given the scoping nature of the review to take a broad look at how health promotion may be integrated into employment-promoting programs for men, the need to review a wide-range of research approaches will allow for future work in addressing ways to better serve this population.

**Research Goals**
The goals of this scoping review of the literature are to:

1. develop an overarching view of the existing literature related to both the non-intervention and intervention-specific research that has been conducted for populations of unemployed men in the U.S., and,

2. identify existing gaps in the research, and understand what future efforts are needed to improve health and employment in unemployed men in the U.S.

**Methods**

The scoping review methodological approach for this review is based upon the work of Arskey and O’Malley (2005). The approach consists of 5 stages with an optional 6, consultation stage. The stages of the scoping review approach developed by Arksey & O’Malley can be found in figure 1 (pg. TBD). CINAHL, PubMed, PsycINFO, and Scopus were searched to identify reports from empirical studies that assessed interventions for unemployed men, ages 18-64, which included outcome measures for employment, as well as physical and/or behavioral health. Searches utilized were limited to include only works published in peer-reviewed journals between January 1, 1995 and February 28, 2015 in English. Time parameters were selected to encompass The Great Depression and allow for a significant breadth of research to be considered. Search terms utilized included: (unemployment OR unemployed OR job loss OR jobless) AND (men OR male OR men’s OR man) AND (intervention* OR program evaluation OR intervention study OR program*) AND (United States of America OR United States OR US OR USA OR America) inclusive of MeSH Terms where possible.

Searches conducted with the parameters and limits detailed above yielded a total of 1,138 articles (see Figure 1). An additional 8 articles were identified after reviewing the references section of the articles identified for full-text review through the database searches. Following the
identification and removal of duplicates, a total of 905 unique articles remained.

Inclusion criteria included 1) study participants were unemployed men between the ages of 18 and 64; 2) the article details the results of an intervention and/or participants’ experience with an intervention; 3) the article contained qualitative or quantitative results; and 4) outcome measures, if present, must have included at least one measure of employment and a measure related to health. Exclusion criteria included 1) articles published in a language other than English; 2) research conducted with samples from countries other than the U.S.; 3) studies with unemployed male participants under 18 or over 64 years of age; and, 4) studies that included men and women, where outcome data were not separated by gender. Studies detailing interventions for individuals with serious and persistent mental illness (e.g., schizophrenia) or addressing marked disability/impairment (e.g., individuals undergoing rehabilitation post-stroke) were also excluded.

Titles and abstracts of the 905 articles were reviewed against inclusion and exclusion criteria, and those that failed to meet criteria were removed. A total of 31 articles remained after the screening process (Figure 1).

These 31 articles were read in their entirety. Of the 31 articles reviewed, 0 were excluded due to language (non-English); 1 article was excluded due to age of participants (Matt, Fischer, & Silverman, 2006); 1 article was excluded as focus was on and data set was from Canada (DeLuca et al., 2010); 1 article was excluded as participants were not unemployed (Allaire, Li, & LaValley, 2003); 1 article was excluded as it included similar/duplicative/follow-up data to another article considered during review (Vinokur, Schul, Vuori, & Price, 2000); 2 articles were excluded as they were solely program descriptions discussing potential interventions with this population or secondary analysis papers (Murphey & Shillingford, 2012; Vinokur & Schul,
1997); 3 articles were excluded due to no specific health measures (Carpenedo et al., 2007; Coviello, Zanis, & Lynch, 2004; Dillon et al., 2004); 7 articles were excluded as they did not include or focus on a specific employment intervention for this population (Bell et al., 1995; Bolton & Rodriguez, 2009; Gowan & Nassar-McMillan, 2001; Jennings, 2014; Kost, 1997; Okech et al., 2013; Rabinowitz, Fredric, & Cochran, 2008); and a total of 11 articles were excluded due to intervention results not being separated by gender (Davis et al., 2012; DeFulio & Silverman, 2011; Kang et al., 2006; Kerrigan et al., 2004; Kidorf, Hollander, King, & Brooner, 1998; Kidorf, Neufield, & Brooner, 2004; Magura et al., 2007; Martin et al., 2012; Staines et al., 2004; Vinokur, Price, & Schul, 1995; Zanis, Coviello, Alterman, & Appling, 2001). This resulted in a final total of 4 articles that met all specified criteria (Baker et al., 2013; Hergenrather et al., 2013; Raj et al., 2014; Zanis & Coviello, 2001). The article yields and review process is detailed in Figure 2 – PRISMA Diagram (p. 28).

