Managing mental health and employment

Annie Irvine

Contents

List of tables

List of figures

Acknowledgements

The Author

Annie Irvine is a research fellow at the Social Policy Research Unit (SPRU) at the University of York. Her current research focuses on employment, unemployment and Incapacity Benefit and she has been involved in a number of focused studies within the evaluation of the Pathways to Work pilots. She has a particular interest in mental health and employment. Her other current areas of work include an investigation of the interactions between Jobcentre Plus personal advisers and benefits recipients during work-focused interviews, using the methodology of Conversation Analysis.

Summary

Introduction

This report presents the findings of an exploratory qualitative study commissioned by the Department for Work and Pensions (DWP) to investigate the experiences of people who had sustained paid employment while experiencing a mental health condition. The study was carried out by the Social Policy Research Unit (SPRU) at the University of York and was designed to complement an earlier 'sister project' conducted by SPRU and the Institute for Employment Studies (Sainsbury *et al.*, 2008) that explored transitions into and out of employment for people who had claimed Incapacity Benefit (IB) due to a mental health condition. The sister project also gathered the views and experiences of employers on supporting employees with mental health problems.

Mental health is currently a key area of policy focus, with concerns about both the social and economic impacts of mental health problems. Recent years have seen a growing number of initiatives from within government, and also the charitable and business sectors to raise awareness about mental health problems and to assist people who experience mental health problems to return to employment. However, there remains a gap in understanding about what helps people, especially those with common mental health problems, to manage in work and to retain employment. The present study aimed to contribute to filling this knowledge gap by exploring, through in-depth interviews, the experiences of 38 individuals who considered themselves to have a mental health condition and had retained paid employment for at least the past 12 months.

The study focused on the experiences of people in mainstream 'open' employment, rather than supported employment interventions, and did not include people who were self-employed. The study group was comprised predominantly of people who worked for large employers in managerial, professional, administrative or skilled technical roles. Many had been with their current employer for several years. The fairly narrow and specific range of employment circumstances overall should be borne in mind throughout the report.

The majority of the study participants had experienced common mental health problems, most describing stress, anxiety, depression or a combination of these. There were a small number of people who had diagnoses of more severe and enduring conditions. Two concepts that appeared relevant to the experiences of the present study group were that of a 'continuum' of mental health and the notion of a 'biopsychosocial' model and these have, to some extent, guided the analysis.

Findings

Disclosing mental health problems at work (Chapter 2)

Disclosure of mental health problems at work could take a number of forms and people's decisions about disclosure included consideration of whether, when, what and with whom to share information about their experience of mental health problems. For around half of the study participants, whether or not to mention experiences of mental health problems had been a relevant consideration when they took up their current job. Non-disclosure was the more common approach at this stage, for two main reasons: concerns about negative impact on job prospects and a feeling that mental health problems were not a relevant issue at this time. During people's time in post, disclosure came about in various ways including: voluntary sharing of information when experiencing problems; observation of distress or difficulty by others; explaining reasons for absence; disclosure of information by others during absence; and voluntary sharing of information at other times. These scenarios were not mutually exclusive; some people described disclosure to different parties in varying ways at different times, indicating that disclosure is often 'partial' and is perhaps better understood as a 'process' rather than an 'event' (Brunner, 2007).

Most people had talked to someone within their workplace about their experiences of mental health problems, including Occupational Health Service staff, Human Resources/Personnel departments, senior managers, line managers, colleagues, Welfare Officers and Trades Union representatives. Several of the study participants had found a particular individual or group of close colleagues who were sympathetic and supportive. However, among many people there was evidence of some reluctance to have their mental health problems known about more widely. People were concerned that employers' knowledge of their mental health difficulties might affect perceptions of their capability or reliability and affect their prospects for career advancement. Lack of personal insight, feelings of embarrassment or self-perceptions of weakness relating to mental health problems could also be reasons for non-disclosure. Thus, as found in previous studies (Sainsbury and Davidson, 2006; Sainsbury *et al.*, 2008a) there were people in the present study group who had 'struggled on' in silence for some time before their mental health difficulties became known to their employer.

There was some evidence that longstanding and positive relationships with line managers and colleagues facilitated voluntary disclosure and that people found it helpful to talk to others who also had close or personal experience of mental health problems. In contrast, a perception that managers and colleagues would not understand, would feel uncomfortable discussing mental health problems, or that workplace support systems were lacking or ineffective could also deter people from mentioning difficulties at work. However, there was evidence that many people would have, in principle, welcomed the opportunity to discuss mental health problems more openly, but not within the climate they currently perceived in their workplace.

Responding to mental health problems at work (Chapter 3)

Responses from employers at the time when people's mental health problems were disclosed at work ranged from very positive and supportive to overtly negative or what was perceived as an 'over-reaction'. There were also a number of people who felt that there had effectively been no response at all to their initial disclosure of mental health problems at work. In some cases, for example where people had attempted to talk to employers about work-related stress, this lack of response was perceived to have led to mental health problems becoming worse and eventually resulting in a long period of absence. Some people described differing responses from different managers and there was evidence that the nature and quality of response and support received from managers and colleagues was largely a matter of individual attitude rather than a consistent organisational approach. There were suggestions that lack of response and engagement in discussion of employees' mental health problems was linked to low levels of knowledge and understanding among some line managers and Occupational Health staff.

Support or adjustments that people had found useful at times of mental ill-health fell into three broad types:

• formal adjustments and support, including temporary reductions to contracted hours, short-notice leave days, short-term alteration or lightening of duties and the provision of counselling via the employer;

• 'softer' forms of support, including sympathetic concern for the individual's circumstances, willingness to engage in discussion about their experience and what might be helpful, alertness to signs of distress and willingness to broach this with the individual, encouragement to seek medical or therapeutic support, and sensitive approaches to periods of absence or reduced productivity;

• standard flexibilities of the job, including flexitime, time off in lieu, and the option to work at home on occasion.

A majority of people in the study group had heard of the Disability Discrimination Act (DDA) although a smaller proportion was aware that it could apply to mental health conditions. Some said that the DDA had played a role in their own circumstances, either explicitly or implicitly. However, the study findings

raised questions about the role of the DDA in relation to common mental health problems where individuals did not perceive their experiences of stress, anxiety or depression as having a severe impact on them in the long term. People's personal understandings and definitions of 'disability' and their views on disclosure also influenced whether they felt it was appropriate or desirable to draw upon the provisions of the DDA in their own case.

Study participants were asked about the role played by medical practitioners and other third parties in managing mental health and employment. Beyond the provision of sick notes, General Practitioners (GPs) and psychological therapists had sometimes been involved in: provision of information to employers about an individual's mental health condition and capacity for work; advising the individual on taking time off sick and/or returning to work; and discussion with the individual about the suitability of roles and strategies to manage work alongside mental health difficulties. Some people thought it would be helpful if there was more communication between medical practitioners and employers.

It was rare for people's family members to have had a great deal of involvement with employers with regard to mental health problems. Where there had been communication, this usually extended only to phone calls about absence from work where the individual did not feel able to make contact themselves. Among the present study group, very few people had had contact with the benefits system and so there was little data regarding the involvement of Jobcentre Plus or external employment support services.

Absences and absence management (Chapter 4)

Just under half of the study group described a period of long-term sickness absence (defined for the present purposes as more than one month) while with their current employer. Most people had received some type of contact from their employer during this time but the format, frequency and perceived usefulness of this contact varied. Again, people had experienced different qualities of response from different tiers of management, with variation in levels of support, constructive engagement and apparent level of understanding. A personalised, caring and sensitive approach was often described as helpful (although some people preferred a more detached form of involvement) and some people had appreciated informal social contacts with colleagues during their time away from work. Even where sensitively approached, contact with line managers or Personnel departments could be difficult for people when they were feeling most unwell, particularly where mental health problems were perceived as originating in the workplace. As such, it was sometimes helpful for a third party to be involved in a mediation role.

There were mixed experiences of Occupational Health Service involvement during, or shortly after, absence from work. Sometimes meetings with Occupational Health staff had resulted in the implementation of positive support, for example, counselling or discussion of how the DDA might be drawn upon. However, some

people did not perceive their experiences with Occupational Health Services to have resulted in any positive action and there were comments that the specialist expertise of these services in the area of mental health could be improved.

Coming back to work from long-term absence, many people had had a phased return to full-time hours and full duties. While this was generally perceived as helpful, some people felt that more structure to their return to full duties, rather than a seemingly 'ad hoc' approach, would have been better. Some had moved into a new role or team and had found this helpful, especially where mental health problems had originated from difficulties at work. Being among supportive colleagues was also beneficial. However, returning to work was still challenging for many people. Some people continued to experience reduced capacity for their 'normal' levels of work after they had returned from absence. This could be frustrating for the individual, where feelings of boredom were in tension with a need to take a step back from previous levels of work. There was also evidence that line managers sometimes found it hard to understand the long-term and gradual nature of recovery. Although (as noted above) a number of people preferred their colleagues not to know about their mental health problems, some participants said it would have been helpful if their circumstances had been explained more clearly to their colleagues during their absence, and would have appreciated their line manager taking the lead in this.

Many people in the study group had only taken brief periods off work due to mental health problems. Flexibility in working hours and location, either as a formalised 'reasonable adjustment' or through standard flexible working provisions, was perceived by some people as reducing the need for time off sick. There was some evidence that people without this flexibility might operate a more covert strategy of taking days off to restore their mental health under the guise of a physical illness.

People described a range of motivations in limiting or entirely avoiding time off sick. Some felt that being absent from work would not be helpful to them, feeling that their enjoyment of work had a positive influence on their mental health. However, there were also less positively nuanced motivations, including a feeling that it simply was not an option to 'give up' in the face of mental health problems and worries about how others would view them if they took time off sick for this reason. There was also evidence that finances could play a part in decisions to return to work or not take any further time off sick where paid sick leave entitlement was reaching its end. Some people were conscious that further time off sick would trigger intervention from Personnel departments and this could be a source of anxiety.

Managing mental health: what helps? (Chapter 5)

Managing mental health could be considered from the perspective of responding to mental health problems at times of more acute distress, but also from the point of view of maintaining more positive mental health as a longer-term strategy.

People described a range of factors that contributed to a better state of mental health, including:

- prescribed medications, counselling or therapy and the coping strategies acquired from these;

- workplace factors and the benefits of work itself;

- social networks, including the support of family and close friends, maintenance of an active social life, and also the companionship provided by pets;

- lifestyle factors, including maintaining good physical health, religious or spiritual involvement and a healthy 'work-life balance'; and

- development of personal insight and understanding of their mental health condition over time.

Workplace factors that were perceived as beneficial to the maintenance of positive mental health on a longer-term basis included: the work setting, with some people preferring to work in a team and others finding home working helpful; flexibility in working hours; positive workplace relationships; openness about mental health at work; the benefits gained from work that was engaging, enjoyable and suitably challenging; and being able to avoid sources of workplace stress that could trigger mental ill-health. Particularly for people who perceived their mental health problems to have originated from work-related stress, an important long-term strategy was to take on a less pressured role and/or a smaller workload. Some people had taken the decision to work part-time in the interests of maintaining a more positive state of mental health.

There was much similarity in the factors that helped people in the study group to maintain better mental health and elements that have been found to prevent work-related stress leading to mental ill-health. As such, employer and government focus on the mental wellbeing of the workforce overall may be equally important as targeted support for individuals with known mental health problems, especially taking into account the notion of a continuum of mental health.

Impacts of mental health problems (Chapter 6)

People had experienced impacts on their employment at both the day-to-day level and in relation to longer-term career plans and progression. When they were feeling unwell, day-to-day work could be affected by tiredness and loss of concentration (sometimes linked to medication effects), avoidance or deferral of certain tasks, agitation or irritability, and withdrawal from colleagues. For some people, this resulted in reduced performance or output, although this was not always apparent to managers or colleagues. Some people made significant efforts to maintain their levels of productivity or conceal difficulties which could require huge effort and exacerbate mental health problems. Perceived longer-term impacts were often in the form of missed opportunities to progress, or having had to take a step down the 'career ladder' due to mental health problems. This was sometimes accompanied

by feelings that there had been a loss of potential income. However, few people in this particular study group had experienced severe financial difficulties because of mental ill-health.

As noted, some people had made changes to their job role or status in view of mental health problems. Although a number of people were comfortable with this decision and found they benefited from changes to their work-life balance, there were some people who now felt frustrated and dissatisfied in roles that did not provide sufficient challenge or were not perceived as utilising their full potential. Some people felt 'stuck' in an unfulfilling role either due to direct effects of their mental health problem, for example, anxiety or reduced confidence, or stemming from apprehension about taking on a more demanding role in case this negatively affected their mental health. A number of people said that, through their experiences of mental ill-health, they had become less confident about advancing their career and described feelings of anxiety about making applications for new jobs or internal promotions.

Job retention (Chapter 7)

While much of the research interviews were broadly focused on job retention, study participants were also asked to reflect specifically on what had been the main things that had kept them in employment throughout their experiences of mental ill-health. To a large extent, the things people mentioned here mapped onto factors that have been discussed above, including the role of supportive line managers and colleagues, flexibility at work, the role of medical and therapeutic input and that, for some people, work itself was an aid to better mental health. However, in reflecting at a broader level on what had kept them from leaving their job altogether, people also emphasised the role of individual motivations and the role of their broader employment context, including entitlement to paid sick leave and the greater capacity of larger employers to offer role adjustments and accommodate reduced productivity. Individual motivations included positive pulls towards staying in work, for example, enjoyment and fulfilment gained through work, but also drivers that were nuanced more towards compulsion or obligation, where people talked about financial necessity or felt that 'giving up' was not an option.

Although the present study participants had retained their current jobs throughout periods of mental ill-health, people were not necessarily free from worries about job vulnerability. Despite knowledge that their employment rights protected them, some people were nonetheless worried about risks to 'role status', how far employers might tolerate effects on behaviour at work or periods of lower productivity, and how performance matters might be handled.

Drawing on the experiences of people in the sister project, who had come to leave or lose their employment because of mental health problems, this report offers some tentative suggestions as to what might have been significant in differentiating the employment outcomes of the two groups of study participants. Potentially

influential factors, which might benefit from further research exploration, included:

- employment factors:
  - contractual terms and sick pay;
  - size of employer: scope for flexibility and role adjustments;
  - type of occupation: scope for flexibility and role adjustments;
- individual motivations and decisions:
  - disclosure, non-disclosure and timing of disclosure;
  - individual expectations of possible employer support, potentially including knowledge of employment rights;
  - 'attachment to employer' – possible influences including time in post and professional status;
- mental health condition:
  - distinct barriers for people with alcohol or drug addictions.

Areas for improvement (Chapter 8)

In reflecting on what could have been done better or differently in their situation, and the key messages that they wished to convey to employers and government, some clear and consistent themes emerged from participants' comments. These themes, which could be seen as related and mutually reinforcing, were:

- the need for greater understanding about mental health problems among employers and employees;
- increased employer engagement in employee mental health, regarding both early intervention and support for known mental health problems and also attention to broader employee wellbeing; and
- improvements to in-work support.

All of these were underpinned by a perceived need for greater openness about mental health and mental health problems both within workplaces and in wider society. There were comments that government might play a useful role in supporting, encouraging or compelling employers to take a more engaged approach to employee mental health. The possibility of a large-scale public health campaign to raise awareness of common mental health problems was suggested.

Despite many people's feeling that they did not want their mental health problems widely known about at work, there was substantial evidence that people would like there to be somebody connected to their workplace, with whom they could talk confidentially about mental health problems and how these interacted with their work. The range of roles that people would have liked to be fulfilled included

both clinical therapeutic support and also something more akin to workplace mentoring or a pastoral support role. A role for government in funding such provisions was suggested. There were also comments that advocacy or mediation type roles, career counselling and peer support would be beneficial.

Sustained and consistent approaches to engagement with employee mental health problems were highlighted as important. Although there was recognition that communication needed to be a two-way process, there was evidence that some people felt nervous about initiating discussion with their employer about mental health problems and so line manager proactivity and alertness to signs of mental distress seems important.

Conclusions and policy implications

As a whole, the study group could be seen as exemplifying successful job retention throughout periods of mental ill-health. In exploring individual experiences, there was evidence that managing mental health and employment had not always been a straightforward or easy process. However, drawing together findings on what **had** and what **had not** been helpful, some clear findings emerged about effective strategies to support job retention. Two factors emerged as key to effective workplace support: flexibility and 'softer' forms of support from line managers and colleagues. Quick access to counselling services via the workplace was also beneficial. A range of parties contributed to people maintaining a more positive state of mental health; medical practitioners, managers and colleagues, family and friends, and the individuals themselves all had a role to play.

A key message was for employers to acknowledge and respond to disclosures of mental health problems at an earlier stage and in greater depth. There were suggestions that a lack of knowledge about mental health problems, rather than stigma or prejudice, was the greater barrier to effective employer engagement. The study therefore reinforces the conclusion of the sister project that there is scope for additional awareness-raising activity to increase line manager knowledge and confidence in recognising and responding to employees who experience mental health problems. Improved 'mental health literacy' among individuals, employers and the wider population seems central to moving forward in supporting people with mental health problems to stay in work. Strategies that involve direct interaction with people who have experienced mental health problems might be a particularly effective way of changing attitudes and deepening understanding.

Although many people perceived an ongoing sense of taboo around mental health, most had found somebody supportive to talk to in their workplace. This suggests that the challenge of opening up discussion about mental health problems may not be so great as perceived, if these small 'islands' of support can be linked up to form a larger and more visible network of positive attitudes and understanding. However, there seems to be something of a vicious circle whereby individuals remain uncertain about disclosing mental health difficulties for fear of negative

reactions and employers do not engage with the subject because they do not know how to respond. In the current climate, there appears to be a 'stalemate', whereby if individuals do not feel able to speak up about mental health problems, then employers (and others) remain in a position of ignorance or misunderstanding about the presence of mental health problems among the workforce and what can be done about this. There would seem to be a role for all parties – employers, individuals, government and mental health organisations – in breaking this cycle.

While it is important to recognise that impacts of mental health problems on day-to-day work are often not permanent or consistent, people in this study did acknowledge that there had been times when they were less productive at work. This study raises questions relating to the concept of 'presenteeism'. This has tended to be presented as problematic in the literature, with discussion of the financial costs to employers and health costs to the individual. However, in the case of mental (and some other) health problems, there is an alternative argument that it is better to be at work, even when not at full levels of productivity. Indeed, this is the direction of current government policy which focuses on capacity rather than incapacity. In light of this apparent tension between the negatively nuanced concept of 'presenteeism' and positive interventions to manage health problems **while at work**, there seems scope for further research into the impacts of 'presenteeism' on colleagues and organisations overall, particularly in smaller enterprises.

Suggested policy implications for government include:

• reflection on the role of the DDA in relation to common mental health problems and the potential for alternative legislation to underpin a broader focus on employee mental wellbeing;

• continued activities to raise awareness of mental health and mental health problems among employers and wider society, with specific attention to more effective strategies to bring about deep understanding and sustained behavioural change;

• further investment in increasing access to talking therapies, possibly including financial support for workplace Employee Assistance Programmes (EAPs) for smaller enterprises;

• further initiatives to enable smaller organisations to access Occupational Health Services;

• training and professional development opportunities to ensure that Occupational Health staff are confident and competent in their approach to supporting individuals experiencing mental health problems.

Potential actions for employers to consider include:

• development of organisational policies on positive management of employee mental health and mental health problems;

- training and awareness-raising about mental health problems to ensure these top-level policies are reflected in line manager practice;

- provision of in-work support through EAPs and other forms of vocational or emotional counselling; increased publicity of these services where they already exist;

- increased opportunities for flexible working, including hours, location and workload management.

This study has not been able to provide substantial findings on the experiences of people working for small and medium-sized enterprises (SMEs). It proved particularly difficult to recruit participants from SMEs and there remains scope for focused and more extensive exploration of this area. Moreover, participants in this study were predominantly professionals working in roles that permitted some autonomy and flexibility in managing their workload. Circumstances are potentially very different for people who work in service or manufacturing roles where there is less scope for accommodating periods of reduced productivity 'on the job'. As such, possible areas for additional research include:

- the experiences of individuals and employers within smaller enterprises, exploring, for example, the scope for effective role adjustments and employers' capacity to accommodate lower productivity;

- the experiences of individuals and employers in companies that provide front-line services or work within time-critical production environments, again with a focus on scope for adjustments and managing fluctuations in productivity;

- the impact of an individual's mental health problems on colleagues, particularly in smaller organisations.

Reflecting on the findings of the IB sister project, there may also be value in further research on the relationships between, and relative role of, individual motivations, organisational structures and workplace context in job retention, for example, to determine where employer or government interventions could be most effectively targeted.

A key theme that ran throughout the findings of this study was of the need for more openness about mental health, which would provide a foundation for increasing knowledge, engagement and support. What is encouraging, however, is that where people in the study had been open about their mental health difficulties, they had often found that they were not alone in their experience and that at least one person in their acquaintance was able to offer empathy and support. Thus, if steps can be taken towards challenging taboo, there may be less distance to travel than anticipated.

There is a burgeoning literature on 'positive' mental health, mental 'wellbeing' and mental 'flourishing'. While there is no question that some people in the present study group had experienced severe mental health conditions that met diagnostic

criteria, by their own account, a number of people described their experiences as reactions to stressful life events and personal circumstances which, though distressing, were only acute for a relatively short period of time. A final reflection, therefore, is that there may be value in moving forward debate and discussion in the direction of mental wellbeing and equipping society as a whole with effective coping skills and strategies to maintain a more positive state of mind and to deal more productively with the challenges that work and life present.

1 Introduction

This report presents the findings of a qualitative study commissioned by the Department for Work and Pensions (DWP) which aimed to explore the experiences of people who sustain paid employment alongside a mental health condition. The research was conducted by the Social Policy Research Unit (SPRU) at the University of York during 2008.

The study was designed to complement earlier work carried out jointly by SPRU and the Institute for Employment Studies (Sainsbury *et al.*, 2008a) which considered transitions into and out of employment for people who had claimed Incapacity Benefit (IB) because of a mental health condition and also investigated the experiences and opinions of employers regarding support for employees who experience mental health problems. This previous study will be referred to throughout the present report as the 'sister project' and its findings will be drawn upon for comparison in later chapters.

This introductory chapter begins with an overview of recent policy developments in the area of mental health and employment (Section 1.1). Mental health is a complex and extensive topic of ongoing debate in policy, practice and theory. With this in mind, Section 1.2 explores in brief some relevant concepts regarding how experiences of mental health problems can be understood. Section 1.3 then outlines the aims, design and methods of the research study. Section 1.4 provides an overview of the study group characteristics, including a focus on their employment circumstances and experience of mental health problems. Finally, Section 1.5 outlines the chapters that follow in the remainder of the report.

1.1 Policy background

A frequently cited estimate is that, at any one time, one in six of the adult population will be experiencing a mental health problem (Singleton *et al.*, 2001) and it has been suggested that poor mental health is one of the biggest social issues facing Britain today (Layard, 2005; Layard and CEP, 2006; Rankin, 2005). 'Severe and enduring' mental health conditions (typically understood to include psychoses, schizophrenia and bipolar disorder) are thought to affect less than two per cent of the population. However, it is estimated that 'common' mental health

problems (sometimes referred to as 'mild to moderate' mental health problems) will be experienced by up to a quarter of the population at some point in their lives (Seymour and Grove, 2005). Common mental health problems are typically defined as including depression, anxiety, phobias, obsessive compulsive and panic disorders. Although not clinically recognised as a mental health condition in formal diagnostic classifications, 'stress' is also frequently mentioned within discussions about mental health, especially in relation to work[1].

In recent years, mental health has been a focus of attention from various policy angles including health service provision, economic activity and broader social exclusion concerns. In 2004, the Social Exclusion Unit reported on the prevalence and impacts of mental health problems, highlighting the relationship between mental health problems and a range of social disadvantages including unemployment, homelessness, debt and barriers to education and community participation. As well as mental ill-health being a contributory factor in worklessness or job loss, there is also evidence that unemployment can have a negative impact on mental health (Waddell and Burton, 2006).

Much research and debate has been focused on the employment experiences of people with severe and enduring mental health conditions and on the design and effectiveness of specialist employment and support (e.g. Grove *et al.*, 2005a). It is known that employment rates are disproportionately low among this group of people, with estimates at or below 25 per cent (Grove *et al.*, 2005b; SEU, 2004). However, there is growing attention to the impact of common mental health problems which, although less severe, are far more prevalent.

The relationships between employment and mental health have received particular attention in light of IB figures, which show that an increasing proportion of claims are due to (largely common) mental health conditions. Although absolute numbers have not increased significantly in the last decade (Black, 2008), a fall in the number of new claims attributed to other health conditions means that mental health problems as a claimant's 'primary condition' now account for around 40 per cent of the IB caseload (DWP, 2006). Thus, the subgroup of people receiving IB for reasons of mental ill-health is now similar to the total number of Jobseeker's Allowance (JSA) recipients. Taking into account secondary conditions, there are estimates that well over half of IB claimants experience mental health problems (Black, 2008). As such, there is a growing focus on the economic, as well as social, costs of mental ill-health.

As well as financial costs to the exchequer in the form of benefit payments, attention has turned to the economic impact of mental ill-health on businesses. The Sainsbury Centre for Mental Health has estimated the cost to employers of mental health problems among staff at £1,035 per employee per year (SCMH,

---

[1]   Seymour and Grove (2005, p.8-10) provide a useful discussion on defining common mental health problems and how 'stress' can be conceptualised alongside this.

2007). This figure takes into account not only the costs of employee **absence** due to mental ill-health, but also the financial impact of **presenteeism** (where an employee is at work but not working at their normal capacity) and staff **turnover** where people leave their job due to mental health problems.

Since 2003, the Government's IB reforms, commonly known as 'Pathways to Work' have introduced a more intensive and specialist programme of support focused on helping workless people with health conditions and disabilities to move into employment. Alongside this, there has also been a focus on job retention for people who become ill while in employment, through the DWP and Department of Health Job Retention and Rehabilitation pilots (see Farrell *et al.*, 2006; Purdon *et al.*, 2006) and on preventive strategies and overall improvements in workplace health and wellbeing (Department of Health, 2004; DWP/DH/HSE, 2005). Layard (2005; Layard and CEP, 2006) has put forward a strong case for increased investment in training therapists to deliver psychological interventions for common mental health problems, arguing that this would 'pay for itself' in the corresponding reduction in benefit payments to people who would instead be able to remain in or return to work. Partly with a view to testing this so-called 'Layard Hypothesis', the Government has invested in the Improving Access to Psychological Therapies programme, a joint initiative between the Department of Health and the Care Services Improvement Partnership which is being piloted and evaluated through national 'demonstration sites' and a number of local programmes[2]. Activity is also underway to develop a National Strategy for Mental Health and Work.

As part of the National Director for Health and Work's review of the health of Britain's working age population (Black, 2008), a background report was produced by the Royal College of Psychiatrists (Lelliott *et al.*, 2008) focusing on mental health and work. This highlighted the significant impact of mental health on employment outcomes, the related costs to the economy and described the particular challenges that pertain to mental (as opposed to physical) ill-health and work, for example, stigma, discrimination, complexities in understanding causal or contributory factors and delays and inefficiencies in receiving appropriate treatment. Recommendations included a government programme to 'educate, train and raise awareness of issues that relate to work and mental health', which would target line managers, Occupational Health professionals and health and social care workers. Also recommended was the production of more clearly defined standards setting out the employment rights and individual responsibilities of people who experience mental health problems while in work.

There are already a number of initiatives coming from government, voluntary, charitable and business sectors to promote mental wellbeing at work, reduce stigma and discrimination, and increase understanding about mental health problems among employers. Written guidance on managing stress and mental health problems in the workplace has been produced by the Chartered Institute

---

[2]   http://www.mhchoice.csip.org.uk/psychological-therapies.html

for Professional Development (CIPD, 2008), the Health and Safety Executive[3], and Mind (Cobb, 2006). The Mindful Employer initiative[4] has been established to offer advice and support to employers in working with employees who experience mental health problems and has produced an online 'resource list' detailing a range of information and guidance sources. Two national initiatives which aim to reduce the stigma and discrimination linked to mental health problems are the 'Shift' campaign[5], led by Care Services Improvement Partnership and overseen by the Department of Health and 'Moving People', jointly led by Mental Health Media, Mind, Rethink, and the Institute of Psychiatry at King's College London[6]. The Shift campaign has produced a 'Line Managers' Resource' (Department of Health/CSIP/Shift, 2007) which gives guidance on promoting mental wellbeing among all employees, on talking about mental health problems with staff who experience difficulties and on managing absences and returns to work.

There has also been some activity focused on mental health in particular professions. For example, specific guidance has recently been developed for the teaching profession (DCSF, 2008), the charity Stand to Reason[7] has been established with a key focus on professionals employed in large private sector businesses in the City of London and focused research has been conducted into mental ill-health among doctors (Department of Health, 2008) and Members of Parliament (MPs) (All Party Parliamentary Group on Mental Health, 2008).

The message coming through much of this guidance and awareness-raising activity is that common mental health problems may affect anybody and attention to mental wellbeing is an important matter for all employers. However, a recent survey of senior managers and Human Resources directors commissioned by the Shaw Trust suggested that awareness of the true prevalence of mental health problems among the workforce remains 'amazingly low' (Future Foundation, 2006). As will be discussed further in Chapter 3, the Disability Discrimination Act (DDA) 1995 (revised 2005) provides a legislative framework to support the employment rights of individuals who experience mental health conditions that have a long-term and substantial adverse effect on their day-to-day activities. However, there is also evidence that employer knowledge about mental health and employment law remains limited in detail (Future Foundation, 2006; Simm *et al.*, 2007).

Despite this level of debate about mental health and employment and recognition of the ongoing need to raise employer awareness, there is limited research evidence about what helps people to manage in work when experiencing common mental health problems. A review of workplace interventions for people with common mental health problems (Seymour and Grove, 2005) found that individual (rather

---

[3]   http://www.hse.gov.uk/stress/index.htm

[4]   www.mindfulemployer.net

[5]   http://www.shift.org.uk/index.html

[6]   http://www.movingpeople.org.uk/index.html

[7]   www.standtoreason.org.uk

than organisational) approaches, focusing on personal support to develop social and coping skills were most effective in job retention, while brief individual therapy (in particular cognitive behavioural approaches) were most effective in rehabilitation. However, conducting a systematic rapid evidence assessment on 'the effectiveness of interventions for people with common mental health problems on employment outcomes', Underwood *et al.*, (2007) found that there was ten times more published research evidence on employment outcomes for people with severe mental health problems than for people with common mental health problems, despite the fact that the latter are significantly more prevalent. Underwood *et al.*, conclude that 'more research needs to be undertaken on what works to help people with common mental health problems find work, if they are unemployed, or stay in work if they are employed' (2007, p.3). Drawing on a range of sources relating to mental health, employment and disability, Thomas *et al.*, (2002) constructed a model of key criteria for an effective job retention service for people with mental health problems. However, they similarly found that much of the research evidence applied to populations with more severe mental conditions and also that, while much research had been conducted on vocational **rehabilitation**, there was a gap in research evidence about job **retention** and mental health problems. It is hoped that this report will go some way to addressing these knowledge gaps.

1.2   Concepts of mental health and mental illness

Understandings about mental health and mental illness are continually developing. The area remains one of complex and ongoing debate about origins, causes, treatments, and the different ways that mental health and mental illness can be conceptualised, from both clinical and sociological perspectives. It is not within the scope of this report to enter into a detailed review of these debates. However, there are some themes and concepts that are of particular relevance to the findings of the present study and will be briefly considered here.

Opinions differ as to whether the relationship between mental health and mental ill-health should be conceptualised as continuous or as discrete and dichotomous, and whether mental health problems should be understood within a biological or a social framework (Horwitz and Scheid, 1999; Parker and Manicavasagar, 2005; Rogers and Pilgrim, 2005). Two ideas that appear relevant to the findings of the present study, however, are that of mental health as a 'continuum' and that mental health problems can be conceptualised within a 'biopsychosocial' model. In the biopsychosocial model, biological, social and psychological factors are all understood to play a part in the development of mental health difficulties; mental health problems may be seen as to some extent 'reactive' to the individual's circumstances and may be mediated by coping strategies and social supports (see, for example, Penhale and Parker, 2008). This is compatible with the concept of mental health as a continuum, from a positive state of complete mental health to an extreme of severe mental illness, on which everyone is positioned and along which anyone may move in either direction at different times. This challenges

the 'categorical' view that an individual either does or does not have a mental health condition and instead conceptualises mental health as 'dimensional' (Pilgrim, 2005). As outlined in the previous section, a distinction is often drawn between 'severe and enduring' and 'mild to moderate' or 'common' mental health problems. However, describing the biopsychosocial model of (ill) health, Seymour and Grove explain that:

> *'In this model the absolute distinction between severe and enduring mental health problems and common mental health problems is less sharply defined. Mental health problems are on a continuum with the overwhelming majority at the less severe end. There remains open the possibility of movement over time in both directions – towards long-term impairment and disability, but more importantly, towards recovery.'*

> (Seymour and Grove, 2005, p.15)

Conceptualising mental health as a continuum also engenders the concept of mental 'wellbeing' as a positive resource which we should seek to nurture and protect (Pilgrim, 2005; Rankin, 2005), but which may become damaged or threatened by circumstances or events. Keyes (2002; 2005) has proposed the operationalisation of mental health as 'a syndrome of symptoms of positive feelings and positive functioning in life'. Adding to the complexity, Keyes does not see mental health as on the same continuum as diagnosed mental illness, but as a separate non-medicalised continuum from mental 'flourishing' to mental 'languishing'. However, he has proposed that mental languishing is commonplace, is correlated with depression and therefore, may be an equally crucial problem for health policies to address.

