

**Department for Work and Pensions**

**Research Report No 513**

# **Mental health and employment**

**Roy Sainsbury, Annie Irvine, Jane Aston, Sally Wilson,  
Ceri Williams and Alice Sinclair**

A report of research carried out by the Social Policy Research Unit and Institute for Employment Studies on behalf of the Department for Work and Pensions

© Crown Copyright 2008. Published for the Department for Work and Pensions under licence from the Controller of Her Majesty's Stationery Office.

Application for reproduction should be made in writing to The Copyright Unit, Her Majesty's Stationery Office, St Clements House, 2-16 Colegate, Norwich NR3 1BQ.

First Published 2008.

ISBN        978 1 84712 399 2

Views expressed in this report are not necessarily those of the Department for Work and Pensions or any other Government Department.

# Contents

Acknowledgements .....	ix
The Authors.....	x
Summary .....	1
1 Introduction .....	11
1.1 Policy background .....	11
1.2 Research questions .....	15
1.3 Research design and methods.....	17
1.3.1 <i>Research with employers</i> .....	17
1.3.2 <i>Research with individuals</i> .....	20
1.4 Structure of report .....	22
2 Understanding mental health.....	25
2.1 Individuals' understanding of mental health .....	25
2.1.1 <i>Describing mental health conditions</i> .....	26
2.1.2 <i>History of mental health conditions</i> .....	27
2.1.3 <i>Recognition and acknowledgement of mental ill health</i> .....	29
2.1.4 <i>Conceptions of 'illness'</i> .....	31
2.1.5 <i>Relationships between work, mental health and                 Incapacity Benefit</i> .....	33
2.1.6 <i>Others' perceptions of mental health</i> .....	36
2.2 Employers' understanding of mental health .....	38
2.2.1 <i>Awareness of mental health conditions</i> .....	38

2.2.2	<i>Employers' knowledge of employees with mental health conditions</i> .....	42
2.2.3	<i>Advice, information and training</i> .....	43
2.3	Conclusion .....	47
3	Mental health in work.....	49
3.1	Talking about mental health at work.....	50
3.1.1	<i>Volunteering information about mental ill health</i> .....	50
3.1.2	<i>Not volunteering information about mental ill health</i> .....	52
3.1.3	<i>Employer-initiated discussion about mental ill health</i> .....	55
3.2	Impacts of mental ill health in work .....	56
3.2.1	<i>Impacts on performance</i> .....	56
3.2.2	<i>Impacts on attendance</i> .....	57
3.2.3	<i>Impacts on behaviour and attitudes at work</i> .....	58
3.2.4	<i>Impacts on work colleagues</i> .....	59
3.2.5	<i>Impacts on line managers</i> .....	60
3.3	Absences and absence management .....	61
3.3.1	<i>Employee experiences of absence and absence management</i> .....	62
3.3.2	<i>Employer experiences of absence and absence management</i> .....	63
3.4	In-work adjustments for employees with mental health conditions...65	
3.4.1	<i>Employer perspectives on making adjustments for employees with mental health conditions</i> .....	65
3.4.2	<i>Types of adjustment made by employers for staff with mental health conditions</i> .....	68
3.4.3	<i>Individuals involved in supporting employees with mental health conditions</i> .....	71
3.4.4	<i>Employee experiences of in-work adjustments</i> .....	74
3.5	Employer policies and the Disability Discrimination Act.....	75
3.5.1	<i>Employer policies</i> .....	76
3.5.2	<i>Employer awareness and views on the DDA</i> .....	77
3.5.3	<i>Employee awareness and views on the DDA</i> .....	79

3.6	The role of General Practitioners .....	80
3.6.1	<i>Employee perspectives on GP involvement</i> .....	81
3.6.2	<i>Employer perspectives on GP involvement</i> .....	82
3.7	Conclusion .....	84
4	Leaving work due to mental ill health.....	87
4.1	Transitions out of work due to mental ill health.....	87
4.1.1	<i>Going off sick</i> .....	88
4.1.2	<i>Leaving work directly</i> .....	89
4.2	The decision to leave .....	89
4.2.1	<i>Employee decisions to leave</i> .....	90
4.2.2	<i>Mutual decisions to leave</i> .....	91
4.2.3	<i>Employer dismissals</i> .....	93
4.2.4	<i>Feelings about leaving work</i> .....	95
4.3	Employees' reflections on preventing leaving work.....	95
4.3.1	<i>Access to health services</i> .....	95
4.3.2	<i>Contact with employers and colleagues</i> .....	96
4.3.3	<i>Dealing with workplace bullying or harassment</i> .....	96
4.3.4	<i>Reducing 'job stress'</i> .....	96
4.3.5	<i>Constructive responses to personal life triggers of mental ill health</i> .....	97
4.3.6	<i>Self-awareness of mental health condition</i> .....	97
4.3.7	<i>Perceptions that no preventive action was possible</i> .....	98
4.4	Conclusion .....	98
5	Mental health and entering work.....	101
5.1	Experiences of people returning to work.....	101
5.1.1	<i>Influences on thoughts about a return to work</i> .....	101
5.1.2	<i>The role of medical practitioners</i> .....	105
5.1.3	<i>Support in seeking work</i> .....	105
5.1.4	<i>Recruitment</i> .....	107
5.1.5	<i>Entering work</i> .....	107

5.1.6	<i>Telling people at work about mental health conditions</i> ....	109
5.1.7	<i>Responses to learning about people's mental health condition</i> .....	113
5.1.8	<i>Employment pathways since entering work</i> .....	114
5.2	Employers' experiences .....	114
5.2.1	<i>Recruiting people with mental health conditions</i> .....	115
5.2.2	<i>Appointing people with mental health conditions</i> .....	119
5.2.3	<i>Job suitability and mental health conditions</i> .....	121
5.3	Conclusion .....	125
6	Attachment to work .....	127
6.1	The meaning and value of work.....	127
6.2	Looking to the future.....	130
6.3	Challenges and support needs in returning to work .....	132
6.4	Conclusion .....	137
7	Conclusion and policy implications.....	139
7.1	Summary of main findings.....	140
7.1.1	<i>Knowledge and understanding about mental health</i> .....	140
7.1.2	<i>Mental ill health in work</i> .....	140
7.1.3	<i>Mental health and transitions out of work</i> .....	141
7.1.4	<i>Transitions into work</i> .....	142
7.2	Policy implications .....	143
7.2.1	<i>Mental health literacy – increasing knowledge and understanding</i> .....	143
7.2.2	<i>Enhancing the role of employers in job retention</i> .....	144
7.2.3	<i>Mental health treatment services</i> .....	146
7.2.4	<i>The role of GPs</i> .....	146
7.2.5	<i>The role of Jobcentre Plus</i> .....	147
7.3	Final comments .....	147
Appendix	Recent claimants of Incapacity Benefit with mental health conditions .....	149

## List of tables

Table 1.1	Main characteristics of the achieved employer sample.....	19
Table 1.2	Main characteristics of the achieved Incapacity Benefit claimant sample.....	21
Table 1.3	Research participant transitions.....	22
Table 2.1	Relationships between mental health and work .....	36
Table A1	Type of health condition now or in past 12 months.....	150
Table A2	Type of main health condition.....	150
Table A3	Whether health condition is constant or fluctuates over time ....	151
Table A4	Socio-demographic characteristics .....	152
Table A5	Work history.....	154
Table A6	Work situation or expectations .....	154
Table A7	Whether and when employees discussed their condition with their employer after it began to affect their ability to do the job .....	155
Table A8	Helpfulness of employer .....	156
Table A9	Whether employees had access to occupational health services via employer .....	156
Table A.10	Whether employees discussed their condition with the occupational health service.....	157
Table A.11	Whether changes were made at work to help accommodate employees' health condition or disability.....	157
Table A.12	Whether other changes could have helped employees to keep working longer than might otherwise have been possible .....	158
Table A.13	Whether employees consulted anyone apart from the employer about the effect of their condition(s) on their ability to do their job .....	159
Table A.14	Whether employees were entitled to sick pay from their employer .....	160
Table A.15	Whether employees discussed returning to work with their employer while they were off sick .....	160
Table A.16	Whether employees discussed returning to work with their GP or other health professional while they were off sick .....	161
Table A.17	Whether claimants felt their health was getting better or worse .....	162
Table A.18	Whether claimants were on a waiting list for medical treatment .....	162

## List of figure

Figure 1.1	Employment and unemployment rates by main type of impairment: Great Britain, April-June 2006 .....	13
References	.....	163





# Acknowledgements

Our main thanks go to two groups of people. First, we would like to thank the 60 current and former recipients of Incapacity Benefit who talked to us about how mental health had affected their working lives. Without their willingness to talk openly about sometimes difficult topics there would have been no project at all. Secondly, we thank the staff in the 40 employing organisations that took part in the study, not only those whom we interviewed but also those who helped to facilitate the interviews.

Our next thanks go to the members of the project Advisory Group who generously gave of their time to help us with all aspects of the research. Their input and encouragement were invaluable.

In the Department for Work and Pensions (DWP) we were ably guided and assisted by our research managers, Athena Bakalexi at the start of the project, and later by Antony Billingham. Their work behind the scenes was patient and persistent and allowed us to do get on with our work as researchers. Thanks to both of them. We also know that DWP data handlers and policy makers (mainly unknown to us) contribute throughout research projects from the design stages to commenting on draft reports. Thanks to them too.

Apart from the authors there were many people in the Social Policy Research Unit (SPRU) and Institute for Employment Studies (IES) who contributed to the successful completion of the project. At SPRU our research colleagues Wendy Mitchell and Anne Corden deserve our thanks as do our administrative support staff under the capable leadership of Sally Pulleyn. Thanks also to Chris Jacobs, our freelance colleague who carried out some of the interviews with the Incapacity Benefit sample. At IES we would like to thank Nigel Meager, IES Director, for his invaluable input throughout the project, and for commenting on report drafts. Thanks also to Will Hunt, who did some of the employer interviews, James Walker-Hebborn who provided administrative support, and Matt Williams for arranging the interviews with employers.

# The Authors

**Roy Sainsbury**, Assistant Director at the Social Policy Research Unit, University of York.

**Annie Irvine**, Research Fellow, Social Policy Research Unit, University of York.

**Jane Aston**, Senior Research Fellow, Unemployment and labour market disadvantage team, Institute for Employment Studies.

**Sally Wilson**, Research Fellow, Work, health and well-being team, Institute for Employment Studies.

**Ceri Williams**, Research Fellow, Unemployment and labour market disadvantage team, Institute for Employment Studies.

**Alice Sinclair**, Senior Research Fellow, Work, health and well-being team, Institute for Employment Studies.

# Summary

## Introduction

This report presents findings of a qualitative research project commissioned by the Department for Work and Pensions (DWP) to investigate the relationship between mental health and employment. The research was conducted by the Social Policy Research Unit at the University of York and the Institute for Employment Studies, during 2007.

Active labour market and benefit policies pursued by the government (in particular the Pathways to Work pilots), alongside the legislation of the Disability Discrimination Act (DDA), have achieved steps in helping more sick and disabled people find and retain work. However, it is known that people with mental health conditions continued to fare considerably worse in the labour market than people with other types of impairment and than the population overall.

The study was therefore designed to address a gap in knowledge about the interplay of forces that lead people to claim Incapacity Benefit (IB) because of a mental health condition, and what factors contribute to people with mental health conditions returning to work after a period on IB. It also explored employers' understanding and experience of dealing with mental health conditions in the workplace. The research involved in-depth interviews with 60 current or recent recipients of IB and with individuals representing 40 employing organisations of various sizes and sectors, many of whom had experience of employing people with mental health conditions. Ten of these organisations were purposively selected because they were known or believed to have proactive and positive approaches to supporting mental health in the workplace. They are referred to throughout the report as the 'engaged' employers.

## Findings

### **Understanding mental health (Chapter 2)**

Among the 60 current or recent IB recipients, there was much variety in individuals' experiences and understandings of mental ill health. The sample comprised people whose main condition was recorded (for the purposes of their benefit claim) as either depression, anxiety-related, drug or alcohol use or other less 'common' conditions such as schizophrenia. However, some people had other ways of describing their mental health, some cited additional or different conditions, and not everybody saw themselves as 'mentally ill' or as somebody with a 'disability'.

People variously perceived their mental health condition to have emerged in early adulthood, in later adulthood, or felt that their current or recent episode of mental ill health was their first experience. In describing the origins of their mental health condition, some people linked this to circumstances in their personal life, some attributed it to workplace situations and others felt that a combination of both had played a part. There were also people who did not identify any specific 'trigger' of their mental ill health.

Although awareness of a mental health condition had been sudden and unambiguous for some people, others talked about a gradual realisation that they were unwell, which was sometimes difficult to acknowledge or accept. Some people now felt that their mental health condition was always present, to a greater or lesser extent, while others perceived that their condition affected them intermittently, or hoped that they had (or would in time) fully overcome their episode of mental ill health. Reflecting on how family, friends and society more generally viewed mental health, people commented that lack of understanding, stigma and discrimination, and a tendency for mental health to be 'swept under the carpet' were among the challenges they faced.

Employers' understandings of the term 'mental health condition' incorporated a wide range of conditions, although unprompted responses suggested broader understandings in larger organisations, with smaller employers tending to highlight the more severe and enduring conditions. On viewing a comprehensive list of mental health conditions, most employers agreed that they would consider all of these to fall within their understanding of mental illnesses. Although a definition of mental illness was questioned for some conditions (for example, substance misuse), employers often noted that it was the effects and impacts of a health condition, rather than its classification or diagnosis, which was of greater importance to them in addressing employees' needs. Stress was one of the most frequently cited mental health conditions and was highlighted as a particular concern for many employers, given its prevalence and complexity.

Around two-thirds of employers had experience of employees with mental health conditions. Some were able to provide estimates of the prevalence of mental ill health among their workforce, but few employers collected specific monitoring data. The difficulty of collecting data on mental illness was highlighted, in that

many employees might choose not to share this information with their employer due to perceptions of stigma. As such, the probability of underestimated figures was recognised.

The main sources of advice and information about mental health conditions, drawn on by employers, were occupational health, human resources and personnel departments, medical practitioners, mental health charities, and web-based resources. The larger organisations tended to have greater access to in-house advice sources and the engaged employers had often taken steps to increase general awareness and understanding of mental health, for example, training days or publicity campaigns. In contrast, small and medium-sized employers tended to make more reactive responses to individual cases as they arose.

### **Mental health in work (Chapter 3)**

Some people who had experienced mental ill health while in work had talked about this with their employer or colleagues. There were very few examples of people with long-standing mental health conditions having mentioned this at the time of recruitment or appointment to their role, but some people had talked to others about aspects of their mental health condition at a time when this began to affect their ability to manage in work, for example, explaining the personal problems they were dealing with or that they were finding it difficult to cope with their duties.

In contrast, several people opted to 'struggle on' without talking to anybody at work about a decline in their mental health. Reasons for this included feelings of pride or that revealing mental health difficulties would be a sign of weakness, with associated perceptions that their employer would see them as less capable, placing their job at risk. There were also people who did not want to share the personal issues underlying their mental health condition, or who felt that there was no appropriate forum through which to discuss their difficulties at work.

Sometimes, employers had initiated discussion about mental health with an employee whose behaviour or performance at work suggested they were unwell, though employers noted that this could be a difficult subject to broach. Some employers reported situations where an employee had been, in their view, clearly evidencing a mental health condition, but when the employer tried to broach the subject with them, the employee was unwilling to discuss it. Employers sometimes attributed this to a lack of insight on the employee's part, possibly as a direct result of the condition itself. Employers had found this situation very difficult to manage or resolve.

Employers and people in the claimant sample identified a range of ways that mental ill health could impact on people's work and the wider workplace. Individuals' performance could be affected by fatigue or loss of concentration, resulting in reduced productivity or quality of work, and there were sometimes changes in people's attitude or behaviour in the workplace, all of which could, in some cases, be perceptible to employers and other colleagues. Attendance was

sometimes affected in the short or longer term, which could have implications for the workload of colleagues. Employers noted how colleagues working alongside an individual with a mental health condition had sometimes observed or been subjected to aggressive or disturbing behaviours. Supporting an employee with a mental health condition could place significant demands on the time of line managers and support of occupational health or human resources departments could be valuable.

Employers reported that, where a member of staff took time off work due to mental ill health, they would generally try to maintain contact during this period of absence, in accordance with general absence management policies, and arrange for a gradual return to full duties. There were some echoes of this in the experiences of people in the claimant sample, but there were also reports of absences and returns to work that had not been 'managed' in any noticeable way. Employers described a range of in-work adjustments that had been made for staff with mental health conditions, including:

- alterations to hours or pace of work;
- changes to elements of a role or the work environment;
- training to develop coping strategies, counselling, or more informal types of support.

In the experience of employers in the study, line managers, human resources departments, occupational health services, and sometimes outside organisations and relatives of employees were involved in supporting the individual to remain in work.

Although they were generally well disposed towards making adjustments where possible, some challenges were noted by employers in that it could be difficult to balance the individual's desire for confidentiality and discretion with providing adjustments that would be obvious to others in the workplace. Encouraging other members of staff to be understanding and tolerant of such 'special' treatment was also noted as a challenge for managers. There were also certain job roles or circumstances where it was felt that it would be very difficult to make feasible adjustments that enabled somebody to continue in that role, for example where there were health and safety concerns, or where the activity required full productivity levels. Perhaps unsurprisingly, it seemed that larger organisations had more opportunity to be flexible and responsive in making adjustments.

Among the claimant sample, few people had any experience of in-work adjustments (by definition, job retention had not been achieved in their cases). It was notable that, when asked more hypothetically about what adjustments could have been made for them, many people did not hold very optimistic views about what their employer might have been prepared or able to implement for them, had they remained in work. Echoing some of the employer findings, there were comments that larger and public sector employers had more scope for supporting employees with mental health conditions.

Few employers had policies applying specifically to the management of mental health in work, though some referred to the Health and Safety Executive's Stress Management Standards. Awareness of the DDA was highest among the large and particularly the engaged employers, who were often aware that the Act incorporated mental health conditions, while there was mixed awareness of the DDA among medium-sized and smaller employers. (These findings echo those of other research that also found a strong relationship between size of employer and awareness of the DDA.) Across all employers, this study found that there remained some confusion about how the DDA was to be applied to mental health. Among the claimant sample, there was very limited awareness of the DDA.

Turning to the role played by General Practitioners (GP), people who had taken time off work due to mental ill health generally described their GP as being supportive of taking sick leave, in some cases even encouraging the individual to take some time off when they were reluctant to be absent from work. There was little evidence that either individuals or their doctors initiated any detailed discussion about the nature of people's work or job retention. Employers cited the main role of GPs as being to provide sickness certification and reasons for absence, though there were also examples of where a medical practitioner had been contacted in response to an urgent situation in the workplace. Some employers felt that GPs were rather too willing to issue sick notes for stress or to 'go along with' a patient's own assessment of their condition, which could be frustrating for employers who wanted to look more constructively at how an employee could be retained in work. A number of employers said they would like to work more closely with GPs to better understand employees' mental health conditions and so to develop job retention and support strategies.

### **Leaving work due to mental ill health (Chapter 4)**

At the point where they no longer felt able to be at work, some people in the claimant sample had initially gone off sick (while still under employment) but others had ended their employment directly. Among people who had an initial period off sick, there were mixed experiences of the level of contact and constructive support offered by employers during this time. There were three ways in which the ultimate decision to leave a job was arrived at: employees' independent decisions; mutual decisions; and dismissal by the employer. Sometimes employees opted to leave their job even though they may have had entitlement to paid sick leave, for example, if they felt their job was contributing to mental ill health or did not think that anything could be done to enable them to manage at work. There was some evidence that employees might opt to leave at the point that their employer broached the subject of their mental health and its impact on their work.

Mutual decisions were arrived at in cases where the employer and employee had discussed or implemented adjustments, but the employee continued to struggle and it was felt by both parties that nothing more could feasibly be done. Dismissal was considered by employers to be a last resort, but could be viewed as the only option in cases where an employee was reluctant or unable to acknowledge

their mental health condition and the impact it was having on their performance or behaviour at work. Among the claimant sample, there were a small number of people who said they had been dismissed from their job for conduct or performance reasons which they themselves believed were linked to their mental health condition. However, these people had generally not talked to their employer about their mental health before being asked to leave their job.

Some individuals described feelings of relief at the point of leaving work, but others would have liked to have stayed with their employer. Reflecting on what might have been done to enable them to retain their job, people suggested: quicker access to mental health services and effective treatments; more contact with their employer, of a more positive and constructive nature, while off sick; addressing workplace issues that were contributing to mental ill health, for example, bullying or job stress; and supportive responses to personal life circumstances that were affecting mental health. There were also people who noted that greater personal insight into their condition, or a willingness to admit to difficulties much sooner, may have helped prevent them from leaving work. However, some people did not feel that there was anything that could have been done to prevent them from leaving work.

### **Mental health and entering work (Chapter 5)**

People who had returned to work following a period on IB frequently explained that feeling 'better' had been a main influence on their decision to return to employment, although better was a relative concept and did not always equate to feeling completely 'well'. Wanting to be in work was also a strong motivator for many people. Financial factors and aspirations to improve one's personal or family circumstances also played a part for some people. In a minority of cases, people had been required to start seeking work because their entitlement to IB had stopped and they had moved onto Jobseeker's Allowance (JSA).

There was little evidence that GPs played a significant role in people's decisions to return to work. Where people had discussed the possibility with their doctor, responses were usually encouraging but also with advice to take things steadily. The research was carried out in localities that were not involved in the Pathways to Work pilot areas, and so it was perhaps to be expected that few of the Incapacity Benefit recipients had had contact with Jobcentre Plus during the period of their claim. Those who had accessed 'mainstream' Jobcentre Plus services had often been disappointed or frustrated with the support received, but people who had been in contact with specialist DDAs spoke positively about the support and advice received.

With very few exceptions, people who had returned to employment had taken up work with a new employer, rather than return to the job they had held prior to claiming IB. Some people had made a gradual return to work, while others had gone directly into full-time hours. There were some examples of people who had chosen to take up work of a less senior or 'pressured' nature, in light of their



experiences of mental ill health. A few explained that the hours or the flexibility of their role were important in enabling them to sustain their job alongside managing an ongoing or fluctuating mental health condition.

Very few people had mentioned their experiences of mental ill health to their new employer, either at the recruitment stage or after appointment. At the recruitment stage, one key reason for this was the concern that it would jeopardise chances of obtaining a job, but another common theme was that people did not feel, at the point of applying for a new job, that it was necessary or relevant to mention their mental health condition. People either felt that their mental health condition was not affecting them at this time, or that any ongoing effects would have no influence on their ability to manage the job. Once they had started a new job, many people continued to feel that it was not relevant or desirable to talk to others about their experiences of mental ill health, some feeling that they did not want to be 'labelled' or receive any 'special' treatment. However, where people had discussed aspects of their mental health with a new employer or colleagues, responses were generally neutral or supportive. Few people said that specific adjustments had been made to their role in light of this discussion.

Larger employers in the study group often had 'equal opportunity' or 'diversity' policies in place, but few talked specifically about any recruitment policies relating to people with mental health conditions. Reflecting the findings from the claimant sample, employers said that it was rare for them to learn about an applicant's mental health condition at the time of recruitment. Employers recognised that applicants may be reluctant to share information about mental health conditions due to perceptions that this would negatively affect their prospects. Many of the smaller employers did not ask for this type of information, and some of the larger employers noted caution about requesting specific information at the recruitment stage for fear of breaching the DDA, preferring to focus more broadly on any access needs or special requirements for the purposes of attending an interview. None of the employers recalled occasions where they had made adjustments to the application process for a candidate with a mental health condition, in contrast to more widespread experience of accommodating applicants with physical or sensory impairments. There was some uncertainty about how the recruitment process could be adjusted for applicants with mental health conditions, with comments that more advice on this would be useful.

Where employers did ask for information about mental (and other) health conditions, this was normally via some form of medical 'questionnaire' after a job offer had been made. Any information provided by an applicant was generally kept confidentially, by human resources or occupational health departments, and was only shared on a 'need to know' basis. There were very few reported instances of a job offer being withdrawn or declined by the applicant in light of information about a mental health condition. In most cases, employers said that newly appointed members of staff who had mentioned a mental health condition had been able to carry out their job without the need for any particular adjustments.

There was general openness among employers to taking on employees with mental health conditions; although not all had known about an employee's mental health condition at the recruitment stage, they reported that when they did it was extremely rare for them not to recruit as a result. Amongst employers who had no experience of knowingly appointing an employee with a mental health condition, they were usually open to doing this in future. Most employers felt that no roles would necessarily be ruled out for people with mental health conditions. It was recognised that the same condition could have varying effects on different individuals, and that people might be affected differently by their conditions at different times. Therefore, flexibility and case-by-case responses were important. (However, it should be noted that the sample was likely to comprise employers with more positive attitudes in this respect.) Nonetheless, some employers felt there were certain roles where they would be wary of placing someone with a mental health condition, including more 'stressful' roles and positions where there could be health and safety implications for the individual or others around them. A minority of employers expressed hesitance about employing someone with one of the more severe mental health conditions such as schizophrenia or bipolar disorder, and some organisations had a 'zero tolerance' policy on drug and alcohol use.

### **Attachment to work (Chapter 6)**

Among the claimant sample, there was great diversity in people's employment pathways and fields of work, and people varied in how strongly they felt about their particular job or profession. However, there was widespread commitment to being in employment and general agreement that work is 'good for you', people often citing the social, emotional and health benefits of work over and above the purely financial. People who were in employment at the time of the research interviews were generally enjoying their work with only a few experiencing difficulties relating to their mental health condition. Most people who had not yet returned to work expected to do so in the future and had ideas and aspirations as to what type of job they would like to do. As with people who had already gone back into work, some people still on IB explained that they would be seeking work that was less demanding than their previous role, and experiences of mental ill health had led some people to reassess the priority they placed on work or income among other aspects of their lives.

A number of factors were felt to be important in helping people to return to employment. Perhaps unsurprisingly, appropriate treatment and support to improve or manage mental health was one key requirement. But importantly, people did not always feel that a complete 'recovery' from a mental health condition was necessary before they returned to work. Many people felt that work of some kind was possible, but emphasised the need for a job that could be managed alongside any ongoing effects of a condition. Part-time work or a job that allowed flexible hours were cited as appropriate and helpful options. Gaps in employment due to mental ill health were an obstacle some people faced, along with perceptions of prejudice or discrimination around mental ill health. In light of this, the need for an

understanding and sympathetic employer was highlighted. Some people felt that they needed to add to their skills or qualifications in order to improve their chances of obtaining a suitable job. Thus, financial or practical support for training was also cited as useful. The perceived 'risk' in moving from IB to paid work was noted by people who worried about the sustainability of work or financial difficulties in the transitional phase. This indicates that the 'safety net' provisions and in-work support already being developed within the IB system will be beneficial to people with mental health conditions. There were also people who explained that an unstable housing situation could be an obstacle in settling into work.

## Conclusion and policy implications

The study drew on the accounts of 60 current or former IB recipients and 52 representatives of employing organisations to explore understandings of mental health, the experience and impact of mental health conditions in the workplace, and transitions out of and into work for people with experience of mental ill health. In drawing out the implications for policy seeking to help people with mental health conditions enter or stay in work, the findings indicate that, while there are important roles for employers and government, salient activities and responses go beyond the remit of these parties, to include medical practitioners and also society more broadly.

The findings point to the importance of increasing 'mental health literacy' among individuals experiencing mental ill health, their employers and the wider population. Lack of understanding, misconceptions and a reluctance to discuss mental health contributed to the negative employment experiences and outcomes for some people in this study, underlining the importance of initiatives already underway to increase public and employer understandings of mental illness and how to promote mental wellbeing. The complex factors underlying the mental ill health of many people in the study highlight a need for employers to take a broad understanding of mental health that encompasses both medical and social influences on wellbeing.

The accounts of employers involved in the study demonstrated a willingness to employ individuals experiencing mental health conditions and that (particularly in larger organisations) effective support and adjustments can be facilitated. For many, these views were based on their past experiences of employing people with mental health conditions, and their intentions to continue to do so. Amongst employers with little past experience, most said that they would be willing to try this in the future, depending on the type of work, and the type of mental health condition. However, the retention strategies of employers can only be implemented where an employee's mental health condition is known about. Enhanced mental health literacy would hopefully encourage individuals to talk to their employer about any difficulties they experience, but at the same time, employers may gain greater confidence in recognising the indications of a mental health condition and so broaching this topic where a member staff seems unwell. Early identification

and intervention of this type might enable responses and adjustments to be made sooner, thus preventing prolonged sickness absence or ultimate job loss.

There are already resources in existence that give advice to employers on recognising the indications of stress or more acute mental ill health in employees. A systematic awareness-raising campaign to bring these resources to the attention of managers, particularly in small and medium-sized organisations, might increase knowledge and confidence in recognising and responding to employees experiencing mental health conditions. The study findings also support the case for initiatives currently under way that aim to increase access to occupational health services for small and medium-sized employers.

Again, underlining arguments that have been made elsewhere, this study has found that increased availability and quicker access to psychological therapies may be central in enabling people to feel able to remain in or return to the workplace. Contributing to ongoing debates about the role of GPs in managing sickness absence, the present findings suggest that there is scope for an enhanced role for GPs in contributing to discussions, with patients and their employers, about work retention and rehabilitation. However, recognising the constraints that GPs face (in knowledge and time), we suggest that there may be potential for a third-party advisory role located within GP surgeries, possibly along the lines of the role being tested in the Pathways Advisory Service pilots.

People in the study group who had had contact with specialist Disability Employment Advisers valued the advice and support they had received and the study findings provide an indirect, implicit endorsement of the Pathways model of delivery that will cover the UK from the autumn of 2008. However, for many individuals who have left employment because of mental ill health, there is a period of time when people do not feel able to enter into discussions about a return to work. Thus, the timing of work-focused interviews under Pathways will need to be handled sensitively for this group of IB claimants.

The individual experiences reported in this study, by IB recipients and employers, demonstrate that the policy area of mental health and employment is diverse and complex. While constructive legislation and employer policies and a more proactive approach from GPs and other health professionals are undoubtedly part of the way forward in improving the employment experiences of people with mental health conditions, long-term progress possibly lies in changing attitudes towards mental health across all groups in society.