Results

A total of 4 of the 31 articles reviewed in their entirety met all review criteria, and these articles will be reviewed individually in a case study format shortly (Baker et al., 2013; Hergenrather et al., 2013; Raj et al., 2014; Zanis & Coviello, 2001). Prior to this, a brief demographic overview obtained from all the studies read in their entirety will be provided, and consideration will be given to the articles that were reviewed in their entirety but failed to meet full review criteria. Doing so provides additional perspective/s on the existing research with this population and allows for greater breadth than would be possible in simply reviewing the 4 articles that met full review criteria.

Articles read in their entirety spanned the years of 1995 to 2014, with 2 articles published in 1995 (Vinokur, Price, & Schul, 1995; Bell et al., 1995), 2 articles published in 1997 (Kost,
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1997; Vinokur & Schul, 1997), 1 article published in 1998 (Kidof et al., 1998), 1 article published in 2000 (Vinokur, Schul, Vuori, & Price, 2000), 3 articles published 2001 (Gowan & Nassar-McMillan, 2001; Zanis & Covielo, 2001; Zanis et al., 2001), 1 article published in 2003 (Allaire, Li, & LaValley, 2003), 5 articles published in 2004, (Covielo, Zanis, & Lynch, 2004; Dillon et al., 2004; Kerrigan et al., 2004; Kidof et al., 2004; Staines et al., 2004), 2 articles published in 2006 (Kang et al., 2006; Matt et al, 2006), 2 articles published in 2007 (Covierdo et al., 2007; Magura et al., 2007), 1 article published in 2008 (Rabinowitz, 2008), 1 article published in 2009 (Bolton & Rodriguez, 2009), 1 article published in 2010 (DeLuca et al., 2010), 1 article published in 2011 (DeFulio & Silverman, 2011), 3 articles published in 2012 (Davis et al., 2012; Martin et al., 2012; Murphey & Shillingford, 2012), 3 article published in 2013 (Baker et al., 2013; Hergenrather et al., 2013; Okech et al., 2013), and 2 articles published in 2014 (Jennings, 2014; Raj et al., 2014). A total of 6 articles included samples consisting of only men (citation), with a total of 24 articles including men and women, with the remaining article consisting of a program description for working with unemployed men (Murphey & Shillingford, 2012), with nearly all articles published in journals focused on substance abuse and/or mental health, vocational rehabilitation, and/or public health.

**Results of Articles that Failed to Meet Full Review Criteria**

Of the 31 articles read in their entirety, 27 failed to meet the full review criteria for this review. Of the 27, 9 of these were non-intervention articles and 18 were intervention articles that failed to meet criteria based largely in part to not having results separated an interpretable by gender. Both the non-intervention articles and intervention articles are presented.

**Non-intervention articles in the literature.** Non-intervention studies identified in the literature consisted mainly of panel studies and correlational designs. Large data sets have been
utilized to examine the relationship between economic changes and health behaviors (e.g., Bolton & Rodriguez, 2009), with smaller data sets used retrospectively to examine the utilization of health care services, primarily regarding emergency departments and emergency psychiatric services (e.g., Dhossche & Ghani, 1998). Agreement among researchers proves difficult to attain; however, most agree that unemployment, as well as poor economic conditions have negative impacts on individual health, especially when unemployment and/or poor economic conditions are experienced on a long-term basis (e.g., Philips & Nugent, 2014; Roelfs, Shor, Davidson, & Schwartz, 2011; Thorpe et al., 2013).