Also relating to the continuum view of mental health is the concept of 'recovery'. In the language and literature of mental health, recovery is not perceived as an absolute state, but refers to a long-term process which **may** arrive at a complete absence of symptoms, but more often involves the individual reaching a point of managing any ongoing or recurring symptoms or problems and being able to lead a meaningful and satisfying life (Shepherd *et al.*, 2008). As explained by Rankin (2005, p.51):

> *'A fact which is often overlooked in the popular discourse on mental health is that the majority of people who experience mental illness can and do recover, although the condition may fluctuate. The term 'recovery' has different meanings in the context of health. In some senses it means a return to wellness. In others, rather than cure, recovery means enabling people as far as possible to live a life on their own terms.'*

That mental health problems can be experienced as long-term or short-term and as permanent, fluctuating, recurrent or as isolated episodes is important to keep in mind throughout this report, as these differences can influence how individuals perceive their circumstances, the decisions they make about talking to others and their own and others' responses to their experience.

1.3 Research aims, design and methods

1.3.1 Study aims

The overall objective of the study was to gain an understanding of the experiences of people in continuous work with mental health conditions, to understand how they manage their conditions and what (if any) forms of support they use. The study focused on the experiences of people in mainstream 'open' employment, rather than sheltered or supported employment interventions and did not include people who were self-employed. Specific questions to be pursued included:

- What is people's attachment to the labour market?

- What are people's motivations to stay in work and what factors influence motivation?

- How do people view what they can and cannot do in relation to work?

- Do people perceive their mental health to have been a barrier in sustaining work? In what ways?

- What is the role of the employer in people managing mental health conditions and sustaining work?

- How do employers' attitudes to people with mental health conditions contribute to people's experiences?

- Do people disclose their mental health condition to employers or work colleagues, and what are their reasons for their decisions?

- Where they exist, do company Occupational Health Services play any role?

- Are adaptations made to help people maintain employment (for example to the duties of a post, hours of work)?

- Are people aware of their rights and the duties on employers of the DDA? Do people have an understanding of 'reasonable adjustment'?

- What is the contribution of external in-work support services (such as Jobcentre Plus, specialist providers, job brokers etc) in maintaining employment?

- What is the role of GPs, hospital doctors and other treatment services?

- What is the role and influence of other third party actors (such as trades unions, advice agencies, family and friends, support groups)?

- Are there other factors that contribute to sustaining work (such as financial incentives through the tax and benefit systems)?

- How do people view the future?

From the outset, it was understood that the study would be exploratory. As will be discussed in Section 1.4, there is no pre-existing sampling frame from which to construct a study group of people who experience mental health problems while

sustaining paid employment. As the study group took shape, therefore, some of the above questions emerged as more relevant and others as less applicable to people's circumstances. In particular, few people in the study group had had contact with the benefits system and so the study produced few findings relating to the contribution of external in-work support services or the role of financial incentives through the tax and benefit systems. However, rich data was gathered regarding the role of employers, individual motivations and the factors that helped people to manage mental health and employment on a day-to-day basis.

1.3.2 Study group design and recruitment

The study group was designed to comprise 30 individuals who met two broad criteria:

• people who considered themselves to have a mental health condition; and

• had been in continuous paid employment for at least the past 12 months.

In order to gather a diverse range of views and experiences, the study aimed to include ten individuals from each of three employer types: a large private sector employer; a large public sector employer; and a number and range of small and medium-sized enterprises (SMEs)[8]. It was hoped that by including the large private and public sector employers, responses would be generated from individuals working in a range of occupations including manual, service, managerial, technical and professional.

No 'natural' sampling frame exists for people who are in work while experiencing mental health problems. As such, an innovative and multi-strand recruitment strategy was necessary. A range of approaches were used in attempting to make contact with people meeting the study criteria.

In the interests of efficiency and maximising the numbers of people reached, initial approaches were made via employing organisations rather than directly to individuals. Drawing on the research team's existing networks and professional contacts, cooperation was gained from three large private sector employers and one large public sector employer, each of which agreed to disseminate information about the research to their staff via email or hardcopy newsletters. In all cases, it was made clear to employers and potential study participants that information about who (if anyone) had volunteered to take part would not be fed back to the employing organisation. People receiving the newsletters were invited to contact the research team by phone or email, either to 'opt in' or to request further information before deciding whether or not to take part.

As well as a number of direct responses, this strand of recruitment also produced a 'snowball' effect with some people offering either to pass details of the study

---

[8]   European Union definitions, based on number of employees, were used to determine whether an employer was classed as large (250+) or as an SME (<250).

on to personal contacts with a professional interest in this area or signposting the research team to other organisations potentially willing to assist in recruitment. From this, contact was made with two organisations that provide transitional support for people with mental health conditions who wish to re-enter employment. 'Invitation packs' comprising details of the study and how to contact researchers were passed on anonymously by representatives of these organisations to clients who met the study criteria. Individuals were then free to choose whether to contact the researchers or not. As with employers, the intermediary organisations were not informed as to which clients (if any) had contacted the researchers. This strand generated a small number of further responses.

In order to reach individuals working for SMEs, a sample of business contact details was purchased from a publicly available database (the Experian National Business Database). Details of 500 SMEs, across two geographical regions, were purchased and packs containing a covering letter, one or two A4 posters (depending on employer size) and a number of A5 flyers were sent to a named contact in each organisation. Despite a follow-up letter around three weeks after the initial packs were sent, this strand generated only a small number of responses. A number of the letters were returned as recipient unknown and it is not possible to establish how many employers displayed the posters that were supplied.

In total, 43 people responded to the recruitment information, of whom 38 were interviewed[9]. Table 1.1 shows the distribution of participants according to employer type and size. Across final achieved study group, ten different employers were represented: two large private sector employers; four large public sector employers; and four SMEs. In order to preserve the anonymity of the individuals and the employing organisations, the specific number of participants recruited from each company is not given here. However, it should be noted that among the private and public sector large employers, a majority of participants came from one organisation in each case. This has been borne in mind by the researchers throughout the analysis of data and care has been taken to avoid drawing conclusions based on organisation-specific factors. However, it must be recognised that the study group represents a fairly narrow range of employment types and the heavy weighting towards large employers will have influenced the nature of the data; although there was much variety in individual experience, certain underlying commonalities remain regarding employment conditions and organisational structures.

---

[9] Where interviews did not go ahead, this was generally because, having discussed the nature of the study with a researcher, people did not feel that their circumstances were applicable or they did not wish to proceed with an interview.

Table 1.1   Distribution of participants according to employer type and size

Employer type and size	Number of employing organisations	Number of participants
Large private sector	2	20
Large public sector	4	14
SME	4	4
Total	10	38

It proved particularly difficult to recruit participants from SMEs and there remains a need for further research into this area of experience along with exploration of more effective recruitment strategies. Moreover, two of the four smaller organisations from which participants were recruited had a specific focus on mental health support work, suggesting that the employment experiences of the individuals working here may not be reflective of more typical experiences with non-specialist employers.

1.3.3   Data collection and analysis

Two researchers were involved in conducting fieldwork. Data was gathered through individual in-depth qualitative interviews. A semi-structured topic guide was used, covering key areas of: personal, employment and health background; managing in work and experiences of absence from work; talking to others about mental health problems; support from others (in and outside of work) and the role of the DDA; long- and short-term impacts on employment and income; suggestions for improvements and future plans. Twenty-nine of the 38 interviews were conducted face-to-face, either in participants' homes or at their workplace (where this was preferable or more convenient for the participant). Nine additional interviews were conducted by telephone, with a view to responding positively to all offers of participation and maximising the amount of data collected, while keeping fieldwork time and travel costs within planned limits.

Interviews were audio recorded, with the permission of participants, and were transcribed verbatim[10]. Interview data was then summarised under a set of thematic headings (each researcher summarising the interviews they had carried out) and imported into the qualitative data analysis programme MaxQDA. Analysis proceeded using an interpretive approach, involving detailed examination of data for emerging themes and categories within each of the research questions.

---

[10]   There was one exception where, due to recording failure, detailed notes were made by the researcher immediately following the interview.

1.4 Study group characteristics

This section describes the study group's characteristics, including demographics, household, employment circumstances and experience of mental health conditions. It is important to note that the study group is not statistically representative of the wider population on any of these variables.

Table 1.2 provides an overview of study group characteristics according to age, sex, household circumstances and time with their current employer.

Table 1.2   Overview of study group characteristics (n=38)

Age	
20s	3
30s	14
40s	14
50s and over	7
Sex	
Male	16
Female	22
Household	
Single person, no dependants	9
Single person, resident dependants	6
Single person, non-resident dependants	2
Couple, no dependants	7
Couple, resident dependants	13
Couple, non-resident dependants	1
Time with current employer	
Less than two years	4
Two to four years	5
Four to eight years	4
Eight to 12 years	5
Twelve or more years	20

1.4.1   Household and demographics

Slightly more than half of the study group was female and a majority of participants were in their mid-30s to late 40s. There was a range of household types, with couples slightly outnumbering single people. Half the study group had dependent children living with them, a third of this subgroup being lone parents. A small number of people were separated or divorced, but retained shared caring responsibilities for dependent children who lived mainly with their other parent. One person, living with a partner, described herself as a carer for her non-resident mother. Most people were owner-occupiers and none of the participants with resident children said they were living in rented accommodation.

The various strands of the recruitment strategy resulted in a large geographical spread overall, including Scotland and England. However, there were concentrations of participants in London/the South East and in the Yorkshire region. Most participants lived in urban or suburban areas.

1.4.2 Employment

Most people in the study group worked in managerial, administrative or skilled technical occupations. A number of people in the study group held relatively senior positions within their organisation. Other job roles included call centre support, clinical support and teaching assistance. Although some worked from home, the majority of people in the study group could be described as having 'desk-based' jobs. Nobody in the study group worked in manual or elementary occupations at the time of the research interviews, although a small number had backgrounds in skilled manual trades.

Detailed information about people's terms of employment and income were not sought in research interviews. However, from people's descriptions of their job status, it appeared that all were in contracted and salaried employment. The large majority of the study group worked full-time.

As shown in Table 1.2, many people in the study group had been with their current employer for over 12 years (some for over 30 years). This may be related to a number of factors, including the age of the study participants, the fact that many worked for large organisations, and also (as noted by some participants) that one organisation had a historical culture of lifetime career paths. Whatever the underlying reasons, this pattern within the study group is perhaps quite different from the overall picture of employment in Britain at the present time, and should be borne in mind throughout the report.

1.4.3 Experience of mental health problems

The recruitment materials for the project used a form of words that invited people to opt in to the study if they 'considered themselves to have a mental health condition'. The range of mental health conditions that would be generated from this could not be prescribed or predicted and in the resulting study group there was much variety in the experiences that participants had chosen to share with the researchers. The research team did not set any boundaries as to what would fall within the definition of a mental health condition, being led by the study volunteers' descriptions. While the wording of the recruitment materials specified people who *'have'* a mental health *'condition'*, people's individual accounts of their experiences of mental health illustrated the complexities and differing understandings outlined earlier in this chapter[11]. As the research progressed,

---

[11] Further highlighting the complexities in defining mental health conditions or mental health problems, a number of people who volunteered for the study initially sought to clarify with the researchers whether or not they would *'count'* within the sample criteria.

a more nuanced understanding of mental health, mental health problems and mental wellbeing developed.

For the large majority of participants, their experience was of 'common' mental health problems. In describing their experience of mental ill-health, most people referred to depression, anxiety, stress or a combination of these. Specifically noted were: panic attacks, seasonal affective disorder, obsessive compulsive disorder, 'clinical' depression, post-natal depression and insomnia[12]. Some described their experience as a 'nervous breakdown' and there were a small number of people who had made suicide attempts. Only a small minority of people in the study group referred to what would be classed as 'severe and enduring' conditions, two explaining that they had received a diagnosis of bipolar disorder and one who had experienced psychosis. Touching on debates around identity in the mental health literature (e.g. Beresford, 2004; Foster, 2007; Rogers and Pilgrim, 2005), it was notable that very few people in the study group used terms such as mental health 'survivor' or 'service user'. Those few who did were people who had had more severe or enduring problems and who now worked in the mental health field.

The conceptualisation of mental health as a continuum (outlined in Section 1.2) emerged as particularly relevant to the experiences of most people in the study group. Some individuals did describe their situation as that of managing a long-term or permanent mental health condition (e.g. bipolar disorder). There were also people who identified an 'underlying' depression which fluctuated episodically, sometimes in response to specific events, but at other times altering without apparent cause. However, for many people, the experience was of managing a variable state of mental health that was currently, or had at certain times in their life been, negatively impacted on by events and circumstances both within and outside of work.

At the time of the research interviews, the way participants talked about their current experiences suggested that they were at different points on the continuum of mental health; while some described (or displayed) a current state of quite deep mental distress, others were feeling very well. Several people's accounts of mental health problems involved a central event of acute 'crisis' or 'breakdown', after which point they had gradually rebuilt their mental health to a point of relative wellness. While these events were fairly recent for some people, it is important to note that, at the time of the research interviews, many people in the study group were reflecting on their most acute experiences of mental ill-health as at some distance in time. Many of these people, however, said that managing mental health was something that they now needed to be more conscious of on an ongoing basis and they recognised that there were things that could again threaten their mental wellbeing.

---

[12] To preserve anonymity, some very specific conditions have not been detailed here.

These varied and nuanced understandings of mental health and mental health problems are important to keep in mind throughout this report, in contextualising people's employment experiences and reflections. As will be discussed in later chapters, managing mental health on an ongoing basis involved, for different people in different combinations, workplace factors, medical/therapeutic input, social supports and lifestyle factors.

A note on language

Drawing together the above discussion on concepts of mental health and the experiences of people in the study group, this section finishes with a brief reflection on terminology and the language that will be used in the remainder of this report. Although in the research design stages, the term 'mental health condition' was used very broadly, it became apparent through the interview process and ongoing exploration of literature that mental health problems are not always conceptualised as health 'conditions' and likewise, a mental health 'condition' is not always perceived as a 'problem' for the individual. Among the study group, there were people who identified themselves as someone with a long-term mental health condition, but one which was managed so that it did not become problematic for them. Conversely, others described periods where they had experienced problems with their mental health which, while certainly very distressing and debilitating for a period of time, was not necessarily perceived as a permanent condition of mental ill-health.

In recognition of this, throughout the report the terms 'mental health problem' and 'mental health condition' will each be used at different points to reflect this variety in individuals' understandings of their experience. Where a specific participant's experience is being considered and it was evident from their use of language that they did identify as having a long-term or permanent mental health 'condition' this term will be used. However, for most people, mental health 'problems' appears to be a more appropriate term to reflect their accounts of a period or periods where they moved away from the positive end of the mental health continuum. The terms 'mental health difficulties', 'mental distress' and 'mental ill-health' are also used in the report to describe participants' experiences.

1.5   Structure of the report

The remainder of this report is made up of eight chapters.

Chapter 2 describes people's thoughts about, and experiences of, disclosing mental health problems at work. It outlines the different ways in which employers and others at work came to know about people's mental health problems (which could be voluntary or involuntary on the part of the individual) and considers people's reasons for not wanting others to know about their experiences of mental ill-health.

In the course of the research project, a number of ways of thinking about the concept of 'managing mental health and employment' emerged:

- managing at work during periods of mental ill-health;

- management of absences by an employer;

- long-term management of positive mental health (which might mean either preventing the recurrence of mental health problems or the effective management of a long-term condition).

Chapters 3, 4 and 5 look at each of these aspects of 'managing' in turn[13].

Chapter 3 focuses on responding to and supporting mental health problems at work. The chapter begins by considering the broad responses that people had received when employers and colleagues had learned about their mental health problems, before going on to detail the adjustments and other support that people had received at times when they had experienced mental health problems at work. The chapter discusses the role of the DDA in relation to the experiences of people in the study group and the involvement of medical practitioners and other third parties in managing mental health and employment is also considered.

Where people take time off sick due to mental health problems there is a need to manage absences and the subsequent return to work. This is discussed in Chapter 4. Long-term absences are addressed in some detail in the first sub-section, before a briefer consideration of shorter-term and intermittent absences. Study participants' views on taking time off sick due to mental health problems are also explored.

Chapter 5 moves beyond specific employer responses at times of more acute mental ill-health and considers the wider range of factors that helped people to maintain a better state of mental health in the longer term. This chapter highlights that support comes from a variety of sources including medical and therapeutic input, social networks, lifestyle factors and individual insight, as well as a number of contextual workplace factors.

Chapter 6 presents findings on the impact that mental health problems had had on people's day-to-day and longer-term experiences in employment. Sections consider the effects of mental ill-health on daily functioning at work, on longer-term career plans and progression, and on income and finances.

---

[13]   Another important aspect of managing mental health and employment is preventing work-related problems from emerging in the first place. This report will not look in detail at this, but it is important to note that a number of people in the study group perceived the emergence of their mental health problems as rooted (wholly or partially) in workplace factors, for example, stress, anxiety or depression attributed to workplace bullying, poor line management or an unfeasible workload. Thus, for some people, another relevant aspect was preventive management of mental health problems by their employer, which they felt had not been well achieved.

While all of the preceding chapters have been broadly related to the question of job retention, **Chapter 7** turns to specific consideration of the factors that people perceived as **key** in helping them retain and sustain their employment throughout episodes of mental ill-health. This chapter also draws on some relevant findings of the IB sister project (Sainsbury *et al.*, 2008a) to contrast the experiences of the present study group with those of people who had left or lost their employment and come to claim IB because of mental ill-health. The discussion identifies some tentative suggestions as to what differences in experience may have been influential in people's different employment outcomes.

Chapter 8 turns to study participants' suggestions as to what could have been done differently or better in their own situation and in doing so, draws out some findings as to areas for improvement in supporting employees who experience mental health problems.

The report concludes in **Chapter 9** with a discussion of main findings and the presentation of some possible implications for government, employers and areas that might benefit from exploration in further research.

Throughout the report, study participants' words are used to illustrate points raised in the text. Some minor edits have been made to aid clarity of presentation:

• hesitations, 'false starts' and most non-content bearing terms (e.g. **you know, sort of, like**) have been removed;

• ellipses [...] have been used to denote where some dialogue has been removed for brevity.

Quotes are followed by an attribution giving the participant's gender, age band and a brief description of the mental health condition(s) that they described during interviews.

2 Disclosing mental health problems at work

This chapter considers people's views on, and experiences of, sharing information about their mental health problems with others at work. Previous research has identified that decision making about whether or not to inform an employer about a health condition is a complex process involving a range of considerations (Brunner, 2007; Ellison *et al.*, 2003). People have decisions to make about whether, when, what and with whom to share information about their mental health. All of these factors were apparent in the experiences of people in the study group.

The term 'disclosure' is often used in this context, typically understood as 'the deliberate informing of someone in the workplace about one's disability' (Ellison *et al.*, 2003). However, it is also known that 'disclosure' may not always be deliberate or voluntary and that it may be 'partial' in various ways (Brunner, 2007; Ellison *et al.*, 2003; Sainsbury *et al.*, 2008a). Also important in the case of common mental health problems is that the difficulties that an individual is experiencing may not be specifically conceived of as a 'mental health condition' at the point at which they consider talking to others at work, but instead may be discussed in terms of problems or concerns in their personal or work life (Sainsbury *et al.*, 2008a). Thus, the term disclosure as it is generally understood perhaps does not accurately reflect the situation of all individuals who experience common mental health problems. Keeping this in mind, however, the term is used in a broad sense in this report for simplicity, and is used to refer to both voluntary and involuntary sharing of information.

Discussion in this chapter focuses on people's decision making and experiences of disclosing mental health problems in the job they held at the time of the research interviews. Particularly among the large employers, people had experienced a number of changes in line management in recent years. Thus, there had been a number of occasions where disclosure may have been considered. Again among those working for larger employers, several people had moved into a new team on their return to work following a long-term absence and so there was also a decision-making process around telling new colleagues about their experience of mental ill-health.

2.1 Disclosing mental health problems at the time of recruitment

For a little under half of the study group, the matter of whether or not to mention their experience of mental health problems was relevant at the time of recruitment to their current job. Choosing not to mention anything at the time of application or appointment was more common than disclosing a past or ongoing mental health problem at this stage, as was also found in the sister project among people who had left Incapacity Benefit (IB) to take up new work.

Where people **had** informed their new employer, this had either been on an application form, at the time of interview, or through a medical report or questionnaire required on appointment to the job. Most of the people who had volunteered information about their mental health at the time of application or interview had been applying for jobs within the mental health support sector and had been aware that that personal experience of mental health problems would be viewed positively among job candidates. One of these people had worked for his prospective employer via the Permitted Work rules[14] while claiming IB and so his condition was already known about in the workplace.

There were two main reasons why people had chosen **not to** mention past or ongoing experiences of mental ill-health at the time of application or appointment to a new job. One related to perceived negative attitudes of employers, with the belief that mentioning their experience of mental health problems would damage their prospects of securing an interview or being selected for the job. The second reason reflects the fluctuating or episodic nature of some mental health conditions. Here, people explained that they were feeling (relatively) well at the time they applied for the job and so they did not think it was relevant or necessary to mention their past experiences. For some people, both of these factors played a part in their decision making.

Some people had not been asked any questions about their mental health when they were recruited to their job, but one person who experienced anxiety and depression said that she had deliberately chosen not to give details where requested on a medical questionnaire. She had considered how this could have implications in future, in that if she did start to have difficulties at work, she did not think she would later be able to claim that her work was too stressful. However, it was more important to her that her employer did not know about her mental health problems, because she perceived that this would be viewed negatively (see further in Section 2.3). Another person commented that she would not have given information had it been requested because she thought this would ruin

---

[14] People who receive IB may undertake 'Permitted Work' up to a limited number of hours and earnings, without their benefits being affected. The number of weeks that people can continue to undertake Permitted Work varies according to the hours worked, earnings received and the severity of the individual's health condition, but there is usually a limit of 12 months.

her chances of getting an interview. Where people had needed to account for an extended period out of employment, they opted to explain this in other terms, for example a break to reassess career direction or a period of full-time childcaring.

2.2 Disclosing mental health problems during employment

For most people in the study group, discussion of mental health problems with others at work came some time after they had taken up their current employment. For many, this was because their first experience of mental ill-health did not occur until some time after appointment to their present job. In addition, a majority of those with experiences predating their current job had not mentioned past or ongoing mental health problems at the time of appointment, for reasons given in the previous section. However, at the time of the research interviews, almost everyone in the study group had spoken about their mental health with one or more others at work at some point.

A range of people at work had been told about, or had otherwise come to know of, an individual's mental health problems. These included:

• Occupational Health Services;

• Human Resources/Personnel departments;

• senior managers;

• line managers;

• colleagues;

• Welfare Officers;

• union representatives.

Awareness and/or discussion of mental health difficulties arose in a variety of circumstances including:

• voluntary sharing of information when experiencing problems;

• observation of distress or difficulties by others;

• explaining reasons for absence;

• disclosure of information by others during absence;

• voluntary sharing of information at other times.

These scenarios are not mutually exclusive and some people described more than one form or circumstance of disclosure occurring at different times. Each is explored in more detail below, including the reasons underpinning voluntary decisions to share information and feelings about involuntary circumstances of disclosure.

2.2.1   Voluntary sharing of information when experiencing problems

Some people had informed their line manager and/or colleagues explicitly about their intermittent or ongoing experiences of mental health problems, in particular depression. A common rationale for this was that people felt it necessary to let their line manager and colleagues know, because it was important for them to understand that they might sometimes be less productive or why they might at times be tearful or withdrawn at work:

> *'I wanted people to know because then they understand what's going on… 'Cause it can have an impact on your colleagues and I think they have a right to know if I'm going to start biting their head off or running out in tears. At least they can think "Oh, well, there she goes again, she's having a bad day", or something, at least they know.'*

(Female, 30s, stress and depression)

> *'Because I get these cycles, he* [manager] *had to understand why on some occasions I was a right miserable old cow, and I had to explain to him why that was and what that was about, and also assure him that, you know, don't worry give me a few days, you know, stick with me and I'll dig myself out of this.'*

(Female, 50s, stress, anxiety and depression)

> *'I felt that I have to let people know that there may be times when I'm not functioning as well as I should do.'*

(Female, 30s, depression)

One individual, who recognised that his depression was impacting on his productivity at work, had approached his managers to explain this and to have it formally noted by the Occupational Health Service, in case it should become an issue in the performance review process. He also told colleagues for whom he was completing assignments at the time and asked them to come and speak to him if there were any problems with the work he was producing. One of the employing organisations from which study participants were recruited had a Welfare Officer who visited the site periodically. A small number of people said they had approached this officer to discuss mental health concerns and their impact on work.

The point of receiving a diagnosis or beginning treatment was, for some people, the trigger for disclosure. Some people had spoken to line managers and/or colleagues at times when they were altering their medication, explaining the short-term impact that this could have on their mood or productivity. Having to explain the need for time off for treatment was another context for disclosure. For example, one person who held a managerial position had explained to some of her staff that she was beginning a course of therapy to deal with some personal issues and so would be out of the office periodically. She also felt it was necessary to explain why she was tearful at times.

Longstanding and positive working relationships underpinned some people's feelings of ease in speaking to line managers and colleagues about mental health difficulties. Changes in management (a fairly frequent occurrence in some of the larger organisations) could be a source of anxiety, where the trusting relationship and understandings developed with a departing manager had to be established anew with the incoming manager. Some people found this particularly challenging and so the matter had sometimes not been broached at all. Others explained that they had waited for a while before telling a new line manager about an ongoing mental health condition. However, there were some people who said that it was generally in their nature to talk about things and they had no concerns about discussing mental health problems at work. Some said that they found it helpful to talk to others at work or that they had 'nothing to hide'.

As noted in Chapter 1, many people in the study group linked their experiences of common mental health problems with events in their personal and/or work lives and for some, these were the terms in which they first discussed their difficulties with others at work. A number of people perceived work-related origins of their mental health difficulties, for example, unfeasible workloads, bullying or poor line management and had approached managers, Personnel or Occupational Health departments with these concerns. In some cases, people had also initiated involvement of their Union in discussions about such work-related problems. Some people had spoken to others at work (in particular close colleagues) about problems they were experiencing in their personal life, which were in turn impacting on their mental health, for example, relationship breakdown or financial difficulties. Again, however, people did not always use a language of mental ill-health in these conversations.

2.2.2   Observation of distress or difficulty by others

In some cases, mental health problems had first been discussed when a colleague or manager had observed signs of distress at work. A common example was breaking down in tears during a conversation or meeting with a superior. A small number of people described how they had had anxiety attacks or episodes of acute distress in the workplace.

In many cases, individuals had responded to these situations of 'involuntary' disclosure by beginning to talk about the difficulties they were experiencing. Involvement of Occupational Health Services had sometimes stemmed from this and for some people, opening up discussion led to helpful support being put in place (see further in Chapter 3). However, some people had not wanted to share details of their mental health problems with their manager or colleagues and continued to regret or have mixed feelings about this involuntary disclosure. Two people described an ongoing sense of unease about having explained their mental health condition to managers who had observed them in some distress in the workplace, as follows:

'I lost it once in a meeting and I ended up having to tell her [manager] *'cause I just couldn't stop crying and she didn't really understand why…Things weren't going right and I just lost it. I just couldn't stop. And I just was crying and really upset with it. I just said to her, "I just can't cope," and then it just came out. I was so embarrassed it just came out.'*

(Female, 20s, bipolar disorder)

'If I hadn't have gone to the Manager the following day and told everything in minute detail, then they wouldn't have known about it, and [the distressing incident] *probably would have been left as a clash of personalities…But because I was so honest, I dug a big hole for myself and now I've got this big stigma following me around.'*

(Female, 30s, depression)

Additionally, one person recalled how the concerns expressed (sensitively) by her colleagues had only served to make her work harder to try and cover the impact of her mental health difficulties. Chapter 6 considers further how some people sought to conceal from others the impact that their mental health problems had on their work.

There were also a small number of instances where managers had noted apparent difficulties with workload or tasks and had first broached this as a performance matter. This was invariably distressing for the individuals concerned, but in most cases, people had been able to enter into constructive discussion with their manager about what might be done to support them, or had taken this as a prompt to seek help. However, one participant felt that her managers had continued to treat her situation as a performance matter even after she had gone off sick due to stress and depression and the 'warning' that remained in place at the time of the research interview was a source of ongoing anxiety for her.

2.2.3   Explaining reasons for absence

Previous research (Sainsbury and Davidson, 2006; Sainsbury *et al.*, 2008a) has identified that many people who begin to experience a gradual decline in their physical or mental health while in work continue to 'struggle on' for a time before making their difficulties known to their employer. For many people in the present study group, it was at the point of going off sick that their line manager became aware of their mental health problems. In this scenario, some people commented that they had little choice about disclosing their health circumstances to their employer.

In some cases, the details of mental ill-health were conveyed by the individual themselves and in others, this information came initially via a General Practitioner's (GP's) sickness certificate. During or after a period of certified sickness absence, Personnel departments and sometimes Occupational Health Services and other tiers of management became involved in discussions around people's mental health and work (see further in Chapter 4).

2.2.4   Disclosure of information by others during absence

Some people said that their line manager had conveyed information to colleagues or people at other management tiers while they were absent from work. In some cases, this went directly against the wishes of the individual who had asked for their circumstances to be treated confidentially. In other cases, it had been with the permission of the individual and/or was not perceived as a problem. Some people also referred to a general scenario of 'word getting round' through workplace conversation. As will be discussed in Chapter 4, some people felt it would have eased their return to work if their manager had conveyed more specific and accurate information to their colleagues about the reasons for their absence and the nature and effects of their illness.

2.2.5   Voluntary sharing of information at other times

Several people in the study group said that they had spoken to selected colleagues, those who they 'trusted' or considered to be friends, about their experiences of mental ill-health. As well as confiding in such individuals around the time that difficulties emerged, some people continued to talk with these close colleagues in the longer term, describing them as a source of ongoing support at work.

A number of people explained that the individuals they had spoken to in most detail about their experiences were people who also had personal or close family experience of mental ill-health. Deciding to share their personal experiences with such people was linked to a feeling that they had greater understanding of, and empathy for, their situation. Where a colleague also had personal or family experience of mental distress, some people commented that there was also a sense of being able to offer mutual support.

When asked about the circumstances under which individuals spoke to colleagues about their experiences, a common account was that people did not routinely go about the workplace initiating conversation about their mental health problems, but that as and when this came up in conversation or appeared relevant to mention, they were open about contributing their own experiences. Some people commented that they had been surprised to discover how many other people had experienced similar mental health problems.

Linked to this, some people said that, in light of their own experiences, they had made themselves available to others who were having similar difficulties, offering a supportive ear or advice on how to manage the situation. One person explained that he had become more alert to indications of stress in others and would sometimes attempt to approach people about this, but found that they were not always very receptive. Reflecting on his own experience of work-related stress, this person acknowledged that he may have been similarly unreceptive at the time he was becoming unwell. The small number of people who worked in roles directly supporting other mental health service users said that they would share their personal experience with clients on what they felt was an 'appropriate' basis.

However, some people noted that there was a balance to maintain between being open about mental ill-health (which they felt was important in breaking down stigma and taboo), but not talking about it 'too much'. The majority of people in the study group who had talked to others at work about their mental health seemed to retain some sense of reserve. There were only isolated examples of people who had placed themselves openly in the role of a type of 'mental health advocate' in the workplace.

2.3   Reasons for non-disclosure or 'partial' disclosure

There were only three people in the study group who believed that nobody at all in their workplace was aware of their mental health problems. However, most people had taken a 'partial' approach to disclosure and gave reasons why they remained reluctant to speak more widely than they had done about their mental health problems at work.

Perceptions that employers and colleagues would hold negative opinions about their capability, reliability or competence played a central part in some people's decisions to keep details of mental health problems to themselves. One person commented that it could be unwise to *'be too open in a job situation about wanting to talk about particular vulnerabilities'*. There was a feeling that if a mental health problem was known about by an employer, this would bring with it an additional and unnecessary degree of *'monitoring'*. People also perceived that an employer's knowledge of their mental health problems would impact negatively on future career prospects, making them unlikely to be selected for promotion. In some cases these views had been informed by the observed treatment of others experiencing mental health problems at work or through overhearing negative comments made about such individuals. One person felt that she had only reached as far as she had in her career because of the way she had kept her mental health problems hidden and made efforts to prevent any impact on her work:

> *'I just put on a front, which I think quite a few people would do with the illness, I would imagine. You have this persona that you give out and then it's not until behind closed doors that you're really your own sort of person…I wouldn't be where I was today if I didn't lie about mental health, because, you know, it's embarrassing.'*
>
> (Female, 20s, bipolar disorder)

There was some evidence that people could 'internalise' this perception that mental health problems were not compatible with a professional status. As one person explained:

'You can't just keep breaking down and crying all the time, you know, they just won't understand, and it shouldn't be like that at work, I feel. I feel at work you should try and be more professional and that's why I hate being like this because, you know, people think I'm super-efficient and very organised and motivated and professional and that is the work persona. So I don't like to have any kind of breakdown at work.'