# 1 Introduction

This report presents the findings of a qualitative research project commissioned by the Department for Work and Pensions (DWP) to investigate the relationship between mental health and employment. The research was conducted by the Social Policy Research Unit at the University of York and the Institute for Employment Studies. The report is based on interviews carried out in 2007 with a sample of employers and a sample of people who had had experience of moving from work to Incapacity Benefit (IB) or vice versa.

Although understanding of the issues relevant to the employment of people with mental health conditions has been growing over recent years, there are still gaps in our knowledge of the interplay of forces that lead people to claim IB because of a mental health condition, and what factors contribute to people with mental health conditions returning to work after a period on IB. This research study was set up to address this gap.

In this chapter we begin by setting out the policy background to the study (see Section 1.1). Section 1.2 summarises the principal research questions explored in the study. Section 1.3 then summarises the research design and methods adopted, including an overview of the main characteristics of the achieved samples of employers and IB recipients. Finally, Section 1.4 outlines the structure of the rest of the report.

## 1.1 Policy background

*Adults with mental health problems are one of the most socially excluded groups in society.*

(Social Exclusion Unit, 2004)

The government has been pursuing active labour market and benefit policies since 1997 aimed at helping people with disabilities and other health problems to find and retain employment. In addition, the 1995 Disability Discrimination Act (DDA) (revised 2005) has provided a framework of rights and responsibilities for individuals and employers respectively to reduce the barriers to work experienced

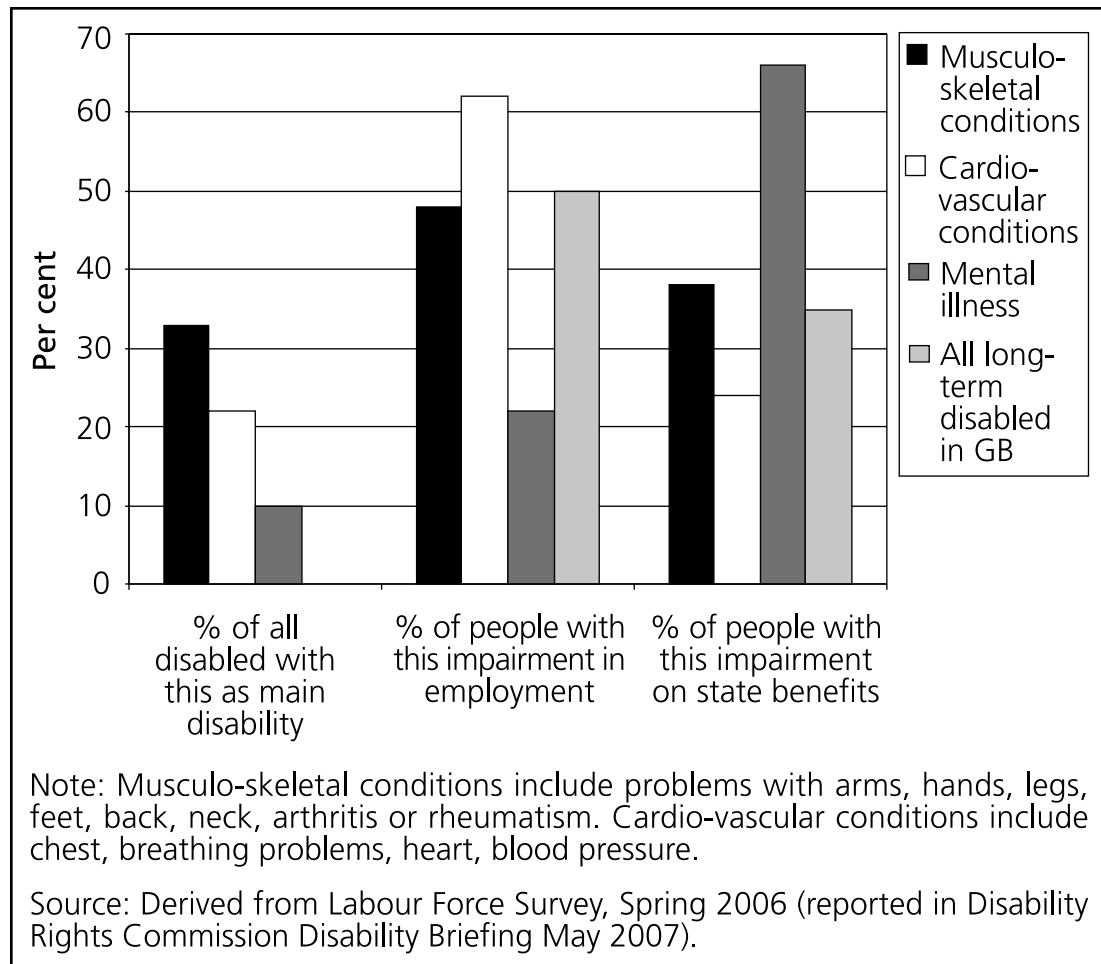
by disabled people. Overall, these policies, and particularly the Pathways to Work programme, have been making a positive impact on the employment rates of disabled people and on reducing the number of people having to claim IB.

However, it is known that people with mental health conditions fare less well in the labour market than disabled people in general, and the population as a whole.

Figure 1.1 presents Labour Force Survey (LFS) data on the incidence of different types of main impairment among disabled people of working age in Great Britain. It shows that, of the 6.9 million people with a long-term disability (i.e. who meet either the DDA definition of disability or the LFS work-limiting definition or both), 680,000 or ten per cent, cite mental illness as their main impairment.

Looking at statistics on their labour market experience, the key feature is the level of employment disadvantage recorded by people with mental health conditions compared with other types of impairment. Whereas the employment rate of disabled people as a whole is 50 per cent (it is 80 per cent for non-disabled people according to the data set), among those with mental health conditions it is 22 per cent, much lower than among any other impairment group (with the exception of people with learning disabilities). Consistent with this is that the proportion of people with mental health conditions dependent on state benefits and not in work is 66 per cent, compared with a figure of 35 per cent for all disabled people (and four per cent for non-disabled people).

**Figure 1.1 Employment and unemployment rates by main type of impairment: Great Britain, April-June 2006**



Many people with mental health conditions want to work. For example, the Social Exclusion Unit (2004: 52) cites Labour Force Survey analysis from 2003 to show that more adults with long-term mental health problems (35 per cent) were motivated to work than people with other health problems (28 per cent). Furthermore, the recent review of the relationship between work and well-being by Waddell and Burton (2006) firmly concluded that 'there is strong evidence that unemployment is generally harmful to health, including ... poorer mental health, psychological distress, minor psychological/psychiatric morbidity' and that, conversely 'there is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity'.

Despite the health benefits of work and the willingness of many people with mental health conditions to take up employment, welfare to work programmes such as the New Deal for Disabled People and, more recently, Pathways to Work have helped more people with physical health conditions into work than those with mental health conditions (Stafford *et al.*, 2007; Bailey *et al.*, 2007; Bewley *et al.*, 2007). Although one study of the impact of Pathways to Work found that some

people with mental health conditions were helped into work, this effect could not be attributed to any aspect of the Pathways provision: 'It was not possible to detect a statistically significant effect of Pathways on the employment or self-reported health of those whose main health condition at the time they were first interviewed involved mental illness' (Bewley *et al.*, 2007: 82).<sup>1</sup>

Administrative statistics show that the proportion of new IB claimants who have a mental health condition has been increasing over a number of years. Around a half of all new IB claimants have been in work soon before making their claim (Kemp and Davidson, 2008) but little is known about the processes by which people come to cease their employment. The study by Bailey *et al.* (2007) of Pathways to Work also points to this gap in knowledge. Previous participants in Pathways who were in work when surveyed were asked how their health affected their ability to do their job. Over a third of those with a mental health condition cited some unspecified 'problem with mental health', suggesting that this research did not identify a specific or distinct set of ways in which mental health impinges upon work (some of which might lead to people eventually losing their jobs).

We mentioned previously that the DDA formed part of the policy framework aimed at helping all disabled people into paid employment. The DDA defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. For the purposes of the Act:

- substantial means neither minor nor trivial;
- long-term means that the effect of the impairment has lasted or is likely to last for at least 12 months (there are special rules covering recurring or fluctuating conditions);
- normal day-to-day activities include everyday things like eating, washing, walking and going shopping;
- a normal day-to-day activity must affect one of the 'capacities' listed in the Act which include mobility, manual dexterity, speech, hearing, seeing and memory.

The DDA 2005 amended the definition of disability. It removed the requirement that a mental illness should be 'clinically well-recognised'. Hence, if an individual's mental illness has a substantial, adverse and long-term effect on their ability to carry out normal day-to-day activities then they are likely to be covered by the DDA. The Act also covers people who have had a disability in the past.

The Act does not provide a list of impairments that are covered, but instead considers the effects of an impairment on a person. For example, someone with a mild form of depression with only minor effects may not be covered, while someone with severe depression with substantial effects on their daily life is likely

---

<sup>1</sup> A recent Pathways to Work study (Bewley *et al.*, 2008) concerning existing (rather than new) claimants found that the employment impact for people with mental health conditions was higher than those without.



to be considered as disabled under the Act. In this study we aimed to explore the salience and impact of the Act for people with mental health conditions in the light of recent studies showing that many employers have a limited, if any, knowledge of its provisions and the responsibilities it places on them (for example, Simm *et al.*, 2007).

The increasing incidence and social consequences (especially unemployment) of mental ill health have continued to feature in the government's development of welfare to work policies, most recently in two policy documents in 2007 (DWP, 2007a, 2007b). Furthermore, health policy more generally has also generated, and continues to generate, new policy initiatives such as the planned expansion in the number of National Health Service (NHS) psychological therapists (Department of Health, 2008). These policy changes will be referred to in Chapter 7 when we present the policy implications of this study.

## 1.2 Research questions

The overall objective of the project was to gain understanding of the employment experiences of people with mental health conditions and understanding of employers' experiences of employing people with mental health conditions. Findings were intended to inform the development of employment policies aimed at helping people move into work and policies aimed at job retention (particularly in the context of the national roll-out of the Pathways to Work programme).

In discussions between the research teams and DWP two groups of people with experience of mental health conditions were identified as being of principal interest:

- people who had become recipients of IB having been recently in employment;
- people who had recently left IB to take up paid employment (of 16 or more hours a week).

The experiences of the first group would generate understanding of how a mental health condition affects people's ability to carry out their work and what responses are made by the individuals themselves, by employers and by third parties such as health professionals, family and friends. Findings here would particularly help inform policies aimed at job retention. The second group consisted of people who had made the transition into employment from receiving IB due to a mental health condition. Their experiences of the barriers they faced, how these were addressed and what and who made significant contributions to that transition were intended to inform the Pathways to Work and other employment-related policy.

The principal research questions that were addressed to people who had moved onto IB from work included:

- How do people experience changes in health that precede a claim (for example, gradual or sudden changes, or intermittent or continuous development)?
- Why do people stop or leave work after experiencing a mental health condition?
- What job retention responses are made by employers and employees?
- What role is played by third parties (for example, General Practitioners (GPs), occupational health services, family and friends)?
- What awareness is there of the DDA and 'reasonable adjustment'?

The main research questions for the people who had moved into work included:

- What are people's motivations to return to work?
- How do people perceive their mental health as a barrier in their return to work?
- How do employers' attitudes to people with mental health conditions contribute to people's experiences?
- What role is played by third parties (for example, Jobcentre Plus, job brokers, GPs, occupational health services, family and friends)?
- What employment do people take; are adaptations made to help people take employment; what role does the DDA play?
- What other factors contribute to a return to work (for example, financial incentives through the tax and benefit systems)?

The interviews with employers were aimed not only at generating data on disability issues generally but on mental health issues in particular and what happens in practice at establishment level. The research addressed the recruitment of people with mental health conditions, and their continuing employment and retention.

Specific research questions included:

- What are employers' policies on disability and mental health, and on sickness absence management?
- What are levels of knowledge and understanding of mental health conditions?
- What is the understanding and awareness of DDA employment provisions and how they relate to people with mental health conditions?
- Do employers adapt recruitment and selection practices for people with mental health conditions?
  - o What experiences do employers have of people with mental health conditions?

- o What adjustments are made? Who is involved?
- o What is the effect of mental health conditions on the organisation, including on individuals' performance and other colleagues?
- What advice, information and support are sought by employers?
- What additional needs do employers have? Where are the gaps in provision?

### 1.3 Research design and methods

The research used qualitative methods to explore the experiences, views and attitudes of employers and of current and former recipients of IB. Qualitative research is ideal for exploring why individuals and groups think and behave as they do, but findings are not statistically representative. The views and experiences of the 40 employers and 60 IB recipients who agreed to take part in this research are indicative only and may not be representative of employers or IB claimants more broadly.

Three geographical locations were used as fieldwork sites for both the employer and claimant interviews: London, the East Midlands, and South West England. These areas provided three different labour markets; with low unemployment, moderate levels of unemployment, and high levels of unemployment respectively.

Topic guides based on the research questions above were developed in consultation with DWP researchers and policy makers.

To inform the research and the development of the topic guides two pieces of work were commissioned. The first was a secondary analysis of a qualitative, longitudinal cohort study of Pathways to Work participants, submitted as a working paper to the DWP.<sup>2</sup> The second was an analysis of a sub-sample of people with mental health conditions who took part in a separate study of new IB claimants. This can be found in *Appendix A*.

A full account of the research design and methods will be produced as a separate working paper by DWP.

#### 1.3.1 Research with employers

The research with employers consisted of interviews with 52 individuals in 40 organisations. The employer study group consisted of two distinct sub-samples:

- a randomly-drawn sample (30 organisations);
- an 'engaged employer' sample (10 organisations).

---

<sup>2</sup> Mental Health and Employment - Findings from a Qualitative Longitudinal Study of IBs Recipients Taking Part in Pathways to Work: Focus on a sub-group of people reported to have mental health conditions by Anne Corden.

### **The randomly-drawn sample**

Thirty employers were recruited from a random sample drawn from a commercial database.<sup>3</sup> Within each of the three fieldwork areas, a recruitment sample of 330 employers in each of the three geographical areas was initially drawn, stratified by establishment size:

- 130 small (three to 25 employees);
- 100 medium (26 to 250 employees);
- 100 large (251 or more employees);

The sample was designed to include all of the following sectors:

- primary and manufacturing;
- distribution, hotels and catering;
- business and financial services;
- wholesale and retail;
- leisure and service industries;
- public administration, health and welfare.

Ten employers were recruited from each of the three fieldwork areas. Within each area, care was taken to ensure a spread by employer size and sector.

### **The engaged employer sample**

Ten employers were purposively selected on the basis that they were known or believed to have a positive, pro-active, or innovative approach to recruiting and employing people with mental health conditions. This was to ensure that the study picked up not only current practice and barriers to employing people with mental health conditions, but also practice which helps to overcome those barriers. The engaged employers were identified through literature and internet searches, through contact with organisations working in the mental health field, and with help from the members of an Advisory Group which DWP set up to assist this study.

Fifty-two interviews were carried out with employers, across 40 organisations. The distribution of the achieved sample by area, size, sector and whether or not interview participants had experience of employees with mental health conditions, is shown in Table 1.1. Among the randomly-drawn organisations, there was a fairly even split by size of across the three geographical areas, while all of the engaged employers were large. Respondents in all ten of the engaged employers, and 23 of the 30 randomly-drawn employers were aware of having had experience of at least one employee with a mental health condition. Seven employers were not aware of having employed someone with a mental health condition.

---

<sup>3</sup> Experian National Business Database.

**Table 1.1 Main characteristics of the achieved employer sample**

	Interviews
<b>Region</b>	
Randomly selected employers	
London	13
East Midlands	12
South West England	12
Engaged employers	15
<b>Size</b>	
Small (3 to 25)	9
Medium (26-250)	12
Large (251+)	31
<b>Sector</b>	
Private	36
Public	12
Voluntary	4
<b>Experience of employees with mental health conditions</b>	
Yes	44
No	8

### **A note on interpreting the findings from employers**

Ten employers were recruited to the study on the basis that they were 'engaged' with the issue of mental health conditions in the workplace. The other 30 were selected to provide a spread of size and sector, but even amongst these, there are reasons, from our experiences with recruitment to the study, to believe that they were also more likely than employers as a whole to:

- be more sympathetic or pro-active towards people with mental health conditions in the workplace;
- have employed someone with a mental health condition which they were aware of;
- have made adjustments to try to accommodate or retain them.

Recruiting employers from the randomly drawn sample was more difficult than in many previous IES studies involving employers. We achieved on average, only one positive response in 30 when we telephoned employers to arrange interviews. Employers who did agree to take part often gave a reason why they were interested in this topic. Experience of dealing with employees with mental health conditions at work, and professional and health backgrounds, were important motivators for involvement. We also found that a considerable proportion of interviewees had

experience of mental health conditions outside work. A number of respondents had family or close friends who had experienced mental ill health, and some had personal past experience. In a few cases, respondents mentioned the influence of the media, although it was often argued that the media generally presented an overly negative representation of people with mental health conditions. A small number of the employers took part in the research as they had experience of employees with learning disabilities, and they felt that this would be relevant to the study.

In other cases, employers' attitudes and their interest in the study were not driven by particular experiences, but by the ethos of their organisation as a caring employer which was interested in the health and wellbeing of its workforce. Some employers had wanted to be involved in the research to share and promote good practice. In a few cases, employers who had encountered an employee with mental ill health were not sure they had managed this in the right way, and hoped that by taking part they might start to gain a better understanding.

Our judgment that the sample of randomly selected employers may be more aware of and sympathetic to people with mental health conditions should therefore be borne in mind when interpreting the findings from employers throughout the report, and we exercise caution in drawing conclusions about employers as a whole from the evidence presented here.

### **1.3.2 Research with individuals**

In order to explore transitions from work to IB, DWP provided a sample of 300 recent claimants (the 'on IB' group) who had made a new claim for IB within the preceding six months from which the intention was to recruit 30 research participants. Also using IB records, DWP provided a second sample of 250 people (the 'off IB' group) who had moved off IB over the past six months. Again, the intention was to recruit 30 research participants.

Selection of participants was purposive. Using details included in the DWP records, we used four main sampling criteria – location, sex, age and recorded primary mental health condition – to build a sample that included a range of people with diverse personal characteristics.

The group of principal interest for DWP was people who had what are usually referred to as 'common mental health problems' such as anxiety and depression because these conditions account for the large majority of Incapacity Benefit claimants in the UK. The sample therefore included a larger weighting of people with experience of these 'common' mental health conditions, but people with 'severe and enduring conditions' (such as schizophrenia and bipolar disorder) were not excluded from the study. Table 1.2 presents an overview of the main characteristics of the claimant sample.

**Table 1.2 Main characteristics of the achieved Incapacity Benefit claimant sample**

	Achieved interviews
<b>Region</b>	
London	17
East Midlands	20
South West England	23
<b>Sex</b>	
Male	26
Female	34
<b>Age</b>	
< 30	18
30 – 49	29
50 +	13
<b>Main mental health condition</b>	
Anxiety	20
Depression	25
Substance use	7
Other	8

As set out in the original study design, interviews were carried out with 60 people who were current or former recipient of IB. However, it was clear from early contact with potential research participants that our two sampling frames (the 'on IB' and 'off IB' groups) did not always reflect a direct transition between work and benefits.

Some people who had recently claimed IB had not moved directly from paid employment, for example, having previously been a full-time carer, in education, or in prison. Likewise, not everybody whose claim had ended had moved into work, for example, having instead moved to Jobseeker's Allowance (JSA) or to being financially supported by a partner. Moreover, some people who were recorded as having recently claimed IB had already returned to work by the time they were contacted by a researcher. Nevertheless, the final achieved sample exceeded the target number of people who were able to describe an experience of returning to work after a period on IB.

For the purposes of sample description, four sub-groups were identified, broadly relating to the original sample design of transitions onto IB and off IB into work. These are shown in Table 1.3.

**Table 1.3 Research participant transitions**

On IB sample		Off IB sample	
Claiming IB at interview	Off IB at interview but not returned to work	Returned to work directly from IB	Returned to work indirectly after moving off IB
19	9	23	9
28		32	

## 1.4 Structure of report

The remainder of this report is made up of six chapters:

Chapter 2 sets some important context to later discussion of mental health and employment by considering the understandings of mental ill health held by the employers and recent or former IB claimants who took part in the study. Firstly, it explores the diverse ways in which people in the claimant group described, understood and experienced mental ill health, including their perspectives on how others viewed their conditions. Secondly, findings are presented on how employers understood mental ill health, including the range of conditions they viewed as falling within this description, their awareness of the prevalence of mental ill health among their workforce, and the sources of advice, information and training that they had drawn upon in addressing or raising awareness of mental health at work.

Chapter 3 presents a large body of findings on a range of themes relating to the experience of mental ill health while in work. It draws on individuals' experiences of the emergence or exacerbation of a mental health condition while in employment and on the experiences of employers in managing and supporting members of staff who are mentally unwell. Several aspects are considered in the chapter, including:

- people's decisions and approaches towards talking about mental ill health at work;
- the impact of mental ill health on individuals and the wider workplace; absences and absence management;
- in-work adjustments for staff with mental health conditions; the role and salience of employer policies and employment legislation (namely the DDA); and
- the role of general practitioners in advising employees and employers about work and mental health.

Chapter 4 draws on the experiences of individuals who had left a job because of a mental health condition and of employers who had had a member of staff leave (or be dismissed) because of mental ill health. The chapter explores the roles played by employees and employers in decision-making processes around leaving work and draws together the reflections of individuals who had left work on what might have helped them to retain their job.



Chapter 5 turns to consideration of the transition into work for people with experience of mental health conditions. First, the chapter explores the experiences of people who had moved into work after a period on IB, including the factors that influenced their thinking about returning to work, the role played by medical practitioners in these decisions, and the other forms of support people received in making the transition. We also present findings on people's approaches to talking about their mental health (past or present) once back in work and the responses they received from others. The second part of the chapter considers this transition from the perspective of employers, including their policies, practices and direct experiences of recruiting and appointing people with mental health conditions. Employers' reflections on the challenges or barriers to employing individuals with mental health conditions in particular roles are also presented.

Chapter 6 draws only on data from the sample of recent and former IB recipients. It begins by exploring the importance and value that people with experience of mental ill health place on employment. It then outlines people's expectations and aspirations for future employment. The chapter concludes with a discussion of what support or conditions people thought would be necessary for them to return to work or, for people who had already done so, reflections on what may have speeded this transition.

Chapter 7 draws together the main findings of the study and presents a range of policy implications, for employers and government, that have emerged from the research.

Wherever possible, data from employers and from recent or former IB claimants has been integrated to present a thematic discussion of findings. However, where issues for each group are distinct, data from each of the two groups is presented under separate subheadings. Key points are drawn together in a concluding section to each chapter.



## 2 Understanding mental health

An important influence on how people think about and make decisions about work is their own understanding and perceptions about their mental health and how they feel they are seen and treated by others. Similarly, the actions and attitudes of employers will be partly influenced by their understanding and experience of mental ill health (including their own and that of their employees).

The first part of this chapter draws on the experiences of people who had claimed Incapacity Benefit (IB) due to a mental health condition. Subsections explore people's insight and understanding of their own mental health condition, including the terms in which they described it, their perceptions of the duration or longevity of their condition, how they had come to recognise and acknowledge mental ill health and what people perceived as the origins or triggers (if any) of their mental health condition. We then consider people's experiences and perceptions of how others, from friends and family to employers and wider society, understand and respond to mental ill health.

The second part of the chapter looks at employers' awareness and understanding of mental health conditions, including the range of conditions they understood to fall within this description, and their perceptions of prevalence among the workforce. The sources of advice, information and training accessed by employers, in developing their overall understandings of supporting staff with mental health conditions, are then outlined. Examples of advice and guidance drawn upon in supporting specific members of staff are considered in greater detail in Chapter 3.

### 2.1 Individuals' understanding of mental health

The 60 individuals in the employee sample had in common that they had all, currently or in the recent past, been in receipt of IB with their main incapacitating condition recorded as a mental health condition. Within this, however, there was a great deal of variety in both the individuals' experiences of mental health conditions

and the routes by which they had come from employment to claiming IB. This section provides some background to the wide-ranging circumstances of people in the study group, which will contribute to contextualising and understanding the data in later chapters.

At the time of the research interviews, there was variation in the extent to which people felt they were experiencing mental ill health. There were people whose direct comments during the interview suggested that they were still experiencing the effects of their mental health condition at the time they met with a researcher. However, there were also people who said they were feeling much better or felt that their episode of mental ill health had been fully overcome. In the interests of simplicity, the discussion that follows will refer to people's mental health conditions in the present tense. However, in some cases, discussion will refer to people's past experiences of mental ill health, which they no longer saw as current.

Furthermore, as will be discussed ahead, it should be borne in mind that some people did not consider what they had experienced to be an 'illness' or did not perceive themselves to have had a 'mental health condition' at all.

### **2.1.1 Describing mental health conditions**

As detailed in the introductory chapter, the study group was drawn from Department for Work and Pensions (DWP) records which listed the primary health condition for which people had been awarded IB. The sample was purposively drawn to comprise mainly people who had experienced 'common mental health problems', in particular depression and anxiety related conditions, though the group also included a small number of people with alcoholism or who were using drugs, and some individuals with a psychotic or 'unspecified' mental health condition.

In describing their experiences of mental ill health, there was variation in the extent to which people used medical terminology or other descriptive language. Some people used medical terms such as endogenous depression, agoraphobia or post-traumatic stress disorder to describe their conditions. In contrast, some people's description of their mental health focused on the symptoms or effects they experienced, for example, crying, feeling faint, or experiencing a racing heartbeat.

Although not everybody used medical language, most people's description of their mental health broadly reflected the type of condition that was listed in DWP records. However, a number of people described experiencing other mental health conditions in addition to the one that was recorded as the primary condition for their most recent IB claim. For example, some people listed as having anxiety conditions also talked about depression and vice versa. Additionally, some people described alcoholism or problematic alcohol use as having emerged as a response to their depression or anxiety, for example as 'an escape' or 'self-medication'. There were also numerous references to 'stress', although this only featured as the recorded primary condition for ten people in the study group. (It is important to note that although 'stress' is not a clinical diagnosis, many people used this

term to describe their own mental health condition sometimes, but not always, as well as referring to clinically recognised conditions such as depression and anxiety. References to stress in this section therefore reflect this common usage.)

In a few notable cases, participants did not make any reference to the mental health condition recorded by DWP. For example, one person who was recorded as having an anxiety disorder spoke only about drug use during the research interview and another, for whom drug use was recorded as the reason for his current IB claim, spoke of schizophrenia and other aspects of mental ill health, with no reference to drug use. There were also some people who referred to the condition recorded by DWP, but focused on another aspect of their mental health during the research interview. An example of this was a respondent whose IB claim was primarily linked to depression, but who spoke mainly about alcoholism.

### **2.1.2 History of mental health conditions**

Among the 60 people in the study group, there was a wide variety of experiences of mental ill health. People described different origins of their mental health condition and different durations or fluctuations over time. People in the study group ranged from age 18 to 64 years and so the potential to recognise or reflect on experiences of long-term mental health conditions will have differed according to age. From the way people described their experiences of mental health conditions up until the time of the research interviews, three broad types of experience emerged.

- Emergence in early adulthood.
- Emergence in later adulthood.
- First experiences.

Among all three of these groups, which are discussed ahead, there were people currently on IB and people who had returned to work at the time of the research interviews.

#### **Emergence in early adulthood**

Some people spoke about their mental health condition as something that had first become apparent (to themselves or other people) during their teens or early twenties. Mental health conditions referred to in this way included anxiety, depression and schizophrenia. Some people also talked about aggression or behaviour problems in their childhood or teens, which they had later come to recognise as being related to their mental health condition. Some people identified particular origins of their mental health condition, for example, child abuse or bullying at school, while others did not feel they could identify specific triggers. In describing their past experiences to researchers, some people identified periods in their lives where their mental health condition had become more acute, and again there was variation in whether people linked these periods to particular events or saw them as unexplained fluctuations.

All the study participants who spoke only about drug use (and who did not identify any other type of accompanying mental health condition) had begun to use drugs in their teens or twenties and so could also be described as 'early adulthood' experiences. Although accounts of drug use did seem to take a somewhat different form to experiences of other mental health conditions among the study group, people nonetheless talked about the origins of their drug use, the gradual development of addiction and 'fluctuation' over time, inasmuch as there had been episodes when they had stopped and then become re-involved with drugs. Some people also identified triggers that led to resuming their substance use including boredom and 'stress'.

### **Emergence in later adulthood**

A second group of people recognised the first emergence of their mental health condition as being later in their adult lives, typically in their 30s or 40s. People here commonly described their mental health condition as anxiety and/or depression, sometimes with alcoholism or problematic alcohol use developing as a response. The majority of people here were able to identify a particular event which had triggered their first experience of mental ill health, for example, a sudden and traumatic bereavement or marriage breakdown. As with the previous group, some people described how, over the years since this initial 'trigger' event, their mental health condition had fluctuated, improving significantly at times, but deteriorating at other times in response to subsequent periods of stress or upsetting events. Among this group, there were also some people who referred to troubling or traumatic events in their childhood, but differed from the first group in that they did not specifically identify the emergence of a mental health condition until some later trigger event in their life.

### **First experiences**

For some people, the episode of mental ill health that had led to their most recent claim for IB was their first experience of a mental health condition. The conditions described by these people typically included depression and anxiety. In some cases, the event(s) that had led to their taking time off work were sudden and clearly defined, for example, a traumatic incident at work or the 'turning point' of leaving an abusive relationship. Other people spoke of a gradual build up of events that had culminated in the emergence of a mental health condition. While we cannot speculate about future recurrences, it is possible that people in this group may, over time, experience subsequent episodes of mental ill health and so may come to recognise their mental health condition as something fluctuating or ongoing that first emerged in their early or later adulthood.

### 2.1.3 Recognition and acknowledgement of mental ill health

From people's accounts of their experiences of past and present mental ill health it was possible to distinguish phases of when they began to realise, or recognise, that they were unwell and a consequent phase of acknowledging that they were in need of some form of help. How people conceptualised their mental health condition as an 'illness' or not and whether they saw themselves a person 'with' a mental health condition also varied.