Substance use, abuse, and dependence were themes identified in the literature, as well as serious and persistent mental illness, such as schizophrenia and bipolar disorder. Suicide was also a focus. Case studies were also identified discussing the clinical presentation of depressed men in therapy and interconnectedness with financial and employment attributes (Rabinowitz, Fredric, & Cochran, 2008) and the experiences of individuals dealing with poverty during an economic recession (Okech et al., 2013). Qualitative articles identified related to young men’s experiences regarding receiving public assistance (Kost, 1997) and at-risk youth involved in work-based education in Canada (DeLuca et al., 2010).

**Interventions identified that did not meet criteria.** Several intervention articles that were reviewed in their entirety failed to provide results that were divided by gender, an outcome measure related to health, or include participants that were unemployed. The predominant designs of these studies were experimental with a total of 8 randomized controlled trials and 9 single arm interventions.

Of the intervention articles that failed to meet full review criteria, those that addressed health outcomes in addition to employment focused primarily upon participants with substance
use, abuse, and/or dependence issues, with the substances of preference being opioids (Carpendo et al., 2007; Kang et al. 2006; Kidorf et al., 1998, Kidorf, Neufield, & Brooner, 2004; Magura et al., 2007; Staines et al., 2004; Zanis et al., 2001), cocaine (Bell et al., 1995; Carpendo et al., 2007, DeFulio & Silverman, 2011; Kerrigan et al., 2004), and alcohol (Kerrigan et al., 2004), as well as mental health and/or distress (Matt et al., 2006; Vinkour, Price, & Schul, 1995; Vinkour, Schul, Vuori, & Price, 2000) and PTSD, specifically in a population of veterans (Davis et al., 2012). Lastly, working to address the re-employment of individuals with HIV/AIDs was the focus of an intervention addressed in Martin et al. (2012).

**Intervention Studies that Met Criteria**

A total of four articles detailing four different interventions were identified (Baker et al., 2013; Hergenrather et al., 2013; Raj et al., 2014; Zanis & Coviello, 2001). Designs ranged from case studies to more formalized intervention evaluations; however, no higher levels of research evidence, such as randomized controlled trials or meta-analyses fitting the inclusion and exclusion criteria were found. Community-Based Participatory Research (CBPR) was a common theme, utilized in the development and implementation of two of the four interventions identified for inclusion (Baker et al., 2013; Hergenrather et al., 2013). Interventions varied in terms of components, duration of intervention, location of intervention, and outcomes of interest with all but one article published within the past two years (Zanis & Coviello, 2001). Each of the four articles will be reviewed in detail in the section that follows with additional gaps, needs, and areas of future research saved for the Discussion.

**The Helping Overcome Problems Effectively [HOPE] Intervention**

The HOPE intervention, as detailed in Hergenrather et al. (2013), was developed utilizing a CBPR approach to improve employment and mental health in unemployed African American
males who self-identified as gay and living with HIV/AIDS. Intervention development and 
implementation occurred in Washington, DC, with the team developing and implementing the 
intervention having collaborated on previous research focusing on employment and people living 
with HIV/AIDS (PLWHA). Social Cognitive Theory, Hope Theory, and aspects of Self-
Management were utilized as frameworks for the intervention (Hergenrather et al., 2013).

The intervention was developed for delivery in seven, 180-minute sessions, with the first 
30 minutes of each session allocated for homework review and working to enhance developing 
problem-solving skills, and the last 30 minutes of each session utilized for the development of 
weekly goals and the provision of feedback on the session. Session topics included the 
following: Instilling HOPE and better understanding HIV/AIDS; Working with Medications; 
Working with Health Care Providers; HIV Tests and Treatments; Lifestyle Management; 
Employment; and Putting it all Together.

The staff member/interventionist who lead program sessions was reported to have 
“…expertise in counseling and 20 years of experience working with PLWHA, including African 
American PLWHA and MSM [men who have sex with men] PLWHA” (Hergenrather et al., 
2013, p. 411). Additionally, “he was trained by African American PLWHA, who self-identified 
as gay, in order to more fully understand and detail the experiences of African American gay 
men living with HIV” (p. 411). No specific information regarding to professional licensure in a 
counseling field, regular area of employment, of specific training required on/in the HOPE 
intervention was provided.