(Female, 40s, depression)

Corresponding to the earlier observations about established working relationships (see Section 2.2.1), some people had not spoken to line managers about their mental health problems because they did not *'trust'* them and worried that this information might be used as *'ammunition'*. There was some caution about broaching discussion of mental health with new managers generally, but these concerns were particularly felt where people perceived (through observation of their general behaviour and attitudes) that their line manager would give an unsympathetic response. For some people, there was also a general sense that colleagues or managers were uncomfortable with discussing matters of mental health, in part due to a lack of understanding or negative and inaccurate media portrayals of mental illness. The words 'stigma' and 'taboo' were used by a number of people to describe how mental health was perceived in the workplace and in wider society.

A lack of confidence in workplace support systems could also be a reason for not raising mental health problems at work. For example, some people said they did not want to approach the Occupational Health Service because of unhelpful experiences with them in the past regarding physical health matters. An individual who was experiencing stress, in part related to the behaviour of his line manager, did not want to go 'on record' with a formal complaint because he felt that this would only cause him more problems. Some people commented that, while they were aware of a workplace welfare provision, they were not sure whether employee mental health came within their remit or did not trust their impartiality or confidentiality, and so had not considered approaching them to discuss their mental health.

Some people's views were also influenced by their own perceptions and understandings about mental ill-health, for example, feeling that it was a sign of weakness, feeling *'embarrassed'* or feeling guilty about taking time off sick. Some people felt that there was a risk of being *'labelled'*, which they did not want. There were also comments that people did not want pity or for others to feel sorry for them. Reflecting on the initial emergence of mental ill-health, some people observed that at this point, they themselves may not have recognised the extent of their illness and so would not have known to discuss it with others.

Some people said that they did not like to *'dwell on'* their mental health difficulties. Others explained that, while it was not something they deliberately sought to hide, their past or ongoing experiences of mental ill-health were not something that they felt the need to talk about at work. Reflecting the concept of a continuum

of mental health (see Chapter 1), some study participants did not think it was necessary to talk about their experiences at work now, because they felt that they were largely recovered and their mental health was not affecting their work. As one person described it, his mental health was not an *'active issue'* at the present time.

2.4   Discussion

In view of the common perception among people in the study group that mental health is a taboo subject in the workplace and in wider society, it is notable that the vast majority of individuals had spoken to somebody at work about their experience of mental health problems. There were only three people in the study group who believed that nobody at all in their workplace was aware of their mental health problems. All of these people had taken up their current employment some time after the first emergence of their mental health difficulties and had chosen not to tell their new employer. There is some evidence, therefore, that when mental health problems initially emerge in work, this will become known to at least one other person in the workplace. Thus, rather than a situation of complete concealment of mental ill-health, the picture is more one of selective and partial disclosure of information.

Despite some people feeling able to talk openly about their mental health problems, the extent to which people chose a form of 'partial' disclosure or had endeavoured as far as possible not to let others know about their experiences demonstrates that there was still a common wish not to have mental health problems widely known about at work. Partial disclosure can be understood in two dimensions: firstly, which people in the workplace mental health problems are discussed with; and secondly, how much is shared about mental health problems. Among the study group there were people whose mental health problems were known about in a 'formal' capacity, with Personnel or Occupational Health departments holding this information on record, but whose immediate line manager or colleagues were unaware. Conversely, there were people who had talked to close colleagues but had never disclosed mental health problems to senior managers or Occupational Health Services. Considering the second dimension of disclosure, some people had talked about their experiences in some depth, using the language of mental ill-health, while others had expressed difficulties in terms of family problems or 'stress' but had not shared the full extent of their mental distress.

In the accounts given by most people in the study group, there were two broad phases of experience where mental health may have been discussed with others: the emergence and initial response to mental health problems; and talking about mental health in the longer term (over which time mental health often improved). Different factors played a part in people's decisions about talking to others at each stage.

Regarding the emergence of problems, echoing previous studies, several people 'struggled on' without approaching their employer for support, although they may

have talked to close and trusted colleagues. For many people, it was only when mental health problems became impossible to conceal, when distress became visible or they had gone off sick that they began to talk about problems with managers, Personnel or Occupational Health departments. However, there were also people who had voluntarily spoken to line managers before a time of 'crisis', often because of a sense that this was the correct thing to do and that their situation needed to be understood at work. There was evidence that voluntary disclosure of this sort was supported by existing positive working relationships with line managers. Feeling able to 'trust' the individual was important for several people and there was evidence that people found it easier to talk to others with similar experiences. Over the longer-term, some people had begun to share details of past or ongoing mental health problems with managers or colleagues as relationships became closer and more trusting, as they developed greater insight or perspective on their experiences, or had talked about personal experiences where these became pertinent, perhaps in offering support to another person. These approaches reflect the concept of disclosure as 'not an event but a process' as identified by Brunner (2007). As will be considered in the next chapter, the timing and context within which mental health problems were first discussed sometimes had implications for the way in which managers and colleagues responded to this information.

A number of barriers to disclosure of mental health problems were evident, and these echoed the findings of the sister project. Some of these came from the 'employer side' where expectations of a negative response to disclosure, based either on perceptions or direct evidence of managers' or colleagues' attitudes, was a deterrent. People worried that they would be perceived as less competent or that their prospects for career advancement would be damaged if managers knew about their past or ongoing mental health problems. However, there were also a number of 'employee side' barriers emanating from the individual's own perceptions of their mental health problems, including feelings of shame or embarrassment, or wanting to keep a 'persona' at work that did not include a label of mental ill-health. This had led a number of individuals, at least during their first experiences of mental distress, to struggle on without seeking support from their employer. This finding that some people wanted to keep their mental health problems hidden or 'separate' from the workplace has implications for developing a culture where mental health problems can be supported in the workplace and the two can be successfully managed alongside each other. As will be explored in Chapter 8 there was evidence, that many people would have, in principle, welcomed the opportunity to discuss mental health problems more openly, but not within the climate that they currently perceived in their workplace.

For some people, however, having mental health problems known about at work had enabled helpful support to be put in place and had prevented situations worsening to a point where their employment potentially became at risk. The next chapter presents findings on the responses that people received when their mental health problems became known to their employer and colleagues, and the forms of support and adjustments that were offered.

3   Responding to mental health problems at work: adjustments and other support

This first section of this chapter (Section 3.1) describes the broad responses to learning about their mental health problems that people in the study group had received from others at work. Section 3.2 considers the specific workplace adjustments and the other forms of support which people had received and Section 3.3 considers the role played by the Disability Discrimination Act (DDA) in relation to these arrangements. Section 3.4 considers the involvement of third parties in managing mental health and work, specifically medical practitioners, family members and employment support services. The chapter ends (3.5) with a discussion of findings and key points raised.

3.1   Responses to disclosure of mental health problems

This section discusses the immediate reactions and more general responses that people perceived in relation to disclosure of information about their mental health problems at work.

As noted in Chapter 2, most of the people who had disclosed past or ongoing mental health conditions at interview had been applying for jobs where it was openly stated that this would be viewed positively (and this had indeed been their experience). The one individual who had mentioned his mental health problems to a non-mental health focused employer said he had explained that he had occasional problems with depression and that the condition was managed. His perception was that the employer had been 'okay' about this at the time of his interview, but no discussion of adjustments or support was initiated. Few of the individuals who had disclosed information via a medical report or questionnaire

perceived any apparent response to this information at the time of appointment, although two people had experienced lengthy delays between being offered their job and starting in post, because of the time taken to obtain medical reports. One person who had told her employer on appointment about problems with depression felt that she had not been 'believed' because at the time she did not appear to be unwell. This has implications for employer understanding about the fluctuating nature of many mental health conditions.

Where mental health problems had first been discussed or become apparent some time after employment, people described a range of responses, from very positive and supportive, to what was perceived by the individual as unhelpful or an over-reaction, to a complete lack of response.

Beginning with more positive responses, some people said that colleagues or line managers had responded with sympathy, for example, saying that they understood the work or personal life pressures that the individual was under, or with empathy, for example, sharing details of similar personal or close family experience. In some cases, managers initiated referrals to counselling services or engaged in discussion about potential helpful adjustments at work (see further in Section 3.2). One person, whose difficulties had initially been perceived as performance concerns, described how, through negotiation with his line manager, his employer had gone on to fund counselling to address the difficulties that were impacting on his work.

In contrast, some people perceived their line manager's response as an over-reaction or as overtly discriminatory. These experiences were fewer overall than positive responses, but had quite severe impacts for the individuals concerned, both in the immediate term and in their future decisions about talking to managers or colleagues. In one example, an individual perceived that on learning of his mental health problem, his line manager had begun to take steps to get him removed from the team: *'My local line management were reacting unfairly and instinctively, as it were, in order just to try and get rid of me'*. Another person described how she had been 'sent' to see the Occupational Health Service when, on being given a promotion, she had decided to tell her manager about her recurring experiences of depression. This instruction to see the Occupational Health Service had made her feel under pressure and had led her to decide not to mention her mental health problems to future line managers:

> *'I was brave enough, on that occasion when I was given the promotion, to say "Look, I do have difficulties" and when I did that* [the manager] *sent me to Occupational Health. I didn't want to go. They sent me, and said "Because I want to know that you're fit to do this job and if you're not fit to do the job, then you shouldn't be doing the job"…I felt kind of blackmailed into going to the OHS, to ensure that I could keep a job that I'd been given.'*

> (Female, 30s, depression)

The above quote suggests that there may be misperceptions from line managers and employees about the intended role of Occupational Health Services and potentially scope for improvement in the way that these services are presented, as supportive rather than threatening.

There were no accounts of overtly negative responses from colleagues among people who had spoken about mental health problems at work, though some were described as being *'nosy'* or curious about the causes and effects of people's conditions, and one person's perception was that his colleagues had initially been a bit frightened of him. Reflecting some of the assumptions and misconceptions about mental illness, some people's colleagues were surprised to learn that the individual was or had been affected by mental ill-health because they were so effective and productive at work.

Finally, some people felt that there had been no response or acknowledgement of the information they had shared. In cases where people perceived work-related origins of their mental health difficulties, there was often a view that their concerns had not been adequately acknowledged when they had mentioned problems to their employer and this had led to situations worsening, eventually leading to extended periods of stress, depression or anxiety-related sickness absence. Responsive actions were only taken by the employer when some type of 'crisis point' was reached and there were questions from some study participants about why this had to be the case. Reflecting on her experience of returning to work from a long absence, one participant described how there had been no proactive offer of support from her employer, only reactive responses when problems occurred:

> *'There was nothing to say, well perhaps she ought to do a different, a lesser role and then work your way back up for it. There was nothing like that at all. So it was just like, okay, we'll pick up the pieces when it happens, but the rest of the time we'll just wait for it…It was reactive to what happened with me really.'*

> (Female, 30s, depression and anxiety)

Likewise, there were some instances where information about pre-existing mental health problems supplied to Personnel or Occupational Health departments at the time of appointment was not responded to in any way until such time as acute difficulties emerged in work.

Some people felt that the lack of response from line managers was because they did not know how best to approach things. As one person commented:

> *'No-one knows how to deal with this, no-one knows what to do. So although there's processes and procedure, individuals don't know how to deal with this at all.'*

> (Male, 40s, stress and depression)

There was a perception from some participants that their manager's uncertainty about how to respond, or discomfort in talking about mental health problems,

had led them to shy away from such discussions or to *'brush it under the carpet'*. One participant, who worked in a mental health setting, perceived that the greater challenge around opening up discussion of mental health was not negative or discriminatory attitudes, but of employers feeling uncertain about what they should say or do, and therefore saying nothing. As he described:

> *'It's not fear of mental illness or the fact that they're carrying a knife in their pocket, which is what most people seem to think, or the newspapers seem to think. It's fear about people not wanting to be seen to be saying the wrong thing.'*

(Male, 30s, bipolar disorder)

A sense that managers had been uncomfortable talking to them about mental health problems had sometimes deterred people from trying to initiate such conversations again. A lack of time for line managers to address employees' mental health concerns, when under pressure to *'get the work done'* at *'grass roots'* level was also noted. Participants' views about a need for greater employer understanding of mental health problems and engagement when difficulties are disclosed are discussed further in Chapter 8.

Notable in some people's experience was that different managers within the same organisation could make very different responses to the employee's mental health problems. There were a number of examples where a change in line management had resulted in a much more positive experience for the individual or alternatively, where much less support was received from an incoming line manager (this was sometimes linked to the individual's decision not to disclose to a new manager, as discussed in Chapter 2). Another circumstance was of a direct line manager seeming reluctant or uncomfortable about offering support, whereas a more senior manager was willing to engage in detailed discussion of mental health problems and what might be done to help. These findings point to implications for consistent and coherent responses to supporting mental health difficulties in the workplace.

3.2   Adjustments and support

From people's accounts of what helped in work, it was evident that support could take a number of forms, including not only formal adjustments to their role arranged by their employer, but also more informal or 'softer' types of support. Notably, for many people, making adjustments to their workload or working arrangements through the standard flexibilities of their job was also a significant part in what helped them to manage. These three broad types of support: formal adjustments; softer support; and standard flexibilities of the job are explored in the sections below.

This section focuses on adjustments and support at times when mental health became problematic for individuals. Recalling the concept of mental health as a continuum and as a resource to be protected (see Chapter 1), people in the study

group also cited a number of things that helped them to maintain a more positive state of mental health day-to-day. Workplace factors played a role in this longer-term management of positive mental health, but discussion of this is reserved for Chapter 5.

3.2.1 Formal adjustments and support

For many people, any adjustments made by their employer were implemented for a period of time when they were most unwell, but at the time of the research interviews, there were few people who described long-term or ongoing formal adjustments to their working conditions. One person who had a diagnosis of bipolar disorder explained that a reasonable adjustment had been written into his contract that enabled him to work half days for as long as required if he experienced a period of more acute ill-health. This reduction in hours was not classified as sickness absence and so did not contribute to any monitoring or intervention regarding cumulative time off sick. A second person, who experienced depression which tended to worsen during the winter months, had arranged an adjustment to her contract which reduced her working hours during January to March. This latter person also had an arrangement whereby she could take a day's annual leave at very short notice (i.e. the same day) if she felt she needed a day away from work. Both of these individuals felt that the arrangements they had in place were helpful in preventing the need for a short-term reduction in work pressures from becoming a long-term sickness absence. One explained that the short-notice annual leave arrangement worked very well because there were occasions where she did not feel unwell enough to necessitate a day 'off sick', but felt the need for a day away from work where she could rest or do an activity that boosted her mental wellbeing. Moreover, neither had needed to draw on the short-notice arrangements very often, each citing only three or four occasions per year, for only a few days at a time.

Among people who described an acute period of mental ill-health while in their current employment, the adjustments offered by their employer at this time typically included a reduction in hours, workload or duties. This sometimes involved a discussion with line managers about prioritising and managing workload more effectively; one person had been given an assistant (though not until after the pressure of work had led to a long period of absence due to stress). Some people described how they were put onto 'light duties' or were not required to undertake tasks which exacerbated their mental health problems, for example, off-site excursions which triggered panic attacks.

Some people had been signposted by a line manager, Occupational Health Service or colleague to counselling or therapeutic services provided via their employer, sometimes referred to as an Employee Assistance Programme (EAP)[15]. There were

---

[15]   EAPs typically provide a telephone helpline staffed by trained counsellors, which employees can access directly, and can offer short-term face-to-face counselling (typically four to six sessions) for employees who require more in-depth support.

also people who had health insurance provided via their employer and who had been able to seek private counselling or therapy which was then refunded. Some people noted that this had enabled them to access support much more quickly than if they had had to join a waiting list for National Health Service (NHS) provision (views on effectiveness of counselling/therapies are considered in Chapter 5). Also helpful was where line managers had been flexible about allowing people to take time off for counselling/therapy appointments during the working day.

Although most adjustments were described as helpful, a small number of people had experienced what they felt to be inappropriate adjustments to their role, or adjustments that did not help their situation. One person described how, following an acute episode of distress at work, managers had put in place a set of narrow restrictions around her work tasks and imposed a regimented timetable, neither of which was helpful (flexibility being one of the key factors that helped her to manage). She had hoped that being open about her mental health problems would have resulted in more positive support at work, but as she described, *'it just went the other way, that they thought I was a liability, I think'*. Another person with a long-term condition described how his manager had allowed him to take extra breaks during the day when he began taking a medication that caused drowsiness. Although his line manager was happy for this arrangement to continue, the individual did not feel that this was a workable long-term solution (in part because of how he felt colleagues viewed this) and so investigated alternative types of medication. Discussions with Occupational Health Services and Welfare Officers were sometimes described as sympathetic, but resulting in no concrete offer of support, which could be frustrating for the individual.

As noted in the previous chapter, some people had never talked about their mental health difficulties with anybody at work. Thus, there was no potential for a supportive employer response in these cases. However, some people who had told their employer about a longer-term ongoing mental health problem said that there had never been any discussion of possible support or adjustments. There were also some individuals who felt that they did not want any formal adjustments to be made for them, preferring to be treated the same way as everybody else in the workplace. Some people also said that they could not think of any adjustments that their employer could make for them.

3.2.2   'Softer' forms of support

In addition to the formal adjustments to role or workload discussed above, a number of people highlighted the more general attitudes and approaches of managers as a helpful aspect of overall support at work.

Elements of a positive approach from line or senior managers included:

• genuine concern for the individual's mental wellbeing and willingness to engage in discussion about this (sometimes leading to more formal adjustments, as above);

- occasional 'light touch' monitoring of how the individual is feeling and how they are coping with work;

- understanding of and alertness to the signs of mental distress and a willingness to broach this with the individual;

- encouraging and supporting the individual to seek medical or therapeutic treatment (including signposting to services available via the employer, as above);

- dealing sympathetically with impact on productivity and not making the individual feel a burden to the team/company during absences or periods of reduced performance.

There were also people who said that colleagues had been supportive in relation to their experience of mental ill-health, for example, providing a listening ear for their worries or frustrations. Some people had discovered that other colleagues had similar experiences of mental distress and had found it particularly helpful to talk to these individuals. As with managers, an understanding response to the need for 'time out' or flexibility was appreciated. One person described how his colleagues were understanding about his need to occasionally take a break from the workplace to release tension, or as he put it, *'walk round the block, kick a cat and come back'*. There were also a small number of examples where a particular colleague had played a key role, for example advocating for the individual at a meeting with their employer.

3.2.3   Standard flexibilities of the job

For a number of people, helpful factors when they were experiencing periods of mental ill-health were the flexibilities that were inherent in their job arrangements and would be available to anybody working in that role. Specifically, these included flexitime and the option to work at home on occasion.

Drawing on flexitime provisions, some people experiencing depression found it helpful to be able to organise their work day with later start and finish times. One person described how anti-depressant medication made her feel nauseous in the early mornings and so it had been helpful to be able to travel later in the day.

Some people were able to work from home on an occasional basis and had found this very helpful in managing mental health and employment. As will be discussed in Chapter 6, some people found they 'withdrew' at times of increased anxiety and depression and found it difficult to engage with others. Another described how travelling on public transport during rush hour exacerbated her anxiety problems. By having a day or two away from the workplace if they were experiencing a period of increased anxiety or depression, people could continue with their work without taking time off sick.

A number of people also found it helpful to be able to take occasional days off work at short notice. Using annual leave or accrued time off in lieu through flexitime were two ways that people were able to take intermittent days off work when

they felt the need for a break. In effect, this closely resembled the arrangements that had been made for some people under the guise of formalised reasonable adjustments, described in Section 3.2.1. However, most people who approached this through normal flexibilities of their job did not explain to their employer that they were taking this time off specifically for mental health reasons.

Some people explained that, because of the flexibility inherent in their job, there had been no need to negotiate a formal adjustment with their employer; had this flexibility not been in place already, they may have had to approach their manager to discuss altered or reduced hours. In contrast, there was some evidence that people who did not have this flexibility to respond to intermittent short-term 'lows' of mental health might adopt a strategy of calling in sick under the guise of flu or a stomach bug rather than being open about their need for time off for mental health reasons (see also Chapter 4).

These flexibilities in working hours and location were also cited as helpful in maintaining positive mental health on a longer-term basis, as will be discussed in Chapter 5.

3.3   The role of the Disability Discrimination Act

This section discusses the role played by the DDA in relation to people's experiences of in-work adjustments and support. The DDAs (1995 and 2005) place a legal responsibility on employers to make 'reasonable adjustments' for employees who have physical or mental impairments or health conditions that have a *'substantial'* and *'long-term'* impact (defined as 12 months or more) on *'normal day-to-day activities'*. The Act has always applied to some mental impairments but the 2005 revisions extended the range which is covered by removing the requirement that the impairment must be *'clinically well recognised'*. Interviews in the present study explored people's awareness of the DDA and whether and how this had played a role in their experiences of support at work.

Around three-quarters of the people in the study group said that they had heard of the DDA, although only about two-thirds of this subgroup were aware that mental health conditions could be covered by the provisions of the Act. What people knew about the DDA had been gleaned from various sources, including: knowledge of health/disability issues acquired as part of their work role; employers' general publicity or awareness training; specific discussion of their own health circumstances with their employer; or contact with Unions or the Citizen's Advice Bureau.

Thirteen people in the study group indicated that the DDA had played some role in their own circumstances although, as discussed below, in three cases this was perceived as primarily for physical health reasons. No formal process exists for 'registering' as a person with disabilities and there were various ways in which people described the status of being in some way 'covered' by the DDA. Among the larger employers, this typically involved a record of the disabling condition

being made on the employee's Personnel file. In most cases, it was Occupational Health Services who had suggested the individual could be covered by the DDA, although there was one example of a Union representative making this suggestion. There was also one participant who said he had recently updated his own Personnel record independently, via the company's intranet, to indicate that he had a disability. At the time of the research interview, he had received no response to this action. The two people working for specifically mental health focused organisations (both of which were smaller employers) had both had detailed discussions with their line managers about what adjustments would be helpful to them. While in one case this was discussed specifically in the language of the DDA and reasonable adjustments, in the other there had been no explicit mention of these terms. Another person said that although the DDA had never been specifically mentioned by his employer, his approach was to '*work on the basis* [that] *I'm covered by it'*.

There were also people who were not aware of the DDA but who described positive responses of employers in supporting them through periods of mental ill-health. More generally, people also mentioned their awareness of employers' provisions for phased returns to work after absence. This may suggest that there were people in the study group whose employers were aware of the legal responsibilities placed upon them by the DDA and were acting under these auspices, although they had not spoken to the employee in these terms. Another possible explanation is that these employers were simply keen to 'do the right thing', as found in the study's sister project (Sainsbury *et al.*, 2008a).

Although some had been surprised to learn that they could be covered by the DDA because of their mental health condition, most people who had taken up an Occupational Health Service's suggestion to record a disability were comfortable with the decision, feeling that there were actual or potential advantages for them in their treatment at work. In discussing their understanding of what being 'covered' by the DDA meant for them, some people referred to a fairly general sense of managers having to treat them more *'sensitively'*, *'carefully'* or to be a bit more *'lenient'* with them. There was also an understanding that this gave entitlement to specific adjustments and flexibilities in their working conditions or that managers could not require them to take on particular tasks or roles. Some people had drawn upon the DDA when work-related problems (for example, stress or performance issues) had arisen and for one person, the provisions of the DDA had been helpful in establishing that periods of absence due to depression would not be counted towards her cumulative sickness absence record. There were also some cases where it appeared that having a disabling condition noted by Personnel had not, as yet, resulted in any concrete changes to the individual's work circumstances. However, these people felt that there might be potential benefits to having their condition formally noted, should they need to call upon the provisions of the DDA in future. As one person described: *'It doesn't bother me one way or the other, but it's a case of it might be useful one day, but I don't know'*.

The three people who had physical disabilities alongside their mental health problems all explained that it was this physical condition and not mental health that had been recorded by Personnel departments in relation to the DDA. Two of these people had not been aware that their mental health condition could also be covered by the Act. Reflecting concerns about disclosing mental health problems at work, the third person explained that her physical disability (which allowed the provision to work from home) provided a *'nice little cover for some of the other stuff'*.

The views of people who had not discussed the DDA with their employer revealed two key areas of reservation about raising this matter. One was that bringing the DDA to bear on their work situation would require disclosing their mental health problem, which some people did not want to do, even in a 'partial' way. The reasons for this have been discussed in Chapter 2, but to highlight an example, some people felt that disclosure of a 'disability' in this sense would change the way their employer viewed them and would put an end to possibilities of career progression. As one person commented:

> *'I think it would just put the kibosh on any kind of career development, because I think that any organisation would look at you and say, well, you know, can that person take on a more stressful job or a more senior role.'*

> (Female, 40s, depression and anxiety)

However, although they did not want to draw upon the DDA themselves, among this same group of people there were comments that it was reassuring to know these provisions existed and that they might be useful more broadly in influencing employers' actions and improving their understanding of mental health problems.

The second common reason for not wishing to use the provisions of the DDA was that some individuals did not consider themselves to be disabled. One person commented that he would *'struggle to convince someone'* that his mental health condition was a disability and moreover, he did not himself see it as disabling. Another person expressed very strongly that only the most severe mental health conditions should be treated as disabilities, and there were others who were not sure that their experience of more mild mental health problems would *'count'*. A view from one person who had experienced fluctuating periods of depression throughout her adult life was that the DDA was *'too extreme'* a measure to apply to her circumstances because there were periods of time when she did not feel mentally unwell. This was echoed by an individual who, although experiencing a period of mental ill-health at the time of the research interview, felt that she did not meet the definition of disability as contained in the DDA and did not see her condition as long term.

As noted elsewhere in this report, many people perceived their experiences of mental ill-health as short term or intermittent, rather than severe and enduring. Although people perceived their experiences as **disabling** for a time, it seems

unlikely from their accounts in the research interviews that many would consider themselves disabled in a permanent sense[16]. As one person explained:

> *'The reality of my mental health condition is that I'm constantly on a spectrum of performance, and have only, on a couple of occasions, dipped below a threshold at which I'm probably unable to genuinely perform. And it's gone away again, which doesn't really happen with a disability.'*

> (Male, 40s, depression)

These views illustrate the complexity surrounding disability, the DDA and common mental health problems. The evidence among the study group was that their own understandings of mental ill-health and definitions of disability, how they thought other people would view their circumstances, and also the wider issue of disclosure, all contributed to whether or not they felt that it would be appropriate or desirable to draw on the provisions of the DDA.

3.4   The involvement of others regarding mental health and work

3.4.1   Medical practitioner involvement with work

The types of involvement of medical practitioners regarding work, as described by people in the study group, can be broadly divided into three main types: provision of information to the employer; advice to the individual on taking time off sick and/or returning to work; and discussion with the individual about managing work and mental health.

Communications with employers

Beyond the provision of sick notes, some people's General Practitioners (GPs) (and less frequently therapists) had written reports or letters about the individual's fitness for work. Sometimes this was at the request of the employee (for example, in support of their position where there was a conflict about appropriate support at work) and sometimes the employee had given permission for their employer to request a report for Occupational Health Services. In a small number of cases, GPs or therapists had been in verbal communication by phone or face-to-face with employers regarding an individual's fitness for work or progress in recovery. One person had initiated this contact herself, but communication after a first meeting had not been sustained. For another person, although she had granted permission for this communication to take place, it remained a source of anxiety.

A number of people in the study group knew for certain that there had been no communication between their GP or therapist and their employer, while others believed that communication had not extended beyond what was detailed in sick

---

[16]   Only one person in the study group said that they received Disability Living Allowance (DLA) because of their mental health.

notes. Although there were some comments that more detailed communication between these parties would not be desirable because of the confidential nature of the doctor-patient relationship, comments that this would be helpful were more frequent. People felt that it would be useful for their managers and employers more generally, to understand more about mental health conditions and their effects and for GPs to engage in productive discussion with employers about suitable return to work plans and in-work support strategies. However, the time constraints under which GPs worked was noted as a barrier in this respect. Among employers who took part in the sister project, there were also people who said they would like to work more closely with GPs, in order to develop their understanding of mental health conditions and so improve job retention and support strategies.

Discussion with individuals about work

GPs were frequently cited as having a role in decisions about taking time off sick. In most instances, people said that their GP had advised or supported their request for a period of certified sickness absence. However, there were also cases where GPs had recommended that the individual continue going to work or had not broached the topic of a sick note. Therapists were not described as having involvement in decisions to take time off work, but both they and GPs were cited by a small number of people as giving an opinion on whether or not the individual was ready to return to work. For different people, these had included concerns that it was too soon or, in contrast, encouragement to try a return to work.

Both GPs and counsellors or therapists were reported by a number of people to have engaged in discussion with them about managing work and mental health. This included conversations about: the impact that mental health problems were having on work and the potential role of work in exacerbating these problems; the suitability of their particular job in view of their mental health problems; the appropriateness of employer responses (sometimes with offers of support or advocacy for the individual should this be required); and discussion of possible return to work arrangements, in-work adjustments or coping strategies.

However, there were also people who said that their GP and/or therapist had not talked with them in any detail about work, for example, saying that the focus of appointments was on prescribing medication or issuing sick notes, or that the topic of work simply did not come up. Again, the time constraints faced by GPs was noted in this respect. A few people commented that it would be helpful to talk to their GP about work and some had faced barriers to opening up such discussion, for example, a GP saying it was *'not my department'* or the fact that they never saw the same doctor twice. However, some people also explained that work was not part of the problem for them, and that sessions with a GP or therapist had focused on managing symptoms and addressing non-work related underpinnings of mental health difficulties.

3.4.2 Relatives' involvement with work

Across the study group, it was rare for family members to have had a great deal of involvement with employers with regard to people's mental health problems. The most common type of contact described was where a partner or parent had rung in sick on behalf of the individual when they were not able to go to work and did not feel well enough to speak to someone about this over the phone. In one of the few examples of greater involvement, one person's partner had needed to collect her from work when she had become very distressed in the workplace and had subsequently had a detailed discussion with her line manager about the nature of her mental health difficulties at this time. There were also isolated examples of a partner liaising with the employer at intervals during long-term absences. However, there were also people who said that they would not want their partner or other family members to become involved in discussions with their employer concerning their mental health, preferring to keep the two aspects of their life separate.

Away from direct contact with employers, some people described how their partner or family had been supportive when it had come to discussing whether staying in their job was the right thing to do, for example, assuring them that they would support their decision and that they would find ways to cope financially if they decided to leave their job. There were also people who said relatives had urged them to take time off sick when it was becoming evident that they were unwell.

3.4.3 Involvement of Employment Support Services

Very few people in the study group had claimed unemployment or incapacity benefits during their experiences of mental ill-health and likewise only a few had been in contact with specialist support services with regard to mental health and employment. Those few who had were all recruited to the study group via an employment support provider (see Chapter 1) and so had been in contact with that service prior to taking up their current employment. One person had come to his current job via Permitted Work, signposted by an employment support provider and three had undertaken training or voluntary work with providers before re-entering paid employment.

3.5 Discussion

There was a great deal of variety in people's experiences of employer responses to and support for mental health problems. The overall impression gained from people's various experiences was that the nature and quality of response and support received from managers and colleagues seemed largely a matter of individual attitude rather than a consistent organisational response. There was evidence to suggest that responses perceived as more supportive and appropriate often came from managers and colleagues who had personal or close family experience of mental health problems themselves. This echoes findings from research from the

Shaw Trust which reported that, among people who had experienced mental health problems, 'their most successful forays into employment came when managers had a strong understanding of mental health, mainly from having experienced it in the past with other employees or with family members' (Future Foundation, 2006). This points to the importance of knowledge and understanding about mental health among people who have a workplace responsibility for others. A relevant concept here, which will be discussed further in the concluding chapter, is that of 'mental health literacy', defined as: 'the knowledge and beliefs about mental disorders which aid their recognition, management and prevention' (Jorm, 2000).

The finding that nobody who had spoken about their mental health condition at work had encountered overtly negative responses from colleagues poses something of a contradiction with the perception that there remains stigma and negativity around mental ill-health. Comments overheard by some study participants about **other** colleagues who were experiencing mental health problems indicate that this is not entirely a misconception. However, there were also people who, having begun to discuss their mental health problems at work, were surprised to discover how many other people had close or personal experience and many people had found at least one supportive person to talk to at work. To some extent then, there is perhaps an overestimation of the degree that mental health remains a taboo subject. The evidence in this study suggests that there may well be many pairs or small groups of people sharing experiences, but with no collective awareness that many people have understanding and support that they would be willing to offer.

A key finding was that where details of mental health difficulties were provided to employers at a time when they were not acutely problematic, this information frequently went unacknowledged. Although there were exceptions, most people's experience was of responses being made only when problems became acute, for example, an episode of severe distress occurring in the workplace or an extended period of absence. The consequence of this was that employer actions sometimes felt 'knee-jerk' and inappropriate rather than being measured and sensitively handled. As will be discussed in Chapter 8, several study participants called for greater employer engagement in discussion of mental health difficulties in a more proactive rather than reactive way.