#### Recognising mental ill health

For some people, awareness of a mental health condition had been sudden and unambiguous, for example, an episode of psychosis or an acute panic attack. In some cases however, the development of a mental health condition had been gradual and not immediately apparent to the individual. A number of people said that they had not been aware of the gradual deterioration in their mental health until reaching some type of 'crisis point' or until their condition had been diagnosed by a doctor. Looking back, some people said that they could now identify signs that their mental health had been declining and that other people had been aware of this, even though they themselves were not.

For some people, experiencing their first episode of mental ill health had sometimes come as a surprise, because they had not seen themselves as being disposed to this type of reaction, for example, feeling that they had 'never been like that'. However, some people who perceived their condition as fluctuating or recurring said that, over time, they had become better able to recognise potential triggers or signs that their mental health was taking a downturn. Sometimes this allowed for proactive, preventive measures.

Reflecting on how their mental health condition had first emerged, some people described how they had been aware that they were not feeling good, but did not realise they had a recognised medical condition until they had spoken to a doctor about what they were experiencing. There were also people who felt that they had not yet been given a satisfactory explanation of their condition which, for some, was a cause of frustration or distress, and people who found the fluctuating and unpredictable nature of their condition upsetting:

*It's difficult not knowing what I've actually got, you know, if it's a condition where it's, you know, I don't know if you can tell, but I mean if you met me you might think maybe she's got something. I don't know.*

(Female, 20s)

*I've been asking all my life for help and find out what's wrong with me. I mean all they keep coming up with is depression and I'm not ... I'm not happy with that, that depression, all the time they keep coming up with, I'm not happy with that word, cos I know I'm worse than depression.*

(Male, 30s)

Moreover, some people explained how their own limited understanding of their mental health condition had made it difficult to express to others what they were experiencing, meaning that the support of friends or family could not be sought.

### **Acknowledgement of mental ill health**

Some people who had claimed IB due to depression or anxiety talked about the difficulties of acknowledging that what they were experiencing had moved beyond 'normal' levels of stress and had become a mental health condition. For some, their General Practitioners (GPs) suggestion of some time off sick had been the first time they had considered the possibility that they might be mentally unwell. At the same time, however, some people said that being deemed eligible for sick leave or IB by someone in an official capacity had been a key factor in acknowledging and beginning to address their mental ill health.

Concepts of 'strength' and 'weakness' featured in some people's accounts of coming to acknowledge that they were mentally unwell. For example, some people in emotionally demanding jobs, or senior or responsible positions had perceived themselves to be 'strong' members of a team or had not wanted to show 'weakness' in their professional role. This had led them to continue working without seeking support from others or, in some cases, even acknowledging to themselves that they were struggling. Among the study participants who perceived their anxiety or depression as originating from their personal life, there were some who said they had delayed seeking the support of medical practitioners because they saw themselves as 'a strong person' or had been brought up to believe that problems should be dealt with in private. Again, reflecting concepts of strength and weakness, one person who had experienced several periods of depression, described how she had been both surprised and disappointed at her condition re-emerging, when she had felt it had been 'conquered':

*It's so debilitating, you know, you just feel totally useless. You know, I felt I'd let everybody down, I'd let the boys down, I'd let my mum down and felt so ashamed of myself.*

(Female, 40s)

In some cases, not wanting to 'admit' that they were 'not coping' had resulted in delays and unwillingness to seek help. As one person described her thoughts about accepting a referral for counselling:

*It's very difficult to admit that you're sort of mentally ill really, and to then have to go through it again with somebody else just keeps going over the same situation really, I don't think I could have coped with that.*

(Female, 30s)



However, with hindsight, some people acknowledged that this reluctance to seek assistance had led their mental health to deteriorate further than it might have done if they had sought (or accepted) help sooner. However, among those who had experienced depression or anxiety, there was evidence that some saw this as a personal or 'internal' problem, which could not be helped by anything other than their own determination to change their perspective on their circumstances or find a different way of responding to events.

#### 2.1.4 Conceptions of 'illness'

There was variation in whether people perceived their own mental health condition to be an 'illness' or not. Some people expressed clear views that their mental health condition should be considered as much a disability or illness as a physical health condition, and felt it was important that mental health be recognised in this way by wider society.

However, other people did not want to accept a 'label' of being mentally ill. Some people distinguished their own experiences of depression or anxiety from what they saw as 'severe' mental illness, while others did not perceive what they had experienced as being an 'illness' at all. One person, who talked about her ongoing experiences of depression, contrasted this with a previous and isolated experience of drug-induced psychosis. From this experience she felt that she could 'empathise' with people with mental health conditions but did not perceive herself as 'mentally unwell' or as having 'mental health issues' at the time of the research interview. A study participant whose IB claim was a result of drug use explained: 'I don't consider myself having a mental illness, you know what I mean. Nah, none of that ... I just think myself, bit wild'. Similarly, another person who identified himself as alcoholic did not see the term 'mental health' as appropriate to his circumstances, saying 'I find that quite offensive as opposed to what I actually am'.

People's comments on claiming IB also gave some insight into how they conceptualised mental health. Some people had been surprised when their GP suggested issuing a sick note, or when Jobcentre Plus had informed them that they would need to claim IB (rather than Jobseeker's Allowance (JSA), for example). One person who identified himself as alcoholic described how he had initially felt that it wasn't right for him to claim IB for this reason:

*I felt 'Whoa Incapacity?' That sounds so much like, you know, it doesn't, it just didn't add up to me ... I felt embarrassed to be honest, for alcohol. I suppose as a drunk you've got to claim Incapacity. How is this going to work out? How are them people going to look at you? You're claiming Incapacity, collecting money for being a drunk.*

(Male, 30s)

Interestingly, while most of the people claiming IB due to drug use acknowledged this as a problem to be addressed, they commonly perceived their IB claim as primarily reflecting their unavailability for work while undergoing drug rehabilitation or (for those who had been charged with drug offences) during their time on probation, rather than as a reflection of being mentally unwell.

Another source of insight into people's perceptions of mental ill health was their response to the offer of leaflets giving information on the Disability Discrimination Act (DDA) and its application in the workplace.<sup>4</sup> Some people were interested to learn more about this and took leaflets when offered by a researcher. However, a number of people felt that this information would not be relevant to them, for example, explaining that they did not see themselves as being disabled, or that they would not need an employer to make adjustments for them in future.

There was variation in the way that people identified with or positioned themselves in relation to their experiences of mental ill health. Some people described themselves as a person 'with' a mental health condition. There was some evidence that this type of self-identification was more common among people who had been diagnosed with one of the more severe mental health conditions, such as schizophrenia or bipolar disorder. Among this group of people, there was also more experience of involvement with secondary mental health services. There were also some people with longer term experiences who considered depression to be a condition that was ever present in their lives, with fluctuations over time. Additionally, some people continued to identify themselves as alcoholic although they were not currently using alcohol (though, as was noted previously, they may not ever have considered this a 'mental health condition').

In contrast to people who identified themselves as a person 'with' a mental health condition, some participants described a tendency towards reactions of depression or anxiety under certain circumstances. Based on prior experiences of recurring periods of mental ill health, some said that they could recognise situations where depression or anxiety might be triggered or exacerbated.

Demonstrating a third type of understanding, some people perceived their recent experiences of mental ill health to be isolated and short-term, something that they had, or hoped to in time, put behind them and 'overcome'.

While some people stressed that they were not 'ashamed' of their mental health condition, there were people who, at the same time, explained that they did not want to receive special treatment or be seen as having 'special needs'. The belief that they would be 'labelled' as mentally ill or treated differently was a factor deterring some people from mentioning their mental health condition to employers or others.

---

<sup>4</sup> Leaflets giving basic information about the DDA and reasonable adjustments (produced by the Disability Rights Commission) were taken to all research interviews with people who had experienced a mental health condition. These leaflets were referred to at the relevant point in the research interview and offered to research participants who expressed an interest in finding out more.

These differing perspectives on how people see the relationship and connection between themselves and their experiences of mental ill health are potentially significant to the forms of medical, employment and wider social support that are perceived as necessary or appropriate, by individuals themselves or people around them. Whether or not people choose to accept an identity of somebody 'with' a mental health condition, somebody 'prone to' certain types of reaction under stressful circumstances, or someone who has experienced a 'one-off' episode of depression or anxiety which they have (or hope eventually to) overcome, will influence and have implications for the extent and form of help people seek or accept, and the way they view their future in relation to work and mental health. Also, key to understanding people's experience is whether they perceive their past or ongoing experiences as 'illness' or rather a natural, albeit strong, reaction to their life circumstances.

### **2.1.5 Relationships between work, mental health and Incapacity Benefit**

This section considers the relationship between people's work and their mental health condition, including the extent to which people felt their work had affected their mental health and vice versa. In considering these questions, we recognise that it is both complex and contestable to talk of causal relationships between work, mental health and other contextual factors. In the analysis that follows, any reference to 'triggers' or 'exacerbating factors' comes solely from the descriptions and understandings of the study participants. The analytic categories are those of the researchers.

As detailed in Chapter 1, the study group was designed to include 30 people with recent experience of moving from work to IB and 30 people who had recently moved off IB and into employment. Of course, many of the people in this latter group were also able to reflect on experiences of leaving work due to mental ill health. However, what the sample as a whole also demonstrated was that people who come to claim IB because of a mental health condition do not necessarily attribute their leaving work to this experience of mental ill health.

Around two-thirds of the study participants gave accounts where the emergence or exacerbation of mental ill health had been a main factor in their leaving work. A smaller number, around a fifth of the sample, explained that, although they had experienced mental ill health concurrently with being in employment, they did not see this as the reason for leaving their job. Instead, they cited reasons such as redundancy or the end of a temporary contract. However, some of these people believed that, given the effects of their mental health condition, they would probably have struggled to stay in their job for much longer anyway, had it not come to an end for some other reason. A small number of people said that they had left their most recent job before their experiences of mental ill health began. There were also a similar number of people who had not been in employment for some years prior to claiming IB and who did not talk in detail about their experiences of leaving their last job.

Among people who did talk about a period of being in work while experiencing a mental health condition, three main relationships between work and mental ill health were described. There were:

- work being a trigger of their mental health condition;
- a combination of work-related factors and circumstances in their personal life as contributing to experiences of mental ill health; and
- mental health condition arising independently of work.

Recalling the different 'histories' of mental health condition (see Section 2.1.2), it was notable that each of the three groups above included people who were experiencing their first episode of mental ill health and people who felt that a previous or long-standing mental health condition had been re-triggered or exacerbated by more recent events or influences. However, in constructing the three categories above, the analysis drew on people's accounts of what they felt had triggered the recent episode of mental ill health that had preceded their leaving work. Thus, for example, there were people in the first group who recognised a long history of depression, or explained that an event in their personal lives some years earlier had triggered their first experiences of anxiety, but who at the time of leaving work more recently, felt that it had been solely workplace factors that had triggered the recurrence of mental ill health.

It should be noted that, across the study group, the boundaries around the three relationships between work and mental health were not always distinct and there were relatively few people who said with certainty that only work or only non-work factors were affecting their mental health. Many people described a combination of work and non-work factors, illustrating the complexity of circumstances which underlie the emergence or exacerbation of mental ill health. Some people who perceived influences from both areas of life also found it difficult to identify whether work or non-work factors were most influential in the decline in their mental health.

It is also notable that there were few examples of work being cited as the first and only reason underlying the emergence of a mental health condition. In most cases, people were either experiencing another stressor in their personal lives at the same time, or 'job stress' had exacerbated a condition that had been experienced in the past, initially triggered by non-work events. As will be discussed further in Chapter 7, this has important implications for employers who wish to retain their staff, in that they will need to be sensitive and responsive to events occurring in employees' lives outside of work, as well as attending to mental health in the workplace, for example, through prevention or management of 'job stress'.

In describing how they arrived at a point where they felt they could no longer be at work, two types of scenario emerged from the study participants' accounts. Firstly, there were people who had been feeling well and managing in their job, but experienced a sudden traumatic event after which they no longer felt they could stay in work. Secondly, there were people who had experienced a gradual

deterioration in their mental health culminating at a point where they felt they could no longer 'cope with' or 'handle' being at work. Among this second group, the 'last straw' in their leaving was sometimes a sudden event.

### **Work-related triggers**

Some of the work-related triggers described by people in the study group were sudden and unforeseen events that had occurred in the course of carrying out their work, for example physical or verbal attack by a client in their care, receiving notification of redundancy or allegations of misconduct. On the other hand, there were also gradually developing situations where, for example, mounting 'job stress' or workplace bullying had intensified over time.

### **Non-work triggers**

Non-work triggers identified by study participants were of two broad types. Firstly, some people talked about specific events or circumstances in their personal life having triggered an episode of mental ill health. In some cases, people described gradually mounting levels of stress or emotionally demanding situations which exacerbated depression or anxiety, until they reached a crisis point where their state of mental health meant they could not manage in work. Other people explained that a sudden event in their personal life had very quickly led to them feeling so distressed that they were unable to remain in work. Examples here included sudden and violent bereavement or unforeseen relationship breakdown.

Secondly, some people cited aspects of their mental health condition itself as having impacted on them at work. Some people who identified themselves as having a long-standing condition explained that its intrinsic effects had made work unmanageable. Examples included a low period in fluctuating depression (for which the individual felt there was no identifiable cause) or experiencing the physical effects of alcoholism or drug addiction. Some people also cited the effects of medication as making work difficult to manage.

Table 2.1 shows some examples of the various relationships between work and mental health experienced by people in the study group.

**Table 2.1 Relationships between mental health and work**

Influences on mental health	Changes in mental health	
	Gradual	Sudden
Work factors alone	Workplace bullying Unmanageable workload increasing over time	Verbal assault Physical injury incurred in the course of duties
Combination of work and non-work factors	'Job stress' plus ... ... supporting a bereaved partner ... PTSD following severe physical injury	... sudden and violent bereavement
Non-work factors alone	Domestic violence leading to eventual relationship breakdown Long-standing fluctuating depression	Discovery of a partner's infidelity Bereavement

### 2.1.6 Others' perceptions of mental health

This section presents study participants' views about wider societal perceptions of mental health, and the ways in which these could influence people's willingness to talk about their experiences with others and their ability to seek or accept support.

Some people perceived that others would not be able to understand what they were experiencing, especially if they had never been through similar experiences themselves, and this had sometimes influenced a decision not to talk about their mental health condition with others, in particular friends and family. Where people had attempted to explain their mental health condition to people close to them, they had sometimes received unhelpful or insensitive responses. Some described how relatives or close friends had found it hard to empathise with their depression or anxiety, not understanding how debilitating the condition could be and encouraging them to simply 'pull themselves together'. Some of the younger members of the study group had been told by doctors, friends or relatives that they should not be feeling depressed or anxious 'at your age'. Some people described how close friends or relatives had distanced themselves because they could not 'cope with' their mental health condition or found it hard to be supportive because they did not know 'how to respond'. When discussing sources of emotional support in research interviews, some people noted that they were mindful of not placing too much of a burden on the people closest to them, and so tried not to talk too much about their mental health condition (or the underlying causes) with their close friends and family.

A number of study participants perceived a difference in societal understandings and perceptions of physical illness and disability compared with mental ill health. The greater visibility of physical health problems was thought to make them more understandable and so easier for people to sympathise with and to accept. On the

other hand, the 'invisibility' of mental ill health meant it was difficult for people with no personal experience to understand how this could affect somebody's ability to manage in work or life more generally.

*You can't like carry a sign around saying 'Excuse me, I'm suffering from depression and anxiety and please make sort of allowances.'*

(Male, 30s)

*Everybody sort of shies it, you know, grow up, pull yourself together, there's no physical scars.*

(Male, 50s)

There were also views that, compared with physical illnesses, mental health problems were 'swept under the carpet'. Depression and stress were noted as particularly challenging for others to understand, acknowledge or support, because of their subjective nature and imprecise definition. Some people reflected on the increasingly widespread use of the terms 'stress' and 'depression' to describe a continuum of minor to more major emotional distress. In the words of one person, the terms had become 'watered down' making it difficult to acknowledge mental ill health as 'real' for both the person experiencing the condition, and those around them:

*A lot of people go off work stressed, you know, stress and depression is such a big term, you know, you break up with your boyfriend, 'I'm stressed' ... 'I'm depressed', it rolls off people's tongues.*

(Female, 30s)

*A lot of people go round saying 'Oh I'm depressed' and I just didn't think it was anything as severe as they make it, I didn't class depression as a severe mental illness and it's not until later that I realised how bad it could be.*

(Female, 20s)

In contrast to the experience of having a mental health condition played down by others, there were also people who felt that there were exaggerated societal misconceptions of people with depression or anxiety as being 'nuts' or 'mad' or 'crazy'.

Finally, perceptions of stigma and discrimination were raised by a number of study participants. There was evidence that for people in the study group, the term 'stigma' did not refer so much to experiences of indignity or overt prejudice, but was reflected more subtle or covert discriminatory attitudes to mental ill health in society in general, and employment in particular. As will be discussed further in later chapters, there was a perception that employers viewed people with mental health conditions as a 'risk' or as unreliable or incapable of coping in their job, and this was a factor in some people's reluctance to mention a mental health condition to their current, or a potential future, employer.

## 2.2 Employers' understanding of mental health

In this section we explore employers' understanding of mental health conditions, and the extent to which they were aware of, or had had to respond to mental ill health among employees. Data are then presented on the advice, information and training used by employers, including measures introduced by some of the 'engaged' employers.

It should be remembered that, on the whole, these employers are likely to have been more aware and/or better disposed towards employees with mental health conditions than might be expected amongst employers in general.

### 2.2.1 Awareness of mental health conditions

Employers' awareness and perceptions of mental health conditions were explored in two ways in the research interviews. First they were asked what they understood by the term 'mental health condition', and to give unprompted examples of what they thought it included. Then the employers were given a showcard listing a range of mental health and other related conditions, to prompt a wider discussion.

#### Unprompted awareness

The engaged employers and most of the large employers from the randomly-drawn sample were aware of a broad range of mental health conditions and, unprompted, cited conditions such as stress, depression and schizophrenia. A few employers also made the distinction between different levels of depression, from mild to severe. Some also mentioned drug and alcohol misuse. Many of these respondents had a professional background, particularly in occupational health roles, which had contributed to their understanding of mental health conditions, but a number of those working in human resources also said that they had taken a particular interest in this area. Their awareness and understanding of mental health conditions was usually associated with a more general awareness and understanding of health and disability. A few of the engaged employers used the phrase 'emotional well-being' to denote a broad concept describing the emotional and psychological health of the workforce. Under this broad heading, employers included mental health conditions and other emotional conditions including stress, post-traumatic stress disorder and post-natal depression. One of the engaged employers mentioned that mental health conditions would be considered by their organisation as those defined as such under the DDA.<sup>5</sup>

As noted earlier in relation to the IB sample, 'stress' is not a clinical diagnosis. However, many employers, particularly large employers, did identify stress as a mental health condition and spoke of it in similar terms to other, clinically

---

<sup>5</sup> But see Chapter 1 for a summary of the DDA and the provisions for mental health conditions. The DDA bases its definition of disability on the effect of a condition on a person's normal day-to-day activities, rather than basing it on the nature or severity of the condition itself.



recognised conditions, such as depression and anxiety.<sup>6</sup> They also said that they found stress particularly difficult to deal with. References to stress throughout this section reflect this usage by employers in our sample.

There was a narrower range of unprompted awareness in most of the small and medium-sized employers. Such employers usually focused, in their responses, on the more severe and enduring mental health conditions such as schizophrenia, psychosis and 'manic depression', the latter being the term which small and medium-sized employers often used when referring to bipolar disorder. Small and medium-sized employers did not always spontaneously cite stress or depression as mental health conditions.

Employers' awareness was often related to the extent to which they had experience of dealing with mental ill health, either in the workplace, and/or in their personal lives. Those with more experience of dealing with mental health conditions tended to also have a wider understanding of them, and this was particularly noticeable in the divide between the small/medium and the large employers.

Some employers mentioned learning disabilities and autism (a developmental disability) in discussion of what might constitute a mental health condition. A number of employers, both large and small, made little or no distinction between these and mental health conditions. From the perspective of these employers, such conditions could sometimes manifest in outwardly similar ways. For example, some employers included people they termed 'a bit slow' in their definition of mental health conditions. Equally, for some employers, there was some blurring between mental health conditions and other circumstances where people were seen not to be coping, for example as a result of bereavement.

### **Prompted awareness**

After employers had talked about the mental health conditions that they were spontaneously aware of, the discussion continued with the aid of a showcard listing mental health conditions. The conditions listed on the showcard were:

- depression, including post-natal depression;
- stress;
- schizophrenia;
- phobias, for example agoraphobia;
- bipolar disorder/manic depression;

---

<sup>6</sup> Stress was a prompt on one of the showcards used in the interviews with employers. This reflected past research (for example, Anderson *et al.*, 2004) which reported that there was a tendency for GPs to write 'stress' on employees' sick notes, and that 'managers often confused stress with mental disorders'. Hence 'stress' was included on the showcard as it was something that employers would recognise and might identify as a mental health condition.

- anxiety disorders – anxiety, worry, fear, panic disorder;
- post-traumatic stress disorder (PTSD);
- obsessive-compulsive disorder (OCD);
- psychosis;
- personality disorders;
- eating disorders;
- self-harm and suicide;
- drug and alcohol misuse.

Most employers said that they viewed all of the conditions on the list as mental health conditions, even though many had not spontaneously mentioned such a wide range of conditions. Some employers questioned whether stress should be viewed as a mental health condition.

Some employers also queried whether some of the conditions towards the bottom of the list were mental health conditions. Eating disorders and self-harm were most often questioned, although not strongly. Not all employers believed that drug and alcohol misuse could be classed as a mental health condition, although most acknowledged that substance misuse and mental health conditions could be related, or could result in similar behaviours:

*Addictions might not be what you would call mental illness but from the point of view of trying to employ somebody the issues they have to deal with are often the same.*

(Engaged employer, large, primary and manufacturing sector)

All of the mental health conditions listed on the interview showcard had been experienced among employees by at least one of the employers participating in this research. The most commonly cited conditions were depression, stress and anxiety. After these were schizophrenia, bipolar disorder and drug and alcohol problems. A few employers reported cases of post-natal depression, psychosis, personality disorders, post-traumatic stress disorder, mania, eating disorders, self-harm, suicide and obsessive compulsive disorders.

Amongst some of the most 'aware' employers, there was a reluctance to use labels for mental health conditions. The key concern for these employers was the way these conditions affected behaviour, and the impact of this in the workplace. Rather than talking specifically about an employee's condition, or diagnosis, if they had one, these employers were concerned with making appropriate adjustments and accommodations for their employees.

There was some evidence to suggest that a few of the less 'aware' employers had a tendency to perceive mental health conditions as severe and/or constant, and that individuals with such conditions would receive statutory support commensurate

with this, as the following quotation illustrates:

*I know everybody with mental health issues has a care plan. ... There's a care coordinator, somebody assigned to that person that that person feels he or she can go to if things don't quite work out.*

(Director, small employer, voluntary sector)

Turning to the way different types of condition were believed to manifest themselves, a few employers thought that some conditions could result in a lack of concentration. Some employers said they were aware that certain mental health conditions were characterised by a lack of personal insight into the condition itself. A number of employers pointed out the potential benefits of work for people with mental health conditions. For example, they believed that employees experiencing difficulties in their personal lives could benefit from the routine of work, and the contact with, and support from colleagues that being at work afforded.

### **Knowledge and awareness of stress**

Stress was one of the conditions most commonly-reported by employers in the sample as a form of mental ill health and it was also viewed by employers as a complex, and increasingly important issue in the workplace. As mentioned earlier in this chapter, stress, unlike many other conditions, is not a clinically-recognised mental health condition. This appeared to have contributed to employers' difficulties in understanding and responding to stress in the workplace. As stress was viewed by many employers as a particularly difficult condition to respond to, it is given separate consideration here.

Many employers, even the most aware and experienced, believed that stress was inherently difficult to define. Employers reported that people responded differently to situations, and that what caused stress to one person, another person handled differently. The Health and Safety Executive defines stress as 'the adverse reaction a person has to excessive pressure or other types of demand placed upon them'. Reflecting this conceptualisation of a subjective reaction to circumstances, some employers held the view that mental health conditions were very much dependent on an individual's personality and on the situation they found themselves in at the time. As one of the engaged employers explained:

*Some people can be negatively stressed by something apparently simple and some people can be positively challenged by things that would be really horrible for others. I think that's what's difficult. If someone says, 'I'm stressed' it doesn't actually tell you anything does it? Whereas if someone says they're depressed, it gives you something to work with.*

(Assistant personnel director, large organisation, financial sector)

Some employers thought that the term 'stress' was used too readily, and some had encountered problems with general practitioners writing 'stress' on employees' sick notes with very little other information about the condition, which they had found unhelpful in looking at ways to help people back to work.

A few engaged employers mentioned the Health and Safety Executive 'stress management standards', which identify stress as a regulatory concern and a priority area of health at work for employers to tackle.

### **2.2.2 Employers' knowledge of employees with mental health conditions**

Thirty-three of the 40 employers reported having had experience of dealing with mental health conditions in the workplace. Some of these employers perceived that mental health problems, together with musculo-skeletal problems, were the two biggest health problems faced by employers. For some, mental ill health accounted for much of their sickness absence. Many of the engaged employers reported that the increasing negative impact of mental health conditions, particularly stress and depression, on their workplaces was the main reason for their focused efforts in this area.

#### **Reported prevalence of mental ill health amongst employees**

Some of the employers were able to give estimates of the proportions of their employees who had a mental health condition. Most of these did not collect any information on this, but were able to provide rough guesses. These ranged from none (usually in the smaller employers where respondents believed that they would know if any of their staff were affected) up to 50 per cent, where the respondent had a very wide definition of mental health conditions. The most commonly-given estimates of the proportions of staff with a mental health condition were between ten and 20 per cent. (According to Labour Force Survey figures, the prevalence of mental illness among people in employment is 22 per cent, see Figure 1.1 in Chapter 1.) Employers' estimates of the number of employees with mental health conditions tended to increase once they had seen the showcard as after this they included eating disorders, self-harm and drug and alcohol problems in their estimates.

Many employers said that it was difficult for them to know the prevalence of mental health conditions amongst their employees. Such employers generally thought that most employees would choose not to disclose a mental health condition unless they had to; for example, if they were aware that it was affecting their work or their attendance record and wanted to explain this to their employer, or if their employer asked them whether there were any health reasons which might account for a change in behaviour, performance or attendance. These employers also said that they would find it difficult to identify a mental health condition without the employee telling them, or associate obvious behaviour or performance changes with a mental health condition. Several, also made the point that the way in which mental health conditions manifest themselves can change over time, making them more difficult to identify at some times than others. Some employers referred to what they perceived as stigma about mental health conditions, and understood the reluctance of some employees to say that they had a mental health condition to their employer.

For these reasons, some employers thought that their figures were probably an underestimate of the true picture, as they suspected that many employees would not tell an employer about a mental health condition. Most employers believed that applicants for jobs were unlikely to discuss mental health condition at recruitment, for fear of the potentially negative consequences of doing so (discussed further in Chapter 5). They thought it was more likely that they would learn of an employee's condition once they were in work, although they again identified fear and stigma as reasons for employees being reluctant to talk about a mental health condition at this stage too. Most of the employers who provided estimates also gave caveats about how mental health conditions can fluctuate over time, depending on factors at work and at home.

Some of the employers had well-developed systems for monitoring the incidence of mental ill health amongst the workforce, usually based on absence records. The engaged employers commonly had these. They reported that a key aspect of their practices was a careful monitoring and recording of sickness absence due to mental health conditions, particularly where stress and depression were indicated on an employee's medical certificate. The equality and diversity manager for one of the engaged employers reported seeing an increase in the number of cases of mental ill health, but was unsure if this was due to an increase in the number of cases, or if there had been an increase in the willingness of employees to disclose mental health conditions. Another engaged employer's analysis of their management information showed that only a small minority of staff had clinically-diagnosed mental health conditions, and that most of those without a diagnosis were suffering from pressure and stress, both work and non-work related.

A few employers were aware of national figures on the prevalence of mental health conditions. For example, one quoted a figure from the mental health charity, Mind, that one in four people would experience some sort of mental health condition during their lifetime. Another employer had found a figure that stated that between 30 and 40 per cent of the working population would at some stage experience an anxiety disorder or a depressive illness.

### **2.2.3 Advice, information and training**

This section turns to the advice, information and training that employers had sought and used to raise levels of awareness and understanding of mental health conditions.

#### **Advice and information**

The research with employers found both examples of advice and information being sought in response to specific situations, and with a view to improving understanding and awareness more generally. Unsurprisingly, the large employers, including the engaged employers, had often taken steps to increase general understanding of mental health conditions, whilst the small and medium-sized employers had fewer examples of this. Large employers often had in-house resources and expertise

to draw on, and tended to be proactive in gaining an understanding of mental ill health and other related conditions. Small and medium-sized employers were more reactive and sought out advice as and when needed, usually from outside the organisation. A few employers reported having received conflicting advice from different organisations they had approached for assistance.

The main sources of advice and information which had been drawn on by employers are discussed ahead.

### **Occupational health**

Most of the large employers (including the engaged employers) had occupational health or employee health departments, and these were typically the initial source of advice and information on dealing with mental health conditions at work. Very few of the small and medium-sized employers had access to occupational health support.

Many occupational health and human resources professionals working for the larger employers thought it was important that line managers received a thorough briefing on measures that had been taken to address and support employees with mental health conditions, and that line managers were provided with an opportunity to have their concerns addressed.

### **Human resources and other managers**

Human resources or personnel departments were another source of information on mental health conditions, particularly in medium-sized employers that did not have access to occupational health support. However, in the absence of employers' occupational health services, there was usually very little advice on understanding mental health conditions available within organisations, and what there was seemed to be based on individual cases and dependent on managers' experiences.

In smaller employers it was often up to the owner or general manager themselves to seek out the information they might need. Many who had encountered mental ill health amongst their staff had relied on their own personal experience and instincts and saw the internet or mental health interest groups as their main resources if they were not familiar with a specific condition or its effects. The general manager or owner was sometimes the most likely initial source of advice for other staff.

### **General practitioners and health trusts**

There were some examples of employers working with GPs about a particular individual, to get a better understanding of their condition, and advice on fitness to work. However, contact with GPs was usually limited to the provision of information via sick notes, giving reasons for an employee's absence and stating a diagnosis where relevant.