An intervention training manual was developed by the group, which detailed components 
of an extensive orientation session, initial/baseline assessment, the seven weekly group sessions, 
and the post-intervention assessment and structured interview, which occurred three months
following completion of the intervention. Recruitment of participants focused on individuals receiving services at a local health clinic for those with HIV/AIDS. Inclusion criteria for participants consisted of being an African American male 18 years of age or older; self-identified gay; unemployed; a confirmed diagnosis of HIV; receiving services at the clinic; and able to understand, converse, read, and write in English.

Intervention sessions were scheduled for the same day of the week participants received services at the HIV/AIDS clinic, an approach that reduced the burden of transportation. Incentives for participation included paid transportation expenses, a $10 gift card for attendance at each session, and a $50 gift card for successfully completing the post-intervention follow-up three months after program completion.

A mixed design was utilized, with demographic information collected from all participants. Quantitative outcome measures included mental health, adherence to treatment, and employment, and qualitative outcomes data was obtained through a structured interview conducted three months post-intervention. Items in the structured interview included perceived benefits of the HOPE intervention; what components of the intervention were most and least helpful; what supplemental materials could have benefitted the intervention; and what improvements could be made to the intervention.

A total of seven participants finished the program, with program completion defined as participating in all intervention sessions, completing baseline and post-intervention assessments and the follow-up interview. The average age of participants was 46.1 years (SD = 7.8; range = 37-57), with three of the seven participants having completed some level of college. All seven of the participants reported having some previous full-time employment experience and over half of the participants received Social Security benefits. While all of the participants were unemployed
At baseline, none of the participants were reportedly actively seeking employment or enrolled in any form of higher education or job training.

At 3-month follow-up, participants reported higher coping self-efficacy, increased hope and self-esteem, as well as lower levels of anxiety and depression. Additionally, participants reported increased adherence with medications and improved self-efficacy related to HIV treatment. Lastly, participants reported higher self-efficacy related to job seeking skills, with three of the participants actively looking for work, three participants reporting they were enrolled in further education courses, and one participant reporting he had obtained part-time employment.

Results from the interview showed that all participants reported experiencing better mental health as a result of intervention participation. Identifying realistic goals and steps to achieve those goals, recognizing barriers to achieving goals, and learning effective coping skills to reduce stress were the components believed to have attributed to this betterment in participant reported mental health. The most helpful components of the intervention identified by all participants were problem solving and goal setting, with the least helpful components found to be sexual intimacy and practicing safer sex negotiation.

Suggested improvements to the intervention included “conducting mock job interviews to improve interviewing skills; creating and critiquing resumes; completing career interest assessments and aptitude assessments; and providing training on the U.S. Department of Labor Occupational Information Network,” as well as identifying a participant peer for support earlier in the intervention (p. 415-6).

The Making Employment Needs [MEN] Count Intervention

Raj et al. (2014) piloted the evaluation of the Men Count HIV intervention, which is “a
peer counselor-delivered program of HIV risk reduction and gender-equity counseling, and employment and housing case management” (p. 152). Eligible participants were African American males who self-identified as heterosexual, were currently unemployed and not homeless, and reported having two or more female sexual partners and unprotected vaginal intercourse within the past six months. Participants were recruited from primary care waiting rooms in a community health center in Boston, MA utilizing a sequential approach. In total 85 men were screened for participation, 68 men were deemed eligible for participation, and a total of 50 men agreed to participate in the intervention. Participants’ ages ranged from 18 to 54.