People's accounts of adjustments, support and other helpful factors at work revealed that it was often a combination of specific employer actions, 'softer' support and also flexibilities within their normal job arrangements which played a part in managing mental health and employment. Flexibility in hours (across the working week or in overall contracted hours) and work location was central to some people's management of mental health and work. This echoes findings of the sister project, where some people cited the hours or flexibility of their role as important in sustaining work alongside a fluctuating condition in the move off Incapacity Benefit (IB). Many people in the present study group were in roles where flexitime and home working arrangements were commonly provided. This

raises questions, however, for employees who do not work in an environment where this is practicable, for example, shift workers, people in customer-facing roles or in 'time critical' production lines.

A noteworthy 'reasonable adjustment' was that of short-notice leave in respect of mental health, but which was not counted as sickness absence. This raises important questions about how mental health and mental 'illness' might be understood and points to wider considerations of nurturing and protecting positive mental wellbeing. There were examples of people who were aware, with hindsight, of the impact of stress (from whatever source) on their mental health and who took preventive or responsive action by removing themselves from the workplace on a short-term basis. However, they themselves did not wish to present this as sickness absence. There was much evidence among the study group that this was an effective strategy and this might have wider implications for employers' policies around sickness absence, annual leave and working hours.

While there was some evidence that GPs and therapists had engaged in conversation with individuals about managing mental health and work, there were few reports of medical practitioners entering into detailed discussion with employers about the nature of people's mental health problems or what support at work might be useful. While there was recognition of the barriers presented by time constraints and confidentiality, some people did think it would be helpful if there were more direct discussion between employers and medical practitioners, with a view to increasing understanding. Across the study group as a whole, family members and employment support services had not played a significant role in advising on work or communicating with employers.

The DDA had featured in the experiences of around one-third of the study group, and for these people, it had helpfully underpinned either the negotiation of specific 'reasonable adjustments' or served as a backdrop for more flexible and sensitive treatment by their employer. However, there were views from a number of people who had not drawn on the provisions of the DDA that this piece of legislation would or should not apply to their circumstances, because they did not perceive themselves to be disabled according to its definition – in particular not seeing their experiences of mental ill-health as permanently (or even at all) 'disabling'. Challenges in understanding definitions of 'disability' and the disparity that may exist between legislative and individual conceptualisations have also been highlighted in research with employers (Sainsbury *et al.*, 2008a; Simm *et al.*, 2007). Moreover, while there is some evidence that employers' awareness of the DDA is increasing, this does not necessarily equate to thorough understanding of its content, scope and implications. Employers still appear to be more aware of 'visible' disability and impairment (Simm *et al.*, 2007) and relative to physical conditions, mental health problems are less often considered as a disability[17].

---

[17]   Although people with 'non-visible' illnesses such as cancer, epilepsy, HIV and diabetes were less likely to be considered as disabled than people with mental health conditions (Simm *et al.*, 2007).

4 Absences and absence management

This chapter looks at people's experiences of absence from work due to mental ill-health, including the actions and responses of employers and colleagues during their period off sick and in their return to work. While it may at first seem paradoxical to include absences from work as part of the overall approach to managing mental health and employment, the benefits to mental health of short periods away from the workplace have already been noted in the preceding chapter and it is important to recognise that for some people (though by no means all), being away from work for longer periods at certain times was seen as necessary and a part of the broader approach to recovery[18].

The first part of the chapter (Section 4.1) looks in some detail at people's experiences of long-term sickness absence, defined for the purposes of this discussion as lasting one month or more, with consideration of employer contact and support during absence and arrangements when returning to work. Section 4.2 then looks at shorter-term absences followed in Section 4.3 by a discussion of people's attitudes towards absence and the reasons why some people had taken little or no time off sick due to mental ill-health. The chapter concludes (Section 4.4) with a discussion of the findings and issues raised.

4.1 Long-term absences

Just under half of the study group described an absence from work while with their current employer that had lasted for a month or more. As described in Chapter 1, several people's experiences of mental health problems involved a central episode of acute mental ill-health, where a period of 'struggling on' had culminated in a 'breakdown' point, followed by a significant period of time away from work. The length of this absence ranged from five weeks to 18 months, most commonly being around four to six months. A small number of people had had two such periods of extended absence at different times.

---

[18]   At the time of the research interviews, none of the participants was in a period of sickness absence due to mental health problems.

As well as long-term sickness absences, there were a small number of people among the study group whose absence was in part related to mental health problems, but coincided with time off work due to other health, personal or employment circumstances and so had not been recorded by their employer explicitly as mental health-related sickness absence. These circumstances included complications during pregnancy, maternity leave allowance, unpaid 'career breaks'[19] to focus on domestic and family matters, and periods of agreed absence from the workplace where grievances were being dealt with.

The financial impact of mental ill-health is discussed further in Chapter 6. Notable here, however, is that everybody in the study group who described a longer-term sickness absence while with their current employer worked for a large organisation and had been entitled to their full salary for the first six months of absence, and in many cases a further six months on half pay (had this been required).

4.1.1   Contact and support during long-term absence

During the time that they were away from work, most people had received some form of contact from their employer and several commented that they understood that this was required under their employer's absence management procedures. The format, frequency, content and perceived helpfulness of this contact varied among the study group, as detailed below.

Line managers or Personnel departments were the most common points of contact during absence, with Occupational Health departments sometimes taking on this role. One person, who had experienced periods of absence with two different employers, described how in her current job, it had been more helpful that contact had been with her immediate line manager, who knew her personally, rather than with the Human Resources department (as in her previous job) with whom she had no existing relationship:

> *'They* [current employer] *were really, really much better than the company I was previously working for. I felt like everybody was involved in the decisions and stuff, whereas in my last company, I had to speak to HR directly…I had to speak to someone who I really didn't know, tell them all these things, what stuff had happened to me, and then knowing full well that they had to relay it back to someone else, and I didn't hear anything from my boss or any of the colleagues that I worked with.'*
>
> (Female, 20s, depression and anxiety)

The timing of first contact and the frequency of subsequent contacts with employers varied, but approximately monthly communications were commonly recalled. Initial contact had usually been made by telephone, but several people had then met with their line manager or another representative in person. In one case, contact had been maintained periodically by email. Some people had met

---

19   A provision made available to all staff, for a range of circumstances, by some employers.

their employer at their workplace, others had met in a public place such as a café or pub and, in some cases, line managers had visited employees at home. There was evidence that these arrangements were usually negotiated with the employee and a mutually agreeable location was selected.

A number of people described finding these meetings difficult, at least in the first weeks and months of their absence when they were feeling most unwell. Especially where mental health problems were perceived as rooted in workplace issues, contact with managers could be very challenging. There were a small number of examples where people had asked their partner to liaise with their employer on their behalf. In recognition that, at times of acute ill-health, people might feel unable to enter into communications with their employer, one suggestion was to have a designated person who was authorised (by the individual) to act as an intermediary on their behalf.

Discussion during meetings or phone calls usually involved an update on appointments with medical practitioners and progress with treatment and recovery, along with expectations of how long absence would continue. Meetings later on in absence periods were sometimes a useful opportunity to plan return to work arrangements.

Some people described very positive experiences of contact with their line manager, feeling that they had taken a personal and caring approach, which did not feel driven by formal absence management procedures and did not involve any sense of pressure to return to work. For one person who experienced depression, the sense that her employer genuinely wanted her to prioritise her health before contemplating the return to work, did not treat her absence as an inconvenience to the team, and was willing to engage in open discussion about appropriate support in the return to work, was crucial in her decisions about whether or not to stay with this employer. Another person who had been off sick due to depression described how his manager's concern during this time had felt genuine: *'I did get the impression it was genuine concern, it wasn't just making noises. It was real'*.

In contrast, some people said that their line manager had seemed eager to get away from their meetings and had dealt with things in a very cursory manner. Some people had found their line manager's approach insensitive or displaying a lack of understanding. In one example, the individual's line manager had only made contact because he had not dealt with an expenses claim. As he explained:

> *'She was interested in the fact that something I hadn't done, by not being there, was causing her a problem, and the last thing I needed was to even think about work at all. So there's that sort of complete lack of sensitivity or thought.'*

> (Male, 40s, stress and depression)

Another person described how her manager had given *'mixed messages'* showing a lack of understanding of her experience of anxiety and depression; he had told her to take as much time off as she needed, but then asked if she would be attending a meeting the following week.

After a time, some people had been asked to come to a more formal meeting with the Personnel or Human Resources department, where a line manager or more senior manager would also be present. Again, these meetings were often a source of anxiety for the individual, especially if there had been workplace problems or grievances underlying their mental health difficulties. In such cases, some people had brought a supportive colleague or a Union representative with them to this meeting, which they had found helpful. While these meetings proved very difficult for some people, there were others who had been pleasantly surprised at the positive nature of these meetings and came away feeling that they had been supportive and constructive.

Some people also described more socially oriented contact with line managers and/or colleagues during absences. For example, towards the end of a five-month absence, one person had begun to meet weekly with his line manager and colleagues at a local pub. These outings had been very much appreciated by the individual, who felt that they had been helpful in keeping him socially involved with the team and in easing the transition when he did come back to the workplace. Other people also described supportive contact from colleagues during their absence, for example, keeping them 'in the loop' regarding workplace developments and social news. Some people had been visited at home by close colleagues. However, there were also some people who had felt quite isolated from colleagues during their time off sick and there were observations that their absence had been treated differently from those of other people who had been off sick due to physical illness or injury. In these latter cases, there were often collections and gifts from the team, with circulation of news about how the individual's recovery was progressing. In the case of mental health problems, some people perceived a reticence to make contact or offer sympathy.

In some cases, people reported no contact whatsoever from their line manager during their absence. Some would have liked some contact to be maintained, feeling that this would have been helpful, as in the following example:

> 'Even just one phone call would have been nice…just to kind of touch base a bit and even just to find out what's going on with work, is there anything new or, you know. I mean if they'd caught me at the right time or whatever, I'd have been all right to sit and talk for a bit and it might have even helped just to keep me in the loop with work.'

(Female, 30s, stress and depression)

However, there were also people who did not want any involvement with their manager due to the circumstances under which they had gone off sick. As already noted, there were greater anxieties and tensions around contact with their employer when workplace stress or bullying had been a part of the original problem and for some people, the contact that had been initiated by line managers had been unwelcome. Some people described how they had been very angry with their employer at the time they went off sick, due to the (lack of) response to developing workplace problems. There were also some people who said they

preferred a more detached form of contact during their absence, being content with brief contacts primarily focused on health updates.

Most of the large employers from which study group members were recruited had Occupational Health Service provision, either in-house or outsourced. In many cases, these Occupational Health Services had been involved during (or shortly after) people's period of long-term absence. People's experience of input from Occupational Health Services varied, some describing them as very helpful and supportive, but others finding them insensitive or not constructive in their advice. There were also some views that Occupational Health Service involvement, while not directly unhelpful, had remained a largely procedural exercise, simply checking that all necessary protocols had been followed by the line manager.

Where meetings with Occupational Health Services took place during the period of absence, this sometimes involved discussion of an appropriate time for making a return to work. For one person, this had been unhelpful, in that when Occupational Health had noted on their report that she would be ready to return to work in six weeks, this had set an expectation and led to her feeling pressure to return to work more quickly than she felt was appropriate.

In some cases, it had been Occupational Health Service staff who initiated referrals to counselling services provided via the employer or who had suggested noting a disability on the individual's Personnel record, opening up the potential for reasonable adjustments under the Disability Discrimination Act (DDA) (see Chapter 4). However, some people perceived that Occupation Health Services did not have a detailed understanding of mental health problems and so the support and advice they could offer was limited.

4.1.2   Support when returning to work after long-term absence

Most of the people who had had a long-term absence from work described a gradual return to full hours and duties when they came back into the workplace, negotiated with their line manager, Personnel department and/or Occupational Health Service. The pace and pattern of returns to work varied. Some people returned on a reduced number of days per week, gradually building up to a five-day week. An alternative approach was to work a reduced number of hours per day but to come in every working day, gradually increasing the length of their day over time. Some people preferred this latter option, finding it helpful to have some work-based structure to each day in the week. The length of time taken to return to full-time hours varied, but was typically no longer than four months. Some people were surprised at the length of the period over which their gradual return was extended, having expected to get back to full-time hours more quickly, and in some cases had negotiated down the length of time originally proposed by their employer. Alongside phased returns to full-time hours, some people explained that their line manager had been supportive of their need for short breaks from time to time in the initial period back in work.

Particularly in the larger employers, some people had moved into a new role or an entirely new team when they came back to the workplace. Sometimes this was as a result of organisational changes during their absence, but in others, arrangements had been made for a new role in light of previous workplace difficulties that had underlain the emergence of mental health problems. Where Unions had become involved in these workplace problems prior to or during sickness absence, people sometimes said that they felt having the Union advocating for them had been influential in the arrangement of their new role. For some people, moving into a new role or team was cited as central to their successful return and sustained mental wellbeing at work.

Chapter 5 will describe how the working environment was an important factor for some people in the long term, in maintaining positive mental health at work. In the initial weeks and months of their return to work, some people again emphasised the benefits of being in an appropriate environment. Changes to the workplace setting such as a move of office to be in a more sociable environment or a change from home working to being based with a group of colleagues had been helpful for some people. Being among other colleagues and working on team projects, especially at first, was more often felt to be helpful than working in isolation.

Coming back to work was not easy for many people, with a number of tensions and challenges experienced. There were experiences of the return to work feeling rather 'ad hoc' and some people said that more structure to their return would have been helpful. One person described having had to initiate discussion with his managers on the day that he had come back to work about how his return to full duties would be managed. This person felt it would have been more helpful to have had this discussion **prior** to his return. In another example, a participant felt that his return to work had been managed perhaps too sensitively, explaining that he had been left to *'drift along'* for too long with no *'meaningful and worthwhile'* tasks to do. This person reflected that, in the early stages of returning to work, people may not be in a position to *'steer'* the process themselves and so more active input from managers would be useful.

While it was helpful initially to go back into a less pressured or demanding role, some people found that they quickly became bored and unfulfilled, which in itself could become detrimental to mental health. However, there could be tensions between wanting to get 'back to normal' as quickly as possible, but also finding work difficult in the early weeks and months. Some people described how they wanted to take on their previous level of work, but at the same time found the smallest of tasks almost impossible at times. Other people's experiences included how their *'perfectionist'* tendencies made it hard to accept their reduced capacity for work during recovery from mental ill-health, a feeling that they had to work 'extra' hard to make up for their time off, or worries about colleagues' perceptions of them when they were evidently not taking on such senior tasks as they had done previously:

'I've stepped back from the mark I set before, so I'm conscious that, again it's probably my imagination, but you feel like people are saying, "Well he used to be able to chew those sorts of things up and now he doesn't".'

(Male, 40s, stress and depression)

'Going back to work after a period off [I] always felt as if there had to be a- not because of anybody, but just myself, felt as if I had to be very apologetic and sort of try and make sure that I did extra specially well to make up for the time that I wasn't there.'

(Female, 30s, depression)

One person described how he had been given *'singleton'* tasks to do when he had returned to work. While he understood why his employer might have chosen to do this, not knowing whether he could be relied upon in the early days to be responsible for other staff or committed to group projects, this was unhelpful for the individual because he had always felt he operated best when working in a team.

For some people, another aspect of the tensions around capacity when back in work was managers' perceptions that, once they were back in the workplace, they were 'fine' and back to their normal capacity for work. Despite having explained the ongoing nature of their mental health problems, some people found that managers quickly forgot that they were still in a phase of recovery and adjustments to their expectations and demands were sometimes too short lived. As one person described:

'You get better and better and then your old self starts coming back and people are very quick to say, "She's fine. We can start planting everything on her that she did before"…That's difficult because you really want to say, "Well I'm not actually, I'm not 100 per cent. Yeah, I might be 80 per cent, but I'm not 100 per cent back to what I used to be".'

(Female, 30s, depression and anxiety)

Some people reported unhelpful responses of managers who had questioned whether they should be back at work at all if they were not yet well enough to cope with the full demands of their job. For one person, who also had experience of managing other individuals with health problems, an approach that supported people to be at work even when they were not fully well was central to his view of positive management:

'There is still this perception that if you're at work, you're at work 100 per cent and if you're not 100 per cent, don't come into work, which is completely inappropriate within the context that we work…[As a manager] *you bring them in and you look after them and you allow them to contribute. That's one of the best ways of getting people better. Mental or physical.'*

(Male, 40s, depression)

In the months after returning to work, some people had had regular review meetings with a line and/or senior manager to discuss how they were settling back into work and how they were coping with their workload and duties. Some people found these meetings helpful, perceiving them as supportive and as having an ethos of genuine concern. However, others said that they were not so useful and felt that their employer did not really understand their experience and the impact of the mental health problem. One person commented that his line manager had taken too much of a *'performance management'* approach in monitoring his return to work, rather than setting a tone of care and support:

> *'I don't think that was at all appropriate because it was managed in a very performance management way, rather than, you know, "Be careful, we're trying to get you back as a valuable and useful employee.".'*

(Male, 40s, stress and depression)

Some people also described having more informal meetings with line managers, for example, meeting for a drink, where they talked on a more general and social level alongside enquiries into how they were feeling. Where there were occasional informal and 'light touch' inquiries into how people were feeling this seemed to be appreciated by most people.

Echoing comments in Chapter 3, changes in line management during or after their period of absence had been experienced as positive or negative for different people in the study group. This again reflects the individualised responses of different managers, some of whom had been very supportive during people's return to work whereas others were described as showing a lack of empathy or inappropriate responses. Some people sensed that their line manager did not know 'what to do with them' when they returned to work. In some cases, this was followed by the individual being moved across teams or placed under the supervision of a different line manager. While this raises broad concerns about the capacity of some line managers to support individuals recovering from mental ill-health, it should be noted that, for people in the study group, a move to a different line manager who was more positive in their approach could significantly improve matters for the individual concerned. Some people felt that it was the existing positive relationship (sometimes extending to friendship) that they had with line managers that had facilitated the supportive response and eased their return to work.

Some people had found Personnel departments very helpful, for example, in arranging a suitable new role or planning their phased return to work. One person described how it had been particularly helpful that the Personnel department had not made her feel she was a burden in her absence and return to work:

> *'HR had told me that this wasn't just a one off thing. They said lots of people have taken time off sick and they've got things set in place so that I shouldn't feel that I'm putting them out and things like that.'*

(Female, 30s, depression and anxiety)

However, there were observations from some participants that having made their return to the workplace, Personnel involvement quickly pulled away and support felt somewhat cursory. People's perceptions of a need for longer-term support during the transition into work are discussed further in Chapter 8.

Where people had returned to work after a long-term absence, either back into their previous role or into a new team, feeling welcomed by old or new colleagues was highlighted as important. It was noted that a long period off work due to mental health difficulties, particularly where this was linked to work-related stress, could impact severely on self-confidence (in addition to the impact on confidence and self-esteem caused by the mental health condition itself). Positive reassurance from colleagues that they were doing a good job had therefore been helpful for some people.

However, some people realised, on returning to work, that their colleagues had been unaware of the reasons for their absence (in one case, having seemingly not noticed their absence at all). This had been difficult for the individuals concerned, both in that colleagues were not aware of the continued impact that their mental health difficulties would have on their work in the initial weeks and months, and also because they felt uncomfortable having to make these explanations themselves. While Chapter 2 has noted that some people preferred their colleagues not to know about their mental health difficulties, there were some people who said that it would have been helpful if their manager had explained to colleagues the circumstances of their absence and that a greater awareness and understanding among colleagues would have eased their return to work. As one person explained:

> 'I think it would have been much healthier if they'd been honest with people and said, you know, "This is why [name] is off. Not sure when he's going to be coming back," but just make them aware, rather than them not knowing and then wondering why they hadn't seen or heard from me for the past five months.'

> (Male, 40s, stress and depression)

Most people in the study group described at least some form of initial adjustment or support in their return to work. However, there were some who said there had been no phasing of the return to hours or duties and no acknowledgement of, or support for, ongoing mental health difficulties from their employer. This seemed particularly the case where absences had been ostensibly attributed to other issues, for example, maternity leave or a 'career break'. Despite feeling substantially better than when they had gone off sick, some people said that returning to work remained very challenging and that they had still felt vulnerable and low in confidence at this time. However, there were tensions for some people, particularly when coming back into a new team after a long absence, between not wanting to have their mental health difficulties known about in the workplace, but at the same time feeling that some gradual re-induction and support would be helpful.

4.2 Shorter absences

Many people in the study group had only taken brief periods of time off sick due to mental health problems, for example, a week or two when they first received a diagnosis or began taking a new medication. While there was a small number of people who described repeated periods of short-term absence over the years with their employer, there were others who had never taken any time off work for mental health reasons, or had only been absent from work to attend medical or therapeutic appointments. Among people who had had a long-term period of absence (described above), some described intermittent absences as they settled back into work, but a majority said that, having returned to work, they had not taken any further time off sick due to mental ill-health. A few people noted that their mental health condition impacted on their physical health, weakening their immune system and so making them more susceptible to colds, flu or viruses, which could also lead to fairly frequent periods of sickness absence.

Some people felt that the potential need to take time off sick due to mental ill-health had been reduced or avoided entirely by the use of flexible working arrangements inherent in their job, which allowed them to alter the working hours of their day, to work at home on occasion, or to take days off in lieu from time to time (see discussion in Chapter 3). As also noted in Chapter 3, some people had agreed formal adjustments with their employer specifically in view of their mental health condition, allowing them to reduce their working hours for a period of time as necessary, an arrangement which was seen as helpful in preventing the need for long-term sickness absence.

There were some reports of unhelpful approaches to short-term absence from employers. This seemed particularly the case among the few people who had had repeated periods of absence (sometimes due to a combination of physical and mental health problems) or recent long-term absences, and who had reached or were approaching the point where further absence would trigger intervention from Personnel departments. These absence monitoring procedures were sometimes experienced as insensitive or threatening and a source of additional stress for people already facing mental health difficulties. One person who worked with children and had experienced anxiety and depression, reflected on how the ending of her paid sick leave allowance had made her feel pressure to come to work when she was not really well enough and felt that this may have put the children she was supervising at risk.

In contrast, one person explained a helpful arrangement, negotiated under the auspices of the DDA, whereby her employer would not treat subsequent mental health-related absences as discrete episodes. Also appreciated was where employers were flexible about time off to attend medical appointments during the working day. Conversely, this was a problem for one individual who was struggling to get his line manager to allow him sufficient medical leave to attend specialist hospital consultations.

4.3   Minimising sickness absence

This section considers people's views on absence due to mental health problems, exploring the reasons why some people had not taken any time off sick or had sought to minimise the extent of their absence from work.

Some people who had not taken any time off sick due to mental ill-health explained that they did not think it would be helpful to have shorter or longer periods of time off work, feeling that the routine of coming to work and the social contacts in the workplace were a benefit to their mental health (see also Chapter 5). For some people, work itself had been a key factor in supporting mental health. Where work was not perceived as 'part of the problem', some people felt that their enjoyment of their job had been a positive contribution to their recovery, or at least the structure and activity of work had provided something of a respite from difficulties in other areas of their life. Illustrating the importance of appropriate and fulfilling work in maintaining employment through mental health difficulties, one person who had not taken any time off due to mental ill-health noted that, had he been in a less engaging job, he may have more readily taken sick leave:

> *'If I was doing a different job, if I was doing something that was extremely repetitive, I think I may well have just gone for, you know, taking time off sick…To have a mundane repetitive job, I don't think it would be beneficial to stay at work.'*

(Male, 50s, depression)

It was important to some people not to take time off sick as a matter of personal principle. Some people described how they were 'of a generation' where there was strong commitment to one's employer and taking time off sick was not the done thing, which had influenced them in taking little, if any, time off sick:

> *'I always made sure that, you know, my focus when I went off was to get back to work. Whether it's an old logic of being of this age, I don't know, but it was always a case of you're brought up to get a job, stay at work and do the best you can.'*

(Male, 50s, anxiety)

There were also people who explained that they felt a particular commitment to their job, either to their employer overall (after many years of service), to colleagues or to the clients they supported through their work. One person in a senior role explained how her sense of responsibility and commitment to her junior and peer colleagues, as well as enjoyment of her work, was influential in the fact she had not taken any time off sick due to mental ill-health:

'Getting out of the house, going to work and doing a job I love, and knowing that I have responsibilities not only to my team, but to the people I liaise with, all over the place…All my team are under 30, whereas I'm nudging retirement, and so there's a big experience and knowledge gap there. And I know they rely on me day-to-day, you know, so that's what's driven me to go to work.'

(Female, 50s, depression)

However, one person described how the responsibility of work could have both positive and negative connotations. To some extent, feeling that colleagues were relying upon him conveyed a positive sense of being needed and wanted and had given him encouragement to keep coming to work, but more often, he had felt negative pressure to be at work, perceiving that he could not afford to be off sick because his workload would simply mount in his absence and colleagues would become annoyed. Another person described how worries about losing her position at work had played a role in her decision making about returning to work from absence:

'I think probably my self-determination really of not wanting to be beaten and wanting to certainly keep my job and being conscious of the fact that if I don't get back to work, there's every chance that I could lose it or certainly have hassle over it, or I could have even lost my standing within work.'

(Female, 30s, stress and depression)

Reflecting the concept of 'struggling on' (Sainsbury and Davidson, 2006), some people described how they felt it was important to be *'strong'* and that they could not just *'give up'*. However, there was also recognition that persevering for too long in the face of growing mental health problems could be detrimental in the longer-term:

'You just have to keep going. Your life has got to go on, and you've just got to deal with this because, you know, I'd like to think I'm a strong person and I can control my emotions. That's why I carried on with my day-to-day everything for the whole time. And I think that was maybe where my problem was, in that a long time before that, I should have gone.'

(Female, 20s, depression)

Perceptions of stigma about mental ill-health also appeared to influence people's behaviours around sickness absence. As noted in Chapter 3, there were a small number of people who, when taking occasional days off work for mental health related reasons, presented this to their employer as physical illness. There was also evidence of these views extending to medical practitioners. One person had been advised by his GP not to take time off due to depression as it would be better not to have this *'black mark'* against him while another person's GP had listed back problems on his sick note on the two occasions he had been absent due to anxiety.

As well as masking the reasons for absence, some people resisted taking time off sick due to mental health problems at all, because of worries about what managers or colleagues would think. One person whose mental health problems had led unhelpfully to disciplinary and performance management intervention from her employer said that she had not taken time off sick, even where this would have been beneficial, because she did not want to *'give them the satisfaction'*. Continuing to go to work throughout this time had been *'exceptionally hard'* for this person. Another person described a combination of internal and external motivations in never having taken any time off sick; her personal determination not to let her mental health condition *'beat'* her, but also not wanting others at work to know about her illness or to perceive her as using mental health problems as an *'excuse'* to take time off work. Despite being diagnosed with a severe and enduring mental health condition, this person had never taken sick leave due to mental ill-health, always arranged medical appointments out of work hours, and had made efforts to conceal times of difficulty or distress in the workplace.

A comment that was made by only a few people, but which may have wider significance in helping people recover from mental health problems, was that during their absence from work, they felt anxious or guilty about leaving the house during the day. This created tensions where people had been advised that taking exercise or undertaking routine chores out of the house would be helpful in improving their mental health. Where people had discussed these concerns with their employer or General Practitioner (GP), responses had been supportive, saying that it was fine and a good idea to get outdoors. However, people remained anxious about being seen out and about by others when they were supposed to be 'ill'.

Finally, there was some evidence that finances could play a part in decisions about absence. As noted earlier, everybody in the study group who had had a long-term absence was entitled to paid sick leave for at least six months. Some people said that nearing the end of their period of full salary sick pay was a factor (sometimes the key factor) in their decision to return to work at this point. With hindsight, some said that this had been too soon, though there was an alternative view that this was a helpful target to aim for. Only two people had remained off sick beyond the point of their employer's sick pay running out. One had moved onto Incapacity Benefit and the other had taken an unpaid 'career break'.

4.4   Discussion

Regarding long-term absences, the evidence from this study is that, even where employers have set procedures in place for the management of absences, these can be approached in very different ways by individual line managers. This adaptability may be positive for the employee, where a supportive and understanding line manager takes a personalised and caring approach to discussing health matters and return to work arrangements. But it also means that there is not a consistent approach that employees can rely upon, and there is scope for some people's experiences of absence management to feel impersonal or pressurising.

Likewise in the return to work, though phased arrangements were often put in place according to organisations' formal provisions, it was the particular attitudes of line managers, as well as senior managers and Occupational Health staff, which often determined the experience of the individual employee. Again, this led to very varied experiences both between individuals and also for the same individual when there was a change in line management. Experiences ranged from very positive, supportive and flexible, to insensitive or unhelpful, to a feeling that their return to work had not been 'managed' in any noticeable way at all.

During periods of absence, people understood that their employer had a duty to maintain contact, but it was particularly valued when line managers approached this in a personal and caring way rather than contacts appearing procedural. For some people, informal contact with colleagues was also appreciated. Where there had been no contact from employers or colleagues during absence, some people had felt isolated and would have appreciated some form of engagement. However, there were tensions for people who perceived their mental health problems as originating in the workplace and who felt anxious about contact with their employer. This points to a need for sensitivity and flexibility in maintaining contact with employees during absence. Consideration may need to be given to who is most appropriately placed to make contact. While some people may appreciate their line manager staying directly involved, where there have been workplace problems it may be preferable for a more neutral third party to make contact with the employee and/or for the individual to appoint a supportive representative to liaise with their employer. Even where mental health problems were not perceived as work-related, there was evidence that meetings with employers could be a source of great anxiety and so a negotiated, sensitive and supportive approach remained important.

In the return to work, a structured, but 'light touch' approach seemed most appreciated, again with an ethos of genuine concern for the individual's wellbeing, rather than one that seemed driven by a 'performance management' agenda. Being placed with a supportive group of colleagues in the initial return to work, which could entail a move across teams, was also beneficial for many people (although in the longer-term, working from home some or all of the time could be a helpful strategy).

Even where people expressed positive views on the approaches of their line manager, Personnel or Occupational Health department, there was much evidence that returning to work from long-term sickness absence was a challenging transition. In particular, there were tensions around being back in the workplace while not yet at full capacity. The evidence in this study indicated that both managers and employees may encounter difficulties in striking a balance between suitably engaging and meaningful, yet not overly demanding, assignments when people return to work while recovering from mental ill-health.

This is a crucial area of concern when considering the question of 'managing mental health and employment'. The current policy direction is focusing on capacity

rather than incapacity, supporting people to be in appropriate and manageable work while simultaneously addressing health problems. Although many people experienced periods of time where they did not feel able to be at work, this policy view was also echoed by many people who felt that being at work, even while not at full capacity, was better for them than being absent. However, there were tensions both for the individual themselves in reconciling their desire to return to full duties with the experience of ongoing struggles at work, and also between individuals and their managers, some of whom did not appear to take on board people's reduced capacity as they returned to work. Moreover, people also experienced conflicts in needing employers and colleagues to understand that they may not be at full capacity, but at the same time not to be over sensitive, to treat them 'with kid gloves', or to perceive that they should still be off sick if they were not fully capable of their duties.

Fewer people spoke about experiences of short-term absences, a number of participants explaining that flexibility in working hours and location (i.e. the option to work at home), either as an integral part of working arrangements or as a 'reasonable adjustment' under the auspices of the DDA, had been effective in minimising the need for time off sick. People without this flexibility, however, had sometimes operated a more covert strategy of taking days off to restore their mental health under the guise of a physical illness.

In describing their motivations for taking little or no time off sick, some people felt that work was a directly positive influence on their mental health or focused on 'positive pressures' such as commitment to their team or clients. However, some people's motivations had more negative underpinnings, for example worries that they would be perceived negatively by colleagues or a feeling that they had to 'struggle on' even when this became detrimental to their health.

Finally, there was some evidence that sickness absence policies could influence people's feelings about taking time off sick. Some people who had had repeated periods of short-term absence and/or were nearing the limit of their paid sickness absence allowance reported stressful interactions with managers or Personnel departments regarding their absence record or had avoided taking time off sick even where this may have been beneficial. The ending of (fully) paid sick leave was also influential for some people in returning to work from absence.

5 Managing mental health: what helps?

Chapter 1 introduced the idea that managing mental health can be considered from the perspective of responding to mental health problems at times of more acute distress, but also from the point of view of managing mental health as a long-term strategy and remaining in a more positive position on the mental health continuum. This chapter considers the various factors that people in the study group said had been helpful in managing mental health on a long-term basis. These factors can be grouped into five main types:

- medical and therapeutic factors;
- workplace factors;
- social supports;
- lifestyle factors;
- insight and understanding.

Many people talked about drawing on more than one of these sources of support in combination. Each of these is discussed in turn in Sections 5.1 to 5.5, with a discussion of key findings in Section 5.6.