A few employers mentioned having links with their local health trusts. One engaged employer had set up an arrangement with a consultant at a local health trust to support their work with individuals with mental health conditions. They had found this arrangement very useful, although it was no longer operating due to key staff leaving.

### **Mental health charities**

A few of the employers had worked with mental health and other third sector organisations, including Mind and the Shaw Trust. In one case, an engaged employer was working with such an organisation to develop some guidance for managers on recognising signs of stress and depression, which they planned to make available as fact sheets on their intranet. This employer had also invited the mental health charity to do some awareness training for staff. Another engaged employer reported finding conflicting advice from various different sources, but had found the guidance from one of the voluntary organisations to be helpful.

### **Other sources**

A number of employers had used the internet to find information on disability generally. The Health and Safety Executive, accessed via a website search, had been used by several employers as a source of advice and information. Other sources mentioned included Business Link and another small business support group run by a local authority.

### **Training**

Many of the engaged employers, and some of the larger randomly-sampled employers had proactively delivered training or awareness-raising programmes to their managers to equip them with the understanding and skills to manage and work with colleagues with mental health conditions.

A distinctive feature of the engaged employers in this study, was the number of proactive measures which they had in place to improve the understanding of mental health conditions in the workplace. Examples of these activities, which incorporated or gave a specific focus on mental health, are summarised ahead.

### **General awareness-raising**

- Occupational health notice board with information on health issues, including mental health conditions.
- Using the intranet to make information available to staff. In one example, an engaged employer provided guidance for staff on managing people with stress.
- Newsletters.
- Poster campaign about mental health conditions.
- National health promotion events which could in the future cover mental health.

- Planned consultation with staff, including some employees with mental health conditions.

### **Training**

- A day of training which focused on how to treat all staff and members of the public with respect and empathy. This training also touched on working with people with mental health conditions.
- A work programme which aimed to improve staff relations and understanding, by exploring how staff at all levels throughout the organisation related to and treated each other, and how this could be improved.
- Training for staff on stress, mental ill health and absence management more generally.
- Training for line managers on managing sickness absence.
- Wider awareness-raising and training for all staff including diversity workshops and seminars.
- Dedicated departments which provided training (as well as information, advice and support), including occupational health, employee health management and human resources.
- (Proposed) staff awareness training to be provided by staff with personal experience of mental health conditions (and a proposal to extend this into a nationwide campaign).

A few of the engaged employers were also involved in national initiatives aimed at improving understanding of mental health conditions, including initiatives run by the Care Services Improvement Partnership (CSIP)<sup>7</sup> and the Health Work and Well-being

---

<sup>7</sup> The CSIP was created in 2005 by the integration of a number of initiatives supporting the development of services to help improve people's lives. Commissioned by the Department of Health and other agencies, CSIP aims to achieve this by supporting the implementation of national policy for local benefit. CSIP works with communities, systems and organisations that are engaged with the health and social care needs of: people with mental health problems; people with learning disabilities; older people; children, young people and families; people in the criminal justice system; and the families, carers and supporters of these groups (<http://www.csip.org.uk/>).



Strategy Review being led by Dame Carol Black.<sup>8</sup>

Overall, the existence of these kinds of systematic activities, aimed at awareness-raising and training on how to handle address and support mental health conditions in the workplace, was the single feature which most clearly distinguished the engaged employers sample from the rest of the sample. As noted elsewhere in this report, it is likely that the sample as a whole was atypical of employers as whole, in the sense that employers who participated in the survey were generally interested in the question of mental health in the workplace and concerned to improve their practices. The main difference between the randomly chosen sample and the engaged sample was that many of the latter had already taken steps in introducing these types of awareness-raising and training initiatives. However, some of the larger randomly-sampled employers had provided disability awareness training which, on occasion, had covered mental health. Some employers had provided training for management in equality and diversity but not on understanding mental health specifically.

## 2.3 Conclusion

In this chapter we have explored knowledge and understanding about mental health conditions from the perspectives of employers and people who have experienced mental ill health.

Given the wide range of conditions that fall within a definition of 'mental health condition' it is not surprising that knowledge and understanding among the employers interviewed in the study was vary varied. Our findings mirror what is known about employers' knowledge of disability more widely. There is a group of employers who have become well-informed about mental health through their own experiences and by proactively accumulating knowledge. These employers tend to be large and to have their own, or good links to, occupational health specialists. Other employers tended to have much more limited knowledge and experience and be generally isolated from sources of advice and expertise.

It was noteworthy how some employers explained that for them, a medical diagnosis of mental ill health was less relevant than people's performance and behaviour. In the following chapters we will explore the implications of this approach for recruiting people, responding when mental ill health affects people's work, and for how people leave their employment.

---

<sup>8</sup> A review of the health of the working age population, assessing current health levels and providing a benchmark against which to measure future workplace health improvements. Its aim is to increase understanding of the beneficial link between work and health, and help identify where the greatest improvements can be made to the health of those who are in or want to return to work. Dame Carol Black, the National Director for Health and Work, was commissioned by the DWP in conjunction with the Department for Health to lead the review. (<http://www.workingforhealth.gov.uk/Carol-Blacks-Review/Default.asp>).

The data from the 60 individuals interviewed for the study are equally diverse. How people viewed their own history and current experience of mental ill health was partly influenced by when their condition emerged in their lives and whether they had recurrent or single episodes of mental ill health. How they viewed their own illness (and whether they perceived that they did have an 'illness' at all) was an important topic explored in the research interviews. We have identified numerous ways in which people had powerful subjective and normative feelings about their own condition and how they thought others saw them. How these views affected their behaviour and decisions about work will be explored in depth in subsequent chapters.

## 3 Mental health in work

As explained in Chapter 1, one of the objectives of the research was to investigate employers' policies and practices on job retention for people with mental health conditions and people's experiences of being at work with a mental health condition before losing or leaving their employment (for whom by definition any attempt at job retention had not succeeded). In this chapter, we therefore explore a range of in-work situations and experiences gathered from the interviews with employers and people who had experienced mental ill health while in work. Sections explore:

- People's decisions about and approaches towards talking about mental ill health at work.
- The impacts of mental ill health on people's own work and the workplace more broadly.
- How absences due to mental ill health are experienced and managed by employees and employers.
- In-work adjustments and other responses made by employers to support employees with mental health conditions.
- Employers' policies around supporting employees with mental health conditions, including the use of the Disability Discrimination Act (DDA).
- The role of General Practitioners (GP) in advising and supporting people with mental health conditions and their employers.

As outlined in Chapter 2, most of the employers had some experience of employees with mental health conditions. In the majority of cases, employers' direct experiences of mental ill health among their staff involved employees who had been working for them for some time, whose mental health condition emerged or became apparent whilst they were in employment. Data from employers on the above themes were extensive and wide-ranging. In contrast, as discussed later in Chapter 5, few employers had experience of learning about an applicant's mental health condition at the recruitment or appointment stages.

For the sample of new and recent Incapacity Benefit (IB) recipients, data in this chapter are drawn primarily from people's discussions of the job they had been in most recently prior to their claim for IB. As detailed in Chapter 1, the study group was designed to include at least 30 people whose benefit claim was 'recent' (within the last six months at the time the sample was drawn). However, some of these people had been out of work for several months or even years before claiming IB, and so a recent claim did not necessarily indicate a recent departure from work.<sup>9</sup> In order to maximise understandings of experiencing mental ill health while in work, the chapter also draws on the past experiences of people who were primarily interviewed about their recent return to work (discussed in Chapter 5). For these people, it should be noted that the time period between leaving their last job and taking part in the research interview ranged between one or two years to, in a number of cases, more than six years.

### 3.1 Talking about mental health at work

This section considers people's approaches to talking to employers and others at work about their experiences of mental ill health, and the approaches of employers in raising the subject where it appeared that an employee was experiencing a mental health condition that they had not voluntarily mentioned.

As noted earlier, discussion in this chapter focuses on people's experiences in their most recent job prior to claiming IB. Some people had already been aware of an ongoing or fluctuating mental health condition at the time they had taken up this employment while for others mental ill health had first developed while in work.

In the first subsection, we explore how and when employees opted to talk to others at work about their mental health, including the data from employers on occasions when members of staff had voluntarily spoken to them about mental health conditions. Next, we present data on the reasons why some people did not to talk to others at work about mental ill health. Among people experiencing longstanding and more recently emerging conditions, the wish not to tell anyone at work about their experiences of mental ill health was a common feature of people's accounts. The third subsection considers examples, from both the employer and employee data, of where an employer had become aware of the mental health difficulties of a member of staff through observable changes in behaviour, performance or attendance, and had been the one to initiate discussion about this.

#### 3.1.1 Volunteering information about mental ill health

Decisions about talking to people at work about mental ill health involved

---

<sup>9</sup> A survey of recent IB claimants carried out for the Department for Work and Pensions (DWP) (Kemp and Davidson, 2008) found that almost half of the sample (46 per cent) had not been in paid employment immediately prior to making their claim.

different sets of factors for different individuals, depending on the longevity and development of their mental health condition. This section outlines the approaches to talking to others at work about mental health conditions taken by individuals who experienced longstanding conditions, suddenly triggered mental ill health, and conditions that emerged gradually while in work. The perspectives of employers on the volunteering of information by employees about mental health conditions are then outlined.

### **Longstanding mental health conditions**

Among individuals with previous or long-standing experiences of mental ill health, there were isolated examples where people had told their employer about this around the time of taking up employment. Only two people said they had detailed their mental health condition on an application form. In one case, this was in the context of disclosing drug-related criminal convictions. The other example was a person with a long history of recurring psychotic and also depressive episodes, who had ongoing involvement with mental health services. This person explained how, although he perceived that this could lower his chances of getting a job, it was better that his potential employer was aware from the outset that episodes of ill health and absence were likely. Neither of these people who had formally shared details of their mental health condition at recruitment had told colleagues about this after they had begun work. After she had been appointed, one further person had told her manager and selected colleagues that she was on long-term medication for depression, and in the few cases where people had taken up work with someone who they knew personally, the employer had already known something of the background to their mental health condition.

### **Sudden emergence of mental ill health**

Where somebody's mental health condition was linked to a specific and sudden event which happened in the workplace (for example, a verbal or physical attack), employers were inevitably aware of this trigger event. Sudden traumas in personal lives were generally also made known to employers, in explaining initial absences from work. In several of these cases, people's accounts suggested that there had been no mental health 'condition' to speak of prior to this event. However, in these situations, people often went 'off sick' in the immediate aftermath of a sudden trauma and, depending on the extent of contact maintained during this period (see Section 3.3), the increasingly severe effects of this incident on people's mental health over time were sometimes not apparent to their employer.

### **Gradual emergence of mental ill health**

Where there were specific and identifiable changes in people's personal lives that were progressively affecting their mental health, these were sometimes shared with employers or colleagues to whom people felt sufficiently close. In the case of one person whose mental health condition was triggered by workplace bullying, this was recognised by other colleagues and had been reported to a senior member of staff (although not until it had already caused her to take time off sick). Among

people who found that their mental health condition was affected by less tangible factors, some had explained to managers that they were struggling with specific aspects of their work, for example, a particular shift pattern, or that they were finding it difficult to manage their duties overall. Notably, however, in many of the cases where people had voluntarily discussed (aspects of) their mental ill health with their employer or colleagues, people had talked about the 'causes' of their condition, for example, family problems, or the 'effects' this was having on them, for example, struggling with early shifts, rather than explicitly referring to a mental health condition.

### **Employer experiences of volunteered information**

Among the employer sample, some had experience of occasions where an employee had chosen to tell them about a mental health condition, usually discussing their situation with either a line manager or human resources professional. Some employers said that they had suspected that the member of staff was experiencing mental ill health of some kind before this conversation but there were also instances where the information had been entirely unexpected, especially when an employee was seen as 'stable' and 'reliable'.

For the most part, it appeared that employees did not volunteer information about a long-standing mental health condition to managers until they had started to experience its effects in work. Often, by then, they would either have taken a period of sick leave or colleagues would have noticed changes in behaviour or mood. Many managers believed that their staff would feel able to approach them directly if they were going through a difficult time:

*We have a system here where our partners and directors and associates are very approachable. If you have any kind of problem, personal or work related, you have somebody to go to. There's never the situation where you haven't got anybody to turn to.*

(Human resources manager, large employer, business sector)

However, among engaged employers and the more aware employers from the randomly-selected sample, there was usually some acknowledgement that this would not happen in all circumstances. People's reasons for not discussing mental health conditions at work are considered in the next section.

### **3.1.2 Not volunteering information about mental ill health**

There were a number of reasons why people chose not to make their experiences of mental ill health known to others at work, relating variously to the individual's awareness of and feelings about their mental health condition and the way in which they felt others would perceive and respond to this.

As has been discussed in Chapter 2, the extent to which an individual was aware or willing to acknowledge that they were experiencing difficulties in work relating to mental ill health (or vice versa) was a factor in whether or not they shared this

with their employer or other people around them. Some people described how a lack of personal awareness that their mental health had been deteriorating was a reason why they had not talked about this at work. One person with long-term depression and anxiety noted that thinking about whether or not to tell others about the difficulties they were experiencing was not something that would necessarily occur to people when in the midst of a depressive episode:

*When you are depressed, you don't ... it's the furthest thing from your mind ... you just don't say anything, you just get on with it, it's just like a big black cloud over you.*

(Male, 30s)

Among the employer sample, there were also people who noted that an employee might lack the necessary insight into their condition to talk about it with others at work. Some employers recounted instances where an employee was, in their view, clearly evidencing a mental health condition, but was thought by the employer to lack insight about the condition, or to be unwilling to admit or discuss it. For example, one employer said of an employee, who later received a clinical diagnosis for his mental health condition:

*His symptoms were paranoid anyway and when you say there's something wrong with them, they don't believe you. He thought it was a big ruse against him.*

(Human resources manager, large employer, manufacturing sector)

Other individuals attributed their decision not to tell others to feelings of 'shame' (or conversely, 'pride') or 'embarrassment' about their mental health condition, examples including people with alcoholism and depression. Some people recognised within themselves a 'stubbornness' to admit to difficulties managing at work or perceived that being open about their difficulties would be a sign of 'weakness', which led them to keep things to themselves. In some cases, this meant working hard to 'cover up' the impact that their mental health condition was having on their ability to manage in work, associated with people's commitment to their work and desire to perform well in their job. There were also people who perceived that, in their field of work generally, or their employing organisation in particular, there was a 'culture' which did not tolerate any type of health-related reduction in performance, be that for physical or mental health reasons. One study participant described how she had been issued a sick note but was then so worried about her employers' response to her taking time off sick that she continued to work without taking any sick leave.

The anticipated responses of employers or colleagues also influenced many people's decisions not to talk about their mental health condition at work. As has been noted in Chapter 2, stigma and misconceptions about mental ill health from people with limited experience or understanding was a factor in people's decisions not to talk about their mental health condition. Some people were concerned that mentioning a mental health condition would place their job at risk, if employers

thought they were not capable or reliable. Respondents in the employer sample also recognised that some employees would be fearful of revealing any mental health difficulties due to stigma and fear of what might happen to them as a result.

Some people talked about the negative reactions they might receive from colleagues, for example, thinking they were 'mad'. However, it was the perceived indifference to their mental health condition that led some people to keep this to themselves. Here, people explained that they did not expect that their employer would have cared if they were struggling in work, and would not have been open to making adjustments to their role or workload. This perspective is explored further in Section 3.4.1.

There were also people who said they had not mentioned their mental health condition at work because they had never been asked about it. One person, who worked for a company where employees each operated on a freelance basis, noted that there was 'no formal structure' for sharing such matters, even if he had wanted to seek support. Reflecting mainly on talking to colleagues about mental ill health, other people explained that their workplace was not the kind of environment where this kind of thing would be discussed. Some people talked about workplace atmospheres, such as male-dominated manufacturing sector settings, where there was little opportunity for or culture of becoming familiar with colleagues on an informal or more personal level. Others noted the transient nature of the workforce where they had worked, for example, being made up mainly of students. The implication was that individuals did not tend to develop the kind of relationships with colleagues where they might feel disposed to share their experiences of mental ill health. Again, there were comments that colleagues would not understand or show sympathy.

Where sensitive family or relationship issues underlay mental ill health, some people chose not to have these personal or private problems known in the workplace (although, as noted above, explaining such circumstances was a form of selective discussion of mental health difficulties adopted by some people).

Finally, there were some people who had not talked about their mental health condition in the workplace because they did not feel that it had any impact on their ability to carry out their work. Examples here included a person experiencing drug addiction, who felt able to perform well in his role when at work (though the effects on his punctuality eventually led to dismissal) and a person who found the demands of their job were manageable despite experiencing depression. However, some people in the claimant sample, who had not explained or discussed their mental health condition with their employer, said they had been dismissed due to aspects of their job performance, which they themselves recognised were related to their mental health condition. Thus, the consequences for people's employment of not talking about mental ill health at work may be severe.



### 3.1.3 Employer-initiated discussion about mental ill health

Where information about a mental health condition was not volunteered by the individual concerned, employers in the study group reported that there were sometimes other ways in which they became aware that a member of staff might be experiencing mental ill health.

Employers explained that, in some cases, a manager first became aware that one of their employees was experiencing a mental health condition during or after a period of sickness absence. Several examples were provided where an underlying condition was first indicated by repeated short periods of absence. Sometimes the nature of an employee's condition became evident only after they provided a sickness certificate from their GP. Most employers acknowledged that absence patterns alone did not provide sufficient grounds for making an assumption about an individual's state of mental health or possible substance abuse. In most cases, if certification was not required for a period of absence, it was argued that an underlying mental health condition would surface in some other way, if not through direct volunteering of information from the employee then through observable behaviours.

Employers in the study group reported that, where an employee did not tell someone directly about their condition or take any time off sick, the most usual way for mental ill health to become evident was through their behaviour towards other staff or in their work performance. This was particularly common in cases where the employer believed that an employee lacked insight into their condition. A number of employers said that they thought the (suspected) condition itself would perhaps prevent an employee from looking objectively at their mental health. When employers had spoken to an employee about the changes in their behaviour or performance, they found that in most cases the employee would eventually enter into discussion about their mental health condition.

Employers who had been in the position of dealing with an apparently unwell employee who was, in their view, 'in denial' had often been wary or afraid of addressing the issue, but had ultimately felt they had no other choice. As one personnel manager described an employee they had worked with:

*He was starting to show signs of psychosis or schizophrenia. He was still at work and in a position where he was leading others. It was very difficult because we had to say there is something wrong. He was very bitter, very annoyed. ... He only went off because we said 'There's an issue here'.*

(Personnel manager, large employer, manufacturing sector)

Some employers said that they had suspected drug and alcohol problems when an employee displayed unreliable behaviour coupled with hearsay that, for example, they were involved in criminal activity or had considerable debts. This presented particular problems for employers. They were understandably reticent about confronting employees with suspicions of illegal activity and believed that the employee was unlikely to admit to having a problem if indeed this was the case.

This was of particular concern to smaller employers who did not have drug and alcohol policies which would have given them a standard procedure to follow in these circumstances.

Echoing these employer experiences, some individuals in the claimant sample described how their mental health condition had become apparent to their employer, who had then approached them to talk about it, sometimes in the context of the effect it was having on their performance. Individuals' responses to this type of unprompted recognition by their employer included denial of a problem, acceptance of support that accompanied this recognition (see Section 3.4 below), but also in some cases a decision to leave the job rather than have their condition known about and supported in the workplace.

## 3.2 Impacts of mental ill health in work

In this section, we explore the impacts of mental ill health in work, both on the individual and on people around them in the workplace. As noted earlier, some people experienced a very sudden emergence or triggering of their mental health condition and stopped work immediately. Many people, however, experienced a gradual onset or exacerbation of mental ill health and continued in work for some time before this eventually led them to leave work or go off sick. Borrowing from earlier research on routes onto IB (Sainsbury and Davidson, 2006), this phase will be referred to as 'struggling on' in the following discussion.

In Section 3.1.2, we have already seen how some people experiencing some form of mental ill health adopt an initial strategy of struggling on, during which time they try to conceal their condition and the effects it has on their work from their colleagues and managers. People who had experienced a period of struggling on with a mental health condition while in work noted a range of ways in which their work had been affected, including impacts on performance, attendance, attitudes and behaviour. Employers also reflected on the impacts that an employee's mental health condition could have on their colleagues and line managers.

### 3.2.1 Impacts on performance

A number of people said that they had struggled in work because of tiredness or lack of energy. People related this to problems sleeping at night caused by anxiety conditions, to the side-effects of medication taken for a psychotic illness, or explained that tiredness or lethargy was a symptom of their depression. For some people, fatigue led to 'clumsiness' in work or problems with punctuality. Timekeeping was also noted by people with drug or alcohol addictions as something which suffered.

Another experience was problems in concentration. Some people linked this directly to their mental health condition, while others, whose mental health was being affected by situations outside of work (including drug addiction), explained that preoccupation with these personal circumstances made it difficult to focus on

their work. Some people had experienced acute episodes of their mental health condition while at work, such as panic attacks, which meant they had had to stop their duties temporarily.

Some people in sales or customer-service roles noted how they had begun to struggle to meet targets, which in some cases had led to fears that their job was vulnerable. Others noted how they struggled to manage tasks which had not been difficult in the past, could not 'keep on top of things', or began to make 'silly mistakes' as depression or anxiety increasingly affected them in work. As the following quotation shows, striving to maintain standards and meet expectations while experiencing mental ill health could be an immense challenge:

*It's very frustrating when you know you're not feeling well but yet, you know, somehow you're still managing to hit target and you're thinking 'You don't even know what I'm going through'. Well, you can't turn round and tell them, you don't want to tell them but you're thinking 'You don't really know what I'm going through and I'm still hitting target, how dare you put this kind of pressure on me'.*

(Female, 30s)

As will be discussed further in Chapter 4, feeling that they could struggle on no longer in work contributed to some people's decision to end their employment.

A number of people who had experienced depression used the word 'functioning' to describe their period of struggling on. As one person put it, 'you go along in a veneer of functionality'. It is also notable, however, that some people who had experienced depression had found work was helpful in providing focus and routine activity that kept their condition 'at bay'.

Employers also described changes they had observed in the performance of staff experiencing mental health conditions, including decreased productivity, poor work quality and, in service oriented environments, unsatisfactory customer service. As noted earlier, several employers said adverse effects on work performance was the way in which they first became aware of an employee's mental ill health.

### **3.2.2 Impacts on attendance**

For some people in the study sample, a mental health condition itself, or the associated tiredness, had led to intermittent short absences from work. People taking these occasional days off said that 'excuses' rather than real reasons were often given, for example, attributing their absence to physical illness. For some other people, mental health conditions had led to longer-term absences from work. These are discussed in more detail in Section 3.3.

Some employers held the view that certain patterns of absence were consistent with a drug or alcohol problem. While it was thought that, in general, mental health-related absence could arise at any time, it was argued that absences due to drug or alcohol misuse were more likely to be 'bunched', perhaps tagged onto a weekend or other prolonged periods when the individual was not working.

### 3.2.3 Impacts on behaviour and attitudes at work

Changes in their attitude towards work were noted by some people. Particularly among those who were experiencing work-related stress or depression, the increasing frustrations and pressures associated with their role had led some people to 'resent' their work, sometimes including the customers, clients or colleagues who were seen to be contributing factors. In a number of these cases, people recalled how when they had first taken up their job, they had very much enjoyed it, but over time, mounting pressures in (and sometimes also outside) work had meant they stopped taking pleasure in their work.

Among people experiencing anxiety conditions that were linked to their job, there were descriptions of severe anxiety attacks being triggered by the prospect of having to go to work, two people recalling having been physically sick on the journey to work. People also referred to loss of motivation, becoming more outspoken or intolerant or, in the case of one salesperson, becoming more 'ruthless' in her sales techniques, a characteristic which she did not like to see in herself. Some people noted that they became less able to manage their behaviour or reactions well when under pressure.

Respondents in the employer sample had encountered a broad range of mental health conditions by both type and severity, and described a diverse range of behaviours that they had observed among employees experiencing mental ill health. It was evident from employers' accounts that the same condition could have different effects on individuals' behaviour and performance at work. Some employers thought that some of the signs suggesting a mental health condition could just as easily be due to normal day-to-day variations in performance or mood. This could include quite subtle changes in behaviour such as an apparent inability to maintain conversation or make eye contact. With depression someone could merely appear 'down' or reduce the number of interactions with their colleagues. Erratic behaviour was another characteristic that employers associated with some common mental health conditions. Employers would find themselves unable to 'trust' the employee with simple tasks and often had an impression that the employee was not fully engaged in what he or she was doing.

Some employers had encountered situations where an employee's condition resulted in what they perceived to be a change in 'character'. For example, someone normally seen as easy-going might develop a short temper or become unapproachable, or an employee would generally act in ways which were reported by the employer as 'completely out of character'. There were also comments from some employers, in their view, the effects on workplace behaviour and performance of the medication taken for a mental health condition might be as much of a concern to the employer as the effects of the condition itself.

### 3.2.4 Impacts on work colleagues

Employers explained that the effects of mental ill health of a member of staff would be experienced differently by colleagues than by supervisory or line managerial staff.

There was a general agreement among the employers in the study that the main impact of mental health conditions was felt by colleagues. Periods of sickness absence, especially with no warning, would put pressure on all staff, who would often be required to absorb the workload of their absent colleague.

Some managers said they had experienced behaviour that was disruptive, distressing to other staff and potentially dangerous. A respondent at a catering company said that the working conditions in the kitchens could often become 'stressful' as a result of a combination of being short-staffed (which was common) and the physical heat of the working environment. This respondent had observed that some employees with what he suspected were mental health conditions could become very agitated in these circumstances. He had seen this literally result in 'pans flying around'. In cases where behaviour had been disturbing or aggressive, employers felt that it was only fair to offer colleagues an explanation. If unacceptable behaviour had occurred it was important to explain the circumstances under which it had been 'excused':

*It was about reassuring people and saying if [the employee] shows any sign of his behaviour changing, or becoming aggressive or bizarre then you need to tell us. Not because it's telling tales, it's protecting you and other people within the business. And protecting [the employee] as much as anybody as well. Once we'd spoke to them they were pretty much okay about it.*

(Deputy manager, large employer, manufacturing sector)

A number of employers referred to how an individual's colleagues would sometimes 'gossip' and discuss them behind their back. Employers usually said that they did what they could to prevent or stop this although they thought that it was often inevitable. Employers reported that, in some cases, the individual would be talked about as colleagues speculated about the nature of the condition and its causes. This in itself was usually perceived as harmless in that the individual concerned was not usually aware. However, several employers reported that 'a talking to' had been necessary in these circumstances to prevent gossip from becoming malicious or slanderous, or to prevent it from leading to bullying. That said, observations of colleagues could, on occasion, prove informative in building up a picture of someone's apparent confusion or eccentricity. On some occasions, colleagues were also able to provide useful information about how the person had been behaving outside work.

Some people in the claimant sample who had not discussed their mental health condition with their employer or colleagues felt that, looking back, people around them at work had probably noticed changes in their behaviour that indicated that they were not managing or were becoming unwell, for example, the way they reacted at times of pressure. One person who had worked in a senior role, and saw herself as being an effective and well-liked member of staff, felt that it was her colleagues' 'respect' for her that had kept them from mentioning any signs of her condition that they might have perceived.

However, some people noted that behaviours associated with their condition were probably not perceptible to their colleagues as reflecting mental ill health. For example, one person thought that his colleagues perceived him as 'unapproachable' because of his tendency to be quiet and solitary at work, but they did not know that he suffered from long-term depression and anxiety. Another person noted that her increasingly outspoken behaviour at work as she became more unwell was not wholly out of character, and so some people would have put this down to 'personality'.

### 3.2.5 Impacts on line managers

In some circumstances line managers found that managing an employee with a mental health condition could be very time-consuming and would place demands upon them which prevented them from giving due attention to their team as a whole. For example, one employer in a line management role described an ongoing situation involving an employee who had returned to work following surgery for a physical health problem. Since coming back to work the employee's mental health had been fragile. She had been tearful on several occasions and talked about feeling out of control, having no confidence, and generally feeling anxious about being back at work. The employee's mental health appeared to be aggravated by workplace interpersonal problems that were already evident before her absence. The line manager had made a considerable effort to respond in a sympathetic manner, but found she had to spend a large proportion of her time on this employee:

*One thing I'm aware of is that I spend a lot of time supporting her, which I then don't give to other people. Particularly the regular one to one thing I should be having and strive to have regular one to ones, weekly one to ones with my team members. It generally happens that she's the only one that is set in stone. I should push myself to see the other people more, but she gets more of my time than most people do, and she certainly takes up more of my time when I'm talking to other people about her.*

*(Line manager, large employer, healthcare sector)*

There were accounts from employers of several situations where line managers appeared to be out of their depth or to have become 'too involved'. Where they had invested a significant amount of energy in a particular person, but the situation did not seem to be improving, this could be very demoralising. However, in situations where line managers had the support of other professionals within

the organisation this could reduce considerably the potential negative impact of managing an employee with a mental health condition, for example through providing practical advice, support, and an opportunity for debriefing if necessary. Returning to the example given above, this line manager had sought assistance from the organisation's human resources and occupational health department, which had been helpful:

*In a way being able to say 'I am referring you to Occupational Health' gave me something I could do that was an action for me to do, rather than just me trying to make things better. It gave me as her manager a tool to be able to say I am proactively trying to help you and this is one of the things I'm going to do. It was a good escape and a release valve for me to be able to refer her there.*

(Line manager, large employer, healthcare sector)

### 3.3 Absences and absence management

This section describes experiences of absences from work due to mental ill health, from the perspectives of people with mental health conditions and employers who had a role in managing such absences and supporting returns to work. This section focuses on accounts of sickness absence where people did return to their job, at least for a time. Absences which culminated in leaving work permanently are considered in Chapter 4.

Not all of the cases of mental ill health described in the research interviews (by employers or employees) had resulted in absence from the workplace. However, a small number of people in the claimant study group had had one or more periods of absence from work, prior to leaving their job eventually. These periods of sickness absence ranged from a week to three or four months. As noted earlier, there were also individuals whose mental health condition had caused them to take occasional days off work, but who had given a different explanation to their employer, for example, physical illness.