The MEN Count intervention was implemented by a Peer Counselor trained in the MEN Count model over three 60-minute sessions, with one-to-two 10 minute check-in sessions over the course of a 60-90 day time period. Sessions occurred at a local HIV/STI clinic. As part of each 60 minute session, 10-20 minutes were allocated to an assessment of HIV risk behavior, including a discussion regarding healthy relationships, and 15-20 minutes were allocated for an assessment of each participant’s current housing and employment situation. Time remaining was utilized to assist participants in developing action plans for obtaining and maintaining stable housing and employment, develop and refine resumes, and practice interview skills. A portion of the second and third sessions (10-15 minutes) was reserved for an in-depth discussion on participants’ relationships with women with focus given to developing respect and trust.

A single-armed intervention design was utilized, including baseline, post-test, and follow-up conducted within five months of intervention completion. Demographic information, including age, income, education, employment, housing, and relationship/family characteristics was collected along with use of alcohol, marijuana, and cocaine. Information related to exposure to violence and history of incarceration was also collected in addition to data related to risky
sexual behavior (i.e., number of unprotected anal or vaginal episodes with a woman in the past 30 days and number of sexual partners within the past 30 days). Participation was incentivized, with participants receiving a $25 gift card for completing baseline assessments, another $25 gift card for post-test (post-intervention) assessment completion, and a final $35 gift card for successful completion of follow-up assessment, two months after post-test and approximately five months after the intervention was implemented.

Results from demographic and initial participant data indicated that nearly half of the participants reported binge use of alcohol, defined as 5 or more drinks in one day and marijuana use within the last 30 days. A total of 68% of the participants (n=34) reported a history of incarceration. A total of 56% (n=28) participants reported having two or more sexual partners in the past 30 days, with 74% (n=37) reporting engaging in unprotected sex within the past 30 days.

Following the intervention, participant self-reported unprotected sex decreased from intervention implementation to intervention completion (baseline to post-test) and also from intervention implementation to follow-up (baseline to 2 months following completion of the intervention). The number of reported sexual partners did not reduce significantly over the course of the intervention or follow-up period. A significant increase in employment was found both from baseline to intervention completion and from baseline to follow-up period. Qualitative results from interviews revealed that intervention content heightened participant consideration of female partners and also equipped participants with tools to effectively avoid relationship violence.

The Men on the Move’s Leadership Job Readiness Program

Baker et al. (2013) detailed the development and implementation of Men on the Move’s Leadership and Job Readiness (LJR) program, an intervention designed to “improve employment
opportunities and build leadership capacity for African American men living in a rural community” (p. 245). The intervention was developed utilizing a CBPR approach in a rural community in Missouri.

Lack of job readiness and “soft skills” (e.g., communication, conflict management, time management and teamwork) were identified in the population of interest and needs to be addressed through the intervention (Baker et al., 2013, p. 248). A community survey conducted by the CBPR group prior to intervention implementation, which was completed by 125 African American men (ages 18-55), revealed that 40% were out of work (this figure excluded individuals that were determined to be unable to work), 30% had less than a high school education, 50% were overweight or obese, 50% were smokers, and 50% of those who reported drinking alcohol were identified as binge drinkers, consuming more than 5 drinks in a single sitting.

The intervention was designed to be completed in one week and was delivered by “trained community health advocates in a community-based facility,” with classes lasting for four hours each day (Baker et al., 2013, p. 249). No additional information regarding qualifications of the community health advocates or training received in the Leadership and Job Readiness intervention was provided. In addition to increasing the “soft skills” of participants, the intervention was also designed to aid participants in obtaining legal documents, increase their social support, decrease their risky behaviors (e.g., alcohol use), and enhance their overall sense of hope. Additional supports and professional development opportunities were made available outside of the highly structured four-hour daily classes.

Key components of the intervention included goal setting, teamwork, communication, stress management, health behaviors and your environment, decision-making, and time
management. Additionally, professional development opportunities were also included, such as provision of interview clothing, interview preparation including mock interviews, transportation, and funds to obtain state identification and other key documents needed for employment.