5.1 Medical and therapeutic input

Reflecting the general picture of mental health care in the United Kingdom (UK) (Department of Health, 1999), most people in the study group had received treatment for mental health problems from within primary care services. Everybody in the study group said that their General Practitioner (GP) had been involved in their treatment, normally as the first point of contact when seeking medical support for mental health. The majority of people had also had some form of input from counsellors or therapists. There was a substantial range in the type of practitioners that had been involved, including psychiatrists, community psychiatric nurses, psychologists, psychotherapists and counsellors. These had variously been

provided from within the National Health Service (NHS), from private practice or from within the voluntary or charitable sector. Referrals had often been made by a GP, sometimes by an employer and sometimes by the individual themselves. A minority of people had received support from secondary mental health services and spent time as a hospital in-patient, including people who had experienced an episode of psychosis and those who had attempted suicide.

At the time of the research interviews, around half of the people in the study group were taking medication in respect of their mental health and some described being in regular contact with their GP. A small number were undertaking counselling or therapy. However, there were a number of people who, at the time of the research interviews, were not in regular contact with any type of medical practitioner and were not using any form of medication. This section discusses in more detail the role that these practitioners and/or the various treatments they provided had played in managing mental health and employment.

5.1.1   Prescribed medications

For the majority of people in the study group, prescribed medication was – currently or in the past – part of what helped them to manage their mental health. Around half were taking regular medication at the time of the research interviews (predominantly anti-depressant and/or anti-anxiety drugs) and among these, some expected that this would be a long-term management strategy, perhaps something they used for the rest of their lives. Some people, particularly those with more severe and enduring conditions, cited medication as the critical factor in enabling them to *'get up and go to work each day'*.

Reflecting the fluctuating nature of some mental health conditions, some people explained that they took a low 'maintenance dose' of an anti-depressant or anti-anxiety medication but could increase their dosage at times of need. Other people had used medication at certain times as a more short-term strategy. Among these, some had stopped taking medication, completely after an acute episode of illness had passed, but had returned to their GP for a new prescription at a time when they felt that they were experiencing a downturn in their mental health.

Although people who used prescribed medication said that it did help to manage their mental health (for example, reducing negative thoughts or tearfulness), feelings about taking medication were sometimes mixed. Some people commented that although their symptoms were reduced, there were also undesirable side effects such as 'haziness' or becoming 'flat' and emotionless. Some people who were currently taking medication hoped to reduce their dose over time and eventually manage without any form of prescribed drugs.

There were also people who had briefly tried medication, but found it unhelpful or unpleasant and so had stopped. Some people had chosen never to use prescribed medications, in some cases due to strongly held views that these were damaging and hazardous. There was very little mention of alternative medicines among the study group.

5.1.2 Therapies and counselling

For many people, therapy or counselling was found to be helpful in regaining or maintaining positive mental health. This had been received from various sources, often NHS services but also private therapists, services provided via an employer or occasionally services provided through the charitable sector. Some people were seeing a counsellor or therapist at the time of the research interviews and others had received a series of sessions at some point in the past.

Some people had had to wait several months in order to receive therapy or counselling through the NHS, and in some cases, by the time this became available, people were feeling well enough not to require the sessions, had received therapy or counselling through other sources, or had found other ways of managing their mental health, including medication in some cases. Some people who had obtained very swift access to NHS counselling noted that they were fortunate in living in a more *'well heeled'* area where they perceived that resources were not in such high demand. There were also people who commented that had it not been for their employer's health insurance that gave access to private therapy, they would have had to wait much longer for support.

The type of counselling or therapy that people had received varied, but there were a number of mentions of Cognitive Behavioural Therapy (CBT) and with few exceptions, this was spoken of very positively. Several people commented that they were able to draw on the strategies and techniques that they had learned during these sessions in the longer-term, and apply them when they found themselves in difficult situations or experiencing unhelpful thoughts. There were mixed experiences of other types of counselling, some people finding them helpful, but others finding that approaches were *'wishy-washy'* or that there was too much focus on the past and exploration of possible origins of difficulties (especially where they did not perceive that there were childhood issues that needed to be analysed or resolved). It was also noted that counselling could be emotionally challenging, having to confront and work through issues that had previously remained unaddressed.

Some people felt that their experience of therapy had been less helpful because it had come at a time where they were not ready to engage with this kind of treatment. Among those who had received a second phase of treatment at a later time, some said this had been much more effective because they were by then in a position to work with the therapist's approach. As with prescribed medication, some people also explained that they had returned to their GP to request a further referral for counselling or therapy at a time when they experienced a recurrence of mental health problems, and had found this *'booster'* helpful.

Few people had been involved in group therapy or group provision for people experiencing mental health problems, some specifically stating that they did not think they would enjoy this or find it helpful. Those who had done tended to be people who had also been in contact with secondary mental health services.

However, there were a few people who had become involved in support groups relating to other aspects of their life (for example a carers' support group) and found that this was very beneficial to their broader wellbeing.

5.2 Workplace factors

Chapter 3 considered the responses and support that were provided by people's employers and colleagues specifically at times when they were experiencing more acute mental health problems. This section considers the additional workplace factors which people in the study group cited as helpful – or unhelpful – in maintaining positive mental health in the longer term.

5.2.1 Work setting

The physical context in which they worked was noted by a number of people as influential on their mental health. Different work settings were preferred by different people. One common view was that it was beneficial to work alongside others in a group setting. Some people preferred a small team while others felt happier working in a busy setting with plenty of social interaction.

On the other hand, some people had found that working at home on a permanent basis was helpful to their mental health, because of the flexibility this gave in managing their workload and interactions with colleagues around fluctuating mental health. Not having to commute had been very helpful for some people in reducing stress. However, it was also highlighted that working alone in this manner could have downsides, in that there could be feelings of detachment from colleagues and any deterioration in mental health may go unnoticed by managers. As noted in Chapter 4, after a long period of absence, it could be especially helpful not to be working in isolation.

5.2.2 Flexibility in working hours

As has been discussed in Chapter 3, a number of people cited flexible working hours as beneficial in managing mental health and employment at times when they felt less well. A number of people also felt that flexible working was helpful as a more general strategy in maintaining positive mental health. Flexitime arrangements often coincided with job roles that gave some degree of autonomy over task and workload management, which was also seen as beneficial. It was also noted that flexitime in itself conferred a sense of control, which was beneficial to mental health. At a broader level, flexitime was helpful for some people in managing family commitments and maintaining work-life balance, which in turn had a positive impact on mental wellbeing.

5.2.3 Positive workplace relationships

A number of people explained that, in the longer term, positive and supportive relationships with managers and colleagues contributed to their mental wellbeing at work. People referred to a generally positive atmosphere, working alongside

colleagues who they got on with and would consider friends, who made them feel a valued member of the team, who respected them and appreciated the work they did. Drawing contrasts with previous negative workplace experiences, which had contributed to the development of mental health difficulties, some people said that it was much better to be working alongside colleagues who were not *'competitive'* or *'egotistical'*.

5.2.4   Openness about mental health at work

A small number of people in the study group commented that the open atmosphere within their workplace around discussing mental health had been a key factor in supporting their mental wellbeing at work. These participants valued the ability to be open and honest about their emotions at times when they were not feeling their best, with acknowledgement, but not over-reaction, from colleagues and managers:

> *'If you can work in an environment where someone can say if they're not happy, or if someone can talk about negatives without fear of being viewed as negative themselves…If you're just working in an environment where you can say that you are unhappy or something has p***ed you off or you are not feeling well, or you don't feel 100 per cent, you know. That's the reason why people throw sickies is 'cause they're experiencing those sort of emotions and they don't feel they can go to work and talk about that.'*

(Male, 30s, bipolar disorder)

Notably, both of the individuals describing this workplace ethos worked in organisations that had a specific focus on mental health. As will be discussed in Chapter 8, there were a number of people who had not had this experience with their employer and who felt that it would be beneficial if there could be more open discussion about mental health in the workplace. The following comments from individuals who had not felt able to talk openly about mental health in their workplace illustrate how challenging it could be to deal with problems alone:

> *'You suffer in silence, and I think that that is the worst thing. I think that's what I want to get across is that it's so hard when you're feeling quite bad, to have to motivate yourself to get up, come in.'*

(Female, 40s, anxiety and depression)

> *'Quite often I'll just bottle it up during the daytime and then let it all out on the drive home and just cry all the way home or something.'*

(Female, 20s, bipolar disorder)

5.2.5   Benefits of work itself

For some people, work or workplace issues had been a contributory factor in their mental health difficulties. However, for others, work itself had been a help in managing mental health. At a general level, there were comments that, during

times of mental distress, the structure and routine of work could be helpful (see also discussion in Chapter 4). The rewarding aspects of work, including a feeling that they were achieving something worthwhile, feeling appreciated by colleagues and managers, and the positive social interactions in the workplace, were also all helpful. More specifically, some people explained that the particular nature of their work was very important to them, something that they had a deep personal investment in or commitment to, and so this was something that made a direct contribution to boosting their mental wellbeing. There were also comments that having work that was challenging and engaging helped to maintain positive mental health. The following quotes, from individuals who had each spent around two years out of employment due to a mental health condition, illustrate how work can play a key role in long-term recovery:

> *'What a lot of people I don't think acknowledge is the fact that work also plays a very positive role of keeping people well…I can certainly say, from my experience, that I thought I was recovered, but I didn't realise that I wasn't recovered until I went back to work. And there was a final, sort of, ten or 15 per cent of recovery that I think you could only get through work and through challenge, and interaction, and reward, and recognition, the things that you can only ever get through work.'*

(Male, 30s, bipolar disorder)

> *'I'm far better working than not working. Even if I'm having a rough patch, coming to work and doing a bit is better than staying at home and just feeling worse and then spiralling. So yes, it keeps me well.'*

(Female, 30s, depression)

However, some people noted how, when work was going badly (for whatever reason) this could impact on their mood, their self-esteem and their confidence. The following two quotes illustrate the reciprocal relationship between work and mental health; how each can impact upon the other, both positively and negatively:

> *'It's like a little dog chasing its tail I suppose really. If work's going well, I can be going well. If work's not going well, I can be not well at all…But equally as well it's a sideline and it helps to take your mind off mental health I suppose.'*

(Female, 20s, bipolar disorder)

> *'If I'm having a low time then that's going to impact my work and then if I'm not getting it right or I feel like I can't get anything done at work then I'm going to take that home with me and, kind of, a vicious circle. And if you're not achieving at work or whatever you do, then that's going to impact on your esteem.'*

(Female, 30s, depression)

Corresponding to the benefits of challenging, engaging and fulfilling work, a number of people described how their current low level of job satisfaction was detrimental to their mental health. As will be discussed further in Chapter 6, at the time of the research interviews, some people were feeling frustrated and unfulfilled in their current role and were seeking to explore other options either within or outside of their current organisation. However, the loss of confidence that had accompanied mental health problems for many people meant that making job applications or speaking to line managers about alternative opportunities at work was all the more challenging.

5.2.6   Avoiding sources of workplace stress

A number of aspects of work that posed problems to people's mental wellbeing were things that might be seen as challenging to all employees, but were felt more acutely by individuals already experiencing mental health difficulties. These included poor management, high workload, times of pressure, organisational change, poor relationships with colleagues and 'office politics'. For a number of people, these were also factors that they perceived to have contributed to the original development of mental health problems.

For some people, therefore, part of managing mental health and work was to avoid the aspects which they knew to be sources of stress. Firstly, at the highest level, some people had made changes to their overall field work as a long-term decision, in the knowledge that certain types of work were detrimental to their mental health. Some people noted that there were particular tasks, situations or individuals at work which they found triggered or exacerbated their mental health problems, and so these were avoided as much as possible.

Particularly for people who had become unwell due to work-related stress, an important long-term strategy, with hindsight, was to take on a less pressured role and/or a smaller workload (see also Chapter 6). Some people described how, in light of their experiences of mental ill-health, they consciously did not take on additional work outside their basic duties, no longer taking work home or working outside their contracted hours, or now took more of a 'back seat' at work. One person described his revised approach to work in the following way:

> *'I'm always very wary of it [stress] and that's why I'll now make, you know, "enough's enough", sort of statements. I'm not doing this anymore. And sometimes people think you're being an awkward sod and being brash or whatever, but, you know, sometimes you've just got to do it.'*

> (Male, 40s, stress)

This attention to minimising work-related stress often came alongside a broader reassessment of work-life balance, as in the example of the following participant:

'[Work is] not as important since I got ill. Up until that point it was very important to have a career and I was career orientated, even though I'd got a son, and then I got ill, and I think when you've been there and on your way back, it does fetch it home to you that work's just to fetch you money in to have a life really. That's how I view it at the moment.'

(Female, 30s, depression)

This reassessment of the priority placed on work and greater attention to achieving a more healthy work-life balance, following experiences of mental ill-health, was also evident among participants in the sister project.

Some people in the present study group had taken the long-term decision to work part-time in the interests of maintaining a more positive state of mental health. Impacts of mental health problems on career plans and progression are considered further in Chapter 6.

5.3   Social supports

Family and close friends had been key sources of support for a number of people. Partners were often mentioned in particular, as well as parents and siblings. Outside the immediate family, people often said that it had been one key friend or a close select few who had provided particularly strong support. The nature of this support was often of a general nature, showing care and concern, providing a listening ear or 'sounding board', continuing to involve people in social circles and not treating them any differently. Some people highlighted that quality time with family, especially their children, could lift them significantly. There were also examples of more practical or specific support in managing mental health, including giving reminders to take medication, noticing and pointing out the reoccurrence of symptoms and encouraging people to go to their doctor if their health took a downturn.

Some people noted that supporting them in times of distress could be very hard on those closest to them, in particular partners. Some people felt that, while supportive and sympathetic, their partner sometimes found it difficult to understand their experience and to know how best to respond. Relating to managing mental health and employment, there was also recognition from some people that, while they were able to project a positive and productive outlook at work, they were not always able to maintain this at home, and their partner and family sometimes bore the brunt of this.

There were individuals in the study group who said that they had not told certain family members about their experiences of mental ill-health because they did not want to worry them (in particular elderly parents) or because they did not think they would understand. Likewise, there were people who had chosen not to share their experiences with a wider circle of friends because of a perceived lack of understanding, or due to a feeling of embarrassment on their own part. Some people also noted that they had kept their difficulties hidden (as far as possible) from younger children.

As well as valuing the support volunteered by family and friends, some people also commented that **proactive** maintenance and the development of friendships and social networks was an important part in maintaining positive mental health. Some people drew great strength from social groups with which they were involved and another strategy used by some people was to telephone a friend or relative if they were feeling low.

A number of people also noted that their pets (predominantly cats and dogs) were an aid to their mental health, through the companionship they offered and also in that their requirements to be fed and walked provided some routine and impetus to get up and out during the day.

5.4 Lifestyle factors

Maintaining physical health was noted as an important contribution to mental health for many people. There were several comments that exercise was beneficial, either as a regular part of people's routine or as something that helped particularly at times when they were feeling low. People mentioned cycling, swimming, running, yoga, gym workouts or walking their dog. Introducing exercise had sometimes been suggested by GPs or Occupational Health Services. A nutritious diet, avoiding excessive alcohol and getting enough sleep were also noted as beneficial to mental health.

Religion or spirituality played a role in maintaining positive mental health for some people. Some were members of a church and found support in this context while others were engaged in other forms of spirituality, such as Buddhism or ancient traditions and beliefs.

A number of people mentioned the importance of relaxation and leisure, having some 'me time' where they prioritised pastimes or household activities that they enjoyed and found fulfilling. Examples included creative arts, getting out into the countryside, watching comedies, or achieving small but specific tasks around the home. For some people, this related to keeping an appropriate work-life balance, in view of previous experiences of work-related stress. Having something to look forward to, for example a holiday, was also helpful for some people.

5.5 Insight and understanding

Finally, in discussing what helped to maintain a more positive state of mental health, some people commented that it was a process of coming to understand themselves and their mental health condition better. By learning about how and by what their mental health was affected and coming to recognise the signs that things were taking a downturn, people became better at taking early action to prevent or address problems. As such, successfully managing mental health could be seen as an iterative process, people refining their approach over time. For example, one participant described how in future she would not struggle on at work for so long, but would allow herself a short break to rest and recover:

'I think just knowing next time that, if anything does happen which is too much for me, that work is not that important that I have to go back to it and make myself poorly with trying to keep up a normal routine. I would know, right, you need time out, you need to go and have a week doing nothing, and not keep up a charade at work, because I think that was my problem in the first place.'

(Female, 20s, depression)

A number of people had accessed information or guidance from books, leaflets, the internet or audiotapes. These included resources on specific mental health conditions and also more general themes such as confidence building, assertiveness and positive thinking. Although it was noted that quality could vary, people had found certain sources helpful in a number of ways, including: gaining understanding about their mental health condition; learning about available medications and their effects; acquiring other condition management or self-help tips and techniques; and – importantly for some people – learning that their experience was not unusual or uncommon.

5.6   Discussion

This chapter has detailed the things that people found helpful to maintaining a more positive state of mental health. As well as specific employer actions at times of greater need (which have been discussed in Chapter 3), medical and therapeutic input, social networks and other lifestyle factors all played a part in supporting mental health, which in turn enabled people to manage at work. Individual insight into mental health problems was also important in improving coping strategies over time.

Access to counselling or therapy, and the strategies that people were able to take from this and implement in the longer-term, had been very important to some people in managing mental health. Counselling or therapeutic support available directly through their employer had been helpful for some people in gaining quicker access than might have been possible through NHS channels. The number of positive experiences of CBT lends support to current government initiatives to increase access to this type of therapy.

A number of workplace factors were identified as being beneficial to mental health. Where excessive job stress could be avoided, there was support for the standpoint that 'work is good for you' and many people cited work in itself as having a positive effect on mental health. An appropriate working environment and flexibility in managing personal workload were helpful. A number of people had flexitime arrangements and could work from home; with this came some degree of autonomy and control in pace and planning of work, factors which have been identified as key factors in stress management (e.g. by the Health and Safety Executive in its Stress Management Standards: http://www.hse.gov.uk/stress).

Although this report is not focusing specifically on prevention of work-related mental health problems, there was much similarity in the factors that helped people in the study group to maintain better mental health and elements that have been found to prevent work-related stress and ensuing mental ill-health from developing. Indeed, several people in the study group believed their mental health problems to have originated, wholly or in part, through work-related stress and felt that earlier intervention to manage workload or address problematic relationships at work could have prevented the development of more serious health problems. As noted by Thomas *et al.*, (2002, p.22):

While the prevention of work-related stress is not equivalent to job retention for people with mental health problems, there are a number of parallels and much useful knowledge to be gained.

As such, employer and government focus on the mental wellbeing of the workforce overall may be equally important as targeted support for individuals with known mental health problems, especially taking into account the notion of a continuum of mental health.

6 Impacts of mental health problems

In the research interviews, participants were asked what impacts they perceived their experience of mental health problems to have had on various aspects of their working life, including: impacts on day-to-day work; longer-term impacts on career plans and progression; and impacts on income and finances. These three areas of impact are discussed in Sections 6.1 to 6.3, followed by a discussion of key findings and implications in Section 6.4.

It is important to recognise the reciprocal relationship between work and mental health: work could impact (positively or negatively) on people's mental health as well as mental health problems impacting on their work. Some people perceived that work-related stress or bullying had been the cause of their mental health problems and several people also described how events or circumstances at work could influence how they were feeling, for better and for worse. This part of the mental health and employment relationship has been discussed in Chapter 5.

6.1 Impacts of mental health problems on day-to-day work

In discussing the impacts of mental health problems on day-to-day work, it is important to remember that some people were reflecting experiences some time in the past, which they did not feel affected their work at the time of the research interviews. Likewise, some people who experienced a fluctuating or recurring mental health problem described the impacts this had on their work at times they were more unwell, but these impacts should not necessarily be assumed to be permanent or constant.

Some people who experienced anxiety or panic attacks described how certain tasks within their job, for example, group activities or off-site visits, could exacerbate or trigger their mental health problems. This made such tasks very difficult to carry out and could lead people to avoid them as far as possible. Some people who

experienced depression similarly noted that aspects of their role, for example, those involving interactions with others, could become harder when they were feeling more unwell, and so they would defer these tasks in favour of others which felt more manageable. At a broader level, simply going to work was very difficult and a source of anxiety for some people at times. Chapters 3 and 5 have described how the option of working at home could be helpful in this respect.

A common experience was to become withdrawn during times of mental ill-health and to reduce interactions with colleagues. A number of people also mentioned being tearful. Some people said these effects had been noticeable to others in their workplace and had occasionally drawn comment:

> *'I shut down. I know that I go quiet and I don't want to interact with people, and then people think you're being standoffish, or you're not being approachable, or whatever. But it's just because you can't cope with another pressure…someone else wanting something from you…And it's like as much as you can do to get through the day sometimes.'*

(Female, 30s, depression)

> *'I would go out of my way to avoid people, so I didn't have to talk to them. If I saw someone coming that I knew would want to talk to me, even if it was just to say hello, I'd be off in the nearest toilet or the next room…I'd just wait until they'd gone. I'd only put myself in places where I wouldn't be able to be approached.'*

(Female, 30s, depression and anxiety)

There were also experiences of becoming more agitated, irritable or short tempered when feeling mentally unwell and this could sometimes impact on relationships with others if this led to snappishness or a *'set to'* with colleagues. Loss of motivation, interest and enthusiasm for any part of life – work or personal – was also part of the experience of depression for some people, which again could have an effect on work and workplace relations:

> *'Often I'd get to work and then I'd just be like, oh God, another day and I just can't be bothered…and I would just be really irritable about everything. So it was quite hard to be at work and be friendly and so positive and not seem like, you know, you're miserable, in the corner.'*

(Female, 20s, depression)

Several people noted that their experiences of stress, depression or anxiety had included extreme tiredness, sometimes caused by sleeplessness or medication effects. Also common were experiences of distraction, difficulty concentrating or loss of focus, all of which had made it more challenging for people to carry out their work. Some people felt that this had impacted on their productivity and two participants noted that the realisation that their performance was being affected had been the trigger for first seeking help for their mental health problem. Another participant felt that, at the time of the research interview, the effects

of his medication were contributing to him *'not firing on all cylinders'*. He was worried that he was not performing to the same level as other colleagues and also felt that this lower productivity was affecting his own job satisfaction:

> *'I compare myself to what I believe my colleagues are doing, and I just don't think I'm doing the level of work that they're doing, and because of that, I'm just not getting anything out of it. I'm just getting through the day.'*

(Male, 40s, depression and anxiety)

In some cases, people did not believe that their reduced productivity was noticeable to managers or colleagues, but they themselves had been aware that they were not working at their normal capacity. Some people explained how their particular role or position within the organisation made it easier to conceal any reduced productivity:

> *'Some days, I'd just stare at the computer screen and not do anything, not be very productive at all. And I think, in those situations…when you're in a position I am, it's sometimes easy to camouflage that you're not doing very much.'*

(Female, 50s, depression)

> *'I have the ability to project intense normality, upbeat efficiency at work, when in fact, okay, I'm not actually that efficient sometimes, and things are appalling. But I still have the ability to project that…All the while that I'm on a downward slide, and starting to lose it a bit, I can still maintain this apparent perception of being completely normal. I mean, to a certain extent, I fool myself early on.'*

(Male, 40s, depression)

In other cases (as noted in Chapter 2), reduced performance had been more apparent to people's line managers, who had initiated conversation with the individual about this, sometimes, though not always, leading to a supportive response.

A number of people mentioned loss of confidence as a symptom and/or effect of mental health problems. This had also contributed to work being more challenging, and some people said that their apparent low confidence had been noted by managers during appraisals (though their mental health problems had not been referred to directly). There was also recognition that one effect of mental ill-health could be feelings of greater sensitivity to criticism (real or perceived) and insecurity regarding one's role at work, and some people were aware that they had become more self-critical and anxious about their performance.

For some people, experiencing mental health problems mean that 'normal' work challenges, such as periods of higher workload or difficult interactions with colleagues, were harder to deal with and it could be harder to stay positive in the face of pressures or frustrations at work. Describing his experience of a long-term

mental health condition, one person used the analogy of *'armour'* which could feel thicker or thinner at times. When his armour was feeling thinner, this individual found that his outlook became less positive in general, the day-to-day challenges of work became harder to manage and he experienced a *'loss of charitableness'* towards people around him.

As will be discussed further in Section 6.2, having experienced a period of mental ill-health (in particular where this had been stress-related), some people found that they were no longer willing or able to take on such demanding roles or to cope with the levels of pressure that they had taken on in the past. As one person described, following a period of stress-related depression:

> *'There've definitely been times when things have been a bit fraught at work, when I've been more anxious about them than perhaps I would have been when I was more in control of things. So I'm conscious that I'm probably not able to deal with the same levels of 'grief' that I did before.'*

> (Male, 40s, stress and depression)

Some people believed that there had been no impact on their performance or productivity at work due to mental health problems, some stating that this was substantiated by their appraisals or other feedback from managers. For some people, this was attributed to successful management of their mental health, for example, through effective medication for a long-term condition. However, for several other people, this sustained performance had been achieved only as a result of significant efforts to conceal difficulties and to 'struggle on' at work in the face of stress, anxiety or depression. Some people noted how exhausting it could be to maintain the external appearance of being 'okay' at work:

> *'My output, my performance didn't alter, it just became an immense effort to continue to achieve anything.'*

> (Female, 40s, anxiety and depression)

> *'I always thought that I was capable of things, and I was good because at the end of the day my results, that job, I delivered what they wanted to do, on time and everything else, but I had paid for it with my health.'*

> (Female, 40s, stress and depression)

As has been noted elsewhere in this report, the above quotes again illustrate how the approach of 'struggling on' without employer support is not generally a very positive or sustainable way of managing mental health and employment and there are implications for changing workplace cultures so that people feel more able to seek support. This will be discussed further in later chapters.

6.2 Impacts on career plans and progression

When asked whether mental health problems had impacted on their career in the longer term, a number of people said that, through their experiences of mental ill-health, they had become less confident about advancing their career. People described feelings of anxiety about making applications for new jobs or internal promotions and worried about whether they would be able to cope if they moved into a more senior or demanding role:

'I would find it really difficult to put myself forward for an interview and put myself in a brand new environment. Everybody has a, sort of, natural reticence perhaps, but I think I do more than most…The fear is humiliating yourself really. Suppose I leapt into a brand new shiny job and I didn't live up to expectations there. I mean, there's no reason to think I couldn't cope, but just suppose I didn't.'

(Female, 40s, anxiety and depression)

A further area of concern for some people was the effect that their sickness absence record might have, if applying for a job in a new company, and decisions about whether or not to disclose a history of mental health problems to a new employer. This tension could also exist within large organisations, where companies were so big that internal moves involved effectively the same process as an external application. As two people working for large employers reflected:

'For two years you walk around with this little badge which says,"I have had six months leave off", and they may ask you why and what do you say then, you know? If they're looking for somebody that they want to be sort of strong and macho and all the rest of it, somebody who wimped out and had a nervous breakdown is maybe not what they're looking for.'

(Female, 50s, stress, anxiety and depression)

Does what's gone before me hinder me? I've had two breakdowns, I've had time off work, have I got a mark on me, metaphorically speaking, which says "Don't really want this guy, this guy's likely to go off sick"…While stuff is, in quotes, "confidence," I don't know what comes out really at the end of the day when you go for an interview.'

(Male, 40s, depression and anxiety)

There was also a view from some people that their employer's existing knowledge of their mental health problems had curtailed their prospects for internal promotion, some perceiving that, under different circumstances, they would have advanced to higher grades by this point in their career. Most people did not have overt evidence of this, but one person had been told she would not be promoted until her mental health problem had been *'sorted out'* and another person, who had returned to work part-time after a period off sick had been told that promotion opportunities would only become available if she returned to full-time hours.

Following an episode of mental ill-health, some people had moved into less senior or highly pressured roles than they had held in the past, or had moved from full to part-time work. This had been a positive change for some people. Although it had often been a move prompted by mental health problems (in many cases stress-related), a number of people said they were content with the balance they now had between career and better mental health (see also Chapter 5). Some commented that they would not sacrifice their mental wellbeing for higher job status or increased remuneration. As one person explained, *'I don't want that* [pressure] *any more, I don't care how much they pay me…my happiness and stability now is what matters to me'*. Other participants described their changed attitudes to career advancement as follows:

> *'I was very career orientated…I was very like, right, have I achieved this, have I achieved that? Right, how much more have I got to achieve before I get to the next level, to the next pay band? What positions are up, what promotions are up? Who is my competition? And basically depression's just thrown all that out the window. I'm, like, not bothered 'cause life is too short to be stressed about that.'*

> (Female, 20s, depression)

> *'I'm approaching work from a slightly more 'looking after yourself' angle, as opposed to, self-fulfilment and achievement and ambition and all this, which I still have, but in a sort of slightly more moderated version now.'*

> (Male, 30s, bipolar disorder)

However, others experienced more mixed feelings about their change of job status. Chapter 4 has already noted the conflicts that some people experienced in their return to work, in reconciling their desire to return to 'normal' with the acknowledgement that their capacity for work had reduced due to mental health problems. In the longer term, some people experienced an ongoing tension between having taken on a less demanding or challenging role and feeling that they were now underemployed or that the work they were doing was of little importance. Some people described boredom and frustration in their current role, which was in turn impacting negatively on their mental health. As noted earlier, worries relating to job applications also presented a barrier to moving forward. Some people felt 'stuck' in an unfulfilling role either due to direct effects of their mental health problem, for example, anxiety or reduced confidence, or stemming from apprehension about taking on a more demanding role in case this negatively affected their mental health. One person, who was contemplating taking up an internal promotion at the time of the research interview, explained his cautious approach as follows:

> *'What I'm doing is all right and it's interesting, but it's not actually stretching enough any more. So I need to do something a bit more demanding. But I'm a bit tentative 'cos obviously I don't wanna push it out too far and fall over that cliff again.'*

> (Male, 40s, stress and depression)

Although most people's thoughts on how their career had been affected related to missed future opportunities or backwards steps, there were some people who reflected back to earlier in their life and felt that, because of mental health problems that had emerged in their teens or twenties, they had never reached their full potential. Some people said that their education had been curtailed or they had not achieved as highly as they might have done because of interruptions from mental ill-health. One participant felt that the effects of depression, including withdrawal and low confidence, had meant she had not had the necessary *'outgoing personality'* to pursue the career area that she had originally hoped for. As another person described:

> *'I don't know where I would have been, but I sure think that I would have done better in my career than I have now. I just feel like I've just let myself down a bit.'*

(Female, 30s, depression)

At the same time, there were people in the study group who did not perceive any negative impact on their career due to mental health problems. Some people explained that, at the time they first experienced mental health problems, they had already attained as high an employment position as they wished to and had been able to retain their job status throughout their period of mental ill-health. There were also people who had disclosed mental health problems at work and had gone on to be successful in internal promotions, the former having had apparently no impact on prospects for advancement. For some people who worked in mental health support settings, their personal experiences had in fact been viewed as a benefit to the role. However, there were other people who felt that they had only reached as far as they had in their career because of the way they had kept their mental health problems hidden and struggled to prevent any impact on their work.

At the time of the research interviews, many people in the study group said that, overall, they were happy in their current employment. Views ranged from their work being a 'means to an end' to something that they were 'passionate' about and most people identified pros and cons to their current employment position. However, many people said they enjoyed their work and there were few people who said they were very unhappy in their job.

However, as discussed above, there were some individuals who said that they were currently very unfulfilled or frustrated in their role, saw limited prospects and felt a need for something more to *'challenge'* and *'inspire'* them. A small number of people were investigating other employment options at the time of the research interviews. Some said that this was driven by positive aspirations to advance their career or move into another field of work, though there were others who said they were motivated by dissatisfaction in their current role. Some people working for large employers said that they would be willing to take up an early retirement or voluntary redundancy package if this was offered to them. Overall, however, where people were seeking to move on, it seemed that a range

of motivations underpinned this and it was rare that people wanted to leave their current employment specifically because of the effect it was having on their mental health.

6.3 Impacts on income and finances

Most people in the study group did not describe any significant impact on income due to their experiences of mental health. This seems largely a reflection of their employment circumstances at the point when they became unwell. For most people, any period of time off sick had been while under a contract of employment and was covered by employer's sick pay and only three people had reached the point of their full-salary sick pay being reduced. Similarly, people's National Insurance contributions and any occupational pension contributions had been maintained throughout this period. However, relating to people's views (described above) about missed opportunities for promotion, or having taken a step down the career ladder, a loss of **potential** income was often mentioned. Again, there were mixed feelings about this, some people being content with a lower income on balance with better mental health, but others feeling conflicted about not having reached or maintained their perceived earning potential.

Only five people in the study group mentioned having claimed Incapacity Benefit (IB) at any point. For one person this had been while under a contract of employment, when her sick pay entitlement had expired with her present employer, but the other four had claimed IB prior to joining their current employer, most having left a previous job due to mental health problems. There were also people who had spent periods of time with no personal income while unwell. There was some evidence that circumstances were less difficult for people who were living with working partners during their period of ill-health, particularly if they had taken a complete break from employment. Most people in the study group had been supported by partners or parents while out of work and said that they had managed to stay financially stable during this time. However, one person had fallen into quite severe financial difficulties while acutely unwell and had needed to seek advice to manage debt problems. Some people were aware that there were gaps in their National Insurance contributions due to years that they had spent out of employment (and not claiming any benefits) or working part-time.