The first subsection considers the perspectives of individuals who had taken one or more periods of sickness absence due to mental ill health, including the responses they received from their employer, contacts maintained with work during this time, and how the return to work was managed. The second subsection considers these matters from the perspective of respondents in the employer sample. The role played by employees' General Practitioners in advising on sickness absence and returns to work is considered later, in Section 3.6.

### 3.3.1 Employee experiences of absence and absence management

In one of the isolated examples of someone who had mentioned a long-standing mental health condition when applying for their job, this person said that his occasional absences due to mental ill health were treated considerately by his employer. While he did not feel that any particular support had been offered, he felt his employer was sympathetic to his situation: 'I wouldn't go so far as to say they helped me, you know, they were just understanding why I needed time off'.

Among people whose mental health condition had emerged some time after taking up their job, there were mixed experiences of the nature and level of involvement of their employer during their time off sick. Some people had not had any contact from their employer during their absence while others had been contacted by a manager to see when they were planning to return to work. For some people, this had made them feel pressure to 'get myself sorted and get back'. The intangible nature of mental ill health was again noted here, in that it was felt that it was perhaps difficult for employers to be sympathetic to an illness that they couldn't 'recognise'. However, as already noted, some people perceived that their employer had little tolerance for sickness absence of any kind, be it due to physical or mental ill health. In contrast, some people had found their employer supportive during their time off. For example, one person had remained in contact with his employer during his initial three-week period of sick leave, and described his manager as being sympathetic to his need to extend his period of time off work when it became apparent that he was not yet ready to return to work.

Aside from perceived pressure from their employer, people had also been motivated to go back to work for reasons including concern about the workload of others at work, and feeling that they did not want to fall behind with their work or lose their connection to projects they were involved with. Recalling the discussion of 'struggling on' in work, themes of strength and weakness were again evident as people described their decisions about returning to work. As such, some people recognised that feelings of 'pressure' to return to work came from within themselves as much as, if not more than, from their employer:

*They never sort of said your job's under threat or anything, and I suppose I put pressure on myself because the project was important to me, I knew we had deadlines to meet.*

(Female, 30s)

*I tried to go back the next day because I just - you don't want to admit those things do you? You don't want to like, it's almost like admitting you're weak or something, that you can't handle things, so yeah, I forced myself to go in.*

(Female, 30s)



Some people's descriptions of their absence and return to work experiences reflected a 'managed' process, sometimes with involvement from occupational health services. Some had returned to their job on a reduced number of hours initially, which they had found helpful. (Among those who had ultimately not returned to their job, there were also people who said that their employer had suggested a phased return.) One person, who had been off work for three or four months with anxiety, described a process of monthly occupational health medicals while off sick, and a gradual return to full-time work and adjustments to his duties for the first year. Although he felt that his employer had largely followed this procedure to 'cover their own backs' he appreciated the support that was offered and had found it helpful. Other experiences of occupational health involvement were less comprehensive, some people explaining, for example, that they had only been given phone numbers for helplines or telephone counselling. Perhaps unsurprisingly, people who had had involvement from, or were aware of, occupational health services, tended to be those who worked for larger employers, for example, national or international companies and public sector organisations such as schools, universities, local authorities and health services.

Some people did not feel that any particular actions or adjustments had been made to support their return to work. In some cases, people had subsequently become aware that there were 'return to work' procedures that had not been followed in their own case. However, in some cases, people's accounts suggested that their employer had not been fully aware of the reasons for their absence. This potentially explains some of the variation in people's experiences of return to work support and has implications for employers' ability to respond appropriately.

### **3.3.2 Employer experiences of absence and absence management**

Turning to the employer perspective, when an employee did take time off due to a mental health condition, most respondents in the employer sample explained that they would try to keep in regular contact with the employee and generally would apply the same principles they would use if an individual was absent due to a physical condition. Many medium-sized and large employers had formal policies setting out procedures for managing sickness absence, such as keeping in contact with absent employees, conducting return to work interviews and implementing phased returns. These policies did not, in the main, make explicit reference to mental health conditions.

In some cases, employers reported that it would be difficult to keep in touch with the absent employee themselves, and that flexibility would be needed. For example, a line manager described that when an employee with bipolar disorder experienced severe effects of medication and needed to take time off work, he would keep in regular contact with the employee's wife instead. On occasions, during acute phases of his illness when he was unable to attend work, this employee's sleep-wake cycle could be erratic and he was not always able to notify his manager about his absence or keep in regular contact. The company were able to apply their absence policy flexibly in order to manage this situation:

*In the absence policy, what is supposed to happen in instances of sickness from work is the individual is supposed to ring their line manager. However, under the circumstances we do make an allowance, it is fine for his partner to ring rather than him, and he is aware of that.*

(Line manager, large employer, financial sector)

As well as this flexible application of the absence policy a number of other adjustments had been made to this individual's role, including changes to working hours, job role and the nature in which he communicated with his colleagues. The line manager interviewed believed that this approach had contributed to a reduction in the level of sickness absence taken by this particular employee.

Many employers thought that it was often in the employee's best interests to get back to work as quickly as possible. They believed that it was important to prevent short-term periods of absence progressing into the longer-term, after which they thought that crossing the threshold into the workplace might become a major psychological barrier. Some employers made the point that employees experiencing difficulties in their personal lives could benefit from the camaraderie and routine provided by a supportive work environment, and that long-term absence could increase the sense of alienation and helplessness commonly associated with many mental health conditions.

Most workplaces, regardless of size, routinely used phased return as a way of easing the transition from a period of absence to full-time work. Many combined this with restricted duties. This was particularly common if a particular task was associated with the development or exacerbation of the mental health condition in question. In small companies a return to work plan would normally be agreed informally with the employee. In larger companies a more formal plan would be put together with the advice of an occupational health specialist. In most cases the plan would be under regular review and behaviour would be closely monitored to check that returning to work was not affecting the person adversely or, in some more extreme cases, to ensure that the employee's presence was not affecting the workplace adversely.

Several employers stressed the importance of regular meetings, often at pre-set milestones which would allow the employee (in consultation with occupational health) to accelerate or slow down their return to their normal working pattern according to their progress. But it was seen as important to make such changes only after careful consideration, rather than simply at an employee's request, in order to prevent a potential relapse.

*Sometimes we will have people who will say I know I said I wanted to do this for six weeks but actually I want to accelerate it, I feel fine. But we wouldn't agree to that without going back through the occupational health route.*

(Human resources manager, large employer, manufacturing sector)

Several of the well-informed employers highlighted the co-morbidity of some mental ill health conditions, such as depression, with some physical conditions. They felt it was important to enable assisted return for employees who had been absent with chronic pain conditions such as back pain, to minimise the risk of depression setting in due to inactivity and isolation.

### 3.4 In-work adjustments for employees with mental health conditions

This section describes the ways in which employers responded in supporting and managing staff where they became aware of experiences of mental ill health in work. Looking first at the employer data, it considers overall attitudes towards and views on the feasibility of making adjustments for staff experiencing mental health conditions. The range of adjustments to roles and work conditions made (or considered) by employers in the study group are then outlined, where possible with examples and reflections on how effective these were perceived to be. Next the range of individuals involved in responding to and supporting individuals in work with mental health conditions is outlined. The final subsection turns to the experiences of people in the employee sample. It presents the reflections of people for whom adjustments had been made in work and also considers more hypothetically the extent to which people felt adjustments could or should have been made for them when in work.

The role played by formal policies and legislation (namely the DDA) in responses to employees with mental health conditions is considered later in Section 3.5.

#### 3.4.1 **Employer perspectives on making adjustments for employees with mental health conditions**

Across all 40 employers, a wide range of adjustments were described to allow employees with mental health condition to return to or remain in work. Examples of the different types of adjustments made (discussed ahead in more detail below) included alterations to the hours or pace of work, changing elements of the role or job conditions, and training or redeployment. A number of employers had funded counselling or anger management courses.

There was a generally positive attitude towards making adjustments regardless of employer size and sector, although it became apparent that some job roles were more amenable to adjustment than others. For example, job roles involving a range of different activities were often easier to adjust than those which concentrated on a single task. Some roles involved relatively inflexible working systems including fixed shift patterns, or a specific number of people were needed to work in a team to operate a piece of machinery, and it was often more difficult to make adjustments in such cases. In general, the research evidence suggests that larger companies were able to be more responsive and more flexible.

Employers were usually more inclined to support longer-serving employees to remain in work than new recruits. However, the employers in this study were generally well-disposed towards making adjustments for existing employees, even if they had joined the establishment fairly recently. A few contrasted this with what they would be prepared to do to accommodate a potential recruit, as in the example below:

*I think we would have been much more ready to talk about adjustments for people who already worked in the business who underwent some change in health status as opposed to someone presenting for a job interview.*

(Human resources manager, large employer, manufacturing sector)

This view conflicts with the requirements of the DDA to make adjustments for people at recruitment, and to enable them to take up work, as well as for people already in employment. However, it is in line with other research which has found that employers were better disposed towards making adjustments for people who became ill or disabled in post, rather than for people at the recruitment stage (for example, Aston *et al.*, 2005).

Most employers did not see the type of adjustments that could enable a person with a mental health condition to continue working as particularly difficult to implement. Respondents rarely mentioned consulting formal policies when making decisions about adjustments but made adjustments based on the individual's circumstances. Normally adjustments (and some aspects of absence management) would be made in consultation with the employees themselves. Some pointed out that they required the employee's co-operation to put suitable adjustments in place. In other cases, measures outside normal organisational practice were not necessary, and applying principles such as flexible working and allocating tasks according to individual's strengths and weaknesses would suffice.

However, some employers highlighted some important factors that were specific to mental health conditions, including their potential 'invisibility' to other staff. They pointed out that, while colleagues would probably appreciate why adjustments had been made to allow a person with mobility problems to continue working, they might misunderstand why adjustments had been made for a colleague who appeared outwardly to be without any impairment. An example was given by an employer of a situation where colleagues had adjusted well to managing without a member of staff who had been absent due to mental ill health, and some did not respond well to this individual coming back to work. As part of the adjustments made to facilitate the employee's return, she had been relieved of some of her duties, and this also contributed to existing tensions. Despite some useful support from the occupational health service, the line manager was finding day-to-day management of the situation very difficult and was struggling to engage the employee's colleagues in supporting and understanding the situation.

Tension between confidentiality and making adjustments that would be noticeable to other members of staff were also highlighted. Employers appreciated that some

employees would not want their colleagues to know about their mental health condition. However, this presented a problem for employers whose employees might be wondering why a member of staff was not carrying out the full range of their work tasks or why they were taking extra breaks. Sometimes resentment could arise. This was particularly problematic in a shop-floor environment where any changes in the behaviour of workmates could be easily observed. One of the engaged employers commented on this:

*How do you show care and concern with the person and work with them to remedy the situation, if they don't want it declared? By definition the treatment they're getting is special. That's very difficult, particularly with mental health.*

(Human resources director, engaged employer, large, financial sector)

Consequently most employers cited the biggest barrier to implementing adjustments as dealing with the reaction of other staff. They felt that this had to be carefully and sensitively handled.

Another challenge noted was that, when mental health conditions became apparent through adverse impacts on performance, employers were not always sure whether to deal with these changes as matters of performance management or as consequences of a health problem. Their ability to respond appropriately to this type of problem was hampered by the degree to which they were familiar with the employee in question. With relatively new employees, it was more difficult to determine whether a decline in performance simply indicated unreliability, a particular 'quirk' or some other (non health-related) problem. There was a view that it would take very close scrutiny to determine whether unsatisfactory performance was due to a mental health condition. In most circumstances employers said that they needed to feel fairly confident that mental ill health was relevant, before involving health professions or implementing health-related company policies.

The perceived benefits of making adjustments were naturally dependent on the outcome. Many employers focused on the business case for adjustments and saw the principal benefit as retaining a valued member of staff who might otherwise have been long-term absent, or might resign. In circumstances where staff had highly valued skills or a long-standing relationship with an employer this was more highly emphasised, not least because of the investments that employers had already made in these employees.

Many employers also spoke of personal satisfaction when adjustments had proved successful. The engaged employers and some of the other large employers would often mention the importance of being seen as advocates of good practice and prided themselves on having a 'progressive' approach to mental health conditions. Another benefit of making adjustments was in complying with legislation, although few employers said that legislation was the main or only reason for their practices and responses.

### **3.4.2 Types of adjustment made by employers for staff with mental health conditions**

Employers described a range of in-work adjustments they had made in order to help people with mental health conditions continue in their job. In cases where employers had limited experience of making adjustments, their willingness to make adjustments was explored in the research interviews using a showcard which provided a list of examples.

#### **Altered working hours**

Most employers were able to accommodate some degree of flexibility in working hours. Reducing hours had been used by most employers, sometimes during phased returns after sickness absence (discussed earlier in Section 3.3). Some employers held the view that flexibility was important generally, not just in managing mental health conditions.

In some workplaces, rotas had been arranged to allow staff with mental health conditions to work at less busy times or shifts when it was easier to monitor them more directly or to 'keep a discreet eye on them'. It was more difficult to implement this in some sectors than others. For example, changes in hours were not always possible in a production line environment, which required the presence of several people simultaneously on one task. Also, adjusting an individual's working hours could make it difficult for employers to find sufficient cover during particularly busy times, potentially putting pressure on other staff. This particularly applied in the service sector.

Altering working hours was also found to be an effective way of accommodating the side-effects of medication. This was particularly important where jobs involved shift work and many employers thought that it was helpful for an employee to have a manageable routine in these circumstances. For office-based jobs it was easier to implement changes to working hours, as roles tended to be more autonomous. It was usually possible to accommodate an employee's preference to work at certain times of day if, for example, they found it difficult to work during noisy or busy periods. In an example from a small employer, when one employee had appeared 'frenzied', his line manager offered him the opportunity to come in and work at quieter times when there was less demand upon him.

#### **Altered pace of working or altered breaks**

Most employers believed that mental health conditions were likely to have a temporary effect on an individual's work output, rather than a long-term or permanent one, and many had shown willingness to accommodate this. In some cases performance targets had been adjusted to allow for slower pace of working or poor concentration. This was, for example, an important adjustment for an employee with obsessive compulsive disorder, while he went through a phase of double-checking every task he completed. In some cases, when a condition was long-standing, employers were prepared to accept a degree of variability in performance on an indefinite basis, 'so long as the job got done'.

However, many employers thought it would be difficult to implement longer or more frequent breaks. Several thought that this could present difficulties with colleagues, and particularly if they were unaware of the employee's condition:

*Longer and more frequent breaks we'd have to be careful about. I haven't tended to do that ... going back to this issue, we're not telling work colleagues that a person is suffering from that particular condition, so why are you giving her a longer break. You're making them obvious.*

(Human resources director, engaged employer, large, financial sector)

### **Changing elements of the job**

A variety of changes to the structure or content of jobs had been introduced to assist the retention and return to work of employees with mental health conditions. In some jobs, elements could be temporarily (or in some cases, permanently) removed if an employee found certain tasks particularly stressful. This might include social elements of a job such as travelling or meeting clients or elements involving face-to-face contact with the general public. In one factory setting, employees were offered roles that were less machine-dependent (and therefore less time-pressured) while they were recovering from illness. However, one manufacturer commented that their ability to provide this option was limited by the increasing mechanisation of many processes in their factory. At another employer, an employee with some signs of psychosis was observed talking to a piece of equipment. When concerns were raised about this, various safeguards were put in place to allow him to continue working. Access to hazardous substances and electrical appliances was removed so that it was possible for him to work without supervision.

### **Working from home or altering the work environment**

Working at home was an option only in some roles and sectors. More than one employer reported that this arrangement 'had not gone down well' with other staff. They were also wary of setting a precedent.

Several employers highlighted the fact that open-plan working hindered opportunities to make changes to the individual's work environment. This made it difficult to adjust working arrangements for employees' whose mental health condition made it hard for them to cope with distraction or face-to-face contact with large numbers of people, although this difficulty could, in part, be addressed by adjusting working hours of the individual, or by allowing them to work at home. Those working within the catering sector highlighted heat as an environmental factor that could be difficult for people suffering from stress. Some employers had accommodated this by moving staff to work in refrigerated areas.

### **Providing training**

Anger management was the most commonly reported form of training offered in direct response to an employee's mental health condition, usually those which manifested in aggressive or agitated behaviour. Other courses, such as stress

management or coping skills had been offered only in a handful of instances. Some employers had provided staff with training in job-specific skills as a means of increasing confidence. One-to-one training, done in such a way that an employee's difficulties were not drawn to the attention of other colleagues, could be helpful in allaying anxiety about particular tasks.

### **Counselling and therapy**

Many employers had allowed, or said they would allow, time off for counselling or psychiatric appointments. Many of the engaged employers, and some of the other large employers had private healthcare or an Employee Assistance Programme. The latter tended to offer over-the-phone support but could also refer an employee to face-to-face counselling if appropriate. Several employers had paid for courses of cognitive behavioural therapy (CBT) for employees. In some cases this was to avoid the long waiting times within the NHS for this type of treatment. For GP referrals to CBT, waiting lists of between six to 18 months were reported, and this was perceived by some employers as a significant barrier to return to work.

### **Redeployment**

Many of the employers interviewed commented on the desirability of redeploying staff but had found this difficult to put into practice. Most employers were not in a position to 'create jobs' to meet specific employees' requirements. Redeployment was a stronger possibility for larger employers, particularly if the employee was also able to be flexible on, for example, hours or job location.

### **Providing informal support**

Not all adjustments mentioned involved tangible changes to the employee's job, particularly those that were more informal. In one company an employee was encouraged to approach occupational health directly at a moment when she felt she might become visibly upset – 'when she was about to burst into tears'. This served to protect the employee's manager from situations that might make him feel uncomfortable, as well as protecting the employee herself. Another employer adapted to an employee's volatile state by encouraging them to 'have a chat or a cup of tea' in situations when there appeared to be tensions with colleagues.

In another example, a human resources manager talked about an employee with a mental health condition described as 'extreme', who found it difficult to accept change. The employee was off sick for a period of time and his duties were restricted to enable his return to work. He had never resumed his full role and the employer was still gradually building up his duties. They had an agreed process to go through with him if they needed to change something about his job, and changes were always introduced slowly. These efforts were complemented by colleagues being generally supportive:



*People will tend to try and encourage him to get involved in things. They may suggest, if it's been a busy day, that they all have a coffee break or they will all go over and have lunch together, really to keep him involved. Or they will try and engage him by just talking so that he doesn't have the opportunity to withdraw into himself.*

(Human resources manager, large employer, manufacturing sector)

Informal ways of identifying potentially problematic situations (with colleagues, or customers, for example) for an employee with a mental health condition and preventing them from escalating, were commonly described in smaller companies and environments where it was relatively easy to 'keep an eye' on the person concerned. Unconventional forms of support could sometimes be highly effective. In one case an employee who was prone to bouts of manic behaviour requested that her manager used a code word to indicate when she was acting unusually with colleagues. This proved successful in helping her gain some insight into her behaviour and recognising when she should seek support.

Whilst these arrangements may not be considered 'adjustments' under the DDA, employers argued that they could, nevertheless, prove effective responses and helpful in managing the impact of employees' mental health conditions.

### **3.4.3 Individuals involved in supporting employees with mental health conditions**

A variety of actors contributed to the organisational response to mental health problems at work. In large employers this typically involved a range of staff including occupational health and human resources professionals, as well as the line manager of the employee concerned. As they were more likely to have formal systems and policies in place, larger employers would generally respond in a more structured way, often following a set referral process. In smaller employers a more ad hoc approach was adopted.

Groups or individuals outside of the employer organisation were also sometimes involved in responses or support strategies put in place for people experiencing mental ill health at work. Employers in the study group talked about contact with and involvement from mental health organisations and the families of the employees concerned.

The roles played by these different actors in supporting employees with mental health conditions are outlined in the sections ahead. (The role of GPs is given separate consideration in Section 3.6.) Data in this section draws primarily on the responses of the employer sample.

#### **Line managers**

Respondents in the employer sample reported that line managers were always involved at some level in the organisational response to the mental ill health of an employee. In smaller employers there were occasions where line managers took

action in isolation. There were also examples of circumstances in larger organisations where line managers would intervene directly in relatively challenging situations without seeing a need to involve the occupational health department, especially if they felt adequately supported by other means.

However, there was also evidence that line managers had struggled to deal with cases on their own. There were several examples from small and medium-sized employers, where managers had made a considerable effort to understand and accommodate erratic behaviour. Managers found it frustrating when their efforts did not bring about an improvement, and were often at loss to know what course of action to take next. In cases where difficulties had not been resolved over a long period of time, some employees had eventually been dismissed, or had left their job (discussed further in Chapter 4).

### **Human resources staff**

Many of the respondents interviewed in medium and large employers were human resources professionals, most of whom had a key role in dealing with mental health conditions at their place of work. Often they believed that their approach was more benevolent and more informed than was the case among some of their line managers and other senior staff. Many saw themselves as drivers of change, with an active agenda to try and change perceptions within their organisation.

Human resources would often be the first point of contact for line managers seeking support for one of their staff with a suspected mental health condition. In general, where in-house or externally contracted occupational health professionals were available, human resources would initiate the referral, although referral processes varied between employers.

### **Occupational health staff**

Occupational health provision of some form was provided by most of the large employers, but few of the medium-sized or small employers had access to this. Where occupational health services were in place, they were brought in routinely in cases of extended sickness absence regardless of cause. Referrals to occupational health were usually made through human resources, although in some cases individuals were able to access occupational health support via their line managers or through self-referral. In general, occupational health staff would see the employee concerned as early as possible (and possibly liaise with the employee's GP) in order to obtain an accurate picture of their condition. The occupational health specialist would then directly advise human resources and/or the employee's line manager on suitable adjustments. In cases where sickness absence had occurred, occupational health would be closely involved in the return to work process, reviewing progress and advising on the employee's fitness to return to normal duties.

## Outside organisations

There were only a few examples of employer contact with other organisations, for example, external mental health experts, charities or interest groups. However, a number of the small and medium-sized employers said that they would go to the voluntary sector, including charities and special interest groups if they felt they needed advice on a situation they were finding difficult to handle. Unlike the larger employers, including the engaged employers, smaller employers did not usually have recourse to occupational health or other health specialists in-house, and they usually lacked on-site expertise as a result. However, one large employer with an occupational health department had turned to an external organisation when it became clear that more specialist input was needed. In this organisation there was confusion as to whether some behaviours observed in a member of staff were signs of a learning disability or a mental health condition. A local charity was asked to intervene and was able to direct the employee towards his GP. One of the engaged employers had consulted with voluntary sector organisations, including the Shaw Trust, to get help with its recruitment practices (mentioned earlier in Chapter 3).

## Employees' families

There were some cases where an employee's relatives played a part in an employer's response to the emergence of a mental health condition, often where the affected employee had a relative working on the same site. In these circumstances, the employee's family usually became involved by default, but they were able provide useful input by helping the employer to understand the condition and formulate an appropriate response. In several other situations, an employee did not have family working for the same employer, but their spouse, partner or parents had alerted the employer about relapses or recurrence of a long-standing condition. Again, they were often able to advise on measures that would help. Employers had appreciated this involvement in times of crisis, but several were unclear where their responsibilities lay in relation to protecting the confidentiality of their workers. In one example, a large financial company had employed an individual with bipolar disorder for a number of years. His line manager would routinely liaise with the employee's partner to gain information about his condition. This employer believed that the support the employee was receiving outside work was a factor in determining his recovery and return to work. Another employer provided a noteworthy example of an employee's support system extending beyond the workplace and family into the wider community:

*If he doesn't turn up for work on time or if he's agreed to do some overtime and he doesn't come in they've kind of got a way of phoning somebody who lives next door or down the road who'll go and bang on the door and get him out of bed and they'll check to see he's taken his medication.*

(Human resources manager, large employer, manufacturing sector)

Among the employee study group, there were very few reports of any contact between family members and employers with regard to their mental health. This may, in part, be a reflection of the finding that relatively few people talked in detail with their employer about a mental health condition before leaving their employment.

#### **3.4.4 Employee experiences of in-work adjustments**

As noted earlier, among the IB sample, most people had not told their employer about a mental health condition until some point at which it began to affect their ability to manage in work, and some had not shared their difficulties until the point at which they departed from work. Therefore, there were few examples of adjustments being made to a role while still in work. However, one person who started a new job soon after a traumatic event in her personal life, which had triggered a mental health condition, did explain her circumstances to her employer, who agreed to arrange her shifts around her family commitments at this time. As he began to struggle in work, another person had been able to negotiate informally with his line manager to be allocated shifts that were more manageable around his depression. However, this arrangement could not be made in the long term, because the needs and preferences of other colleagues also had to be taken into account in allocating work.

In one of the more detailed examples, a person whose mental health condition had become apparent to her employer through changes in her performance and behaviour at work, had been offered a number of adjustments to her role, including changing some of her duties and receiving additional support. The sympathetic and supportive approach of line managers was, in itself, also seen to be helpful. There were also a small number of other cases where people had been offered additional support in their role, for example, an assistant to relieve some of their workload. Another person, whose mental health had mainly been affected by job stress, described how he had spoken with his line manager about possible changes in his role, but had concluded that ultimately there were fundamental and unchangeable parts of the job that were unmanageable for him, and so he had decided to leave.

Given the very small number of people who had remained at work after others had become aware of their mental health condition, there was little data on the more general workplace responses to the awareness of a colleague's mental ill health. What examples there were showed that concerns about stigma were sometimes, but not always realised, and that different colleagues could react in different ways within the same workplace. For example, one person received positive support from her line manager and more senior staff but had simultaneously received insensitive comments from a close colleague and was aware of 'gossip' among other staff.

In responding to more hypothetical questions about what adjustments could have been made to their role, some people described how their line manager, or employer as a whole, was entirely focused on targets, profit or productivity and that they would have little sympathy or inclination to make accommodations for somebody who was not able to meet the expectations of the role. Linked to views noted earlier, that managers or organisations had little tolerance for employee sickness of any kind, there were also suggestions that such employers would prefer to 'let people go' than take steps to retain employees who were not able to perform to full capacity. People working on a freelance basis, or via employment agencies also noted that, if the individual could not manage the work, the employing body was more likely to move on to a more capable individual than to dedicate resources to supporting somebody who was struggling.

Notably, some people did not see these employer attitudes as especially unreasonable. There were comments that employers could not be expected to retain people who were frequently absent or could not cope with the full demands of the job, and some people did not think that there were any adjustments that could have been made to their job, had this possibility been raised:

*At the end of the day, it's a job and, you know, they can't say 'Oh we'll let you off because you're not well' you know, they need someone who's gonna be there, turn up on time, do the work, do you know what I mean?*

(Female, 20s)

*I guess they could have done more but then in a sense how can they? They've got a budget to meet and they're responsible for that budget, they can't give me any leeway, I either hit the budget or I don't. Sales is not the job to go into if you're stressed, there is no, they can't give you any leeway apart from giving you a P45.*

(Female, 30s)

Some people gave the view that there was more likelihood of adjustments being made if you worked for particular types of employer. Larger employers who had greater financial resources and 'support networks' in place were felt to be more willing or able to support the needs of people with mental health conditions, in that adjustments could be made and lower productivity among some staff could be accommodated. Public sector employers were also cited as having better equal opportunities policies on recruitment and more supportive approaches to people experiencing health problems at work.

### 3.5 Employer policies and the Disability Discrimination Act

This section begins by briefly considering the policies that employers in the study group had in place that had some relevance or application to employees with mental health conditions. The second and third subsections considers in more detail employers and employees understanding and awareness of the Disability

Discrimination Act (DDA) and the salience it was felt to have for individuals experiencing mental health conditions while in employment. (For a summary of the DDA and mental health conditions, see Chapter 1.)

### **3.5.1 Employer policies**

Employers mentioned a range of policies which had some bearing on mental health including absence policies, equal opportunities policies, health and safety policies and also those dealing with harassment, bullying and unacceptable behaviour. In general, policies were tailored to individual business needs with different emphases on various factors according to the nature of the work carried out.

The extent to which policies were in place was typically related to the employer's size. Medium-sized employers usually had a less rigorous approach than large employers but recognised the value of set down procedures. Most small employers responded to instances of mental ill health in the workplace as and when they occurred and were less likely to have formal policies in any of the relevant areas. Respondents in the employer sample were rarely aware of the details included in their organisation's policy documents, even where they existed, and were not always able to say whether they specifically mentioned mental health conditions.

Public sector employers and large private sector employers tended to have comprehensive disability policies which made reference to adjustments that could be made. Not all employers had a policy on disability but most were aware to some extent of their statutory obligations under the DDA. However, few employers referred to the DDA spontaneously when talking about mental health conditions. This is discussed further in the next section.

Few employers spontaneously referred to mental health as a health and safety matter, although some larger employers had policies designed specifically for dealing with or preventing stress at work. A handful of employers mentioned the Health and Safety Executive (HSE) Management Standards and some of the areas identified in these such as pressure, workload and support. These had contributed to their understanding of managing some mental health conditions in the workplace. Those working for smaller employers, while aware of the link between stress and mental health, rarely mentioned this in the context of managing health and safety. As noted earlier, where organisations had absence management policies, these rarely made specific reference to absence due to mental ill health.

Some of the larger private sector employers had policies specifically dealing with drug and alcohol misuse. These were typically multinational companies with the resources to support employees through the process of cessation of use and rehabilitation. In contrast, some companies had a 'zero tolerance' policy towards any kind of illegal drug use. An employer in the business and private enterprise sector approached drug and alcohol problems in a manner that was distinct from their generally sympathetic approach to mental health conditions. They did not see employment of people with drug and alcohol problems as consistent with the 'family environment' that they wanted to encourage, and admitted to having an uncompromising approach to staff using illegal drugs:

*Instant dismissal for drugs on any of our premises. No discussion. ... There is a three-step policy in reference to alcohol abuse. Drug abuse zero. Alcohol there's a consultation, then a written warning. The written warning is followed by you need to seek help. Then it's a follow up of have you done that? AA [Alcoholics Anonymous] if it continues then it's instant dismissal.*

(Managing director, medium-sized employer, business and private enterprise sector)

In contrast, a large private sector employer had a drug and alcohol policy which aimed to support affected employees to recover and remain in work. They sought to encourage a culture in which employees would feel able to disclose drug or alcohol problems and saw the disciplinary route as a last resort:

*Drugs are something we see very little direct evidence of. On the other hand, particularly in the young, it's a normal part of life. We don't do any form of random screening. We do have a drug and alcohol policy and our aim is where possible to support people who either self identify, or identify in a way we can salvage the situation, support them and help them deal with the issues and stay in one place.*

(Head of health services, large employer, transport sector)

At the same time, the company took a strong line with employees reporting for duty under the influence of drugs or alcohol and would treat this as gross misconduct.