A total of 139 participants participated in the intervention with pre-and-post intervention questionnaires completed by 138 of the participants. The mean age of the participants was 30.92 (SD = 12.02). Just over 50% (n=73) of the participants were high school graduates, with only 1 participant identified as being a college graduate. Participants completed pre-and-post intervention questionnaires, and qualitative interviews were conducted with a total of 15 participants to more precisely identify what participants identified as the most beneficial aspect/s of the intervention. Outcome measures of interest for the questionnaires included hope and psychosocial and behavioral coping responses. Employment outcomes were determined via qualitative interview and follow-up conducted with participants.

Results from the qualitative interview revealed that participants enjoyed the structure of the intervention, the manner in which the facilitator related to the participants, that curriculum was engaging, and transportation and funding was available if needed. Opportunities for self-evaluation and support were also identified as beneficial aspects of the intervention.

Following the intervention, over 10% of participants obtained full-time, paid employment within 1-3 months following the intervention, while an un-specified number of others successfully obtained part-time employment. In addition, participants reported increased hope and an improved ability to cope, as measured by the Hearth Hope Index (Herth, 1992) and the John Henry Active Coping Scale (James, Hartnett, & Kalsbeek, 1983), along with qualitative interviews conducted post-intervention.

The Employment Case Management Intervention
Zanis and Coviello (2001) detailed the Employment Case Management intervention, which was established to “motivate chronically unemployed persons to engage in work, assist in job placement, and provide post employment support through workforce integration, while maintaining progress in drug treatment” (p. 67). A non-randomized case study by design, this article provided results for ten participants, 7 of who were male, with ages of the male participants ranging from 40 to 60.

Prior to being eligible for ECM services, participants successfully completed two other employment interventions – 10 sessions of vocational counseling and a job seeking skills workgroup focused on obtaining employment – and still remain unemployed. All participants were identified as chronically unemployed and currently maintained on methadone; however, chronically unemployed was not operationally defined. The vocational counseling program was “designed to provide motivational support and problem solving strategies toward job acquisition. The second intervention required weekly attendance for a minimum of eight weeks in a two-time per week job seeking skills workgroup” (Zanis & Coviello, 2001, p. 68). Participants received ECM support and services for a total of 26 weeks with follow-up conducted at both two and eight months post-discontinuation of ECM.

Each participant was provided with a case manager, and the case managers were themselves part-time methadone counselors, working approximately 10 hours each week as part of the ECM intervention. Case managers received two days of training prior to the intervention and two hours of weekly supervision from the project director during the intervention.

Services provided by the case managers through the ECM intervention were divided into two main categories – job development and advocacy, and counseling and life skills training. Job development and advocacy services and supports focused on connecting participants to
potential employers, public assistance, and treatment. Counseling and life skills training services and supports served to assist participants with coping and issues related to daily functioning, such as how deal with stress and drug cravings, as well as how to use public transportation, proper budgeting, selecting health insurance, and effective communication with potential and future employers.

Outcome measures included job acquisition, job maintenance, impact of employment on drug treatment, and value of the ECM intervention and case managers. Results of intervention were mixed, with only one male participant reportedly obtaining and maintaining full-time employment, another male participant making the decision to pursue Social Security Insurance/Social Security and Disability Insurance as opposed to employment, and others working for intermittent periods of time. Qualitative results obtained from a focus group approximately one year following enrollment in the ECM program served to determine the value of ECM services as identified by the participants. Participants reported that as a result of the ECM intervention they had gained respect and independence, established future plans, learned how to handle stress, overcome fear of job failure, realized that employers do care about the participants and will hire them, and recognized that the ECM staff cared about the participants and the job coaching ECM staff provided had helped. Limitations identified through the focus group included participant recognition that ECM services could not meet all the demands of the participant and that participants did not want ECM services to be discontinued.

**Discussion**

While extensive research has been conducted regarding the impact and effects of unemployment and poor economy on the health and health behaviors of the unemployed, research regarding interventions to increase employment and promote improved health and
health behaviors of unemployed men in the U.S. is significantly lacking. Results of the interventions reviewed showed that specific health conditions (e.g., HIV/AIDS) and health-related behaviors (e.g., risky sexual behavior) have been the focus. HIV/AIDS and substance dependence were of central focus, with additional behavioral health and stress management aspects (e.g., coping) considered. While substance use, abuse, and dependence were issues identified in the literature, the Employment Case Management (ECM) intervention detailed by Zanis & Coviello (2001) was the only one that directly addressed this problem.