Not directly related to interactions between mental health and employment status, some people noted that they had financial difficulties for other reasons, such as the costs of ongoing divorce proceedings, or substantial loans and debts. Some single people noted that they had to be careful with money in general, to meet their living costs. There were also some people who explained that spending money unwisely was one effect of their mental health condition. One person described having got into some difficulty with credit card debt and others knew this was something they had to be mindful of. Another person described how she had got into financial difficulties during a period of mental ill-health because she had not felt able to open letters and deal with bills.

There was virtually no evidence that mental health problems had impacted positively on people financially. However, one person, who had disclosed her mental health problems at work, described positive support from her line manager in moving into a more appropriate role, which had incidentally resulted in an increased salary.

6.4   Discussion

The findings presented in this chapter illustrate how mental health problems can impact on people's employment at the level of day-to-day work and also on career plans and progression in the longer-term. The impacts on day-to-day work that were identified by the present study group closely mirror findings of the sister project, where participants similarly noted impacts on performance and output, often linked to tiredness and loss of concentration and on relationships with colleagues through withdrawal, irritability or visible distress. There were also impacts on attendance, as has been discussed in Chapter 4.

The combined effects of mental health problems (in particular depression) could lead to a sense of needing to 'just get through the day' and some people dealt with this by avoiding certain tasks, withdrawing from others, concealing impacts on productivity and essentially 'struggling on' in silence. The finding that – at least for a time – some people were able to hide or limit any impacts on their work, sometimes to the detriment of their mental health, poses a challenge to employers in providing early and effective support. There is evidence from this study and the sister project that 'struggling on' is not usually sustainable in the long term and implications for more timely and effective employer – and employee – responses are discussed in later chapters.

Among the present study group, perceived impacts on longer-term career plans and progression were often in the form of missed opportunities to advance their career, either due to personal decisions and/or the (perceived or actual) barrier of employer attitudes. Some people were comfortable with their decision to prioritise mental health over higher status roles and career advancement. However, there were others who experienced frustration and dissatisfaction with their current position or conflicting feelings about whether it was sensible to move up the 'ladder', which could contribute further to mental distress. This finding indicates that there may be a need for longer-term in-work support and for employees, whose careers have been affected by mental health problems, going beyond short-term adjustments or phased returns to work. As will be discussed further in Chapters 8 and 9, there may be implications for employers in supporting staff who feel frustrated in their role and may benefit from guidance and support in balancing job satisfaction with mental wellbeing. The strategy of taking up a less pressured or less senior role in view of mental health problems was also evident in the sister project. However, the frustrations that this had caused for some people in the present study group were not apparent in the earlier project.

It is known that mental health problems can have serious financial impacts for many people and this is an important area of concern for policy. Among the current study group, however, there were few examples of people who had reached a point of extreme financial difficulty due to mental health problems. Although some people (particularly those who were single or lone parents) described tightly balanced finances, most people had not experienced significant loss of income due to their experiences of mental ill-health. This was in large part related to their employment status at the time they became unwell; most people had been entitled to sick pay from their employer, often at their full salary for the first six months. Some people in the study group also had partners who were in employment at the time they had been unwell, which had eased the financial burden. Linked to findings on career progression, however, a number of people talked about missed opportunities to increase their earnings over time.

7 Job retention

People in the present study group could be described as exemplifying successful job retention throughout experiences of mental ill-health, having (in line with the study's recruitment design) sustained employment for at least 12 months. Several people had been with their current employer continuously for over ten years. Among the large employers, there were a number of 'lifelong' employees who had worked for the company since leaving education, some of whom were approaching 30 years in service. As such, many people in the study group had been with the same employer throughout their experiences of mental ill-health, though there were some who had moved between employers since the time when their mental health problems first emerged. Some of these people described how they had had to leave a previous job because of mental health problems[20], but there were a small number who had moved between employers without breaks due to ill-health. While experience of benefits was not a theme explored in great detail, the impression was that among the study group as a whole, people had a strong attachment to the labour market and paid employment, many describing unbroken employment records of over 20 years.

While much of this report has been broadly related to job retention, in considering the factors that are helpful in managing mental health and employment, the first part of this chapter (Section 7.1) presents people's views on what they felt were the **main things** that had helped them to retain their job while experiencing mental health difficulties. It also considers people's feelings about whether their employment had ever been vulnerable.

The present study was designed to complement an earlier sister project (Sainsbury *et al.*, 2008a) that explored the experiences of people who had lost their employment

---

[20] These aspects of people's experience were not explored in great detail in the research interviews, the focus being on how they had maintained their current employment. However, from the brief accounts given, it seemed that people's employment had usually ended during a period of sickness absence, most people having made a decision during this time that returning to work would be undesirable due to the negative impact of job stress on mental health.

and come to claim Incapacity Benefit (IB) because of a mental health condition. In widening understanding of what supports job retention and what contributes to loss of employment when mental health problems emerge, an important question to consider is what differentiated the experiences of these two study groups. The second part of the chapter (Section 7.2) draws on the findings of the sister project, to explore any salient differences in the circumstances and perspectives of the two study groups. The chapter ends with a discussion of main findings (Section 7.3).

7.1   Staying in employment

7.1.1   Key factors in job retention

In research interviews for the present study, participants were given a brief verbal outline of the sister project, explaining that people in the previous study had come to leave work and claim IB due to a mental health condition, and were then asked what they felt were the main things that had kept them in employment throughout their own experience of mental health problems. As a follow-up question, people were also asked whether there had ever been a time when they felt they might leave their job and if so, what it was that had kept this from happening.

To a large extent, the things people mentioned in response to these questions map onto factors that have been discussed in earlier chapters, including the role of supportive line managers and colleagues, the role of medical and therapeutic input and that, for some people, work itself was an aid to better mental health. These findings will not be repeated in detail here, but are summarised below. However, in reflecting on what had kept them from leaving their job altogether, some additional themes emerged concerning the role of individual motivations and the role of their broader employment context, including organisational structures, employer policies and individuals' terms of employment.

The role of individual motivations

When asked about the main things that had kept them in employment, a number of people said that what had stopped them from leaving their job during periods of mental health difficulties was their own determination, perseverance or 'drive'. A range of motivations underpinned people's strong desire to stay in their job. Some people talked about personal attributes such as seeing themselves as a 'strong' person who did not 'give up easily'. One participant described how she did not want to be 'beaten' by her mental health condition:

> *'There's something in me. I think I've always- I do get some sort of relief out of going to work, I suppose, and trying to lead a normal life, so I'm always sticking two fingers up to the condition, to say, "Well, s*d you, you want me to give up, but I ain't going to and I'm going to carry on."'*

(Female, 20s, bipolar disorder)

Some people explained that they had invested time and effort in building their career to reach their current position and did not want to give this up. As described by one participant:

> *'I said* [to myself]*, effectively that, you know, you've made this decision, you've got this far, are you really going to give that up, are you really that stupid? If this is really what you want to do, what you should be doing is finding out how you get back there, how you sort yourself out, you know, why give up?'*

> (Female, 50s, stress, anxiety and depression)

Finances were also a key motivation for several people; some explaining that staying in employment was a *'necessity'* in order to support themselves or their families and to pay their mortgage. A small number of people who had dependent children commented that, if it were not for their family commitments, they would not hesitate to walk away from their job for a less stressful life. Some lone parents and single people said that financial considerations were particularly important because they did not have anybody else who they could rely on for financial support. As one person put it, *'when you're a single parent, you don't have that choice, you've got to keep working'*. There were also people who explained that their income from work was important in maintaining the standard of living that they enjoyed. As one person explained:

> *'We've got a lifestyle and it would be maintaining that lifestyle, maintaining the family unit as we know it, that's what made me stay. Quite often you think, "Well, why do I put up with this c**p?" But no, that's what made me stay.'*

> (Male, 40s, stress)

Echoing findings about why some people had not taken time off sick, there was also a view that 'giving up' was not an option. The following quote, from a participant who had not disclosed her mental health problems at work, illustrates the combination of factors that can contribute to people feeling that they must 'struggle on' in the face of mental ill-health:

> *'Your personality, your general expectations in life, the responsibilities that you have on you, will dictate the extent to which you allow it to engulf you, you know, and I can't allow it to engulf me.'*

> (Female, 40s, stress, depression and anxiety)

Particularly among people who had experienced long-term absence and the small number who had had a period on IB, there were comments about **wanting** to be in work and echoes of the perspective that 'work is good for you'. Even where they perceived work as having contributed to their mental health problems, some people viewed being at work as better for them than being off sick from their job and better than being out of employment altogether:

> *'I don't want to be on benefits and sitting on my bum all day long, cos I know that's worse for me...I was once unemployed, I was unemployed for about ten weeks and that was terrible, the impact that actually has on your brain, it's terrible.'*

(Female, 40s, anxiety)

> *'I take a lot out of employment. I get a lot out of it. I get a lot out of positive reinforcement and I get a lot out of working with – I get a natural lift out of being around people, it does something for me. So that's been a very helpful part of it.'*

(Male, 30s, bipolar disorder)

Some study participants had met other people who had become long-term unemployed due to mental health problems, either when attending mental health support groups or through their own field of work. These experiences had been influential in people's views that being in work would be better for them than to stay out of employment. One person, who had attended a day centre for people with mental health problems during her long-term absence from work, described how the circumstances of other service users had impacted on her:

> *'I was frightened by seeing people who had drifted into being mentally ill and depressed and that was all they saw as their future. That scared the hell out of me; that was never going to happen to me.'*

(Female, 50s, stress, anxiety and depression)

Some people said they had never considered leaving their job because of their experiences of mental health problems, for example, explaining that they had always felt confident that they would recover or perceiving that their difficulties had never been so severe as to contemplate leaving employment. As already noted, very few people in the study group had ever claimed IB and, when this was mentioned by the researcher, some people commented that claiming IB had never crossed their mind. In giving an outline of their employment histories during research interviews, there were also very few mentions of periods claiming other benefits. Although some people in the study group had taken time out of employment to care for young children, few people described periods of time when they had been unemployed and 'jobseeking'. There were comments from some people that being out of work in the long term would *'bore'* them or that they simply would not know what else to do if they did not go to work.

The role of organisational policies and employment terms

When asked what had kept them in employment throughout their experiences of mental ill-health, some people, all of whom worked for large employers, cited their employer's overarching policies or structures. These included: entitlement to paid sick leave (typically six months on full salary and a further six months on half pay); phased return to work plans; and opportunities to move into a new role within

the company. Regarding the relatively generous amount of paid sick leave that was permitted, one person described his employer as having *'traditional policies'* that *'provide that safety net and that support for its employees'*. For some people, these provisions of paid sick leave and phased returns to work were very important in allowing time to recover, as reflected in the following two comments:

> *'Basically when you have some kind of breakdown, you just need a break and knowing that your company's still paying your salary is huge.'*

> (Female, 40s, depression)

> *'It was a huge thing coming back in, you know, staggered hours a little bit at a time…being allowed to have the time to sort myself out.'*

> (Female, 40s, stress and depression)

Some people explicitly recognised that the size of their employer was important in its ability to make such provisions. Reflecting on his period of absence due to mental health problems, and his reduced capacity in the initial months back in work, one person explained:

> *'Because it's such a big organisation it can carry people. A small organisation, if I'd gone back after six months off, and been barely effective for another six months, I think I'd have been out of work in a lot of companies…The company can sustain it. It may not consciously do it, but it does do it.'*

> (Male, 40s, stress and depression)

There were also comments that, in larger organisations, the absence or reduced productivity of one individual employee did not have such a large impact on the overall company. These observations about the relatively higher capacity of larger organisations to support and make adjustments for staff with mental health problems were also made by employers and employees in the sister project.

Other key factors in job retention

In their final reflections on what had helped them to stay in employment, many people echoed the factors that were helpful in managing mental health and work day-to-day and in the longer-term. These have been discussed in detail in Chapters 3 and 5 and will be briefly summarised here.

Workplace factors that people cited as important in sustaining employment during periods of mental ill-health included:

- supportive line managers;
- supportive and friendly colleagues;
- flexible work hours;
- short-term reductions in working hours;
- working at home (occasionally or permanently);

- a change of role or team; and

- the beneficial role of work itself, where the job is appropriate and enjoyable.

For some people, moving out of a job role or setting that had been a source of work-related stress, and into a more positive work environment, was cited as key in sustaining their employment. There were again comments that being in a role that was enjoyable, appropriately challenging and engaging was important to staying well and in turn staying at work. One participant also reflected more broadly on the circumstances of people who were contemplating returning to work from a period on benefits, emphasising the importance of stimulating work that matched with people's skills job aspirations:

> *'It's important not to be shoved back into any old job. You have to have some of your heart's desires met by what you go back to, cos that's part of the incentive of getting you back to work, you know you're going back to something you really want to do, not just the next boring penpusher's job.'*

(Female, 50s, stress, depression and anxiety)

The role of supportive line managers and colleagues was also reiterated as very important for several people, with comments that it had been the positive, caring attitudes of people they worked alongside that had kept them coming to work and *'on the straight and narrow'*. Some people also noted the importance of general social contact and interaction that came through being at work.

Some people cited the input of therapists, or the coping strategies they had learned through their treatment, as central in managing their mental health and thus being able to return from absence and continue on in work. Cognitive Behavioural Therapy was mentioned a number of times in this context. A small number of people, including both of the participants with a diagnosis of bipolar disorder, said that the prescribed medication, which they took on a long-term basis, was crucial in managing their mental health condition.

7.1.2   Job vulnerability

In the research interviews, people were asked whether they had ever felt their job was vulnerable because of their experiences of mental ill-health. A number of people said that they had never felt their job was at risk in this way, explaining that they were aware that their employment rights protected them from being dismissed for mental health reasons.

However, despite an understanding that employment laws protected them from dismissal, some people still worried that their mental health problems might place their job at risk. One person described how she was reluctant to disclose her mental health condition at work because she felt employers could use this as a *'prime good excuse'* to try and get rid of an employee who they felt could not manage their job:

'They can't [dismiss you] *can they, but it does make you worry that you could be easy pickings, you know, to be made a scapegoat of.'*

(Female, 20s, bipolar disorder)

Another participant, whose mental health condition was known to her employer and had to some extent been supported, explained how she still worried about how secure her employment was:

'I feel like I'm walking on eggshells because I see myself as a bit of an inconvenience and I think how many more times will they put up with it? Because I suppose they do have a right to turn round and say, well, I can't cope with the job, so it is a little bit of a worry.'

(Female, 30s, depression)

There were also comments from some people that they felt their **status** at work had become vulnerable because of their mental health problems. As discussed in Chapter 6, some people felt that their opportunities for promotion had been restricted through their employer's knowledge of their mental health problems. There were others who perceived this would be the case if their employer came to know about their circumstances; Chapter 2 has described how people perceived that managers would view them as less competent or reliable if they knew about their mental health problems. Where people's mental health problems had at first been perceived by their employer as a performance matter, there had been concerns about job vulnerability for people who had initially been taken through a disciplinary route.

Two people in the study group, neither of whom had disclosed their difficulties to their employer, perceived that there could be a potential risk to their employment in future because they feared that mounting stress and anxiety might at some point lead to an act of aggression or violence at work. Again, there are implications for individuals and employers in being open about mental health difficulties and intervening earlier to manage work-related stress.

Finally, some people reflected on the loss of confidence that often accompanied mental health problems, explaining that they had felt their job was vulnerable when they were most unwell, but with hindsight could see that this had been unfounded. As one person described his experience of returning to work after a period on IB:

'Mental illness smashes your self-confidence, and it's only recently that I thought, I'm probably not going to get sacked now! I've been here about four and half years and I realise now that I'm probably alright now. But yeah, the bad thoughts which we all get when we start a new job, it's just multiplied seriously.'

(Male, 30s, bipolar disorder)

7.2 Staying off Incapacity Benefit: reflections on the sister project

This section draws on the findings of both the present study and the sister project (Sainsbury *et al.*, 2008a) and, in comparing the experiences of the two groups of research participants, offers some tentative suggestions as to what might have been significant in differentiating the employment outcomes of the two groups.

A first observation in comparing the two study groups is that, although individual experiences differed, overall there were few striking differences in the way people described their mental health problems. Depression, anxiety and 'stress' were the most common problems experienced and severe and enduring mental health conditions were relatively rare among both study groups. In both studies, the perceived origins of mental health problems were also comparable, many people citing a combination of personal and/or workplace factors that had contributed to 'reactive' mental health problems and others who perceived their condition as longstanding and 'endogenous'. As such, for the people in these two studies, it might be suggested that it was not the experience of mental health problems *per se* that posed a barrier to job retention. This is consistent with other research evidence that cites organisational factors and 'person-environment fit' as more salient in job retention outcomes (Kirsch, 2000, cited in Thomas *et al.*, 2002).

One difference to note, however, is that the present study group did not include anybody who identified their mental health problem as alcohol or drug use. In the sister project, there was a subgroup of participants whose 'primary condition' for IB purposes was substance misuse and small number of others who referred to problematic alcohol use. It is known that some employers do not treat substance use in the workplace in the same way as other mental health problems (Sainsbury *et al.*, 2008a) and there may be additional tensions around disclosure where alcohol or illegal drugs are being used. Alcoholism had been directly linked to work becoming untenable for some people in the sister project, for example, where a transport worker had lost his licence through drink-driving or where an individual had been employed in a bar and could no longer continue working in this setting.

There was some evidence that non-disclosure could be a barrier to job retention. Attitudes and approaches to disclosure were very similar across the two groups of research participants, with reasons for non-disclosure including lack of insight, feelings of shame or embarrassment about mental health problems, and also perceived negative attitudes and responses of employers and colleagues regarding their reliability or capability. Among participants in the sister project, however, it appeared that not feeling able to share details of their mental health difficulties and the impact that this was having on their work had led some people to 'struggle on' without support to the point that they felt they had no choice but to leave their job. In the sister project, there were also some people who had been dismissed due to supposed poor performance or conduct, which they

themselves believed to be related to their mental health problems. However, they had not explained or discussed this with their employer before leaving their job. In contrast, there was some evidence among the present study group that, although sometimes distressing, having mental health difficulties 'exposed' somehow at work could be positive in that it might prevent more severe consequences for people's employment. One person explained that a poor performance review had spurred him to acknowledge the depression he was experiencing, commenting that:

> 'If I had stayed at work and had ignored the depression, then I am sure that I would have been driven down a poor performance route and yes, always at the back of your mind is the fact that that could lead to, eventually, dismissal.'

(Male, 40s, depression)

In a similar way, another participant reflected that:

> 'If I'd have kept it to myself, I would have got more stressed and more depressed and more angry…and I would have, I think, walked out. Yeah, I would have walked out, I think. I wouldn't have given my notice, I'd have just gone and that would have been the worst possible thing because then I would have been back at square one.'

(Female, 30s, depression)

Contrasting the experiences of people in the two studies, there was some evidence that the nature and conditions of people's employment could also influence job retention in a number of ways. Firstly, while the predominance of people under permanent contracts of employment in the present study was largely a product of the recruitment strategy used, there was evidence that this provided a crucial 'safety net' of paid sick leave during times of ill-health. In the sister project, there were a number of people whose employment terms meant that there had not been the option of taking time off sick while remaining contractually 'attached' to their employer. This included people who worked on a freelance basis, were self-employed or who worked via an employment agency. At the time when they were most unwell, paid sick leave had given many people in the present study a degree of financial and contractual security for a period when they could focus on treatment and recovery. Although not always experienced positively by people in the study group, this was also a time where employers could potentially negotiate adjustments and offer other forms of support – an opportunity that was lost for people in the sister project who had no contractual sick pay and so had left their employment directly. It can be suggested, therefore, that people might be more likely to retain their job if they are able to have some time on paid sick leave, which may be crucial to job retention, before feeling compelled to reach a decision about ending their employment.

Secondly, in the present study group, many people were in 'professional' jobs and had invested significant amounts of time in developing a career with their current employer, often reaching fairly senior positions. In contrast, in the sister

project's study group, there were more people who worked in less skilled or professional occupations and had spent fewer years with their current (or most recent) employer. The previous study group also included a larger number of young people who, it might be argued, had not yet set out on a clear career path. The sister project investigated people's attachment to work, and found considerable evidence that people placed a high value on being in employment and perceived a range of benefits, not only financial, but also pertaining to individual fulfilment and social contacts. However, in considering what distinguished the two study groups, a possible inference might be that, while people across the two studies were committed to being in work generally, there was greater attachment to a **particular employer** in the present study, and this may have influenced their thoughts about staying in or leaving their job. In the sister project, there were some individuals who had also developed a professional career over a number of years with one employer (tending to be larger employers in the private or public sector) and it is notable that their experiences were more similar to those of the present study group. Here, people had become IB claimants while still under contract, when their 12-month sick pay entitlement had expired. The circumstances under which these people's employment ended included: redundancy unrelated to mental health problems, reaching retirement age, finding new work, or negotiating a compromise agreement[21] with their employer. There was perhaps some evidence, therefore, that where people had been able to remain under contract while claiming IB, jobs were retained until some other 'positive' or unrelated reason to end employment was presented.

A third observation, that might be relevant to retaining work during periods of mental health, was that most people in the present study group worked in 'desk-based' occupations where, to some extent, they managed their own workload and could allocate or defer tasks according to how they were feeling. Working at home, either on a permanent or occasional basis, was also an option for several people – indeed this was encouraged by some employers for other business reasons. In the sister project, there were a greater number of people who worked in customer-facing roles, care or service delivery or manufacturing. Conceivably in these types of role there was less flexibility in when and where job tasks could be completed. Reduced productivity at certain times seems more likely to have to be compensated for by another colleague, rather than the individual being able to manipulate their own workload. The scope for and nature of feasible adjustments in jobs such as retail, catering, personal care or manufacturing is an area where further research insight would be valuable.

Among the present study group, people's individual determination to stay in their job was cited as important to job retention (and also to not going off sick;

---

[21]   A 'compromise agreement' is a legally binding agreement following the termination of employment. It usually provides for a severance payment by the employer, in return for which the employee agrees not to pursue any claim they may have to an employment tribunal.

see Chapter 4). This was underpinned by a range of factors including personal 'drive' and commitment to their career, the enjoyment they gained from work, a feeling that being in work was better for their mental health, and also financial considerations. Psychological factors including motivation and self-efficacy have also been demonstrated as influential in job retention in other research (Grove and Membrey, 2005). It is not within the scope of this study to make inferences about the levels of self-efficacy of study participants or whether people in the sister project were less motivated to retain their jobs. However, if the proposed notion of attachment to a particular employer is valid, it might be suggested that the motivation to retain their specific job was higher among the present study group.

In the sister project, people offered a range of suggestions as to what could have been done to prevent their leaving employment, including:

• quicker or more effective treatments for mental health problems;

• more positive contact with employers and colleagues during absence;

• dealing with workplace bullying or harassment that had contributed to mental health problems;

• reducing job stress that had contributed to mental health problems;

• constructive responses to personal life triggers of mental ill-health;

• individual insight into mental health problems.

However, there was some evidence to suggest that people in the sister project had lower expectations of what might potentially have been done to help them stay in employment. A number of people felt that there was nothing that could reasonably have been done to help them to retain their job. Some believed that they were simply not suited to the job or could not meet the basic requirements of the role. For example, some people described how the effects of depression meant that they were simply not able to 'handle' or 'hack' the particular type of work they were in (in some cases describing a mutually reinforcing relationship between mental ill-health and struggling in work). Here, some people's view was that it was 'only fair' to their employer to leave when they did. Moreover, some said that they would not have wanted any allowances or adjustments to be made for them. For these people, their personal work 'ethic' dictated that if they were not able to manage the job in front of them, then it was only right and fair that they leave. Very few people in the sister project's study group were aware of the Disability Discrimination Act (DDA).

7.3   Discussion

Among the present study group, job retention was attributed to a combination of individual motivations and positive and supportive work environments, underpinned by the 'safety net' of paid sick leave entitlement for those who had needed this.

The range of factors that people had found helpful in managing mental health and employment was reiterated in their final reflections on what had supported job retention, including positive support from line managers and colleagues, flexibility in work hours and location, appropriate and enjoyable work, and effective medical treatment. These echoed the findings of previous research on factors that improve job retention (Thomas *et al.*, 2002). Notably, individual motivations could include positive pulls towards staying in work, for example, enjoyment and fulfilment gained through work, but also drivers that were described more in a language of compulsion or obligation, where people talked about financial necessity as a reason for staying in their job or felt that 'giving up' was not an option.

The influence of employer size and organisational structure was noted, with the recognition that larger companies had greater scope for offering redeployment options and accommodating times of lower productivity. Despite having retained their jobs throughout mental ill-health, people were not necessarily free from worries about job vulnerability. Although some people knew these were unfounded and that their employment rights protected them, there were still worries about risks to 'role status', employers' tolerance for effects on behaviour at work or periods of lower productivity, and how performance matters might be handled by their employer.

This chapter has reflected on the differences that were apparent between the experiences of people in the sister project, who had left or lost their work due to mental health problems, and the present study group, who had retained employment during periods of mental ill-health. Due to the exploratory nature of the present study, only tentative suggestions can be made. However, some potentially influential differences were noted, including:

- employment factors:
  - contractual terms and sick pay;
  - size of employer: scope for flexibility and role adjustments;
  - type of occupation: scope for flexibility and role adjustments;
- individual motivations and decisions:
  - disclosure, non-disclosure and timing of disclosure;
  - individual expectations of possible employer support, potentially including knowledge of employment rights;
  - 'attachment to employer' – possible influences including time in post and professional status;
- mental health condition:
  - distinct barriers for people with alcohol or drug addictions.

These areas would benefit from further investigation in strengthening understanding of what aids job retention and the relative importance of each aspect.

8 Areas for improvement

This chapter presents study participants' thoughts on what could be done to improve the management of mental health and employment, both for themselves and for others in future. Towards the end of the research interviews, people were asked what they thought could have been done better or differently in their own situation, and at various points, people also made spontaneous comments on what else would have been (more) helpful for them. As a final question, people were also asked what they would like to convey as their 'key messages' to employers and to government. This chapter draws together responses to all of these questions which, taken as a whole, produced some clear and consistent findings.

Three major themes emerged from the data: understanding, engagement and in-work support. These are discussed in separate sections below (Sections 8.1 to 8.3), but are closely linked and might be seen as mutually reinforcing. Underpinning these three themes, there were also several references to the need for more openness around the topic of mental health, as will be considered in Section 8.4. Taken together, these four strands reflect a perception among study participants of a need for improved 'mental health literacy', a concept that has been defined as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (Jorm, 2000).

A number of other suggestions for improvement were also made, relating to better management of absence, greater flexibility and a more positive working environment. These themes have been reflected on in some detail in other chapters of this report and so are reviewed only briefly in Section 8.5. The chapter ends (Section 8.6) with a discussion of main findings.

8.1 Greater understanding about mental health problems

A first key theme was about the need for greater understanding about mental health problems. This was particularly noted in relation to line managers, but the importance of greater awareness of mental health problems among Occupational Health Services, employees as a whole and society more generally

was also highlighted. Specifically, people talked about a need for managers to be knowledgeable about the nature of common mental health problems, early signs of mental ill-health and the treatments available for mental health conditions. As noted in Chapter 3, some people perceived that a lack of knowledge and understanding had led their managers to shy away from discussion of mental health problems. There were also comments that employers should acknowledge stress as a mental health issue. Some people perceived that Occupational Health Services had limited specific knowledge of mental health problems and that better understanding of their diagnosis, symptoms and treatment could have led to more effective support.

Reflecting on the importance of employer knowledge and understanding of mental health problems, another person noted that it could be important for line managers to understand the effects of a condition or treatment, so that people were not asked to undertake tasks that could prove detrimental:

> *'They need to know that you've got a condition and that it's being treated and what that means for them in terms of your capabilities, or how they're gonna be impaired or not impaired…They could be asking you to do things that you're not really capable of doing anymore and that could exacerbate the condition.'*

(Male, 40s, stress and depression)

Some people talked about the need to overcome misconceptions about people who experience mental health problems and to achieve a more accurate and balanced view. For example, one person felt that employees who were off work with depression or anxiety were perceived by their colleagues as either *'skiving'* or *'carrying knives around'* while another stressed that people should not *'assume that anybody that's got mental health issues is on the edge'*. Reflecting the idea of a continuum of mental health, some people emphasised the need to understand that *'mental health is just part of life'* and that anybody's mental health could be affected for different reasons at different times. There were also some comments that it might be more helpful to move away from the language of mental illness and the medicalisation of common mental health problems to focus instead, for example, on notions of positive or negative *'ways of thinking'*.

One participant, who worked in a role providing emotional and practical support to others, expressed a view that there should be a more positive perception of people who experience mental health conditions and what they can offer to employers. As she explained:

> *'I think there's a big cloud over mental health and people are reluctant to take on people with mental health problems. You often find people with mental health problems are quite creative really, I've found anyway. And they can bring a lot of life experience to a position, especially the kind of job that I do.'*

(Female, 30s, depression)

Although there was recognition that people experiencing mental health problems may have a reduced capacity for work at certain times, there were comments that these individuals could nevertheless be very productive for most of the time and should not be perceived as unemployable:

> *'It's not insanity, it's just a general unwellness…It doesn't stop you from functioning, it just stops you from functioning at full efficiency, and you just need sometimes just to step back a little bit and slow down, so. But you should be able to function OK, but sometimes you just need a bit of time out.'*

(Male, 40s, depression)

> *'I think some of the things that people don't appreciate, there are plenty of times when you feel better than others and actually, despite the fact that I have this illness, I'm probably far more effective than the majority of people who work in the organisation.'*

(Female, 40s, depression and anxiety)

There was also recognition that increased understanding of common mental health problems would be helpful to the individuals concerned. Some people said that, with hindsight, they might have been quicker to recognise or acknowledge that they were experiencing problems and so could have acted sooner in seeking help. As noted by one participant:

> *'Being ill requires you to know that you're ill. And one of the significant features of my mental health problem, at the point at which I was very worst, I wasn't aware that I was ill at all…I'd thought this was just a combination of circumstances, and it wasn't until I was told that I was ill, and that was demonstrated to me, that I started receiving treatment, that I started getting better.'*

(Male, 40s, depression)

The individual quoted above explained that this lack of insight at the time he was becoming unwell had presented a challenge in receiving appropriate support from his employer, because *'I can only be ill, as far as they're concerned, if I say I'm ill'*. This dilemma highlights that there is a role for both employers and employees in being better able to recognise and respond to signs of mental ill-health.

Some people felt that government could or should play a role in driving and supporting an increase in employer knowledge and understanding, for example, through training or guidance resources. One idea was a central online database that could be accessed by all employers and would provide information about a wide range of mental health conditions. There were also suggestions of a large scale campaign to raise public awareness of mental health and mental health problems, one person suggesting a specific focus on educating young people about this. People referred to previous government public health and awareness-raising campaigns such as those around drink driving, HIV/AIDs and physical

disability which, although long-term projects, had slowly had a positive impact on changing attitudes and behaviours. There was also a suggestion that mental health charities could play a role in awareness raising.

8.2 Increased employer engagement in employee mental health

A second key theme was the view that employers need to be more engaged in addressing employee mental health. In the main, this related to being more responsive when an employee's mental health problems became known to them. However, there were also comments about a need for more proactivity around managing and monitoring the mental wellbeing of all staff.

8.2.1 Engaging with known mental health problems

Considering first the responses to existing or emerging mental health problems, earlier chapters have noted how it was often not until an employee's mental health reached some kind of 'crisis' point that line managers, Personnel departments or Occupational Health Services took up an active involvement. As one person commented:

> *'It's only when people become self-destructive that people suddenly say, "Oh is there a problem?" And that's way too late in terms of where help can come from at work.'*

(Male, 40s, depression)

In the experience of the study group, information provided at the time of appointment to jobs, or early approaches to line managers regarding workplace stress, bullying or other problems, often went largely unacknowledged or were perceived as being underplayed. Even where there had been some degree of response to their disclosure of mental health problems, some people felt this had been little more than *'lip service'*.

A key message from several study participants, therefore, was for employers to acknowledge and respond to such disclosures at an earlier stage and in greater depth. Some people believed that this could have prevented their mental health problems from becoming as severe as they ultimately did. There was also some evidence that early discussion prior to a time of acute distress could allow for a more measured consideration of appropriate responses and support strategies, rather than 'knee jerk' reactions.

Elaborating on what they would like from a more 'engaged' employer, people said that they would have welcomed the opportunity to talk in detail with their line manager or somebody else at work about the nature of their mental health condition, the effects they experienced and what would be helpful for them at work (see further in Section 8.3). There were also comments that a more sympathetic and sensitive response to learning of personal problems such as relationship

breakdown (the emotional impact of which later led to mental health problems) would have been appreciated. Reflecting the above comments on knowledge and understanding, one person (who had a more uncommon mental health condition) would have particularly appreciated if his manager had independently gathered some information about this condition, seeing this as an active show of support.

Although there was recognition that communication needed to be a two-way process, some people felt nervous about initiating discussion about mental health at work and would have appreciated it if their employer had made the first move. There was evidence that people wanted to be **asked** about their experiences and views on potential adjustments, rather than having to volunteer explanations and make requests for support. Moreover, some people described how, when experiencing mental distress, the impact on confidence or energy levels meant it was very difficult to assert oneself or take steps to seek help. However, the challenge that employers may face in striking the appropriate balance between proactive engagement and not *'treating people with kid gloves'* was acknowledged by some participants, who recognised the tension between their wishes to downplay the significance of their mental health problems at work while, at the same time, a feeling that some degree of acknowledgement from line managers would be helpful.