Other than these 'zero tolerance' policies on substance use, there was a general consensus that policies provided a framework for good practice as opposed to a strict set of rules that should be followed. Policy documents tended to be consulted when other options had been exhausted. Employers generally thought that they needed to respond flexibly to mental health conditions to reflect individual circumstances. Interestingly, some employers expressed reservations about developing policies specifically for mental health as they considered it unhelpful to label people.

### **3.5.2 Employer awareness and views on the DDA**

This section explores employers' and employees' awareness of the DDA and their understanding and perspectives on how it applies to mental ill health conditions. Brief mention is also given to public sector employers' perspectives on the Disability Equality Duty (DED).

Awareness of the DDA was generally high amongst large employers, and this (alongside the DED in public sector employers) served as a backdrop to what the majority of large employers said they did. Public sector employers and large private sector employers who, as previously noted, tended to have comprehensive disability policies, also often had some awareness that recent changes to the DDA had potentially expanded the range of mental health conditions that it covered. A few of the large employers spontaneously mentioned the DDA (particularly the

duty to make reasonable adjustments) and related it to dealing with mental health conditions in the workplace, but most talked about the DDA in relation to mental health conditions only when prompted.

As might be expected, the engaged employers had a high level of awareness and understanding of the DDA. The engaged employers, and some of the other 'aware' large employers believed that the DDA represented a minimum standard for accommodating disabled people and people with mental health conditions. Most of these 'aware' employers said that their practices went beyond what was required under the DDA. One engaged employer mentioned that recent amendments to the DDA on the provisions for mental health had led to the inclusion of mental health in their disability policy. Some employers expressed the view that it was prudent to treat every case as a potential DDA case.

Awareness of the DDA among medium-sized employers varied, with some having fairly high levels of awareness and others being far less aware. Among small employers, awareness of the DDA was fairly low, and they had rarely thought of how the DDA might apply to mental health conditions.

There was some confusion amongst employers about the extent to which mental health conditions are classed as a disability under the DDA. For example, a small employer thought it was only clinically-recognised mental health conditions which would be covered. Among the engaged and large employers, there were also examples of uncertainty about exactly how mental health conditions were covered within the DDA:

*With mental health conditions it's difficult. You're probably not blind or deaf, you're not in a wheelchair, you are able to drive, you're probably not at this point taking medication. You're fit. Very difficult to categorise that within the DDA although I'm sure it must be there.*

(Human resources manager, large organisation, business sector)

*It's probably not clear to everybody how mental health conditions are covered by the DDA. I think I'm all right but then I would because it's my duty. People are getting better about it, but I think a little more information wouldn't go amiss.*

(Engaged employer, large, primary and manufacturing sector)

There was some lack of clarity about what constituted a 'reasonable adjustment' for someone with a mental health condition, even among employers who had a good understanding of the DDA. The point was also made by some respondents in senior positions that while they had a good understanding of the DDA, their line managers were likely to be less well-informed. Some of the more 'aware' employers made the point that the DDA covered physical disabilities in more detail than mental health conditions. One engaged employer argued that since the requirement to compare disabilities to the World Health Organisation's ICD-9 classification was removed from the DDA, there had been a lack of clarity about



mental health conditions for employers.<sup>10</sup> They gave the example of whether stress was classified as a mental impairment under the DDA, and believed that the lack of case law on stress and the DDA compounded this confusion.

Bearing in mind the caveat that the sample is likely to be skewed towards employers with more positive attitudes in this respect (see Chapter 1), the employers in this study who were not aware of the DDA were still usually keen to 'do the right thing':

*To be quite honest, we are such a human organisation that actually even if it wasn't for all these regulations and legislations, we'd still be behaving in the same manner because of the way we treat people. This doesn't mean we are saints but we look at each case individually and see what we can do.*

(Human resources manager, medium-sized employer, manufacturing sector)

### **The Disability Equality Duty**

Among the public sector employers, the DED was rarely mentioned spontaneously. When asked specifically about the DED, not all respondents were familiar with it, and most had little to say about how it connected with mental health issues in their workplace. One of the public sector employers reported that they were very aware of the DED, and had taken steps to 'mainstream' or systematically integrate an equality perspective into everything they did, from a personal level to an organisational level, in order to achieve what they referred to as an equality-based culture for their staff and the public. They argued that having initiatives specifically for people with mental health conditions would potentially go against this method of meeting their DED obligations.

#### **3.5.3 Employee awareness and views on the DDA**

All participants in the employee sample were asked whether their current or previous employer had ever mentioned the DDA to them, or if they had become aware of it in another way. Strikingly, few people in the study group had ever heard

---

<sup>10</sup> The International Classification of Diseases (ICD) is published by the World Health Organisation (WHO). The WHO produces international classifications on health so that there is a consensual, meaningful and useful framework which governments, providers and consumers can use as a common language. In addition to the ICD, the WHO also produce the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed in 2001, and puts the notions of 'health' and 'disability' in a new light, by taking into account the social aspects of disability, rather than viewing disability only as 'medical' or 'biological' dysfunction. By including environmental factors, the ICF also considers the impact of the environment on a person's functioning. (World Health Organisation (2005) ICD-10 2nd edition International Statistical Classification of Diseases and Related Health Problems, 10th revision, WHO: Geneva; World Health Organisation (2001) ICF: The International Classification of Functioning, Disability and Health, WHO: Geneva; <http://www.who.int/classifications/en/>).

of the DDA or the term 'reasonable adjustments' and none of the people who had had changes made to their role or other forms of support in work perceived that these had been made specifically as 'reasonable adjustments' in the context of the DDA.

The minority who were familiar with the Act had mostly become aware of it through their own work, in roles that involved a duty of care to people in their workplace, for example, as a human resources manager, a care worker, or an employee of a public sports facility. There were also a very small number of people who said they had learned about the DDA in the course of general reading on the internet or in leaflets they had picked up. Even among those who were aware of the DDA already, many said they had not realised that it could apply to people with mental health conditions.

As discussed in Section 3.4.2, a perception that their employer would not be willing or able to make any adjustments to their role was a factor in some people's decision not to mention their mental health condition to them. It is conceivable that knowledge of this legislation might alter some of the views given above, on perceived unwillingness – and in some cases, lack of duty – of employers to help people with mental health conditions to carry out their work. A small number of people said they would look into the provisions of the DDA and might even raise this with a future employer. However, there were also some frank statements from other individuals who felt that the DDA could have little or no impact on employers until wider societal perceptions of disability and mental health were altered:

*That is wishful thinking, it is, that is political ideology that is out of touch with, with reality ... I personally don't feel that that's where the, the development lies, the development lies in the way that this society understands depression as an illness.*

(Male, 30s)

Reflecting on the recruitment stage, another view from some people was that, despite such legislation, employers would still be able to find ways of rejecting an applicant with a mental health condition by finding other reasons that they were not suitable for the job, for example, qualifications or experience.

Finally, it is also important to note that many people did not perceive themselves as disabled, and would not have wanted to utilise the provisions of the DDA in managing their experiences in work.

### 3.6 The role of General Practitioners

This section considers the role played by employees' GP in advising on and certifying sickness absence and in discussing returns to work or job retention. The first subsection presents data from the employee interviews on consultations with GPs when managing mental health and work became difficult. The second subsection considers the perspectives of employers on the advice and information provided to both themselves and their employees about work and mental ill health.

### 3.6.1 Employee perspectives on GP involvement

Data in this section is drawn from the experiences of people who had taken a period of sickness absence due to mental ill health, including temporary absences followed by a return to work, and also periods of sick leave that ultimately ended in leaving a job.

Some people in the study group had already been in contact with their GP about their mental health condition, or had been receiving counselling or other mental health support, prior to leaving work or going off sick. Among these were people with long-standing mental health conditions who were receiving ongoing treatment or medication, but also some people who had approached their GP more recently, when they began to feel the effects of anxiety, depression or 'stress'. Others approached their GP at the point of going off sick.

In almost all cases, people described supportive responses from their GP when it came to discussing time off work. Among people who had taken temporary periods of absence, some said that their GP had recommended some 'rest' or 'time out' and there were no accounts of GPs being hesitant to issue a sick note. Some people who had spoken to medical practitioners about their mental health prior to leaving work said that their GP or counsellor had been advising them that a break from work would be a good idea some time before the individual themselves had come to agree with this view. There were also people who, having approached their GP because of the mental ill health they were experiencing, were nonetheless quite surprised that time off sick was recommended.

*She said 'How would you feel if I put you on the sick for the while?' and I said 'Do you really think it's that serious?' and she said 'Yes I do' and I said 'Right, well fair enough, so be it.'*

(Male, 50s)

Reflecting their desire to remain in work, despite how their mental health was being affected, some people recalled how they had been reluctant to accept their GP's recommendation of taking time off sick, or had told their doctor that they couldn't be off work for 'too long'. Some people were uncomfortable with the idea of being signed off sick because of their commitment to being in work or the difficulty of 'accepting' that they were unwell:

*I just broke down in the doctor's surgery and he said 'No, I want you to take some time off of work' and I said 'Oh I can't do that. I've never done, taken time off of work' and I thought well they've won if I'd done that. He said 'No. You need a break'.*

(Female, 20s)

*At the time, I didn't like what [my GP] was saying. He was saying that 'You are ill as in, if you'd been involved in a car accident and you'd had to go into hospital for a month ... You are ill in the same way as that, you need to have some time off' ... Looking back what he told me was absolutely right and he was very supportive and he was brilliant. At the time, it's hard to accept.*

(Female, 30s)

Among the study group, people's own reluctance to accept that time off work was needed was more apparent than any unwillingness on the part of their GPs to issue a sick note. The only example of a GP exercising some form of restriction in managing time off sick was for one younger person in the study group, who had moved from JSA to IB. This person explained that her GP had explicitly stated that he would not issue a sick note for more than a couple of weeks because he believed she was able to seek work or to return to studies.

There was little evidence that people talked about work in any depth with their GP other than to discuss time off work. Some respondents said this was because of a lack of opportunity or expressed the view that this would not be necessary or helpful. Although some people described positive and long-standing relationships with their GP, others said they did not find them easy to talk to or rarely saw the same practitioner twice. Some people said their GPs had little time to enter into discussion with patients beyond their immediate health concerns. Moreover, beyond establishing whether they should be at work or not, a small number of people commented that they did not feel it was their GP's role to talk to them about work.

There was also very little evidence from the interviews with employees of contact between GPs (or other health practitioners) and people's employers. Where this had taken place, it generally comprised written communications regarding sickness certification or occupational health consultations. In an exceptional case, one study participant described how her manager and GP, who knew each other personally, had spoken to one another about her phased return to work and the adjustments and provisions that would need to be made in order for her recovery to be supported at work. Some people commented that they did not feel that any more comprehensive contacts between their GP and employer would be necessary or desirable. However, one person whose condition had not been specifically diagnosed at the time of the research interview did think it would have been helpful if his GP could have spoken to his employer, because they could have provided a better explanation of what was happening to him, thus helping his employer to understand his situation.

### **3.6.2 Employer perspectives on GP involvement**

Data from employers suggests that, in organisations without occupational health support (typically the smaller employers) there was greater reliance on the judgement of the employees' GP. GPs generally provided employers with two things: advice regarding fitness to work at a particular time and a reason for absence, stating a diagnosis where relevant.

Small employers varied considerably in terms of the level of communication they had with an absent employee's GP. Most did not query or request further information beyond statutory sickness certification. Some employers had approached GPs to obtain letters of consent (to release confidential information with the permission of the employee) and medical reports. Whether a manager working for a smaller employer sought this advice appeared to depend on their confidence, experience

and knowledge about absence management practice. There were some examples where expert medical assistance was needed urgently, such as when an employee was exhibiting alarming behaviour or in severe distress. In these cases, a human resources professional had taken the decision to send or take an employee directly to their GP. This had usually involved liaising with the employee's family to ensure that they had somewhere safe to go after seeing their doctor.

Employers expressed a range of opinions about the input of GPs and the extent to which the information they provided was useful. There were some instances where employers had seen GPs in an adversarial role, particularly when they believed that they had no means of contesting a GP's interpretation of an employee's condition. Some employers were not convinced that GPs themselves always knew what was wrong with an employee. It was also commonly argued that GPs were too quick to ascribe symptoms of mental ill health to stress and that they wrote sick notes 'to order'. Some employers believed that GPs tended to tell the employer 'exactly what the employee has told them'. This was particularly frustrating if, for example, drug and alcohol problems were suspected. One employer had strongly suspected that an employee had a substance use problem but thought that the GP had been 'fooled' into believing that her difficulties at work were solely attributable to depression.

In another example, a human resources manager described a senior factory operator whom he had suspected for some time was a drug user. Several aspects of his behaviour had led the respondent to believe this: the employee's attendance was erratic, when he was at work he was 'constantly on the phone' and he appeared to have debt problems despite being 'well paid'. This belief was also shared by the employee's colleagues. The respondent described the employee as 'totally in denial', and felt that the employee's GP was hindering rather than helping the company to manage the situation.

*We've actually got to the point now where he's been telling us his GP won't allow him back to work and his GP is getting the story from him that we're not allowing him back to work.*

(Human resources manager, large employer, manufacturing sector)

This was an ongoing problem. At the time of the research interview, the employee in question had been absent for several weeks and the human resources manager appeared at a loss as to how to move the situation forward.

A number of employers said that they would prefer to work more closely with GPs in identifying an employee's condition and looking at ways to enable them to come back to work.

*I think it is about working with employers and GPs because they are very often the biggest issues we have about keeping people with mental health conditions in work. It's their GPs who are trying to keep them out of work and are telling them they will never work again.*

(Head of human resources, engaged employer, large, manufacturing sector)

There were mixed opinions from these employers on how important it was to have a specific diagnosis for an employee's mental health condition. Some employers had found this useful in helping them to respond appropriately, while others felt that this was not relevant or necessary. In general, employers preferred to focus on performance and behaviour and how best to adjust to assist this, rather than on obtaining a diagnosis. Several felt it was not helpful to label people.

*We're not experts in mental health, we're here to produce and try and resolve issues that come up each day.*

(Deputy manager, large employer, manufacturing sector)

Conversely, there were some cases where lack of a clear diagnosis had hindered management of employees with mental health conditions. One employer felt he had no choice but to invoke disciplinary procedures to deal with an employee with an apparent mental health condition, because his GP and psychiatrist did not provide a specific diagnosis. This was coupled with the fact that the individual concerned refused to accept they had a problem:

*After they were temporarily sectioned, they were told there was no ongoing problem or mental health issue so we've been completely lost as to how we should deal with it. In the end they acted in such a way we had to protect other members of our workforce, which is very unfortunate.*

(Workforce manager, medium-sized employer, health sector)

### 3.7 Conclusion

This chapter has presented a substantial amount of data on a range of themes relating to the way mental ill health at work is talked about, addressed and supported, and how it can impact on the work of individuals and others around them.

The research interviews with people who had experienced a mental health condition revealed a range of reasons why people may not mention this to their employer or others at work, including lack of personal insight, feelings of shame or weakness associated with mental ill health, or perceptions of stigma or discrimination by employers and colleagues. These factors were also recognised by employers in the study group. People who had experienced mental ill health at work also cited lack of opportunity or forum to talk about this, or a feeling that it had no bearing on their work, as reasons why they had not mentioned their condition to anybody.

There were also people whose mental health condition was known about by others at work, but there was evidence that the extent and detail of this knowledge varied according to people's own perceptions of their condition and how it had emerged. Notably, there were a number of instances where people at work were aware of traumatic circumstances that had occurred in a person's work or personal life, but this may not, at the time, have been discussed or responded to specifically as a 'mental health condition'.

The data also indicated that colleagues and employers could be similarly reluctant to raise the possibility that a person was experiencing some episode of mental distress, even when there was sometimes a compelling reason for thinking so. A fear of making things worse, of being wrong, of not knowing how to broach the subject all seemed to act to prevent people in this study from taking any sort of action.

Employers gave a wide range of examples of adjustments that they had either made for individual employees or would consider appropriate in some circumstances. Attitudes towards people experiencing some episode of mental ill health were largely constructive, with each employer using the resources and experience available to them as best they could. Clearly, the larger employers had access to far greater resources (such as human resources and occupational health staff) than smaller employers and this was reflected in the options open to them. Knowledge about how to respond, and who might be available to offer support, was much less in evidence among the medium and small employers in the sample. Some of the responses made were interesting for probably not falling within a definition of 'adjustment' under the DDA, for example encouraging other staff to take coffee breaks with people in need of some sort of immediate support in the workplace. It is possible to suggest therefore that there is scope for disseminating knowledge of these practices and examples of their effectiveness more widely among employers.

There were fewer examples from the employee data of adjustments being made to their role, perhaps influenced by the small number of people who had discussed their mental health condition in any depth with their employer. A few people reported constructive responses where some adjustments had been made. However, a perception that adjustments were not possible or not likely to be made had led some people to 'struggle on' in work without asking for support. In some cases, the adverse impact on work performance had led people to 'choose' to leave or to be dismissed, an important finding when considering employers' job retention attempts.

Even when an employee and employer did share knowledge about a mental health condition, the employer data illustrated how tensions could be created for employers who needed to balance making some form of adjustment (for example, extra breaks, working at home, or discreet provision of training) with maintaining the confidentiality of the employee by not explaining those adjustments to work colleagues.

Awareness of the DDA and its application to mental health conditions was mixed among employers and very limited among the employee sample. Employers who were aware of the DDA (in relation to mental health) tended to view this as underpinning good practice, rather than their central reason for facilitating adjustments. In outlining the provisions of the DDA to participants in the employee sample, there was some scepticism about the extent to which this legislation could really be effective in the cases of people with mental health conditions.

Finally, it is worth reflecting on the evidence from this study of the limited role that GPs play in the relationship between people with mental ill health and their employers beyond the initial and continued provision of sickness certificates. There were relatively few examples of employees, employers and GPs working collaboratively to manage someone's job retention, sickness absence or return to work, although some employers expressed the opinion that they would welcome closer collaboration. There was a common perception however that GPs were often cast in an adversarial role of providing justification for their patients not working rather than helping them to stay in or return to work.



## 4 Leaving work due to mental ill health

This chapter draws on the experiences of people who perceived their mental health condition to have contributed to leaving work, and the sub-sample of employers who had lost, or dismissed, an employee because of mental ill health.

By the time of the research interviews, the majority of people in the study group had permanently ended their connection to the employer they had worked for prior to claiming Incapacity Benefit (IB). Only two people who were currently in receipt of IB were still under a contract of employment or otherwise 'on the books' of the company they had worked for.

Fourteen of the 40 employers said they had experience of an employee leaving or being dismissed from their job as a direct result of a mental health condition. Some were able to provide examples of specific cases, while others talked more generally about the kinds of situations in which employees would be dismissed, or might decide to leave of their own accord. A number of the engaged employers had had several cases of employees leaving due to their mental health condition.

The first section of this chapter considers the different routes people in the IB sample took out of employment, namely an initial period 'off sick' before their employment ended permanently, or a direct departure from their job when they felt they could no longer be in work. The second section looks at the different ways in which decisions to leave employment were arrived at, including employee decisions, mutual agreements, and dismissals by the employer. This section also briefly considers people's feelings at the point of leaving work. The third section brings together the reflections of people in the employee sample on what (if anything) might have been done to help them retain their employment rather than begin the route to IB.

### 4.1 Transitions out of work due to mental ill health

Among the IB sample, there were two broad types of route out of employment when work became unmanageable due to mental ill health: going 'off sick' or

leaving work 'directly'. Across both these groups, there were people:

- who had struggled on in work with a deteriorating mental health condition;
- whose mental health condition had emerged suddenly;
- who had told their employer or colleagues about their mental health condition and people who had not.

#### **4.1.1 Going off sick**

Having reached a point when they felt they could no longer be at work, some people's first transition was to go off sick, whilst still under a contract of employment. At some point during their sick leave, the decision to end their employment permanently was then made.

Most people who went off sick before leaving work did so without having discussed their mental health condition with their employer. In some cases, this was because their mental ill health had emerged suddenly, while in other cases, people had not talked about mounting levels of anxiety or depression with their employer or colleagues.

With hindsight, we can see that this phase of being off sick prior to departure from a job was a crucial time where retention attempts might have been made by employers. Experiences of the management of sickness absence that preceded eventual departure from a job varied among the research participants. Some people said that no contact was initiated by their employer during their time off sick, or that any contact made had only been general messages to staff about developments in the workplace. Other people said they had had occasional phone calls or visits from their manager, and some described more informal visits or messages from colleagues.

As described in Chapter 3, relatively few people had contact with occupational health services. Where there was occupational health involvement in the period of absence leading up to leaving work, people described attending medicals and being referred to counselling. For some people, occupational health involvement was viewed positively, for example, one person said that her discussions with occupational health had made her feel less 'guilty' about being off sick and that the counselling she had received was very useful. However, in some cases referrals to occupational health had never amounted to the individual receiving treatment. One person perceived that her employer had 'ignored' the recommendations of occupational health that she be referred for cognitive behavioural therapy, while another recounted that her employer would at first not 'agree to' funding the counselling that had been recommended.

As their period on sick leave extended, some people said that they felt increasing pressure from their employer either to return to work or to take a decision on whether or not they were going to stay in their employment. Contact that focused on return to work plans was sometimes perceived as insensitive and unsympathetic.

One person was in grievance proceedings with her employer at the time of the research interview about the way her sick pay entitlement had been managed. This person felt that her employer did not believe her mental health condition to be as severe as she was presenting it and perceived her as 'angling for a pay off'. It was also apparent that, where people's going off sick involved possible litigation (for example, about employer negligence, workplace bullying or allegations of employee misconduct), this had implications for the level and nature of contact that was offered. In such cases, contact from employers was sometimes perceived as perfunctory or completely absent and some people believed that absence management procedures had not been followed correctly in their own case.

#### **4.1.2 Leaving work directly**

Some people's employment had effectively ended immediately at the point where they no longer felt they could be at work. Among the claimant sample, leaving work directly was more common than taking time off sick before ultimately ending employment.

For some of the people who left work directly, the nature of their employment meant that there had not been the option of taking time off sick while remaining 'attached' to their employer, for example people who worked via employment agencies and people who were self-employed or worked on a freelance basis. However, some people had left work directly even though the nature of their employment indicated that they would have had an entitlement to paid sick leave. Reasons underlying a direct departure from work, despite a possible entitlement to paid sick leave, are considered further in Section 4.2.

### **4.2 The decision to leave**

From employers' and employees' explanations of how people eventually came to leave their employment, three types of scenario emerged: situations where the decision was seen to have been made independently by the employee; decisions that were described as 'mutual' between employer and employee; and situations where an individual had been dismissed by their employer. There were examples of each of these three situations in both the employer and employee data, but (perhaps unsurprisingly) accounts of employee decisions to leave were found more often in the employee data and details of dismissal came more often from the employers in the study group. Employees' accounts of leaving work suggested that most people felt the ending of their employment was, at least to some extent, a decision that was under their own control.

This section considers, in turn, situations where the employee took an independent decision to leave their job, scenarios described (by employers or employees) as 'mutual' decisions, and circumstances where the individual was asked to leave by their employer. The final subsection briefly outlines employees' reported feelings about leaving their jobs.

### 4.2.1 Employee decisions to leave

There were accounts of personal decisions to end employment among people who had left work directly and people who had first gone off sick. Of particular interest are the cases where an individual, in principle, had an entitlement to paid sick leave but opted to leave work directly rather than take up this allowance. Some of these people had experienced very sudden traumas or gradually building situations in their personal or work lives and explained how, at the time of leaving work, they had felt that they could not continue with their employment. Illustrating the intensity of distress some people felt when they reached this 'crisis point', one person explained that 'I didn't feel that I could stay there and I didn't know what else to do and in a panic I handed my notice in'.

As noted earlier, there were also people whose employment conditions did not include any type of sickness absence arrangements. However, one person, who had been on paid sick leave for one month, explained that she had had to leave her job at this point because she did not feel able to return to work yet, but was told she was not entitled to any more sick pay.

Others had decided that leaving work – rather than taking time off sick – was, for them, the right thing to do at the time. Included among this group were a number of people who had taken a previous period of time off sick because of mental ill health, and who had initially returned to work but found they continued to struggle. Some of these people had gone back to work for a few months and continued to 'struggle on' before finally leaving permanently, while others had only returned for a matter of days before deciding that they were not able to stay in their job.

There were others who had not told their employer about their mental health condition while they were in work, and from their accounts of leaving work, it appeared that not feeling able to share details of their condition and the impact it was having on their work, had led them to leave their job without taking time off sick. There were also people who attributed their mental ill health specifically to circumstances at work and who, having struggled on for a time had reached a point where they could no longer stay in their job. Additionally, there were people who were not enjoying their job for reasons unrelated to their mental health condition and so they had chosen to leave their employer for a combination of mental ill health and other factors.

Where people said it had been solely their own decision to leave work, some described how their employer had been willing to keep them on, for example, offering to 'hold the job open' for a time. However, people here did not talk in any detail about specific adjustments being offered.

Employers also cited some examples of employees choosing to leave a job which was proving unsuitable, or too difficult to manage without negatively affecting their health. This was usually after a discussion with the employer, where the options were considered. An example was given by the manager of a medium-

sized cleaning company. One of the cleaners who had depression but had worked for the company for some years, was promoted to a supervisory post, but then was unable to perform in the role, as she found it very stressful. The manager was being pressured by her clients to make sure the job was done properly, and when the manager, who had had a good relationship with this employee for some years, broached the subject with the employee, she chose to leave.

In another example, a large company had an employee who had agoraphobia, who had been off sick for some time, but had started a phased return to work. Towards the end of a day during this phased return period he went to see his manager in a very distressed state. The human resources manager explained, 'He was on his hands and knees crying ... said he just couldn't do it and he'd phoned his wife to say he was on his way home'. The employee never returned to work after this. The employer elaborated on the stigma which is often attached to mental health conditions, and how this too becomes part of the problem:

*He wanted to leave. When people have mental illness if they're aware of what the problem is and then realise they're going back into an environment where other people might be talking about them it's quite difficult for them.*

(Human resources manager, large employer, design sector)

There were also situations reported by employers where a staff member had chosen to leave because of frustrations with the way their employer managed their situation. As one engaged employer put it, 'they get so angry with the company they only see a way forward in terms of escape'. Another reported scenario was where employees left rather than face disciplinary action. For example, a large public sector employer told of an employee, who they believed probably had 'bipolar or personality disorder', manipulating and bullying colleagues and members of the public for some time. When this came to light, the employee was told she would be investigated and might be subject to disciplinary action, at which point she resigned.

In none of the examples of employee decisions to leave reported by employers was there any involvement from occupational health or other health services.

#### **4.2.2 Mutual decisions to leave**

Accounts of mutual decisions to leave were more common among the employer than the employee data. The employers interviewed cited a range of examples of people leaving work by agreement. There were a few cases where, although the decision for an employee with a mental health condition to leave employment was prompted by the employer, the employee also agreed that this was the best, or only available course of action. This was usually after a number of different adjustments and working arrangements had been tried, but both employer and employee eventually concluded that they were not proving satisfactory. Sometimes, employers had made adjustments for a number of months or years before it

became apparent that these arrangements were definitely not going to work on a long-term basis. In this situation, for employers, the concerns usually centred on adjustments not being successful in enabling regular attendance and reasonably consistent performance, alongside concern for the health and wellbeing of the individual.

Employers sometimes described how a member of staff would have concerns that because of their mental ill health they felt that they were letting their employer down, and wanted to avoid this in the future. When the point was reached where the employer believed that the possibilities for accommodating the employee had been exhausted, or that any further efforts would almost certainly fail to remedy the situation to the satisfaction of both sides, the possibility of the employee leaving was discussed. It was usually unclear from the interviews whether the employer or the employee had initiated this discussion, but employers typically reported that both sides had agreed it was the best way to proceed. A mutual decision of this kind was often reported by smaller employers, where there was a relatively informal relationship between the employer and the employee.

One detailed example of such a situation came from an employer running a small restaurant business. The owner-manager had experience of employing several people with mental health conditions. He was generally sympathetic towards these employees, wanted to 'do the right thing', and had made adjustments for several people in the past. One employee who had worked on the till had a chaotic lifestyle that the manager had been aware of when she was appointed. He believed that situations outside work led to the employee becoming unable to cope, and she was prescribed medication by her doctor. However, she did not always take the prescribed dose, sometimes taking more than was advised. Over time, the employee's attendance at work became increasingly erratic, and she often rang in sick because of panic attacks, was very late to work, or was absent with no phone call made to the manager. As he described:

*It came to a point where she'd ring and say she was coming in and then she'd get a panic attack and then she wouldn't be able to come in, or she'd be phoning up sick, she wasn't in a position to come in. We're trying to do our bit and you end up not knowing what to do for the best ... and you feel that you've failed as a human being for another human being, but you can't help them, you don't know how to help them.*

(Manager, small employer, catering sector)

The employee worked at the restaurant for six years and was reportedly able to do her job 'as normal' for about half of that time. Despite all the difficulties they had had, the employee left on good terms, agreeing that leaving the job was the only available option.

### 4.2.3 Employer dismissals

There were more examples of terminated employment from the employer data than in the employee accounts. A number of the large employers, with well developed policies and procedures on managing health conditions, spoke generally of circumstances in which they would dismiss an employee with a mental health condition, or where they would reach an agreement where the employee would leave. These employers usually saw dismissal as a last resort, after having tried a range of adjustments including phased returns to work, changing duties, hours worked, and regularly reviewing progress. The main focus of these organisations was to find ways to get the employee back to work, rather than have them on long term sick leave, or dismissing them. If, after a time, it became clear that an employee's ill health would continue to prevent them from working effectively, or that redeployment was not possible, then the employee leaving was felt to be the only option left.