Interventions reviewed contained a number of the same components, with stress management emphasized across articles. Stress was not directly linked to chronic health conditions nor did the interventions reviewed focus upon chronic health conditions or comprehensive health promotion. The absence of any well-established, evidence-based interventions for working-age, unemployed men in the U.S. with chronic and/or co-morbid conditions in the literature is of serious concern, given the population most likely to encounter periods of unemployment also has a higher prevalence of comorbid chronic health conditions.

Statistics from the CDC will provide a more detailed picture of the impact of chronic health conditions in the U.S. both in terms of the number of individuals affected and the cost to treat. According to the CDC (2014), “As of 2010, about half of all adults – 117 million people – have one or more chronic conditions, with one of four adults having two or more chronic conditions.” Additionally, it has been reported that of the top 10 causes of death, 7 were chronic diseases, with cancer and heart disease accounting for nearly 50% of all deaths in 2010 (CDC, 2014). Furthermore, the rate of the overweight and obesity continue to be of significant concern as over one-third of adults in the U.S., roughly 78 million people, are now recognized as obese, which has lead to increased rates of type 2 diabetes and other chronic conditions (CDC, 2014).
Medical costs related to these conditions are extremely high, with costs for heart disease and stroke estimated to be $315.4 billion in 2010, cancer care costing $157 billion, diagnosed diabetes at $245 billion, $69 billion of which is attributed to decreased work productivity (CDC, 2014). Costs for obesity are reported to be $147 billion, the costs for smoking being $289 billion, and the cost to treat excessive alcohol consumption being $223.5 billion (CDC, 2014). Behaviors related to these health conditions and behaviors, including lack of aerobic or physical activity, unmanaged hypertension and cholesterol, smoking, poor/diet nutrition, and alcohol use/abuse/dependence would all be most worthy foci of future interventions for the unemployed.

Individuals receiving SSI and/or SSDI are another population that could be positively impacted by proven health promoting interventions for unemployed men, both in terms of assisting those currently receiving SSDI in returning to or moving towards employment, while also providing structure and additional supports to those receiving SSI. Furthermore, when more rigorous research methodology is applied to intervention research in this area, more forceful and evidence-based arguments could be made regarding reduced societal cost-related burdens and improved outcomes with this particular population of men.

To put the potential impact of serving this population with healthy promoting employment interventions, in December 2014, approximately 4.4 million men between the ages of 21 and 64 were identified as disabled worker beneficiaries through the Social Security Administration (SSA, 2015). In 2013, a total of over 4.9 million individuals in the U.S. between the ages of 18 and 64 received SSI benefits, with this number projected to remain relatively consistent for the foreseeable future (SSA, 2014). Future research testing interventions designed to focus on the non-mutually exclusive goals of unemployment and health would be remiss in not considering these populations for inclusion.
Recommendations for workplace-wellness, focusing on chronic disease prevention are readily available, with the Centers for Disease Control and Prevention providing a “Worksite Health ScoreCard” to assist employers in identifying needs and implementing evidence-based health promotion interventions for their employees (CDC, Division for Heart Disease and Stroke Prevention, 2014). Potential work-place wellness options available through the CDC include stress management, weight management, depression, cholesterol management, diabetes, identifying the signs and symptoms of heart attack and stroke and emergency response to heart attack and stroke, along with tobacco use, hypertension, and appropriate nutrition (CDC, Division for Heart Disease and Stroke Prevention, 2014). While such options are able to be mobilized with relative ease by employers in the hope of reducing medical and insurance expenses, funding for and interest in the well being of individuals seem to vacate quickly once individuals fall off employer rolls.