Other aspects of engagement that people would have found helpful included: line managers making referrals to employee counselling provisions or to Occupational Health Services; asking if the individual wanted colleagues to be informed about their mental health problem; and taking the lead in conveying this information to colleagues if desired.

Sustained engagement was seen as important by some people, with regular 'light touch' enquiries into employees' wellbeing beyond the time when mental health problems were first discussed and not only at times when problems became acute. Where adjustments or other support strategies had been put in place, it was felt to be important to periodically review these arrangements and check that they were still effective.

Consistency in response was also highlighted as important. As has been discussed in earlier chapters, people's experiences of responses and support varied substantially. The evidence across the study group as a whole, and as highlighted by some individuals, was of a *'piecemeal'* approach to support that often depended on the outlook of the particular manager or other member of staff who became involved. Although there was some recognition that policies and training could not necessarily change individuals' personal beliefs or attitudes, there was a view that line managers should be expected to engage in a discussion of difficulties where these were expressed and to give a consistent offer of support (although any adjustments would need to be individually tailored). As one person reflected on his experience:

> *'I think there could have been a policy at work which would have understood mental illness. That policy would have then been applied, rather than local managers deciding that they had their own opinions about what mental health meant and what had to be done to me.'*

(Male, 40s, depression)

There were observations from a number of people that, although progress had been made by their employer at the overarching level, in the implementation and promotion of mental health policies and support strategies, these messages did not appear to have permeated the practices of individuals at lower tiers of line management, where there remained a patchy and inconsistent response. There were suggestions that Occupational Health or Personnel departments could have a key role in driving improvements in this respect.

8.2.2 Engaging with employee mental wellbeing

Although this report has not focused on the prevention of work-related mental health problems, people's suggestions for what would help included comments about greater employer engagement in mental wellbeing in a proactive and preventive sense. There were references to better management of stress in the workplace and to a broader concern with the happiness and welfare of the workforce as a whole. Some people working for large employers felt that over time, there had been a move away from this type of caring and personalised workplace culture, with suggestions that it would be beneficial for senior managers to get *'back to the floor'* to understand the conditions that people were working in and to engage with staff about their daily experiences and concerns.

Some people perceived a role for government in enforcing policies and compelling employers to be more proactive in the area of employee mental health, as one person put it, for managers to *'realise that your welfare is their responsibility at work as well'*.

8.3 Improvements to in-work support

The third major theme related to the forms of support available for employees experiencing mental health problems, either based within, or accessible via, the workplace. Broadly, the majority of suggestions related to services providing somebody to talk to about mental health matters. However, there was a range of suggestions about what roles could be usefully fulfilled, from clinical counselling or therapy, through more 'mentoring' type roles, to mediation/advocacy, career counselling and peer support.

Regarding the potential role for government, there were some suggestions that there could be government investment in funding counselling services (rather than sick pay), or in funding in-work support services. Another suggestion was that government could invest money in mental health charities so that they could provide a more extensive service.

8.3.1   Counselling and therapeutic services

Some people felt that more accessible and sustained support from counselling and therapeutic services would have been beneficial to them, and perceived that these could usefully be provided by, or via, their employer. In one example, a participant had been receiving counselling at a mental health clinic during a long-term absence, but this was a day provision primarily for people who were not in work and she had felt she could no longer attend once she had returned to work. She had particularly felt the loss of this provision and it had been very difficult going back to work *'cold turkey'* with no transitional support from a counsellor.

Quick access to free or employer-funded counselling, directly through their workplace, was seen as particularly helpful by some people. One person explained that she had avoided approaching her General Practitioner (GP) for a long time, hoping that she could obtain some help to manage depression without having to take a medical route. She had approached the Welfare Officer at her workplace, but had been disappointed that their only suggestion was to go and see her doctor. Linking to the theme of employer knowledge, a participant who had received very positive experiences of support from a Community Mental Health Team and private therapy, wondered if employers knew about the range of mental health services available and suggested that it would be useful if employers were better equipped to signpost people to appropriate services.

There were also suggestions from people working in emotionally demanding fields of work that employers could provide counselling or therapeutic opportunities for all staff as a matter of course.

8.3.2   Workplace mentoring and emotional support

Despite a feeling among many people that they did not want their mental health problems to be widely known about at work, there were a number of suggestions for a confidential in-work provision within which people could discuss work-related or other matters that were impacting on their mental health. These suggestions differed slightly from the above calls for counselling or therapy, in that they were less focused on clinical therapy and more akin to a listening ear or 'mentoring' type provision.

In some people's experience, although there may have been generally sympathetic responses from people they had talked to at work, there did not seem to be anybody whose specific role it was to provide dedicated or ongoing support. One person, who had received assistance from Personnel in finding a new and more appropriate role after a period of work-related stress and depression, described how she had felt she was being a *'nuisance'* to the Personnel department in repeatedly returning to them for support:

'The only person you had was Personnel and I kept thinking "I'm being a nuisance, I'm being a nuisance, I don't want to talk to them" because effectively they weren't there to counsel, they were there to get me another job and to push me out on the lake of find your way kind of thing…HR didn't want to do it cos they didn't see it as part of their role and yet who else was there?'

(Female, 50s, stress, anxiety and depression)

Although there were calls for greater engagement in employee mental health problems from line managers, in describing a potential in-work support service the overall impression was that people conceived this as a separate and distinct role. One person noted that line managers may not necessarily be the best people to take on the role of support for an employee with mental health problems, recognising that line managers did not always have the skills and attitudes that would be important to this role:

'It's someone who understands it and has an awareness of it…line managers are just people, and some are sympathetic and some aren't, and if you get a sympathetic one, that works; and if they're not, you've got a problem.'

(Male, 40s)

Knowledge of the structures and operations of the employing organisation was noted as important, for this role to be carried out effectively. One suggestion was that this provision could sit within Occupational Health services. There were also comments that it was important for the person fulfilling this role to understand and take a positive view of individuals with mental health problems, not seeing them as *'a diminished person'* or *'idiots or stupid or incapable of doing a job'*. Usually, people suggested to a face-to-face provision, though the possibility of a telephone helpline was also mentioned.

Suggestions as to how in-work support might be structured indicated that there was variation in who different individuals would have wanted to become involved. Some people wanted a 'network' including their line manager and Personnel department. Others wanted a space to talk about their difficulties to a neutral third party, but did not want wider involvement of line managers. The importance of this service being confidential and impartial was emphasised by some people. However, there was also a suggestion that part of the role could include encouraging employees to talk to their line manager about work-related problems rather than suppressing them until problems got worse.

It was felt that having such a provision in place would be useful in encouraging people to come back to work from absence, in the knowledge that there would be someone to support them as they made this often challenging transition and somewhere where they could *'offload'* if they were having a more difficult period. One person noted how such a provision could also be helpful to employers in raising their awareness of the extent of mental health concerns among their employees. Although users of the service would remain anonymous, the numbers

of people accessing the service could be monitored and this knowledge could perhaps improve preventive and early intervention strategies.

Reflecting earlier findings about the value of 'softer' support, some people's views about helpful in-work services were more akin to a general pastoral care role, without too great a focus on detailed discussion of mental health problems, but providing a supportive space for time out when needed. One person envisaged this as:

> *'A nice room I could go to and someone sympathetic. It would almost be like going to see Matron at school when you'd cut your knee, you know, go downstairs and get a reassuring cup of tea and a chat, and you wouldn't get asked lots of questions…somebody who recognised the condition and can say, "Oh are you having a bit of a low day", you know, "Yes I am", "Ooh well come in and I'll make you a cup of tea and just sit quietly here and read some magazines and lie down", or whatever it is you feel you need to do until you feel ready to go back upstairs and face the world as it were. That would be helpful.'*

(Female, 40s, anxiety and depression)

The above comment also highlights the benefits that some people perceived of an on-site, quick to access, 'drop in' type facility, where it was not necessary to make an appointment for some time in the future and immediate concerns could be talked over informally.

8.3.3   Advocacy and mediation

Slightly different again from the confidential mentoring role, some people felt it would be useful to have someone at work who could act as an intermediary or advocate for employees experiencing mental health problems. Here, there would be less of a focus on anonymity and a more active role in conveying information about work-related stress or other mental health problems and negotiating adjustments and support for the employee. Some people commented on how Occupational Health services had been contracted out to external companies or how on-site welfare officers had disappeared over the years, changes which had reduced the sense of personal care and concern that they perceived from their employing organisation. Reflecting on the experience of people moving off Incapacity Benefit (IB), one person similarly suggested that an in-work support service, offering guidance to the employee and advocating and mediating for them with their employer, would be helpful for people returning from a long period out of employment[22].

---

[22]   As part of the 'Pathways to Work' IB reforms, an In-Work Support service of this nature has been piloted. See Dixon and Warrener (2008) for a qualitative evaluation of this service.

8.3.4 Career counselling

At a number of points in preceding chapters of this report, it has been highlighted that some people felt frustration and tensions about their changed capabilities, role or status within the workplace, following experience of mental health problems. Moreover, it was noted that the normal anxieties of career management and progression were magnified for people experiencing mental health difficulties. As such, there were suggestions that some form of careers counselling would be helpful.

8.3.5 Peer support

A final suggestion was for in-work peer support, for example, a group or online forum where people could talk with other company employees who had similar experiences and could discuss what adjustments or support they had received and found useful.

8.4 More openness about mental health and mental health problems

A fourth theme, which can be viewed as underpinning all of the above, was the need for more openness about mental health and mental health problems. This went beyond the workplace and extended to comments on the need for a widespread change in societal attitudes to talking about mental health problems. Conceivably, understanding about mental health problems may exist without people necessarily talking openly about the subject. However, engagement and effective support for employees seems only to be possible within an atmosphere of openness about mental health problems in the workplace and beyond.

Within the workplace, there were comments that if there was a generally more open atmosphere around discussing mental health, then people would feel able to speak up sooner when they experienced difficulties, perhaps preventing problems from escalating:

> *'If people were prepared to be more open about it, it would help everybody I think, because people will recognise it was a problem and perhaps we'd be able to pick problems up faster, so people aren't in quite such a deep hole when the problem surfaces.'*

> (Male, 40s, stress and depression)

> *'I think we do have to have a culture where it's reasonable to acknowledge that we have periods of our life where our mental health is just not that great.'*

> (Female, 50s, depression)

There was also a view that a more open atmosphere around talking about mental health problems could improve people's confidence and ability to access support

when needed. Illustrating the interrelations between openness, understanding and support, one person described how – at the time – she had felt that she should manage her experience of depression on her own, but on reflection, perceived that more openness about mental health problems at work could lead to a more supported process:

> 'I thought of it as being something down to me as an individual, because 'I' had a mental health problem, but to me, what it should be is a wider thing of people being more aware of it, so that it can be talked about and dealt with on a wider scale.'

(Female, 50s, depression)

Some people noted that there had been progress in their workplace through employer awareness-raising campaigns, the development of mental health policies and training on stress management, but nonetheless felt that there was more work to be done. While workplace stress was being more openly discussed, there was a view that things had not moved forward sufficiently in talking openly about mental health problems, where stigma and taboo still remained:

> 'Until we can formally remove the stigma it's quite difficult, I think, because if it comes with a stigma, people aren't gonna be open about it. People are quite proud to talk about how they broke a leg and which bits were broken and how many branches of the tree they fell through before it broke, but people won't have that discussion about this sort of condition. It's not a badge of honour.'

(Male, 40s, depression)

In discussing the need for more openness around mental health, some people recognised that there was a role for the individual in overcoming their reluctance to discuss their personal experiences with employers, which was in part contributing to the perpetuation of misconceptions and taboo around mental health problems. Again highlighting the close link between openness and understanding, one participant referred to evidence[23] that the best way to increase understanding about mental illness is for people to come into direct contact with people who experience mental health problems:

> 'The best thing that people can ever do is to literally sit down with someone like me and then talk to them for the day, and then at the end of it, when you say, "Oh, by the way, I'm bipolar." And they go, "Ohh!" You know, they go, "Oh right. Well I wouldn't have thought that at all." Well that's the whole point.'

(Male, 30s, bipolar disorder)

However, as has been described elsewhere in this report, a number of employee-side barriers to more open discussion of mental health problems remained,

---

[23]   A leading figure in this area has been Graham Thornicroft (see, for example, Thornicroft, 2006; Thornicroft *et al.*, 2008).

including: concerns about the impact of disclosure on employment or promotion prospects; lack of personal insight; and determination to conceal difficulties and 'struggle on' in the face of mental health problems.

8.5   Other suggestions for improvement

Other suggestions that people made as to what could have been done better or differently in their situation largely reflected the findings presented in earlier chapters about what had already been helpful for other people in the study group. As such, these will be discussed only briefly here. There were also a small number of additional comments about improvements that related to health services and health insurance providers.

Some people's suggestions for what else would help related to how their absence and return to work had been managed. As already discussed in Chapter 4, some people felt that their line manager could have dealt better with their period off sick, in acknowledging their absence and communicating with them during their time away from work. In particular, the 'softer' forms of support were noted as potentially helpful, including general enquiries into how they were feeling, making the employee feel that they were *'valued'* and *'missed'* and keeping them updated with events in the workplace. One person described how he had felt *'very disconnected'* during the time he was off work.

Where people's experience of mental ill-health was linked to work-related stress, however, there was evidence that such an approach could be difficult. Some people had not wanted any contact from their employer where work had become a source of acute anxiety or relationships had become antagonistic, and here the suggestion for what could have been done differently or better was for their line manager not to have made any contact at all. As Chapter 4 has noted, there may be a useful role for an intermediary third party in such circumstances.

People also noted scope for improvement in employers providing more structure in the return to work, alongside recognition that people were still in a phase of recovery during this time. Related to this, there were also comments that a change in attitude of employers and line managers towards productivity was needed, to enable people to keep coming to work even at times when they were less well.

Another area for improvement related to greater flexibility at work for people experiencing mental health problems. Chapters 3 and 5 described how some people found the option to take occasional days off work, either using flexitime or through an agreed short-notice leave arrangement, very helpful in responding to times of increased difficulty or managing mental health more generally. When considering what else would help them, some people who did not currently have this flexibility in place felt that similar arrangements would be useful. Sometimes referred to as *'duvet days'* there was a view that being able to take a day's annual leave at short-notice, without this being counted as a day off sick, would be helpful. Another suggestion was for a form of compassionate leave to be granted

on particular dates that were difficult for an individual (for example, the anniversary of a significant bereavement), which would not be counted as either sick leave or annual leave.

Other points that were reiterated in people's final reflections on improvements to workplace support included:

- the need for attention to role suitability and job satisfaction;

- better management of stress in the workplace;

- allowing time off work to attend medical appointments;

- more positive relationships with colleagues; and

- making employees feel valued.

Finally, there were some suggestions relating to medical practitioners, health services and health insurance providers. Some people emphasised the need for quicker referrals and more widely available access to therapies. Linked to this, there was a call for GPs to make less instant recourse to prescribed medication, where talking therapies might be equally if not more effective. Going beyond the medical profession, some people noted that mental health conditions were excluded from cover in some health insurance policies and suggested that it would be better if this exclusion was removed.

8.6   Discussion

This chapter has presented findings about what people in the study group felt would improve their own and others' experiences of managing mental health problems in work. In part, these suggestions reflected an absence of the types of support that **had** been helpful to others in the study group and which have been discussed in earlier chapters. These included improvements to absence management, greater flexibility in working hours, and attention to job suitability and stress management.

However, a number of areas for more fundamental or overarching change also emerged through people's final reflections and the key messages that they wished to convey to employers and government. These related to increases in knowledge, understanding, engagement and dedicated in-work support for managing mental health problems at work. Permeating and underpinning all of these was a need for greater openness about mental health and mental health problems in workplaces and wider society.

Despite many people's feeling that they did not want their mental health problems widely known about at work, there was substantial evidence that people would like there to be somebody connected to their workplace, with whom they could talk about mental health problems and how these interacted with their work. A recent evaluation of in-work support services for people moving from IB to

employment (Dixon and Warrener, 2008) identified that the support of a dedicated individual as they made the transition to work was particularly valued by people with experience of mental health problems. Although many people in the present study group had found a close and trusted individual with whom they could talk about difficulties (see Chapters 2 and 3), there was some evidence that a formal and dedicated channel of support within the workplace was lacking.

The range of roles which people would have liked to be fulfilled included both clinical therapeutic support and also something more akin to workplace mentoring or a pastoral support role. Reviewing the literature on effective job retention services for employees with mental health problems, Thomas *et al.*, (2002) make the useful distinction between 'mental health counselling' and 'vocational counselling', and recommend that the latter should include attention to employment issues, job satisfaction and preference and disclosure, with a guarantee of confidentiality. This structure closely reflects the picture of desired support that came together through study participants' comments.

An important question, which the data from this study cannot fully answer, is whether people were aware of the support provisions that already existed within their workplace. As explained in Chapter 1, a substantial proportion of the study group was recruited from within two large employers. Among these two subgroups there was some evidence of uneven knowledge about the employee support that was already in place. There are implications, therefore, for employers in publicising and encouraging the use of existing support such as Employee Assistance Programmes (EAPs) and welfare officers.

Where there is scope for increased provision of in-work support, questions are raised about how best to structure and fund these services. Some people in the study group suggested a role for government in investing in employee counselling. There were also proposals that government could spearhead awareness-raising campaigns and provide momentum for increased employer engagement, perhaps through legislative powers. This again implies that there may be scope for more wide-reaching publicity of the campaigns and initiatives that are already underway.

As well as dedicated mental health support roles, there were also calls for greater knowledge and understanding about mental health problems among line managers and also Occupational Health Services, and greater engagement with employees who express mental health concerns. A strong message was that it would be much more productive if employers and employees felt able to talk openly about mental health problems and useful supports at an early stage rather than waiting for a 'crisis' to occur before addressing the issue. It might be supposed that greater knowledge about mental health problems and more openness to discussing difficulties would support and reinforce each other in a reciprocal manner. This relates to the concept of 'mental health literacy' and thus reiterates the policy implication identified in the sister project, that increased mental health literacy could be seen as a crucial step in addressing the uncertainty, secrecy and

silence that frequently surrounds mental health problems. Drawing on their own experiences, people in the study group knew that mental health problems were common, treatable, and not insurmountable and could be managed alongside work. However, there was still a sense that line managers would have uncertainties about the capabilities of employees who had periods of mental ill-health, which in turn deterred people from disclosing problems.

A key challenge that was apparent through people's accounts was that of where to break into this 'vicious circle' of lack of knowledge, misunderstanding and fear of discrimination, which together amounted to mental health remaining a taboo subject. It has been noted at several points in this report that perceived misunderstanding, negativity and stigma, from employers and others had influenced people in not disclosing mental health problems, but there were clearly tensions between feeling a need to keep their circumstances hidden and wanting someone at work to talk to and engage with about mental health. This will be returned to in discussion in the final chapter.

A final point to recall here is that the vast majority of study participants worked for large employers. While their suggestions for enhancements to in-work support may be feasible for larger organisations that have greater resources and flexibilities at their disposal, smaller employers may face greater challenges in implementing support or accessing advice and expertise. That said, softer forms of support were often very valuable to people and positive line manager attitudes need not depend on the size of the organisation.

9   Conclusion

This report has presented findings drawn from the experiences of 38 individuals who had each sustained employment while experiencing episodes of mental ill-health and/or managing a long-term mental health condition. The project set out to explore how people accomplished this and the forms of support that they drew upon. This chapter begins by drawing together and discussing the main findings (Section 9.1) and goes on to present some policy implications for government and employers and some possible directions for future research (Section 9.2). The chapter concludes (Section 9.3) with some final thoughts of the researchers.

9.1   Discussion of main findings

As a whole, the study group could be seen as exemplifying successful job retention throughout periods of mental ill-health. However, in exploring individual experiences, there was evidence that this had not always been a straightforward or easy process. Although some people had had very positive experiences of employer support, others had perceived negative responses or felt that they had effectively managed mental health and employment on their own with no employer support. Although everybody in the study group had retained their employment for at least 12 months (sometimes many years longer), there were differences in how 'well' people were managing. The concept of a continuum between 'languishing' and 'flourishing' has been applied to experiences of mental health (Keyes, 2002 and 2005) and while some people in the study group appeared to be flourishing at work, drawing on a range of effective support strategies, others seemed to be languishing to some extent and their circumstances continued to reflect the notion of 'struggling on'. There were as many comments about what had been unhelpful to people at work as about what had been helpful. However, these were largely the mirror of each other and as such, some clear findings emerged about effective strategies to support the management of mental health and employment.

9.1.1   What helps to manage mental health and employment?

Two factors emerged as key to effective employer support: flexibility and 'soft' forms of support. Flexibility in working hours and location was very helpful to some

people in preventing the exacerbation of mental health difficulties and enabling them to arrange and continue with their work around periods when they felt less well. 'Softer' forms of support from line managers and colleagues, including a listening ear, displaying genuine concern and offering understanding responses to people's fluctuating mood or need for occasional time off, had helped people to feel able to keep coming to work during times of ill-health or had encouraged and supported them to return to work from absence. Quick access to counselling services via the workplace, either through Employee Assistance Programmes (EAPs) or insurance packages that would reimburse the costs of private therapy were also beneficial. People's positive experiences of Cognitive Behavioural Therapy (CBT), alongside some participants' preference not to use prescribed medication, suggests that the Government's current initiative on Improving Access to Psychological Therapies (IAPT) will be of value.

Throughout this report, the concept of mental health as a continuum has underpinned the analysis. The findings of this study illustrate that a range of parties, not only employers, contributed to people maintaining a more positive state of mental health, which in turn enabled them to be at work and productive. Medical practitioners, family and friends, and the individuals themselves all had a role to play. For some people, prescribed medication played a crucial role in managing a long-term mental health condition. However, there was evidence that 'non-medicalised' approaches to maintaining positive mental health, involving cognitive coping strategies, supportive social networks and a balanced lifestyle, could be very effective instead of, or in addition to, the use of medication. Although this report has not focused on preventing the onset of stress-related mental health problems, it is perhaps to some extent a false distinction to treat prevention and management of common mental health problems as two separate areas, especially if the notion of a continuum of mental health is to be adopted. Common mental health problems may affect anybody and it is not just a discrete section of the workforce which requires attention. In developing government and organisational policies around mental health and employment, therefore, a focus on proactive management of the emotional, psychological and physical wellbeing of all employees seems equally important.

Table 9.1 summarises the factors that people in the study group had found helpful, or said would have been helpful, in maintaining their employment throughout periods of mental ill-health. Reflecting the different 'tiers' at which managing mental health and employment can be understood, this is divided into three columns, underpinned by some key factors that supported all aspects of job retention.

Table 9.1   What helps in managing mental health and employment?

Responding to mental health problems in work	Managing absence and return to work	Maintaining positive mental health
• Employer acknowledgement of and response to disclosure • Employer engagement in discussion about mental health problems • Adjustments to working hours and/or location • Short notice occasional days off • Adjustments to duties • Provision of/signposting to counselling or therapy • Display of genuine concern • Line manager alertness to signs of distress • Tolerance and sensitivity at times of lower productivity • Support and encouragement from colleagues	• Sensitive and constructive contact with employer • Third party liaison where appropriate • Where desired, employer explanation to colleagues about the individual's experience of mental health problems • Where desired, informal social contact with close colleagues and/or line manager • Negotiation of suitable return to work arrangements (phased return; new role or work setting) • Understanding, by all parties, of recovery as a gradual process	• Prescribed medications • Counselling and therapies • Appropriate work setting • Flexibility in working hours and location • Positive workplace relationships • Openness about mental health in the workplace • Work itself (where suitable and enjoyable) • Effective stress management • Support of friends and family • Maintaining physical health • Religious or spiritual engagement • Relaxation and work-life balance • Individual insight and understanding
Individual motivation, commitment and determination Enjoyable and engaging work Employment conditions and organisational structures (contractual sick pay; scope for redeployment and/or role adjustments; capacity to support times of reduced productivity)		

These findings closely mirror what has already been established in previous research about factors that improve job retention (Thomas *et al.*, 2002). However, one participant, in his final reflections, urged the research team not to seek to present a 'model' of the best way to manage mental health and employment. It is important to acknowledge that experiences of mental health problems are personal and subjective. The evidence from this study is that people desire different levels and forms of involvement from others and indeed it is neither possible nor appropriate to set out one ideal way of supporting an employee who is experiencing mental distress. People will have their own perceptions of how salient the mental health condition is within their lives, how it sits within their identity (if at all), who they want to know about it, and how they want others to respond (if at all). This presents a challenge for employers. But the solution seems to be in consistent and sustained but sensitive engagement, asking questions about the individual's experience and what would be helpful to them both in the workplace and during absence from work. People in this study group were able to describe what had (or **would have**) been helpful to them in managing work and mental health and where they had been able to express this to a supportive employer who was

willing to meet these needs, then attendance and productivity at work could be successfully maintained.

9.1.2 The role of the Disability Discrimination Act

The study findings raise some questions about the role of Disability Discrimination Act (DDA) in relation to common mental health problems. Although some people in the study group considered themselves to be in some way 'covered' by the DDA, there were others who did not feel their circumstances met the criteria for disability as set out in the Act. Moreover, some people did not wish to be identified as disabled, feeling that this was not an accurate reflection of their experiences of fluctuating or (as they currently perceived it) short-term health problems. Also taking into account findings on employers' lack of clarity about mental health as a disability (Sainsbury *et al.*, 2008a; Simm *et al.*, 2007), there is a picture of some uncertainty about how the DDA can or should be applied in practice. While it arguably provides a useful underpinning for good practice, it may be that other types of policy tool may be more directly influential in supporting people with common mental health problems at work. Some people who experience short-term or milder difficulties may indeed not 'count' under the DDA definitions and others may not wish to formally identify themselves as disabled with their employer. Moreover, it may be that the 'reasonable adjustments' that are most helpful to people fall within normal flexibilities and structures of the job.

9.1.3 Disclosure of mental health problems at work

The study's findings contribute to understandings about how individuals contemplate and experience the disclosure of mental health problems at work, and concur with Brunner's (2007) suggestion that disclosure is best viewed as a 'process' rather than an 'event'. This process is influenced by a range of factors including individuals' own understanding of and perspectives on their mental health problems and the perceived responses of others. Although most people in the study group had told **somebody** at work about their experiences of mental ill-health, this was not always somebody in a 'formal' capacity, for example, their line manager or somebody within Personnel or Occupational Health departments. Support from close colleagues emerged as an important element of managing mental health and employment, and these were sometimes the people who knew most about individuals' mental health difficulties.

Some people had not wanted to tell anybody at work about their mental health problems and sought – for as long as possible – to minimise any (noticeable) impact that this was having on their job performance. Reasons for this approach related both to expectations of an unfavourable response from employers or colleagues and to the individual's own negative feelings about experiencing mental health problems. However, such masking of problems often involved great effort on the individual's part, which could in turn be further detrimental to mental health. There is substantial evidence from this and the sister project that 'struggling on' alone is only sustainable for so long before people become unable to be at work. There

is, therefore, a challenge for employers in identifying members of staff who are experiencing mental health problems at work and who may benefit from support, but who endeavour to keep their difficulties hidden. Early intervention may be particularly compromised, given the evidence that it is often only when problems become perceptible at work (either through visible distress, reduced performance or sickness absence) that employees begin to talk with line managers about their difficulties. Not only were there accounts from participants of the significant effort required in 'struggling on' in silence, but evidence from this and the sister project illustrates the potentially severe consequences of non-disclosure when this led to people being disciplined or dismissed for what was perceived by their employer as poor performance or misconduct.

9.1.4   A need for greater employer awareness and engagement

A main finding of the study was that, where people had talked to their line manager or others at work about mental health problems, responses were very varied and appeared to depend on the personal approach and attitude of individual managers. There was evidence that the existence of a positive company policy on mental health did not necessarily mean that the ethos of this policy would be conveyed at the individual line manager level[24]. Particularly where managers had personal or close family experience of mental health problems, people had received positive and supportive responses. In contrast, there were also people who felt their manager had been uncomfortable talking to them about mental health and did not know how to respond, sometimes resulting in no discussion or offer of support (either while in work or during absence).

There were a number of people in the study group who felt they had been largely unsupported until some point of crisis where their mental health problems were first responded to by their managers. Disclosure at earlier times had often gone unacknowledged. A key message from several study participants, therefore, was for employers to acknowledge and respond to such disclosures at an earlier stage and in greater depth. However, although some people felt that responses were inappropriate or lacking, there were very few examples of overtly prejudiced or discriminatory responses. These findings suggest that it may be a lack of understanding and confidence that prevents some line managers from making more positive steps towards supporting employees who experience mental health problems, and points to another key finding – the need for greater knowledge and engagement around employee mental health.

---

[24]   Research for the Shaw Trust found that of the 20 per cent of senior managers who said that their organisation had a formal policy on mental health; only 16 per cent felt it was well understood and 14 per cent perceived it to be effective. This translates as just three per cent of organisations with senior managers who feel they have an effective and well understood policy on mental health (Future Foundation, 2006).

People's suggestions for what might be done better to support employees who experience mental health problems centred on the themes of knowledge, engagement and support, all of which were underpinned by a need for greater openness about mental health and mental health problems, both in the workplace and in wider society. As noted in the introduction to this report, there is a growing body of advice and guidance materials produced by government-led initiatives, charitable sector organisations and the business community and there is some evidence that awareness of common mental health problems is increasing. However, there are also observations that awareness does not necessarily equate to understanding. As noted in recent research by the Shaw Trust: 'attitudes in general toward mental ill-health have changed somewhat, and are certainly more liberal than in past generations. This does not mean, however, that it is understood to any real extent' (Future Foundation, 2006, p.9).

The present study therefore reinforces the conclusion of the sister project (Sainsbury *et al.*, 2008a) that there is still scope for additional awareness-raising activity to increase line manager knowledge and confidence in recognising and responding to employees who experience mental health problems. Improved 'mental health literacy' among individuals, employers and the wider population seems central to moving forward in supporting people with mental health problems to stay in work. There seems to be scope for increased activity around developing not only employer awareness of mental health issues but also deepening real understanding of the nature, treatment and effects of mental health problems. There is evidence that direct interaction with people who have experienced mental health problems is one of the most effective ways of changing attitudes (Thornicroft *et al.*, 2008). Therefore, useful strategies might include approaches that follow the model of initiatives such as the Stand to Reason *'Breaking Glass Ceilings in Mental Health'* campaign, which aims to change attitudes among private sector Chief Executives and Human Resources Directors through seminars that will provide direct contact with 'professionals who have achieved high levels of recovery', and the Shift initiative's *'Speakers' Bureau'*, a bank of people are willing to speak to the media about their experience of mental health problems. The recent introduction to the UK of 'Mental Health First Aid', a training package developed in Australia that teaches people to recognise the symptoms of mental health problems and provide initial help and signposting, may also prove beneficial[25].

9.1.5 Breaking down taboo

A notable finding from this study was that, although people perceived an ongoing sense of taboo around mental health, most had found somebody supportive to talk to in their workplace. Drawing together the collective experience of the study group, a picture formed of isolated 'islands' of positivity and support divided by a perception of more pervasive stigma and taboo. However, there was also some awareness that common mental health problems are, indeed, common.

---

[25]   See www.mentalhealthfirstaid.csip.org.uk for details.

This suggests that the challenge of opening up discussion about mental health problems may not be so great as perceived, if these 'islands' can be linked up to form a larger and more visible network of positive attitudes and understanding. However, there seems to be something of a vicious circle whereby individuals remain uncertain about disclosing mental health difficulties for fear of negative reactions and employers do not engage with the subject because they do not know how to respond. In the current climate, there appears to be a 'stalemate' whereby if individuals do not feel able to speak up about mental health problems, employers (and others) remain in a position of ignorance or misunderstanding about the presence of mental health problems among the workforce and what can be done about this. However, if employers do not make a more visible demonstration of support, people will continue to believe that it would be dangerous to speak up. As noted by a study participant:

> *'It's proven that's what's needed is people to stand up and say, "I have this or I have that, and I am perfectly okay." But it's chicken and egg, isn't it. You know, you can't get people to do it, because they're worried about people's reaction.'*

(Male, 30s, bipolar disorder)

Figures 9.1 and 9.2 illustrate (first) the current cycle of misunderstanding and taboo of mental health problems and (second) a more positive potential circle of openness and support for employees.