The small and medium-sized employers tended to have less experience of employees with mental health conditions, and so, inevitably, had less experience of employees with mental health conditions leaving as a result. In these cases, interview participants spoke hypothetically about how such situations might be managed.

In the interviews with employers, two issues emerged that were of particular significance in cases where an employee's mental health condition had led to an eventual termination of employment. The first of these was the perceived lack of self-awareness from some staff that they were experiencing a mental health condition. There were accounts of situations where an employer had formed the view, on the basis of a staff member's behaviour, that the employee might have a potentially severe mental health condition (for example, personality disorders, schizophrenia or bipolar disorder). However, attempts to discuss this concern or to refer the employee to an occupational health or human resources department were unsuccessful because the employee had responded by saying, for example, that 'there wasn't anything wrong with them'. In such situations, employers acknowledged that the condition itself could have been a contributing factor in employees' apparent lack of insight, and their reluctance to enter into a dialogue. Employers also reported a related situation, where an employee accepted to some extent that they had a mental health condition, but seemed not to accept that they needed to take regular medication to control it. In such cases, employers reported that the individuals did not take their medication as prescribed, took more or less than instructed, or did not take the medication at all.

The second issue was the problem of dealing with unsatisfactory performance or behaviour. The most commonly reported situation which proved to be unmanageable in the workplace was where employees' attendance continued to be erratic and unpredictable, despite a range of adjustments having been made to try to minimise this. Speaking hypothetically, an employer from a medium-sized construction company also said that, in theory, if they had an employee who

was likely to be off sick for a long time, they would have to consider terminating their employment. However, they admitted that they did not know whether they would be within their rights to do this. They thought that they might be breaking employment law, and would need to seek advice if they ever encountered that situation. There were also examples where employees' conditions had proved too difficult to manage in the workplace itself, and the employee had had to be dismissed as their behaviour was very disruptive to colleagues and the work environment.

Some employers, particularly the larger ones, said that there were a number of potential arrangements that could be applied in the event that an employee was dismissed, including medical insurance schemes which could pay salary until retirement age, and offers of a 'financial buffer' or severance payment to tide someone over until they found a new and more suitable job.

One example came from an employee health manager for a large engaged employer in the manufacturing sector. This employer had worked with an individual who was believed to have had a personality disorder. She described the employee as being 'very manipulative, lying all the time, creating conflict within the team ... not a good performer but not enough to warrant a dismissal around her performance.' The employee herself reportedly felt that she was not being given opportunities to progress, but her managers thought that she was not capable of performing well in her current role. After seven years, during which time, according to the employer, she had continually created conflict and disorder in her team, the employee was made redundant with a compromise agreement.<sup>11</sup>

Only a minority of people in the employee sample described leaving work as being dismissed or being made redundant. There were very few who talked about being made redundant after a period of sick leave which they described as being on the grounds of being medically unfit to carry out the job. However, illustrating the complexity and blurred boundaries between mental ill health and traumatic personal circumstances, one person, who had 'walked out' when work became unmanageable due to difficulties with a violent partner, explained that her employer had classed this abrupt departure as 'misconduct'. Although the employer had been aware of the individual's personal situation and had facilitated telephone counselling beforehand, the employee described her contract as having been 'cancelled' around one month after the date she had last been in work.

Finally, a small number of people said they had been dismissed due to poor performance, which they themselves recognised was related to their mental health condition. However, they had not explained or discussed this with their employer prior to leaving their job.

---

<sup>11</sup> A 'compromise agreement' is a legally binding agreement following the termination of your 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.



#### **4.2.4 Feelings about leaving work**

People described various feelings at the point of leaving work, be that directly or entering an initial period off sick. For many people, the immediate feeling was of 'relief', particularly for people who had been struggling on for some time, becoming increasingly anxious or exhausted by their efforts to sustain their work. For these people, although being out of work was not preferable in the longer term, coming out of their job when they did was seen as a good thing.

However, there were also people who had not wanted to come out of work when they did. These included people whose decision to leave work stemmed from a sudden traumatic event in their personal lives, and who had been managing and enjoying work up until this point. Some people noted feelings of guilt on leaving work, for leaving the people they work with short staffed or without supervision.

If leaving had been by mutual agreement or personal choice, some people commented that things had ended on a positive note, and that they had parted from their employer on good terms. In contrast, given the circumstances under which their mental health condition emerged, for example, workplace bullying or events due to negligence, there were also some people who did not wish to return to their employer. However, some of these people did feel sorry to have had to leave and had enjoyed their work overall, these events notwithstanding.

### **4.3 Employees' reflections on preventing leaving work**

This section draws together people's reflections on whether they felt anything could have been done to prevent them leaving their employment. Analysis of these accounts suggests that these views were influenced by the relationships they perceived between their mental health condition and their work. It is important to remember that people's accounts of the emergence or exacerbation of their mental health condition were typically complex and involved a number of contributing factors. As such, ameliorating conditions in one area of their life might not have been sufficient to prevent other factors leading to their having to take time out of work. It is also worth noting that some people described a number of factors in their job that had frustrated them and felt that, notwithstanding their mental ill health, they would have been seeking to leave their job anyway.

#### **4.3.1 Access to health services**

For some people, the key to retaining or regaining employment was for their mental health to improve. (As we will see in Chapter 5, this perspective is supported by the accounts of people who had returned to work after getting 'better'.) Quicker or more effective treatments for mental health conditions were mentioned by some people, including those with schizophrenia and drug addictions. In some cases, these people had not been receiving any medical treatment at the time when they left work, while others felt that their medication at the time had not been effective or had adversely affected their ability to manage in work.

### 4.3.2 Contact with employers and colleagues

We have noted in Chapter 3 and earlier in this chapter that few of the employees interviewed for this study had received much contact from their employer while they were off sick (although many of the employers interviewed said that such contact was a routine part of the sickness management procedures).

One person particularly felt that the complete absence of any phone calls or letters to see how she was feeling, after the traumatic event at work that had led to her time off sick, had played a major part in the deterioration of her mental health during this period:

*Just supposing I'd have had two or three phone calls, they'd have seen how I was, right, I don't think the panic order (sic) would have started ... I think I'd have probably got over the fright, you know, got over the fear ... Knowing somebody cared about it, I think they would have avoided all of this.*

(Female, 60s)

Another person had been signed off sick while on suspension due to alleged misconduct because the stress of a pending disciplinary, plus the simultaneous notification of possible redundancy, had triggered depression. Although she had ultimately chosen not to return to work, under the circumstances, she noted that the lack of support from colleagues, who she said had been instructed not to make contact with her during the suspension, had added to the 'hurt' and 'isolation' that she felt.

### 4.3.3 Dealing with workplace bullying or harassment

Some people identified the behaviour of a particular colleague or colleagues as central to the deterioration of their mental health at work. For these people, the removal of these persons from their immediate work environment, or a change in their behaviour would have helped to reduce the anxiety they felt at work.

In one case, the individual had initiated and won a tribunal case, though not until she had left her employment. However, another study participant had opted to leave her job because the colleague who she found difficult to work with had been employed there longer, and she did not think it was likely that she would leave. To this person's knowledge, there was no forum through which she could have made an official complaint.

### 4.3.4 Reducing 'job stress'

For some people there were perceptions of unmanageable workloads or unreasonable demands being placed upon them, and some people identified adjustments to the role that might have helped them to manage better, for example, a change in shift patterns, changes to hours, duties or the provision of additional support, either practical or emotional. Some people had made direct requests for such changes, although none had explicitly related these requests to mental ill health. In the words of one person, these approaches to managers

were 'cries for help'. Other individuals who were experiencing severe stress or the effects of depression talked about how they had approached managers and asked for changes to shift patterns or for workloads to be lightened, but in all cases people had been told this was not possible.

#### **4.3.5 Constructive responses to personal life triggers of mental ill health**

Among people who described their personal life as having triggered or exacerbated their recent experiences of mental ill health, some people cited sudden incidents and others talked about gradually mounting levels of stress or distress in their lives outside of work. People in these situations often recounted how, at the time, they had not felt that anything could have been done at the time to prevent their taking time off work. With the benefit of hindsight, however, many people could identify possible ways that they might not have had to leave their job permanently.

Among people who had struggled on for a time, willingness or ability to admit to difficulties featured in people's reflections on what might have been done differently. With hindsight, some people could see that there were adjustments to their role that could have been made, or that an employer might have been willing to give them some time off to address their mental health problem (or the underlying personal circumstances). Another view was that having somebody at work with whom they could discuss the personal circumstances that underlied their mental health condition (for example, domestic violence) would have been helpful.

#### **4.3.6 Self-awareness of mental health condition**

Regardless of how a mental health condition had emerged, the themes of insight and willingness or ability to admit to difficulties again featured in people's reflections on what might have been done differently. Some people who, with hindsight, placed the first emergence of their depression several years earlier, felt that if they had recognised and acknowledged their condition sooner, and allowed themselves this time to address their mental health – as one person put it, taken a 'foot off the gas' – then they may not have reached the stage where they had to leave their job completely, although some time off work may still have been necessary:

*I struggled through until such points as I couldn't struggle any more and I'm not, I'm not saying that to be, you know, appear stronger than the average buck or arrogant or whatever but it was my fault in a way.*

(Male, 30s)

*Part [of it] was my fault, I'm blaming myself for that because if I was open, if I'd come out - I guess the fear of losing that job again and in the end I still lost it anyway. That fear and being honest, coming out and being honest with them and saying look this is my- this is where I'm at.*

(Male, 30s)

Some people in the study group commented that it was not until they had left work and begun to address their mental health condition that they began to realise the extent of their mental ill health and to recognise the multitude of issues that they had been suppressing while attempting to struggle on.

#### **4.3.7 Perceptions that no preventive action was possible**

A number of people felt that there was nothing that could reasonably have been done to help them to stay in 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:

*The only fair thing was for me to get - me to get out because, you know, he couldn't afford - he couldn't afford a supernumerary, or somebody who wasn't giving a hundred per cent value for money.*

(Male, 60s)

*I just couldn't handle it. So I had to leave unfortunately ... I pretty much jumped because I have very high morals. I don't like - if I can't do a job, I won't do it because it's not fair on me or the people I'm doing the job for.*

(Male, 20s)

## **4.4 Conclusion**

In this concluding section, we attempt to draw some general lessons from the accounts of people in our research sample who had experienced the end of a period of employment and employers who had experienced staff leaving as a result of mental ill health. Discussion of the policy implications of these lessons will be found in Chapter 7.

We should reiterate at this point however that the employers taking part in the study are likely to have more constructive attitudes towards mental health and have more developed policies and practices in place than a more representative sample of employers. The employers in this study generally reported that when they became aware that an employee had a mental health condition, they had addressed it as soon as possible, by trying to discuss it with the individual concerned, referring to and involving other parties to provide advice and support.

Among the people who had had their employment ended several common experiences emerged from their accounts, which we will discuss in turn:

- Decisions to leave work without a period of sick leave.
- Low levels of engagement with managers, colleagues, health service professionals, occupational health departments over job retention.
- High level of 'voluntary' or 'mutually agreed' decisions to leave.
- Lack of impact of the Disability Discrimination Act (DDA).

By definition, when a person leaves their job by resigning with immediate effect, then any opportunities for employers of discussing any type of response (for example adjustments, time off to improve, help with treatment) are effectively precluded. Typically, people only resigned in this way when some point of 'crisis', at work or in their personal lives, had been reached and work had become, from their perspective, untenable. For some people, the route to unemployment also involved a period off sick during which there was little contact with employers and little discussion with General Practitioners (GPs) and other health professionals about returning to work.

Some people in the study group explained that leaving work had been a constructive decision for them, but it is possible to suggest that individuals may be in a very vulnerable position at this time and that, rather than ending their connection with work (usually voluntarily or by mutual agreement), their long term interests might have been better served by a continuing, responsive and constructive connection to their employer.

Apart from the larger, 'engaged' employers, the evidence of this study is that many employers also feel vulnerable in dealing with people who have a mental health condition. They often feel ill-equipped, lacking in knowledge and isolated particularly when their experience is that their employee is either not aware of or ignoring their condition.

In Chapter 2, it was reported that many employers explained that mental health problems themselves were not their concern as much as performance, behaviour and attendance. This is an understandable approach but the evidence in this chapter suggests that this approach can quickly transform into remedial or disciplinary action that can be experienced very negatively by people with a mental health condition. It is also important to note the complex relationships between traumatic personal circumstances and mental health in that it may be the former of these aspects of mental ill health that is most salient to individuals – and most apparent to employers – at the time people leave or go off sick from work. Thus, there may be implications for the capacities or policies under which employers are able or inclined to respond.

The final lesson from the experiences of people leaving their employment is to reinforce findings from earlier chapters that the DDA had not had any relevance for many employees and employers. It is interesting to note that the attitudes to work expressed by many people in this study, that the onus is on them as individuals to take up work they can manage, rather than the employer accommodating to their needs or limitations, runs counter to the premise of the DDA and equality of opportunity policies more broadly that employers have responsibilities towards them and that they as employees have rights that can if necessary be enforced.

# 5 Mental health and entering work

As explained in Chapter 1, we know that people with mental health conditions are less likely to return to work than those with physical health conditions. One of the key groups of people of interest for this study therefore comprised those who had successfully made the transition from a period on Incapacity Benefit (IB) into paid employment. By exploring their experiences it was hoped that lessons could be drawn about how people made this transition, what events or circumstances were relevant, and how, if at all, employers, external organisations or individuals were helpful.

In the first part of the chapter, we therefore draw only on the experiences of people in the study group who had moved back into work after a period on IB. (People's experiences of returning to work after a period of sickness absence are covered in Chapter 3.) The second part of the chapter draws on the interviews with the 40 employers who took part in the study and presents data on their experiences of recruiting people with mental health conditions, including how they find out about an applicant's mental health, the role of recruitment strategies and policies, and how their views and attitudes about mental health and work influence their practices.

## 5.1 Experiences of people returning to work

### 5.1.1 Influences on thoughts about a return to work

This section looks at the factors that influenced people's thoughts about returning to work. A range of influences featured in people's thinking, with most people describing more than one. These included:

- Feeling 'better'.
- Wanting to be in work.
- Financial reasons.

- Aspirations.
- A requirement to seek work.

### **Feeling 'better'**

For almost everybody who had returned to work, the feeling that there had been some degree of improvement in their mental health was a factor in their decision to return to work. Some people attributed their progress to medication, therapy or counselling. In other cases, particularly where a specific event or circumstance had led to anxiety or depression, changes, improvements or abatements in these situations over time, along with support from friends and family, had helped people to feel better. Some people with long-term conditions could identify a key turning point, perhaps an event or episode in their lives (for example, a holiday), after which they felt more positive, more well, and more motivated to return to work, while others felt that 'something just clicked' in them at a certain point. It is also notable that, where people cited workplace factors as the main trigger of their mental health condition, some had felt much better as soon as they had left this previous job.

It is important to recognise, however, that 'better' meant different things to different people, depending on how they perceived their mental health condition. At the time they returned to work, some people felt that they were no longer experiencing a mental health condition or were well on the way to 'recovery' from their episode of mental ill health. Other people were taking prescribed medication, which they felt was working well in managing their condition. However, for some people, 'better' could mean better compared with how they felt at their lowest point, better than they had felt in a long time, or having felt comparatively well for a sustained period of time.

### **Wanting to be in work**

With very few exceptions, a common feature among people who had moved off IB was that they wanted to be in work. As will be discussed further in Chapter 6, for most people in the study group, being in work was important to them and made a positive contribution to their lives in a number of ways. Some people, in particular those who had experienced depression, explained how they had felt that returning to work would be good for their mental health:

*The thing that was driving me [was] that I thought if I could get back to work I would get better from a mental point of view ... I was already getting better but I pushed myself, myself and the doctor, to let me find a job if I could.*

(Male, 50s)

For some people, 'boredom' had been a motivator to return to work and it was noted that the inactivity and isolation of being out of work could in itself begin to exacerbate mental ill health. Some people said they had never really stopped thinking about work throughout their time on IB. For example, one person



described how he had always looked through the job advertisements in the local paper, although he had not seriously considered applying for jobs until he was feeling better. Another person described her strong desire to keep seeking work as follows:

*I always wanted to look for work, even when I was down on my last legs, my last knees, ... I wanted to like look for work because that's just the way I am, but I knew in my heart of hearts I wasn't ready at the same time.*

(Female, 30s)

There was also evidence that people saw being in work as part of 'normal life', to which they were keen to return after a period of ill health. Some people said they had felt it was 'time' to get back to work and that they could not just 'sit around' forever. For some people, being on IB in particular, or out of work in general, was not a status that they wanted. This was reflected in some people's voluntary decision to move off IB onto Jobseeker's Allowance (JSA) prior to securing employment:

*I took it on myself to come off the Incapacity and go onto the dole so that people wouldn't say 'Oh you're on Incapacity Benefit, what's up with you?', you know, I could just say, you know, 'I'm on the dole'.*

(Male, 30s)

Unsurprisingly, this feeling of wanting to be back in work was normally underpinned by feeling 'better'. However, this was not always the case. It is again important to note that better was a relative term for many people. Although they were feeling better than they had at their lowest point, some people were still experiencing the effects of their mental health condition when they decided to return to work. For some people, there had not been a significant change in their mental health condition at the time they entered work. Some people wanted to get back to work (for reasons previously noted) and felt that their state of mental health was such that they could manage work, but was not necessarily 'good'. While most people who had returned to employment were enjoying being back in work, there were some people who had found it difficult to manage at first and who, on reflection, felt they had perhaps gone back 'too soon'. A small number of people described continued difficulties in managing at work at the time of the research interviews.

### **Financial reasons**

For some people, finances had played a part in their decision to return to work. In some cases, income from work had been a financial necessity because people's benefit claim had stopped or they were not able to meet their basic living costs on the income provided by benefits. Some people, while managing to live on the income provided by benefits, said that they had wanted to return to their previous level of earnings, or at least raise their income through paid work. The experience of uncertainty about when IB payments would be received, in contrast to the predictable regular income from work was also a contributory factor in one person's decision to return to paid employment.

While a few people cited financial factors as their primary driver in seeking to return to work, most people here also felt that feeling better and wanting to be in work had also contributed their move back into employment. There was only one person who said that financial need had led her to return to work before she felt she was really ready to do so.

### **Aspirations**

Another type of influence on returning to work was the wider benefits and possibilities that being in employment opened up for individuals and their families. While intrinsically linked to financial factors discussed previously, these accounts had a somewhat different focus in that they emphasised the positive secondary outcomes that an income from work could bring. People here talked about wanting to enhance their opportunities to improve their social lives or material standard of living. Study participants who described their motivations in this way tended to be younger people looking to take steps towards independence from their parents, or who were just beginning families of their own and wanted to build a comfortable and enjoyable life for their partner or children.

### **Requirement to seek work**

Most people who had returned to work had moved off IB voluntarily. However, four had been deemed no longer eligible for this benefit following a Department for Work and Pensions (DWP) medical assessment. Of these people, three had initially claimed JSA and one had moved directly into work. Notably, none of the people whose IB claim had ended in this way had felt they were ready for work at this time, but all had decided not to appeal.

One person had lodged but later abandoned an appeal because she found the process stressful and had difficulties managing on a reduced rate of Income Support (IS) during this time<sup>12</sup>. She had chosen instead to claim JSA and felt she had no other option than to 'pick myself up and try and be strong again' and start looking for work. Another study participant, who had been feeling somewhat better, but not yet 'a hundred percent', had been advised by a friend to appeal the outcome of the medical assessment, but had decided that she didn't 'want the hassle of it'. However, on explaining her health circumstances to a Jobcentre Plus adviser when claiming JSA, this person had found that the adviser was understanding of her situation and said they would take into account the ongoing effects of her mental ill health, not 'pressurising' her as she looked for work.

A third person commented that, although he agreed with the medical assessor's decision that he was physically fit, the assessment process was 'asking me the wrong questions'. In his view, there had been no focus on his mental health, which he felt was still not good at the time his IB was stopped. The final study participant to be taken off IB following a medical assessment commented that the way the assessor had posed questions to him had not allowed him to explain fully the effects of his condition. This person had been advised by his General

---

<sup>12</sup> A reduced rate of IS is paid to people while in the process of an appeal.

Practitioner (GP) to appeal the decision, but again had decided this was not worth the 'rigmarole' and chose to get on with seeking work: 'My doctor told me to appeal it but I was anything for a quiet life, I just wanted to get on'. This participant found work relatively quickly, and felt that he was back in employment in less time than it would have taken to go through the process of appeal.

### **5.1.2 The role of medical practitioners**

While most people had been in contact with health services during their time on IB, there were relatively few accounts of GPs or other medical practitioners playing a significant role at the time people returned to work. Many people did not mention any involvement of their GP in their thoughts about returning to work, and few had spoken to their GP in any depth about returning to work.

There was only one account of somebody's GP being the main instigator of thoughts about returning to work. This person described how she had talked to her GP about feeling lonely and her GP had made the suggestion that work could be helpful in alleviating her isolation. Initially, the individual had not thought that this would be beneficial, and had felt that her GP did not understand the nature of her mental health condition. However, she decided she would try work and see if she could manage. At the time of the research interview, this person was finding work difficult due to a combination of physical and mental health conditions, although she did find that work had increased her social contacts.

A small number of other people said that they had mentioned their plans to return to work to their GP and in most cases had received positive and encouraging responses. One person described his GP as being 'over the moon' when he had told her about his new job. However, there were also examples of GPs being more hesitant to support people's plans for a return to work. Sometimes, this was only to the extent of advising the person not to 'overdo it' at first, or to begin by taking up something 'part time and not stressful'. However, one person felt he had really had to 'push it' with his GP in order to get him to sign him as fit for work.

Some people had talked about work with other types of health practitioners, for example psychotherapists or counsellors, who had been involved in the treatment or management of their mental health condition. In some cases, this discussion was described as more exploratory or therapeutic, looking at the part work had played in the development of a mental health condition or providing an opportunity to express concerns or frustrations about work. However, some people said that their therapist had been a source of support or advice in thinking about options for future work, for example discussing what types of job would be most suitable.

### **5.1.3 Support in seeking work**

Most people did not describe receiving any specific support in finding job vacancies or making applications, although, some people had been aided informally by the contacts of family or friends. People variously described looking in local papers, on the internet and at Jobcentre Plus to identify potential opportunities for work. Some people had spotted job advertisements in shop windows.

Few people said that they had received any support from Jobcentre Plus as they took steps toward work. To some extent, this is unsurprising because, at the time of the research interviews, IB claimants in the study areas were not currently required to have any regular work-focused meetings with advisers at Jobcentre Plus.<sup>13</sup> For many people who had moved directly from IB to work, there had been little or no contact with Jobcentre Plus since they made their benefit claim.

For various reasons, a number of people in the study group had spent a period on JSA between leaving their previous job and returning to work more recently. For these people, there had been mandatory contact with Jobcentre Plus at fortnightly Jobsearch Reviews. Some other people in the study group had visited Jobcentre Plus voluntarily while on IB, for example, to seek advice about training opportunities. Overall, views on the contribution of Jobcentre Plus in supporting moves into work were rather negative. When asked whether they had received any support from Jobcentre Plus, one person commented that current staffing levels meant the provision within Jobcentres was 'more or less self-help'. A common experience among people who had initiated an enquiry about training opportunities was to be told these were not available, or for the referral process to break down somewhere between their initial approach to Jobcentre Plus and a response from a training provider. One person gave the view that Jobcentre Plus was not interested in facilitating this type of vocational support, and only wanted to move people off the benefit caseload, while another person, reflecting on past experiences, believed that fewer training opportunities were now available from Jobcentre Plus than in previous years.

Some people had, however, been in contact with a Disability Employment Adviser (DEA) during their time on IB. DEAs were consistently spoken of positively. Their approach was described as supportive, encouraging and empathetic, one person noting that this was the only member of staff in Jobcentre Plus with whom she had felt able to share the nature and underlying causes of her mental health condition. Some people highlighted how their DEA had emphasised the need to take account of their possible health constraints in returning to work and had advised part-time employment in the first instance. This advice and support had been a key factor for some people in their decision to return to work.

The evidence suggests that experiences of specialist support from Jobcentre Plus can be positive and helpful in making plans for work. However, for people who make the move to 'mainstream' jobseeker status, the experience is less supportive, even negative. Two people who had moved from IB to JSA commented on the 'pressure' they had felt from Jobcentre Plus to move into full-time work. This is in contrast to the experience of the participant noted above, who appreciated the more gentle approach of Jobcentre Plus advisers she had encountered.

---

<sup>13</sup> The research locations for this project were deliberately chosen to avoid Pathways to Work pilot areas, which have specific interventions and initiatives for IB claimants and which have been the focus of substantial research evaluation. Pathways to Work will be rolled out nationally during 2008.

Some people mentioned that an adviser at Jobcentre Plus had spoken to them about Working Tax Credit or had worked through a better-off calculation with them. Some people were also aware of permitted work rules, and three people had used these in making a gradual return to full-time work. There were also isolated examples of people who said they had been given a sum of money by Jobcentre Plus when they moved off IB (presumably from the Adviser Discretionary Fund (ADF)).<sup>14</sup>

Finally, some people had received support in preparing for work from other organisations. People who had had involvement with probation services (often due to convictions associated with drug use) had had some support in preparing for or seeking work. One person also described support from a Job Broker, whom he said had played a key role in helping to find and secure his job. Some people who had been in contact with drug rehabilitation services or had spent time in residential mental health facilities or supported accommodation had also been involved in training or job preparation activities.

#### **5.1.4 Recruitment**

Few people described undergoing a lengthy or formal recruitment process in obtaining their job. For some people, the recruitment process was very simple – they enquired about the job in person, were interviewed within a few days, and were offered the job immediately. While the majority of people had begun actively to seek work when they found their job, two people described being approached unexpectedly by agencies that they had worked for in the past. While both were feeling able to work by now and accepted the job offer, they had not begun actively job searching at this point.

#### **5.1.5 Entering work**

The vast majority of people in the study group had not returned to their previous employer. Only two people had gone back to their former job, and one other person had returned to her previous employer in another capacity, having first taken up work with a different employer when she initially moved off Incapacity Benefit.

Some people explicitly stated that they would not have wanted to go back to their previous employer. As was discussed in Chapter 4, some people felt that leaving their former employer had been the right thing for them, because of the impact the job was having on their mental health. In other cases, there had been

---

<sup>14</sup> The ADF provides awards of up to £100 (previously £300) in any 12-month period, which can be used to help certain groups of benefit claimants to resolve the barriers to employment and job search that they face. The ADF allows Personal Advisers (PAs) flexibility and discretion to use financial assistance to respond to customers' individual need in circumstances where a small amount of money can be instrumental in breaking down barriers to work or job search (Irving *et al.*, 2004).

additional negative aspects of their job that had precipitated their decision to leave, notwithstanding the impact on their mental health.

Some people had returned to their previous field of work. These included people in freelance self-employment and people who routinely worked via employment agencies on temporary contracts. There were also people whose work histories comprised a number of jobs in the customer service, hospitality or manufacturing sectors who had returned to this same broad field of work, but sometimes took up work that they had not specifically done before. However, other people had deliberately made a more 'radical' shift in the type of work they took up, sometimes influenced by their experiences of leaving work due to job-related stress. Such changes of perspective on job and career plans will be considered in more detail in Chapter 6.

There were very few illustrations of phased returns to work in the sense of gradually increasing one's hours with one employer. This is perhaps a reflection of the fact that only two people had returned to a prior position, one of whom did make a phased return on the strict advice of her manager and GP. Several people had moved directly from IB into full-time work. However, there were a number of examples of people independently planning their return to employment in a way that was gradual and incremental.

Some people had made use of the permitted work rules to take up work on a part-time basis, in the first instance, while retaining their entitlement to IB. For one person, this continued for the maximum permissible period of one year, after which she decided to move into full-time work. There were a number of examples of people who had occupied professional or senior roles before their period on IB taking up less skilled or more casual employment as a first stage. Taking account of their prior experiences of work-related stress, anxiety or depression, some people had deliberately begun by taking up jobs that entailed less responsibility or pressure than their previous roles. In some of these cases, people had gradually worked towards a role that was more comparable to their former position. However, other people had changed their aspirations and were content to work in a less senior or prestigious role for the benefit of their mental health. For example, one person had been offered a promotion since starting her job but had chosen not to take this up, being mindful of the detrimental effect that greater work pressures could have on her mental health. Another described her partner's frustrations that she was 'overqualified' for her current role and was 'wasting' her abilities. While she acknowledged this and saw her partner's comments positively, she was nevertheless conscious of her need to take things gradually.

Some people, who recognised that their mental health condition was still present despite feeling able to return to work, described decisions they had made in selecting the type of work they went into, for example, giving consideration to how the hours of work would interact with the fluctuating effects of their mental health condition. In a notable example, one person described how he had taken a decision to work via employment agencies, because this meant he could accept

work when he was feeling well enough, but state that he was 'unavailable' when he did not feel able to work. This approach had the dual advantages, as he saw it, of not needing to tell employers about his mental health condition and also not 'letting people down' as would happen if he became unwell under a permanent contract of employment. Another person felt that the only reason she had been able to take up and maintain a job was because of the flexible hours, which meant she could work as and when she felt able, and again had not needed to tell her employer about her mental health condition. In a third example, working an afternoon shift had been helpful to an individual whose depression affected him more strongly in the mornings.

Most people in the study group felt that they had been able to exercise choice in their return to work, both in the timing and the type of work they went into. Among the small number of people whose initial move off IB was not voluntary, there was some evidence of more limited choice in waiting for a preferred job opportunity to arise, given the reduction in benefit level and requirement to seek work if claiming JSA. However, even among this group, there were people who felt that, once they had begun the process of looking for employment, they too had been able to return to work on their 'own terms'.

Although, on reflection, some people initially felt that they might have gone back to work before they were fully ready, most people felt they were now managing well in their new role. Some people had left work for other reasons by the time of the research interviews, but only a few study participants described ongoing struggles in work or subsequent departures from jobs because of the effects of their mental health condition.

There were also some people who felt that, while their job was manageable and relatively enjoyable, they had not been able to go into the sort of work that they really wanted to do. In most cases, however, people identified reasons other than restrictions imposed by their mental health condition, for example training and qualification needs, age barriers or local labour market conditions.