In addition to including and incorporating further health promoting behaviors and considerations to address preventable chronic health conditions, higher-level evidence for interventions for this population is needed. While randomized controlled and clinical trials of health promoting employment-focused interventions have been conducted, not one focusing specifically on the needs of unemployed men in the U.S. was identified. Piloting interventions is a strong start; however, longitudinal studies and more in-depth and longer-term follow-up are needed, as a replication of research once larger-scale, randomized controlled trials have been conducted. Also, considerations must be made for the continuum of employment and ways of engaging this population at various points in the continuum and various places in the communities in which they live. One option for doing this would be to utilize a model that has been developed largely for identifying individuals with behavioral health issues and connecting
them with services and supports to improve treatment outcomes and minimize costly and often unnecessary involvement with the criminal justice system. This model is the Sequential Intercept Model developed by Munetz and Griffin (2006). By mapping out available resources and physical and chronological points of potential intervention, communities and researchers will be better able to identify and assist those that would benefit from existing community resources and supports, appropriately screen and connect those who qualify to established interventions and/or active randomized controlled trials. Lastly, doing so would firmly place the health and employment issues and needs of men in the U.S. on local and national maps, respectively.

Community-Based Participatory Research (CBPR) is one strategy that has been beneficial to those developing the intervention, the communities in which they are developed, and the participants who successfully engage in the intervention. “Most significantly, [it] is to combine intensive support and skill development with men along with engaging workforce development and the regional or local agency on economic development” (Baker et al., 2013, p. 256). CBPR has been utilized very successfully in large-scale, randomized controlled trials, for similar populations, such as the work conducted by Kneipp et al. (2011). Through CBPR and a unique integration of public health nursing case management within existing programs and social service entities, women with chronic health conditions realized increased health and functional status in addition to improved knowledge of health benefits and healthcare utilization (Kneipp et al., 2011). Such work is extremely promising as it simultaneously provides hope for a disadvantaged, often overlooked population in addition to the establishment of an evidence-based practice providing guidance on necessary components and how to move forward with future implementation. When it comes to men’s health, and more specifically health promoting
employment interventions for men in the U.S., it is time we must do something drastic and uncharacteristic of men - stop and ask for directions.

**Limitations**

There are several limitations to this review of the literature that must be discussed. First, articles identified and reviewed for inclusion may have been limited due to the number of databases utilized. While promising articles identified in the references of articles reviewed were also examined for inclusion, expanding the search across additional databases may have yielded additional articles that met review criteria. Search terms utilized focused on employment interventions for unemployed men, though over the course of the project the continuum of employment with terms such as “underemployment” and “job insecurity” began to gain traction in the literature. Expanding the search terms and focus to include the full-continuum of employment could have allowed for a wider breadth of review and establish the groundwork for a sequential-intercept model approach that was aforementioned.

Also, focusing on research conducted with purely U.S.-based populations, though appropriate given the focus of the review, likely limited the number of interventions to be considered when serving unemployed men of working age. Future work may expand the focus to include both U.S.-and-non-U.S. based samples from English speaking, industrialized countries.
<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Identify the initial research questions determine which aspects of the question are particularly important to facilitate the most appropriate search</th>
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</thead>
<tbody>
<tr>
<td>Stage 2</td>
<td>Identify the relevant studies comprehensively answer the central question(s) including any time, date, budget constraints and range of sources</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Study selection adopts similar methods to systematic review from the outset adopts greater flexibility with inclusion and exclusion criteria, as familiarity with data progresses search terms may be redefined.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Charting the data is representative of data extraction processes in a systematic review, but take a broader approach. Uses narrative descriptive-analytical framework method but does not attempt to weigh the methodological quality of the evidence.</td>
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<tr>
<td>Stage 5</td>
<td>Collate, summarize and report the results utilizing a framework approach.</td>
</tr>
<tr>
<td>Stage 6</td>
<td>Optional consultation stage with key stakeholders. Can add value, insights and perspectives, and additional references.</td>
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</table>

Table 1 – Scoping Literature Review Framework suggested by Arksey & O’Malley (2005).
Figure 1 – PRISMA Diagram