Figure 9.1   Current cycle of misunderstanding and taboo of mental health problems
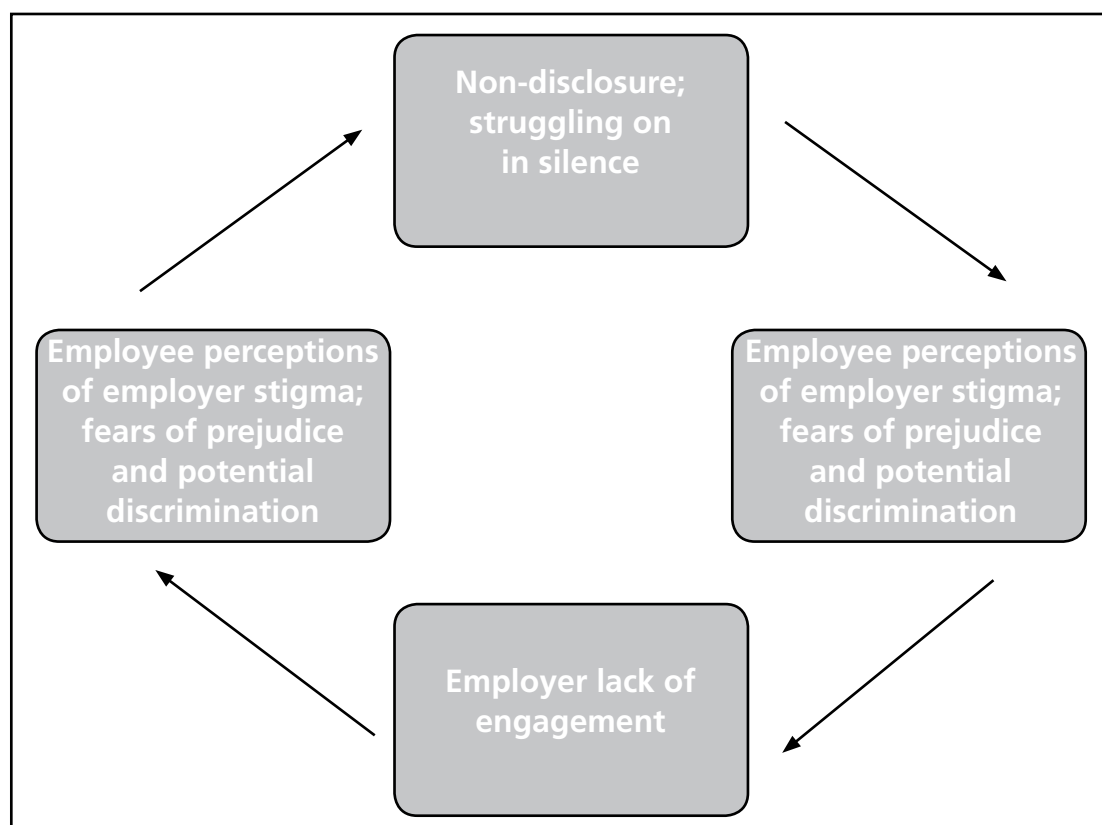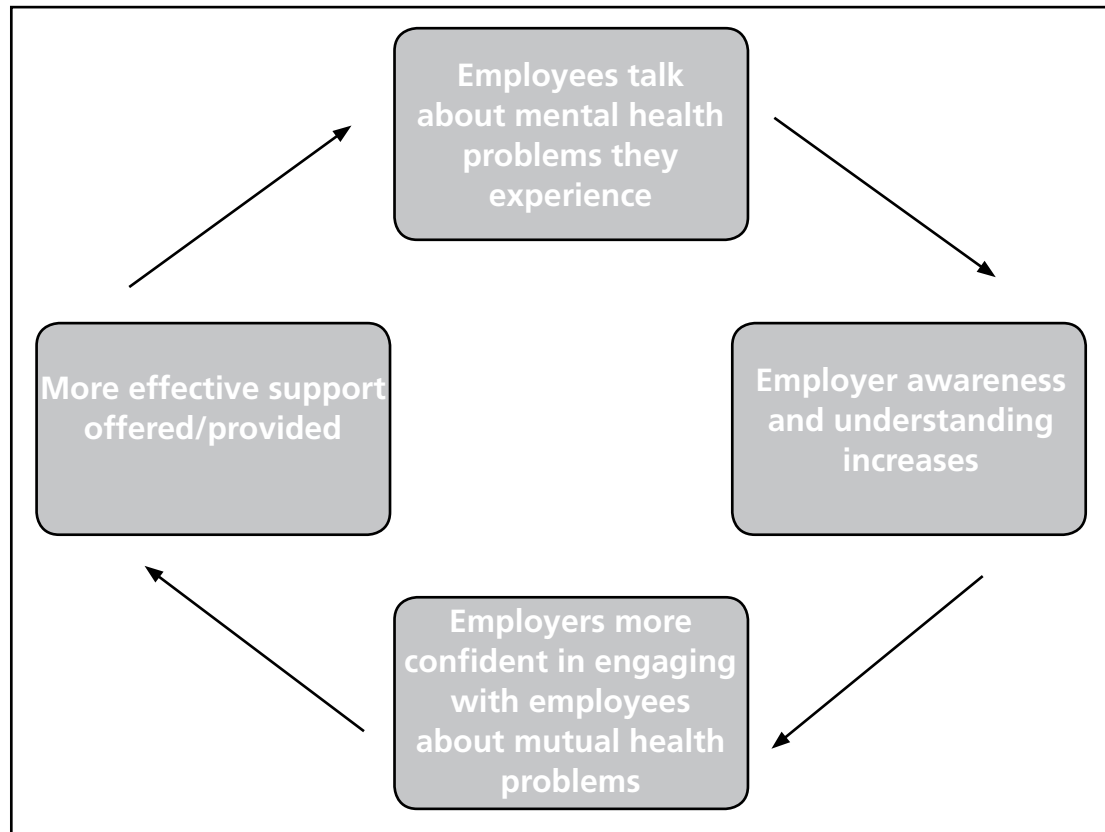
Figure 9.2 Positive potential circle of openness and support for employees

Where the responsibility lies for breaking this circle is unclear – there would seem to be a role for all parties. Conceivably, more visible displays of positive attitudes towards mental health at the organisational level could be an effective step, with people in key roles demonstrating that they are genuinely committed to supporting employees' mental health. In order for employees to feel confident in being open about mental health problems, there need to be clear procedures and structures where a consistently positive response and constructive discussion of support can be expected. However, as already noted, there is a challenging task in making the links between top level policies and the practices and attitudes of individual line managers.

9.1.6 Enhancing in-work support

Despite their reservations about disclosing mental health problems more widely at work, many people in the study group said that they would have liked to have somebody in a dedicated role at their workplace (separate from line managers) who they could have talked to about their mental health problems, how this impacted on their work and vice versa. There were various components to the kind of in-work support that people would have found useful. These included:

• access to counselling or therapy via the workplace;

• workplace mentoring;

- emotional support;

- advocacy and mediation;

- career counselling;

- peer support.

A recent evaluation of in-work support services under the Department for Work and Pensions (DWP) Pathways to Work initiative (Dixon and Warrener, 2008) identified that they key areas of support for people returning to work from Incapacity Benefit (IB) included:

- support for coping emotionally and socially at work;

- physical adaptations;

- support in liaising and negotiating with employers; and

- financial reassurance and support.

This study has highlighted that ongoing in-work support may be as important for people who have sustained their employment throughout mental health problems as for people who are returning to work from IB. Moreover, the areas where support is appreciated are not vastly different. While physical adaptations and financial reassurance were of lesser concern to people in the present study group, emotional and social supports and support in liaising and negotiating with employers were clearly areas where support was valued or would have been appreciated. Thomas and Secker (2005) have proposed a model for an effective job retention service, as summarised in the box below. To a large extent, the range of desirable in-work support suggested by people in the present study group closely mirrors the key criteria that Thomas and Secker's model incorporates.

Key criteria for an effective job retention service
Source: Thomas and Secker (2005)

- Vocational Counselling: ability to address employment issues, job satisfaction and preference, and disclosure issues without bias and ensuring confidentiality from employer.

- Mental Health Counselling: ability to address mental health issues, symptom management in the workplace, perspectives on illness, psychological detachment from work, self-esteem and self-identity issues, also ensuring confidentiality primary allegiance to client.

- Advocate for client in the workplace.

- Specialist regarding DDA, legal issues, and relevant financial incentives or benefits.

- Provides training and advice to employers and managers on dealing with mental health issues in the workplace.

- Provides training to employers on healthy workplaces for all employees.

- Facilitates communication between employee and employer regarding time off work, return to work plans, modified work programs and adjustments.

- Facilitates natural supports within the workplace.

- Promotes early intervention and is easily accessed by employers and employees.

- Keeps all parties informed – including employer, employee, mental health workers, General Practitioners (GPs).

- Ongoing support to manage any problems in the workplace as they arise.

- Provides training and advice on employment issues for people with mental health problems to mental health workers and GPs.

9.1.7   The role of medical practitioners

Although there are considerations of doctor-patient confidentiality, there was some evidence in this study that people would have liked some communication between their GP and employer, in order to increase their employer's understanding of their mental health problem and its effects. From the sister project's findings, there was also evidence that some employers shared this view. The extent to which GPs engage in discussion of job retention and rehabilitation may begin to increase with the proposed introduction of 'fit notes' concentrating on areas of capacity for work, to replace 'sick notes' (Black, 2008). The planned extension of the Advisers in GPs' Surgeries pilot (Sainsbury, Nice *et al.*, 2008b) also offers scope for medical practitioners to be brought into a closer relationship with support for job retention and rehabilitation.

Research with GPs has identified that there is wide variation in the extent to which doctors view work rehabilitation and discussion of employment options as falling within their remit and no apparent pattern in the characteristics of GPs who take a more or a less engaged approach to job rehabilitation (Mowlam and Lewis, 2005). Both the present study and the sister project explored the extent to which GPs had been involved in discussions about people's current work (where applicable) and employment more broadly. There was insufficient evidence from the two studies to draw even tentative conclusions about influences on medical practitioner engagement in the topic of work. However, a potential area for further research that is indicated by these studies is whether a patient's current employment status affects the extent to which GPs feel able to enter into discussion about job retention. The research by Mowlam and Lewis (2005) focused primarily on patients who had a job to return to, but further research might consider in a more

directly comparative way the question of whether GPs feel better equipped to discuss mental health and employment where people **still have** a specific job to go back to as opposed to discussion in the abstract when people have lost their job and are claiming benefits.

9.1.8 Effects on capacity for work: presenteeism and reduced productivity

This study did not look at the views of employers or the colleagues of people who experience mental health problems in work. The sister project has provided some understanding of how employers perceive and respond to employees with mental health difficulties. However, there remain gaps in understanding the impact that mental health problems in the workplace have on the wider workforce. It is important to recognise that impacts of mental health problems on day-to-day work are often not permanent or consistent and between episodes of more acute ill-health, many people are able to carry out their work effectively. As noted by Thomas *et al.* (2002, p.14):

> *'In reality, many people who have been diagnosed with a mental illness may only have short periods where they are unable to work (due to severity of symptoms or indeed hospitalisations). At other times they may have no symptoms, only mild symptoms, or are able to manage their own symptoms so that they do not have a severe impact on their ability to work or participate in other social roles.'*

However, people in the study group acknowledged that mental health problems **could** impact on performance and productivity at work when problems were most acute and also during the return from long-term absence. From people's accounts, there was evidence that line managers sometimes had difficulty in understanding the ongoing impact that mental health problems could have on capacity for work. These findings have implications for government and organisational policies that seek to support people to be **at work** despite mental health difficulties. It is now widely accepted that, when it is 'good' work, being at work is better for mental health than being out of work (Waddell and Burton, 2006). However, a concept that is receiving increasing attention is that of 'presenteeism' – being at work but not performing at full capacity because of ill-health – and this has been presented as a significant cost to employers (SCMH, 2007). The concept of presenteeism appears to have developed in relation to physical illness, highlighting both the detriment to individuals when they do not take the time that is needed to recover their health, and also risks of infection to other colleagues. In the case of short-term and contagious physical illnesses, the benefits of taking time off work seem fairly clear. However, when applied to mental health problems, there is perhaps a balance to be struck between negatively nuanced notions of presenteeism and the standpoint that being at work, even when not fully productive, is better for the individual. If the aim is to help people be in work while managing mental health then there is perhaps a need for some adjustment of employer expectations and an understanding that recovery can be a long-term process. However, the implications

of reduced productivity for employing organisations and colleagues, particularly within small and medium-sized enterprises (SMEs), need to be acknowledged and investigated further.

There was evidence in this study that reconciling their desire to return to their 'normal' work with acknowledgement of the ongoing impacts of mental ill-health was also a challenge for the employee concerned. Some people had made a positive choice to move to a less pressured role in view of their experiences of mental ill-health, but there were others who felt frustrated and unfulfilled in a less demanding role. Thomas *et al.* (2002) highlight the importance of job satisfaction and job preference in retaining employment, but also note the need for 'realistic appraisal of one's own capacities in light of the mental illness' (p.21). Thus, there may be implications for employers in providing additional in-work career guidance and job mentoring for staff who have had to adjust their role or status within the workplace. The evidence of this study suggests that this kind of support might be equally important to senior or 'high flying' employees as to people who are re-entering the workforce into lower skilled or more junior roles.

9.1.9 Influences on job retention

This report follows a sister project which considered the experiences of people who had come to leave their job and claim IB because of a mental health condition (Sainsbury *et al.*, 2008a). Some tentative suggestions have been made in this report as to the differences in experience that meant that the present study group had not ended up losing their employment and having to claim IB. With the possible exception of drug or alcohol addiction, the evidence suggests that it was not any specific difference in the experience of mental health problems that meant that some people were able to sustain their job while others were not, but that salient factors were the individual's employment terms and conditions, their employer size and structure and perhaps also their attachment to their particular job and the investment they had made in their career. There were indications that that determination to keep going to work and to stay in employment overall came from a variety of positive or more negative motivations, sometimes a combination of both. An individual could be driven to sustain their employment through financial necessity, through fear of the consequences of absence, or through positive motivations of job satisfaction and commitment and a belief that work is good for mental health. Whether or not the individual had felt able to disclose problems before reaching a point where either they or their employer perceived job retention as untenable also seemed influential. It is not possible to infer from this study what the relative importance of these factors was, and there is scope for further research in this area.

9.1.10 Gaps in knowledge about SMEs and other occupational types

Most of the people who took part in this study worked for large employers who had some form of phased return to work provisions in place and scope for redeployment or role adjustment, both of which were found to be important in job

retention. That said, because much seemed to depend on the individual attitudes and openness to flexibility of particular line managers, whether or not underpinned by a company policy, there was evidence that experiences of people working for smaller employers could be equally well, if not better managed. However, this study has not been able to provide substantial findings on the experiences of people working for SMEs and there remains scope for focused and more extensive exploration of this area. Moreover, participants in this study were predominantly professionals working in roles that permitted some autonomy and flexibility in managing their workload. Circumstances are potentially very different for people who work in, for example, customer-facing or manufacturing occupations, where there is conceivably less scope for accommodating reduced productivity 'on the job' during periods of mental ill-health.

9.2 Policy implications and future research directions

This section provides some implications for government policy and for employing organisations that have emerged from this research project. It also identifies some areas that might benefit from further investigation.

Policy implications for government and employers can be thought of as applying at three levels:

- prescription;

- advice and guidance;

- services or tools.

The two following sections will address each of these three areas, firstly for government and then for employers.

9.2.1 Implications for government

At the level of policy prescription, this study has suggested that there is scope for reflection on the role of the DDA in relation to common mental health problems. Participants in this study, many of whom could be described as experiencing common mental health problems, gave varying views about whether their own experiences met the criteria of the DDA. Differing personal understandings of disability also influenced whether people felt the DDA could or should apply to them. The recent policy interest in common mental health problems has resulted in a growing understanding of the way that these may be prevented or managed through non-medicalised approaches. There are also arguments that milder forms of anxiety and depression might be perceived as extensions to 'normal' sadness, stress or worry. Within this understanding of common mental health problems as on a continuum of everyday emotional responses to circumstances (as opposed to longstanding disabilities) it might be that there is a need for alternative ways in which government can drive momentum around supporting employees who experience milder mental health difficulties. To recall the words of one study

participant, the DDA might in some cases be *'too extreme'* a measure. Policies that compel employers to address the mental wellbeing of **all** employees, rather than respond to those who perceive a disability, might be more effective in the prevention and management of common mental health problems.

This findings of this study have reinforced the message of the sister project that there remains a need for greater awareness and understanding of the nature, effects and treatment of mental health problems – in other words a need to improve 'mental health literacy' among employers and also wider society. There is no doubt that activity to raise awareness of mental health and mental health problems is on the increase, for example in the growing number of government, charitable and business-led initiatives and resources that have emerged in recent years. However, there still appears to be a need for more effective channels of communication to bring these sources of information, advice and guidance into the consciousness of employers and individuals. This study has emphasised the need to develop deeper understanding about mental health problems among employers (in particular line managers and occupational health services), which does not necessarily come about simply through general awareness raising or broadly improved attitudes. One way of achieving genuine and effective change in levels of understanding might be through campaigns that bring employers (and the wider workforce) into direct contact with individuals who are willing to discuss their own personal experiences of mental ill-health and how they have been able to manage mental health difficulties alongside employment. Government investment in training for line managers (for example, the 'Mental Health First Aid' course) might also bring improvements in understanding and, in turn, increased confidence to engage with employees who experience difficulties.

Turning to services and tools, there was much evidence in this study that employees who experience mental health problems would appreciate some form of in-work support service that could provide assistance both when problems are more acute and also on a longer-term basis, for example, when career counselling or more 'softer' emotional support are required. An area for consideration is how best to structure such in-work support services. Research suggests that a 'case management' approach is most effective (Thomas *et al.*, 2002). In large organisations, there may be scope for developing the role of in-house occupational health services and strengthening specialist knowledge of occupational health staff in the area of mental health. However, smaller employers may find it more difficult to develop in-house expertise or fund access to external provision. Recent initiatives to deliver occupational health services to SMEs have included the 'Workplace Health Connect' pilot[26] and the 'NHS Plus' project[27]. There may be a useful role for government in expanding and developing occupational health support for smaller employers, with a specific focus on mental health problems and employee mental wellbeing. The mixed experiences of participants in this study

---

[26]   http://www.hse.gov.uk/workplacehealth

[27]   http://www.nhsplus.nhs.uk

suggests that investment in training and continuing professional development for Occupational Health practitioners, specifically in the area of mental health, would be beneficial, to ensure that people delivering such services are confident and competent in supporting individuals who have mental health difficulties. Government investment in funding or subsidising EAPs for smaller organisations might also be an effective measure. However, in light of the recognised significance of interpersonal relationships within the immediate workplace, it is important that externally provided counselling services are not treated as a replacement for active engagement and support from line managers and employing organisations.

Finally, the evidence of this study supports the Government's current policy aims to invest in the training of psychological therapists and so increase the availability of 'talking therapies'.

9.2.2 Implications for employers

A main finding of this study was that, although there were pockets of positive experience where people had found a supportive and sympathetic individual in the workplace, there was often an absence of consistency running through all levels of an organisation. Top level policies that took a positive approach to employee mental health did not always transfer to 'ground level' practices. Where they already exist, there seems to be scope for increasing the visibility of organisational policies on mental health at work; where they do not exist, the development of an organisational policy might be an important step in increasing line manager awareness and improving employee confidence in seeking help when necessary.

However, it is unlikely that written policies alone will change attitudes and alter behaviours among line managers, individuals experiencing mental health problems, and their colleagues. As with implications for government, there seems scope for more active and participatory approaches to increase understanding and offer effective support for mental health problems. The importance of line manager knowledge and understanding has been emphasised in this report, in that this might increase their ability to identify and to engage confidently with employees who are struggling with mental health problems at work, perhaps in silence.

The scope for government involvement in developing in-work support services has been noted above. Employers may have a role to play both in publicising existing in-work support (for example, EAPs) and developing additional provisions. For smaller organisations, there may be a need to access external services and funding constraints may need to be addressed. As already noted, however, it is crucial that external support is not treated as a substitute for good line management. Moreover, the evidence of this study is that 'softer' and informal forms of support may be equally valued by employees, so small changes to the workplace, for example, to provide a comfortable 'time out' space or supporting an existing member of staff who has an interest in mental health to develop basic counselling skills, might also be beneficial steps.

Having in place an individual or team which has a dedicated focus on in-work support for employees with mental health problems and which is seen to positively embrace this role could be a demonstration that employers take mental health seriously. This could act to encourage people to seek help when experiencing difficulties and perhaps also be effective in a preventive way. There was some evidence among the study group that, even where employers already had in-work support provisions in place, awareness of these services and the scope of their role was patchy among employees. As well as developing new services, therefore, there also seems a role for greater publicity about existing provisions.

A key 'tool' in managing mental health and employment that emerged from this study was flexibility in working hours, location and tasks. To the extent that such flexibilities can be offered by employers, increasing the availability of flexitime and home working arrangements might be beneficial both in preventing and managing common mental health problems among employees. However, it is recognised that this study drew on a relatively narrow range of employer types and job roles; questions remain about the feasibility of flexible working arrangements in organisations that deliver, for example, personal care, customer service or time-critical manufacturing. The implications for overall company productivity and the impact on colleagues in such environments is something that would need to be considered in exploring the scope for 'reasonable adjustments' in such roles.

9.2.3   Directions for future research

This study has gone some way to filling the observed gap in research (Thomas *et al.*, 2002; Underwood *et al.*, 2006) on what helps job retention for people experiencing common mental health problems. However, there are aspects it has not been able to address and further questions it raises. These relate in particular to small and medium-sized employers and occupations that involve different types of role than the largely 'desk-based' jobs that were represented in the present study. This study has also begun to highlight the potential impacts on the colleagues of people who experience mental health difficulties at work and the effects on overall organisational productivity.

As such, we suggest there is scope for additional research on:

• the experiences of individuals and employers within smaller enterprises, exploring, for example, the scope for effective role adjustments and employers' capacity to accommodate lower productivity;

• the experiences of individuals and employers in companies that provide front-line services or work within time-critical production environments, again with a focus on scope for adjustments and managing fluctuations in productivity;

• the impact of an individual's mental health problems on colleagues, particularly in smaller organisations.

Reflecting on the discussion in Chapter 7, which also drew on the findings of the IB sister project, there may also be value in further research on the relationships

between, and relative role of, individual motivations, organisational structures and workplace context in job retention, for example, to determine where employer or government interventions could be most effectively targeted.

9.3 Final thoughts

This study has considered the experiences of a group of individuals who had retained their employment throughout a period or periods of mental ill-health. As has been highlighted in previous research, relatively little is known about the experiences of people who sustain work alongside common mental health problems. Though there remains much scope for further research, it is hoped that this study has shed some light on this question.

It was understood from the outset that the study would be exploratory, both in the recruitment methods used and in the direction that research themes might take. From a methodological perspective, the researchers encountered challenges in recruiting study participants from SMEs. The reasons for this can only be speculated upon. However, from the experience of conducting the sister project (Sainsbury *et al.*, 2008a), we have some evidence that it is difficult to engage employers in research who do not already have positive attitudes towards, or vested interests in, employee mental health. Survey data indicates that employer awareness of the extent of mental ill-health among the workforce is low and it might be that many of the SMEs that were approached for the present study perceived the research themes as not relevant to any of their employees. Furthermore, people's reluctance to disclose mental health difficulties at work may have influenced their willingness to respond to recruitment materials displayed in their workplace. Gaps, therefore, remain in understanding of the experience of employees and employers in smaller organisations and thought will need to be given to more effective recruitment strategies in any future research projects.

A key theme that ran throughout the findings of this study was of the need for more openness about mental health, which would provide a foundation for increasing knowledge, engagement and support. The collective experience of the study group suggested that there is a 'vicious circle' of misunderstanding, lack of engagement and fear of discrimination which needs to be broken to remove the taboo of mental health and pave the way for more effective support. To achieve this, it seems that responsibility cannot lie with just one party – government, employers, people who experience mental health difficulties and individuals in wider society all have a role to play in opening up discussion. What is encouraging is that, where people in the study had been open about their mental health difficulties, they had often found that they were not alone in their experience and that at least one person in their acquaintance was able to offer empathy and support. Thus, if steps can be taken towards challenging taboos, there may be less distance to travel than anticipated.

It has not been within the scope of this study to address questions of clinical diagnosis or engage to any extent in the debates about biological, social or psychological underpinnings of mental health problems. However, there is a burgeoning literature on 'positive' mental health, mental 'wellbeing' and mental 'flourishing'. There is no question that some people in the present study group had mental health conditions that met diagnostic criteria, but by their own account, a number of people described their experiences as reactions to stressful life events and personal circumstances which, though distressing, were only acute for a relatively short period of time. A final reflection, therefore, is that there may be value in moving forward debate and discussion in the direction of mental wellbeing and equipping society as a whole with effective coping skills and strategies to maintain a more positive state of mind and to deal more productively with the challenges that work and life present. As suggested by one participant in this study, as well as the current workforce, an important focus of attention might therefore be on young people who will become the next generation of employees.

References

All Party Parliamentary Group on Mental Health (2008) *Mental Health in Parliament* (online). Available:http://www.mind.org.uk/NR/rdonlyres/85684C08-42A7-415A-A477-84F46794961E/6566/MentalHealthinParliament.pdf [accessed 21 July 2008].

Beresford, P. (2004) 'Madness, Distress, Research and a Social Model', in Barnes, C. and Mercer, G. (eds) *Implementing the Social Model of Disability: Theory and Research*, Leeds: The Disability Press.

Black, C. (2008) *Working for a healthier tomorrow*, London: The Stationery Office.

Brunner, R. (2007) *Exploring disability disclosure amongst college and university staff in Scotland*, Stirling: Equality Forward.

Chartered Institute for Professional Development (2008) *Mental health at work* (online). Available: http://www.cipd.co.uk/subjects/health/mentalhlth/mentalhth.htm [accessed 8 July 2008].

Cobb, A. (2006) *Mind Guide to Surviving Working Life* (online). Available: http://www.mind.org.uk/NR/rdonlyres/80D5ACB5-15C2-4B6D-B0F9-8C51D11DCF78/0/TheMindGuidetosurvivingworkinglife2006.pdf [Accessed 8 July 2008].

Department for Children, Schools and Families (2008) *Common mental health problems: Supporting school staff by taking positive action*, Nottingham: DCSF Publications.

Department for Work and Pensions (2006) *A New Deal for Welfare: Empowering People to Work*, London: Department for Work and Pensions.

Department for Work and Pensions, Department of Health, Health and Safety Executive (2005) *Health, work and Well-being – Caring for our future* (Cm 6374), London: Department of Health.

Department of Health (2008) *Mental health and ill-health in doctors*, London: Department of Health.

Department of Health (2004) *Choosing Health: Making health choices easier* (Cm 6374), London: Department of Health.

Department of Health (1999) *National Service Framework for Mental Health: Modern standards and service models*, London: Department of Health .Department of Health, Care Services Improvement Partnership and Shift (2007) *Action on Stigma. Promoting mental health, ending discrimination at work*, London: Department of Health.

Dixon, J. and Warrener, M. (2008) Pathways to Work: Qualitative study of In-work Support, London: Department for Work and Pensions.

Ellison, M.L., Russinova, Z., MacDonald-Wilson, K.L. and Lyass, A. (2003) Patterns and correlates of workplace disclosure among professionals and managers with psychiatric conditions, *Journal of Vocational Rehabilitation*, 18, 3–13.

Farrell, C., Nice, K., Lewis, J. and Sainsbury, R. (2006) *Experiences of the Job Retention and Rehabilitation Pilot*, DWP Research Report 339, London: Department for Work and Pensions.

Foster, J.L.H. (2007) *Journeys through mental illness: Clients' experiences and understandings of mental distress*, Hampshire: Palgrave Macmillan.

Future Foundation (2006) *Mental Health: The Last Workplace Taboo* (online). Available: http://www.shaw-trust.org.uk/file_uploads/st_mental_health_full.pdf [accessed 21 July 2008].

Grove, B. and Membrey, H. (2005) 'Sheep and Goats: new thinking on employability', in Grove, B., Secker, J. and Seebohm, P. (eds) *New Thinking about Mental Health and Employment*, Oxford: Radcliffe Publishing.

Grove, B., Secker, J. and Seebohm, P. (eds) (2005a) *New Thinking about Mental Health and Employment*, Oxford: Radcliffe Publishing.

Grove, B., Secker, J. and Seebohm, P. (2005b) 'Introduction: rethinking employment and mental health', in Grove, B, Secker, J. and Seebohm, P. (eds) *New Thinking about Mental Health and Employment*, Oxford: Radcliffe Publishing.

Horwitz, A.V. and Scheid, T.L. (1999) *A Handbook for the Study of Mental Health: Social Contexts*, Theories, and Systems, Cambridge: Cambridge University Press.

Jorm, A. (2000) Mental health literacy. Public knowledge and beliefs about mental disorders, *British Journal of Psychiatry*, 177, 396-401.

Keyes, C.L.M. (2005) Mental Illness and/or Mental Health? Investigating Axioms of the Complete State Model of Health, *Journal of Consulting and Clinical Psychology*, 73, 3, 539–548.

Keyes, C.L.M. (2002) The Mental Health Continuum: From Languishing to Flourishing in Life, *Journal of Health and Social Behaviour*, 43, 2, 207–222.

Layard, R. (2005) *Mental Health: Britain's Biggest Social Problem?* Paper presented at the No.10 Strategy Unit Seminar on Mental Health on 20 January 2005 (online). Available: http://cep.lse.ac.uk/textonly/research/mentalhealth/RL414d. pdf [accessed 8 July 2008].

Layard, R. and The Centre for Economic Performance Mental Health Policy Group (2006) *The Depression Report: A New Deal for Depression and Anxiety Disorders* (Paper No. CEPSP15), London: LSE.

Lelliott, P., Boardman, J., Harvey, S., Henderson, M., Knapp, M. and Tulloch, S. (with contributions from others) (2008) Mental health and work: A report for the National Director for Work and Health (online). Available: http://www.workingforhealth.gov.uk/documents/mental-health-and-work.pdf [accessed: 11 July 2008].

Mowlam, A. and Lewis, J. (2005) *Exploring how General Practitioners work with patients on sick leave*, London: Department for Work and Pensions.

Parker, G. and Manicavasagar, V. (2005) *Modelling and Managing the Depressive Disorders: A Clinical Guide*, Cambridge: Cambridge University Press.

Penhale, B. and Parker, J. (2008) *Working with Vulnerable Adults*, Oxon: Routledge.

Pilgrim, D. (2005) *Key Concepts in Mental Health*, London: Sage.

Purdon, S., Stratford, N., Taylor, R., Natarajan, L., Bell, S. and Wittenburg, D. (2006) *Impacts of the Job Retention and Rehabilitation Pilot*, DWP Research Report No. 342, London: Department for Work and Pensions.

Rankin, J. (2005) *Mental Health in the Mainstream*, London: Institute for Public Policy Research.

Rogers, A. and Pilgrim, D. (2005) *A Sociology of Mental Health and Illness* (Third edition), Berkshire: Open University Press.

Sainsbury Centre for Mental Health (2007) *Mental Health at Work: Developing the business case*, Policy Paper 8, London: Sainsbury Centre for Mental Health.

Sainsbury, R. and Davidson, J. (2006) *Routes onto Incapacity Benefits: Findings from qualitative research*, DWP Research Report 350, Leeds: Corporate Document Services.

Sainsbury, R., Irvine, A., Aston, J., Wilson, S., Williams, C. and Sinclair, A. (2008a) *Mental Health and Employment*, DWP Research Report 513, London: Department for Work and Pensions.

Sainsbury, R., Nice, K., Nevill, C., Wood, M., Dixon, J. and Mitchell, M. (2008b) *The Pathways Advisory Service: Placing employment advisers in GP surgeries*, DWP Research Report No. 494, London: Department for Work and Pensions.

Seymour, L. and Grove, B. (2005) *Workplace interventions for people with common mental health problems: Evidence review and recommendations*, London: British Occupational Health Research Foundation.

Shepherd, G., Boardman, J. and Slade, M. (2008) *Making Recovery a Reality*, London: Sainsbury Centre for Mental Health.

Simm, C., Aston, J., Williams, C., Hill, D., Bellis A. and Meager, N. (2007) *Organisations' Responses to the Disability Discrimination Act*, DWP Research Report No. 410, Leeds: Coporate Document Services.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. and Meltzer, H. (2001) *Psychiatric morbidity among adults living in private households*, 2000, London: The Stationery Office.

Social Exclusion Unit (2004) *Mental Health and Social Exclusion*, London: Office of the Deputy Prime Minister.

Thomas, T., Secker, J. and Grove, B. (2002) *Job Retention & Mental Health: A review of the literature* (Unpublished) London: Institute for Applied Health & Social Policy, King's College London.

Thomas, T. and Secker, J (2005) 'Getting off the slippery slope: what do we know about what works?' in in Grove, B., Secker, J. and Seebohm, P. (eds) *New Thinking about Mental Health and Employment*, Oxford: Radcliffe Publishing.

Thornicroft, G. (2006) *Actions speak louder: Tackling discrimination against people with mental illness*, London: Mental Health Foundation.

Thornicroft. G., Brohan, E., Kassan, A. and Lewis-Holmes, E. (2008) Reducing stigma and discrimination: Candidate interventions, *International Journal of Mental Health Systems*, vol.2, no.3.

Underwood, L., Thomas, J., Williams, T. and Thieba, A (2007) The effectiveness of interventions for people with common mental health problem on employment outcomes: a systematic rapid evidence assessment. In: *Research Evidence in Education Library*. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Waddell, G. and Burton, A.K. (2006) *Is work good for your health and wellbeing?* London: The Stationery Office.