### **5.1.6 Telling people at work about mental health conditions**

This section considers people's decision making and experiences of telling people at work about their experiences of mental ill health, during either the recruitment process or once they had taken up their job. (Chapter 3 considered the decisions and experiences of people at the time when a mental health condition began to affect them in work.)

For the few people who had returned to a previous employer, their mental health condition was already known about by their manager at least, and sometimes by other colleagues. A further two people had initially taken up employment with someone they knew personally, and who was already aware of their experiences of mental ill health. Among people who had applied for work with a new and unfamiliar employer, very few had mentioned their mental health condition at the recruitment stage. Two main themes emerged from people's explanations of why they had not done so.

Firstly, a number of people felt that telling a potential employer about their past (or ongoing) experiences of mental ill health would damage their prospects of getting the job and would not be a very good way to 'sell yourself'. Some people perceived that employers would view people with mental health conditions as a 'risky' appointment or that telling a prospective employer about mental ill health would effectively eliminate their chances, although the employer might find other ways of explaining their decision:

*I've not mentioned it ... I just think that as soon as you mention that you might as well say, thank you very much, good bye.*

(Female, 50s)

*As an employer myself, I think when people tell you some of these things you're thinking hmm, this is going to be a bit risky. You're a risk and do they really want that risk at the end of the day? Probably not, and they're probably not going to tell you that that's the reason.*

(Male, 50s)

For these reasons, some people had not said anything about their time off work, and others said they had given a different explanation for the gap in their employment history, for example as a 'career break' or time they had chosen to spend out of employment while they raised their family.

A second common theme was that people did not feel, at the time they returned to work, that their mental health condition was something that was relevant or necessary to mention. This reflects the earlier finding that most people were feeling 'better' when they decided to go back to work. People explained how they believed there was no need to tell their prospective employer about their previous experiences because they were no longer feeling affected by mental ill health, because their condition was being managed through medication or other 'coping strategies' or because they felt that they could meet the demands of the job despite any ongoing effects of their condition.

For some people, both of these factors contributed to their decision not to mention their experiences when applying for a new job, as this quotation illustrates:

*I thought no I'm not going to tell you because that will prejudice your decision about me – understandably, because they're bound to think well it could happen again – and I just felt that I'd got to the point where I could apply for this job knowing that I was going to be OK.*

(Female, 40s)

Some people said they had not mentioned their mental health condition at the recruitment stage simply because no question had been asked about this. Among people who had taken up work via employment agencies, there were also comments that there was no need to mention anything because these agencies would not 'care' about their mental health condition. This lack of concern referred to the role of the agency as a broker between employer and employee, who



had little interest in supporting or otherwise addressing any health needs of the individual:

*Temps are a commodity, their business is to sell the commodity or rent out the commodity rather, and make money from it. If the commodity goes bad, either the client or the agency does something about it, it isn't anything like permanent employment.*

*(Male, 60s)*

Among people who had told employment agencies about their mental health condition, there were mixed experiences. One person described an understanding and sympathetic response, when she had described the traumatic event that had led to her anxiety condition, while another person had been told that as long as he felt able to manage the work, his mental health condition was of no consequence to the agency. However, a person with a long-standing experience of schizophrenia and depression said he had struggled to obtain work via agencies in the past because of the long gaps in his employment history and the agencies' concerns about the effects of his mental health condition on his performance in work: 'They think it might reoccur and they're too worried about their own name'.

There was also a small number of people who had mentioned their mental health condition to a prospective employer at interview. In some instances, this was in response to a question about recent gaps in employment, but in other cases people had volunteered this information. One person explained how she had wanted to be 'up front' about her mental health condition and make sure this was not going to be perceived as a problem should it affect her in work at any point. In each of these cases the individual had been appointed to the job, their experiences of mental ill health not being seen as problematic, or indeed in one case said by the employer to be a potential advantage to the role.<sup>15</sup> Nobody in the study group mentioned having any adjustments made for them at the time of application or interview.

Turning to whether people had talked about their experiences of mental ill health with employers or colleagues after moving into their new job, a feeling that there was no need to mention their condition if it was not impacting significantly on them or their work was again a key reason why people had not raised this in the workplace. By the time they returned to work, some people said that their experiences of mental ill health, and the events underlying this, were something that they wanted to 'move on' from, or in the words of another person, wanting to 'leave my past as that'. Some people said they did not want others in the workplace to know about their experiences of mental ill health because they were 'embarrassed' or because this was a personal or private matter. A view expressed

---

<sup>15</sup> We should note here that, by definition, the sample of people moving into employment did not include people who had mentioned a mental health condition during the recruitment process and who subsequently were not successful in getting the job.

by a small number of people was that they chose to keep work and their personal life 'separate'.

Another reason given for not mentioning a mental health condition to their employer was the perception that this could lead to them being 'labelled' or 'judged'. A further explanation was that people did not want to 'draw attention' to themselves or be given 'special treatment', some people feeling that being 'singled out' would make things harder for them. There were also comments that being treated differently would be 'isolating' or make them feel like an 'outcast':

*I've always been the kind of person that I don't like special treatment, because then people are gonna be like 'Oh she's got this and she's got that and she's got the other' and, you know, I don't want to be different, it makes things harder when you're singled out. It makes things harder.*

(Female, 20s)

In contrast, one person who experienced depression described how, in previous jobs he had not told employers about his mental health condition because he perceived it as a 'weakness' at this time. However, having come through the events in his personal life that had contributed to his depression, and having attained a better understanding of his condition, he now did not see this as a weakness, but as something that had made him stronger and that he was no longer concerned to hide from other people.

Some people said that they had shared some information about their mental health condition but not 'the full story', for example, explaining the personal circumstances that had led to their time off work, but not going into detail about the effect this had had on their mental health. In another example, when asked informally by a colleague why he had left his previous job, the individual said that he had not been able to 'hack it' but had not described the extent of the depression he had experienced. Some people, who had moved through a number of jobs since coming off IB, had chosen to tell certain employers about their mental health condition but not others, their decisions at each stage reflecting their views on the relevance of this information and how it would be received. For example, one person who had held a professional role prior to claiming IB had initially taken up a low-skilled job and had not mentioned her mental health condition to this employer because it was 'none of their business'. She later joined an employment agency that arranged temporary placements in her previous field of work. Here, she had informed the agency on joining that she had taken time off due to depression. Finally, she moved into a new role with her previous employer, who was already aware of her experiences of mental ill health, and who offered adjustments and occupational health support.

One person explained that he was waiting a while before deciding whether to tell his new employer about his mental health condition. Although he had mentioned his experiences to one of his closest colleagues, he had chosen not to explain his mental health condition to his managers yet because it might 'scare them a bit' and he wanted to demonstrate to them that he was capable of doing the job first.

Another person noted that, although he had decided not to tell his new employer about his experience of mental ill health, he had become aware of the positive response and support that another colleague had received and so was giving some thought to whether he might also mention his own mental health condition to his employer.

### **5.1.7 Responses to learning about people's mental health condition**

In almost all of the cases where people had told their employer or colleagues about their mental health condition, responses had been either positive or neutral. In both of the cases where people had returned to the same job, managers and colleagues had been supportive, and the individuals said that they had felt welcomed back into work with few or no negative repercussions. One person noted that she had become aware of some 'gossip' among certain colleagues in other departments than her own, but felt that this was to be expected. From this individual's account of her return to work, it seemed that the supportive comments and actions of other members of staff had outweighed the more negative remarks.

Where people had told a new employer about a mental health condition, responses were again predominantly sympathetic and supportive. In most cases, no particular adjustments had been made, but employers and colleagues were said to have been understanding of the occasional effects of the mental health condition on people's behaviour or mood. One study participant, who had explained the personal circumstances surrounding her mental health condition when it became apparent to her manager that she was struggling in work said that, on reflection, she wished she had told them sooner. This was a temporary position and the perceptible difficulties she was having were not discussed with her until close to the end of the appointment. However, her employer said that had she mentioned her difficulties earlier, they may have been able to arrange for her to take some time off as necessary. For most people, having things 'out in the open' (to a greater or lesser extent) appeared to be a positive thing. However, the point was also raised that there was a fine line between the benefits of telling employers about a mental health condition in order for its effects to be understood and supported, and the disadvantages of being treated as 'different'.

Only one person in study group recounted an overtly negative response to knowledge of her mental health condition at work, describing how colleagues had made insensitive remarks and showed prejudice towards her. This eventually led to the person leaving work, and to her decision not to mention her mental health condition to her subsequent employer. There was also one case where, although the employer had initially appeared to listen to the individual's request for 'gentle' treatment in light of her mental health condition, this 'adjustment' in behaviour was short-lived and led to the person struggling in work.

### 5.1.8 Employment pathways since entering work

In concluding the discussion of former IB claimants' experiences of returning to work, this section briefly outlines people's employment pathways from the time they first re-entered employment to the time of the research interviews. It highlights that, while most people had sustained their employment, either with one employer, or moving through two or more jobs, some people had experienced challenges in sustaining their return to employment.

Among people who were in work, not everybody was still in the first job they had taken up after moving off Incapacity Benefit. Twelve people (including the two who had returned to their previous post) were still in the same job that they had initially taken up. However, several had changed jobs, sometimes more than once, for various reasons. Furthermore, some people who had made a move back into work were no longer in employment at the time of interview. Importantly, however, among people who had left jobs since moving off IB, very few attributed this to factors relating to their mental health condition. More commonly, people had moved on through choice, because their work had been temporary by nature, or due to conduct or performance matters which they did not feel were related to their mental health.

Most people who had made a return to work but were not in employment at the time of the research interviews were seeking work while claiming JSA or while being supported through another source of income. Additionally, one person was not currently seeking work due to family circumstances that had emerged unrelated to her mental health condition.

Only two people had moved back onto IB after a period of time in work. In both cases, leaving work had been due to the temporary nature of their contract, rather than the impact of a mental health condition on work. However, having left employment, both these individuals had returned to their doctor, who had agreed that issuing a sick note would be appropriate at this point. Both of these cases are illustrations of people who had found work that was manageable alongside their mental health condition. However, having finished in their temporary job, one person had reached a point where he was ready to acknowledge and address his alcoholism and the other, who was reaching retirement age, conceded that there had been an element of 'collusion' with his GP in signing him off sick for the remaining few months before he was entitled to his pension. He was grateful for this because it spared him the 'stress' of making what he felt would be 'fruitless job applications', as would be required if he had had to claim JSA at this stage.

## 5.2 Employers' experiences

In this section of the chapter we look at employers' experiences of recruiting and appointing people with mental health conditions. It covers employers' recruitment practices and policies, whether and how employers find out about a mental health condition at recruitment or appointment stages, their responses to learning about

potential employees' experiences of mental ill health, and areas of the workplace or job roles in which they believed it might be difficult to employ someone with a mental health condition.

### **5.2.1 Recruiting people with mental health conditions**

#### **Recruitment strategies**

The employers who took part in the study used a range of methods to recruit and attract applicants for posts. Some advertised jobs in the press (local, national or specialist), Jobcentre Plus, online or through recruitment agencies. Smaller employers tended to attract applicants through more informal means such as word of mouth and recommendations from friends and family. The most common method for selecting applicants was the use of application forms or CVs followed by one or two interviews. In some of the larger employers, more sophisticated recruitment techniques were also used, including psychometric tests and spending time at an assessment centre, whilst many of the smaller employers told how they gave applicants a trial period to see how well they suited the job and how they 'fitted in'.

#### **Recruitment policies and practices**

When asked about their policies on employing people with mental health conditions, most of the large and medium-sized employers spoke in general terms about their 'equal opportunity' or 'diversity' policies, without specifying any detail about how these influenced their recruitment practices. Often their policies referred to disabilities or equalities broadly rather than to mental health conditions specifically. Sometimes this reflected a deliberate decision by the employer to move away from listing specific conditions towards a more inclusive approach.

The smaller employers rarely had any policies in place. Only one, a small voluntary sector employer that operated as part of a national organisation, mentioned having a written policy on recruitment. Most small employers did not have anything written down, and explained that they relied instead on their experience.

Some of the large and medium-sized employers had worked with Mind, Shaw Trust<sup>16</sup> and other employers to get advice on their policies, procedures and training, but not specifically for advice on their recruitment process (see Chapter 2 for discussion of more general advice and information sought by employers to increase their understanding of mental health conditions and employment). Employers had little to say on the subject of advice and information sought on recruiting people with mental health conditions. Where they had sought advice this tended to be more general, for example, on their diversity policies, or as a result of a situation with an existing employee. There were no reports

---

<sup>16</sup> The Shaw Trust is a national charity which works with employers, social services and disabled people to help them find employment. See [www.shaw-trust.org.uk](http://www.shaw-trust.org.uk).

of training activity which focused specifically on recruiting people with mental health conditions. The head of human resources of a medium-sized voluntary sector employer reported that they wanted to recruit more people from the local community, and would like more information to ensure that they could achieve this effectively. She thought that they might need to deliver more training to staff involved in recruitment to ensure that it was not discriminating in any way.

### **Learning about mental health conditions at recruitment**

A small minority of employers asked about health conditions during the application and selection process. A few (some of which were large, some small) said that they asked applicants to declare a disability on the application form or during an interview, but typically did not ask specifically about mental health conditions. Many of the larger employers in the sample reported that they deliberately avoided asking these questions during the selection process itself for fear of breaching the Disability Discrimination Act (DDA). They asked instead about access requirements or special requirements so that they could ensure people were able to attend an interview, but did not go beyond this.

*If an individual volunteers it then that's up to them. The whole process is set not to ask until after recruitment. ... It means that people are coming in on an even footing and we're not disadvantaging them in any way.*

(Occupational health director, engaged employer, large, primary and manufacturing sector)

Most of the small employers and some of the medium-sized employers did not ask about any health conditions either before, during or after recruitment. Some did not know whether they were legally allowed to ask for this information. In contrast, most of the larger employers did ask about health conditions including, in some cases, mental health conditions, but typically this was through use of a pre-employment health questionnaire, and took place only once a job offer had been made. Because of this, many of the employers believed that they would not find out at recruitment unless applicants elected to share this information themselves and most employers accepted that they may choose not to do this (see discussion in Chapter 2).

Regardless of size, few of the employers collected information on mental health conditions for monitoring purposes. One of the engaged employers asked for this information in an equal opportunities form but only once an applicant had been offered a job. They admitted that it would be useful to know more about the mental health of those who were not successful, so that they had more information on the numbers of people with mental health conditions sending in an initial application.

One of the engaged employers said that they were trying to improve recruitment practices to make them more reflective of the wider community. They wanted to introduce more monitoring, and under the Disability Equality Duty (DED), they were legally obliged to, but had been struggling to think of ways to add to their

application form without putting applicants off. At the time of the interview they were planning to do an impact assessment on the proposed changes by consulting with organisations such as Shaw Trust on the proposed new forms.

In some of the larger employers, information about mental health conditions obtained from pre-employment questionnaires was kept confidential by the occupational health department unless adjustments were required. This would suggest that human resources and line managers would not necessarily be aware of the number of applicants providing this information. However, the study included some interviews with individuals working in occupational health, and they too reported little disclosure of mental health conditions prior to employment.

As such, most of the employers in the study group had little or no experience of finding out about mental health conditions at recruitment. A few gave examples of applicants who had been open about their conditions at an early stage, either on application forms or at interview, but these examples were rare, and limited in the main to the larger employers. A line manager in a large public sector employer told of applicants who, during their interviews, had mentioned periods of depression. However, on the whole, employers believed that applicants were far more likely to declare a physical disability than a mental health condition. Many of the employers recognised that an applicant might decide not to share this information, citing the stigma that still surrounds mental health conditions. However, one employer thought that the decision not to disclose a mental health condition at the recruitment stage could ultimately disadvantage applicants, both in terms of their likelihood of being offered the job, and also their likelihood of being successful in the role. This respondent wondered whether the decision not to disclose a mental health condition during recruitment actually made it more difficult for these applicants to be successful because the applicant might themselves feel uncomfortable during the recruitment process because of their knowledge that they were not revealing all possibly relevant factors to the employer:

*I suspect at the recruitment stage if somebody is genuinely uneasy, or not sure of themselves, that will come over. That's where the problem will be. It might be easier for some people to be more honest and then they'd be relaxed. The ones who aren't, who try to hide things, it may mean that they're not relaxed at interview and therefore don't interview as well, therefore they don't get the job.*

(Occupational health director, large employer, primary and manufacturing sector)

She stressed how the employer went to great lengths to try to match the individual with the requirements of the job, but for this to work effectively they needed applicants to be 'honest' about their condition from the beginning.

### **Adjustments to the recruitment process**

None of the employers could recall occasions when they had made adjustments to the application and selection process itself for people with mental health

conditions. Many had made adjustments (or were able to make adjustments) for people with physical or sensory impairments, such as ensuring access and providing materials in different formats for applicants with visual or hearing impairments. A few mentioned making adjustments for people with learning disabilities, such as allowing a carer to accompany the applicant to an interview. The only example came from a large public sector employer that had provided support to an internal candidate in managing their health at work so that the individual could take up a promotion.

Some of the employers thought it would be possible to adapt their recruitment processes to accommodate applicants with mental health conditions, and some suggested possible adjustments such as allowing partners or other third parties to accompany the applicant and wait in reception during the interview. However, some employers were unsure what changes they could make, and others were concerned about how they might adjust a recruitment process to make it fairer whilst at the same time keeping the assessments standardised. Some employers said that they would like more advice on how to make adjustments at the recruitment stage.

A few of the employers (usually medium-sized or large) had been proactive in helping people with disabilities into work, and had worked in partnership with voluntary and government organisations. One of the engaged employers, a large financial organisation, had occasionally worked with a WORKSTEP<sup>17</sup> provider to help people with mental health conditions apply for jobs in their company. The equalities and diversity officer worked regularly with WORKSTEP providers and occasionally received a telephone call from a representative on behalf of a client with a mental health condition, who wished to apply for a job. In these situations the employer provided information on the recruitment process so that the provider could help the applicant prepare through coaching and confidence building.

However, the respondent believed that in these examples it was the WORKSTEP provider rather than the employer making the adjustments. In practice, she thought it would be hard to adjust their assessment activities for those with mental health conditions as they were closely tied in with competencies for the role. Although the respondent thought they could adjust some aspects of the selection process, for example, by providing breaks during the psychometric tests, allowing tests to be completed in a separate room and providing tours of the premises before an interview, she did not know how they could adjust the tasks themselves, particularly the group tasks conducted in their assessment centres. A personnel director from this same organisation agreed that it would be difficult, and thought that the only real adjustments available needed to come from the applicant, such as taking medication to control their condition during the recruitment stages and (if successful) when appointed to the position.

---

<sup>17</sup> WORKSTEP is an employment programme funded by Jobcentre Plus, which provides support to disabled people facing complex barriers to getting and keeping a job. The programme also offers practical support to employers.



## 5.2.2 Appointing people with mental health conditions

### Pre-employment screening

Employers that did seek information from applicants on health conditions usually did this after the selection activities were complete. Most of the large employers and many of the medium-sized employers explained that they asked about health conditions in a pre-employment screening questionnaire, commonly referred to as a 'medical questionnaire' or 'health questionnaire'. In most cases these were only given to job applicants once a job offer had been made, and were checked alongside references and, in some organisations, Criminal Records Bureau (CRB) reports. The larger employers using pre-employment questionnaires stressed that they kept the information obtained strictly confidential and provided it only to those involved in the final appointment of the individual on a 'need to know' basis. This was to ensure that there could be no discrimination on the grounds of mental health conditions:

*A lot of these disorders are very taboo aren't they? If somebody suffered from schizophrenia, a non-qualified person seeing that word might think 'I'm not taking this on'. We would never see that information and nor would we need to. It would go to our occupational health adviser.*

(Personnel manager, large employer, manufacturing sector)

In employers with an occupational health department (typically only the larger employers) the completed screening questionnaires were sent directly to an occupational health adviser who checked through each to assess whether the applicant was 'fit for work'. If a problem was identified or the information was unclear they invited the applicant in for a face-to-face meeting to find out more about their condition and treatment plan. If more information was still needed, they asked the individual's permission to write to their GP, although it was relatively rare for more information to be required at this stage.

The type of information asked for in the pre-employment questionnaires varied. Some employers asked about a range of specific conditions, including mental health conditions, while others asked more generally for information on any health conditions the employer should know about. Many included questions on days of absence with previous employers, over a specified period.

A few of the larger employers had adjusted their screening questionnaires in recent years to make the process less resource-intensive. Some now asked only for information that was relevant to the applicant's ability to do the job. For example, one of the engaged employers said that their questionnaire had previously asked for information on a wide range of conditions which had resulted in many unnecessary queries over simple conditions such as visual impairments. As a result, they had scaled down their health questionnaire, making it more job-focused. They thought that this would make it less likely that they would pick up information on mental health conditions during recruitment, unless applicants felt that at that time, their condition might have a direct bearing on the way they did their job.

Some of the larger employers had stopped using pre-employment questionnaires altogether to speed up their recruitment processes. Another of the engaged employers in the retail sector had stopped using their pre-employment survey 18 months previously and opted instead to ask about relevant health conditions at interview. Another engaged employer, a large financial firm, thought that health screening questionnaires at recruitment were 'a complete waste of time'. They preferred to ask applicants to declare any disability themselves.

### **Learning about a mental health condition at appointment**

The employers who had been made aware of a successful applicant's mental health condition reported that it was extremely rare for them not to be able to appoint as a result. The head of occupational health for a large public sector employer reported that, of the few applicants whose job offer had subsequently been withdrawn, most of these had been people with drug and alcohol problems, although he also recalled an applicant with psychosis whose application was rejected because she appeared to have little awareness of her own condition. The human resources manager for a large manufacturing employer told of an applicant who voiced concern that the shift work in the post he was applying for might interfere with his medication regime. They met with him to try to work out a way forward but the applicant did not want to declare any more information about his condition and eventually withdrew his application. Most of the employers did not appear to be actively discriminating against applicants with mental health conditions. However, one interviewee, who said that she did not believe that an applicant's history of stress would preclude her from offering them the job, said that she knew of managers in her large construction firm who had rejected applicants who declared at interview that they had suffered from this condition.

Employers who asked for information about mental health conditions at recruitment said that they used this information to see what could be done to help a successful applicant in their new role, rather than as a basis for not recruiting them. It is important to remember that some of the employers in this study had no experience of learning about (and so responding to) information about an applicant's mental health condition at the recruitment or appointment stage. Some of the smaller employers (who did not have recourse to occupational health departments) were unsure what they would do in this situation, but most thought they would start by talking to the individual concerned to find out how their condition affected them and then, if necessary, they would seek information from elsewhere.

### **Adjustments for newly appointed employees with mental health conditions**

Examples of adjustments made included allowing the new employee time off to see a counsellor, and informing them of the support available internally, such as an Employee Assistance Programme. However, in most cases employers had not needed to make adjustments to accommodate a new employee. Matching the evidence from people in the study who had returned to work (see Section 5.1.6), the head of health services for an engaged employer in the

transport sector suspected that this was because people tended to be well when they applied for work:

*Most people with mental health issues, if they're in a position to be applying for an appointment it tends to be when they're currently well. Whether on medication or whatever. The adjustments tend to come more often for those who are in employment and are having issues.*

(Head of health services, engaged employer, large, transport sector)

Some of the employers were able to give examples of occasions when they had successfully employed someone with a known mental health condition. For example, a medium-sized employer that provided cleaners for a variety of premises told of an applicant who was open about his seasonal affective disorder at recruitment but had not had any problems since starting. A large employer in the construction sector reported recruiting someone with a history of depression who similarly had not experienced any problems since being in post. One respondent, from a medium-sized local authority employer, thought that by employing an applicant with a known condition they had actually helped her to deal with it. She had become unwell after a bereavement, but the respondent thought that the new job gave her 'something to focus on'.

Compared with the larger employers, small employers felt more limited in the adjustments they could make to a role, due to a lack of resources, and because their smaller staff base provided less flexibility to alter roles and duties.

Some employers called for better partnership working between all the parties currently providing support to people with mental health conditions and employers. For example, the director of a small voluntary employer thought that there needed to be more 'joined up' working between social care services and employers.

### **5.2.3 Job suitability and mental health conditions**

All of the employers were asked whether there were any roles in their establishment in which it would be difficult to employ someone with a mental health condition. Many of the employers made the point that they did not view all people with mental health conditions as the same. They said that different mental health conditions could have very different potential effects on people's behaviour and performance, and some also said that people with similar conditions could experience them differently, and could behave differently from each other as a result. In general, many employers said that they would need to look at each situation individually, at the role in question, at the person, and at their experience of mental ill health and the ways in which it affected them. This finding on employer willingness to employ someone with a mental health condition is similar to findings on willingness to employ people with various disabilities or impairments – it varied according to the type of condition and job role, as well as by size of employer, with larger employers generally having more flexibility than smaller employers (Simm *et al.*, 2007).

Most employers were open to the idea of appointing someone with a mental health condition (but, as noted in Chapter 1, it is likely that our sample is skewed

towards employers with more positive attitudes in this respect). They reported that their decision to appoint would depend on the individual and the way in which their condition affected them but that there were no roles that would be ruled out. Many said that rather than imposing a 'blanket ban' on a particular condition or role, they would spend time talking through the condition and its effects before deciding whether an applicant was suitable.

*You'd have to look at each position and each condition. Certain conditions may be appropriate or inappropriate for certain roles and not for others.... So you wouldn't say no you can't have a mental illness in that role. You can't be as broad brush as that.*

(Personnel manager, large employer, manufacturing sector)

Nonetheless, some of the employers were able to think of certain roles where they would be wary of placing someone with a mental health condition. This was because these roles were stressful, or there were considerable health and safety considerations to take into account, for example, working with hazardous substances, on building sites, with heavy machinery, or in other potentially dangerous environments. Employers also had concerns about placing people with some mental health conditions in situations that involved working with vulnerable groups. These are discussed in the subsections ahead.

### **Stressful roles**

Many employers were wary of appointing someone with a mental health condition, particularly a history of stress, into one of their more stressful roles. For example, the personnel manager at one of the engaged employers, a large retail organisation, said she would be concerned about putting people with a history of stress into their design or buying roles which tend to be highly pressured. The head of external affairs and human resources from a large employer in the financial sector voiced concern about putting people with a history of stress into one of their customer-facing roles:

*Our front line customer service areas are quite stressful, dealing with customers who might have complaints, then that might be an area where you might have to think carefully. I'm not saying that would preclude anybody, but you have to be conscious that they are stressful areas.*

(Head of external affairs and human resources, large employer, financial sector)

### **Health and safety issues**

Some organisations' work involved activities in potentially hazardous environments, such as construction, manufacturing, and working with animals. Some of the respondents were wary of placing someone with a mental health condition into one of these potentially dangerous roles. Employees in these environments had to keep alert and focused, and respondents worried that someone with a mental health condition could suffer a lapse in concentration which would put them in

physical danger. For example, the human resources and health and safety manager in a large construction company said he might have reservations about employing someone with a mental health condition in one of their service technician roles where people were required to work at heights. Again, this concern stemmed from a previous experience of employing someone with a mental health condition who, in this case, had committed suicide while at work. This respondent was consequently particularly wary of employing anyone who had displayed suicidal tendencies or had a history of self-harm, but did not have any concerns about employing people with mental health conditions in their office-based posts.

Some of the employers noted that they wanted to ensure that people were not put into jobs or situations that could exacerbate an existing mental health condition. Again, the need to consider individual job suitability on a case-by-case basis was emphasised:

*We take it on each condition as assessed and each individual as assessed... What their prognosis is, what their stability is like at the time, what medication they're on, what their advice is. We do it on an individual condition. One person can be in a completely different place to another.*

(Occupational health director, large employer, primary and manufacturing sector)

### **Working with vulnerable groups**

Some of the employers provided services to the public, including vulnerable groups such as elderly people, children and healthcare patients. A few of these employers expressed concern about the impact of employing a person with a mental health condition on their service-users and how it might lead to claims of inappropriate or unsatisfactory service from members of the public.

*I don't really want to recruit somebody into a situation where they're working with vulnerable people. They can transfer their depression and stress on to them, into a team that's already busy and quite vulnerable and I have a responsibility as an employer... I will tell them 'This is too stressful for you'.*

(Manager, large employer, healthcare sector)

A respondent in a medium-sized private residential care home voiced concern about employing someone with a mental health condition in a role where they were responsible for handing out medication to residents. The occupational health adviser at a large healthcare organisation was mindful of the greater consequences of 'getting it wrong' in their work environment compared with others, as they were responsible for patient welfare:

*The consequences of our lot getting it wrong are probably more significant than somebody who works in a factory or maybe types up some letters wrong.*

(Occupational health adviser, large employer, healthcare sector)

Some of these employers thought that they would risk breaching other legislation, such as health and safety legislation, if they employed someone with a mental health condition. For example, the contracts manager for a medium-sized employer, which employed cleaners in a range of public premises including schools, was very concerned about employing anyone with a mental health condition that resulted in aggressive behaviour. However, this employer had no concerns about employing someone with a history of depression in one of these roles, and had done this in the past.

### **Concern about particular mental health conditions**

Most of the employers believed that there were roles at their establishments in which it would be possible to employ someone with a mental health condition, although they often felt that some roles would be less suitable for people with certain types of condition than others. Those employers who had concerns were typically more worried about the effects of some mental health conditions than others. As already mentioned, there was some concern about people who suffered from stress and how they would cope in more stressful roles. A minority were particularly concerned about bipolar disorders and schizophrenia. These were perceived as relatively severe conditions, and were thought to be more likely to cause unpredictable behaviour.

*I imagine schizophrenia would be something we would have to be very careful about. One minute they can be calm and placid and the next minute they can be totally erratic and running around and doing terrible things.*

(Human resources representative, medium-sized employer, voluntary sector)

The human resources representative for a voluntary sector employer was concerned about employing people with certain mental health conditions, including drink and drug problems, in roles where they were likely to come into contact with visiting children, but said she would be happy to employ them in the gardens, where they currently had two employees with bipolar disorder. A number of the employers voiced concern about employing people with drink or drug problems, and one, mentioned previously in Chapter 3, had a 'zero tolerance' policy on this.

Just two respondents were altogether wary of employing someone with a mental health condition, regardless of the specific condition. This stemmed in both cases from past experiences. The owner and manager of a small restaurant told how his challenging experience with a previous employee had put him off employing people with mental health conditions again:

*I would steer clear of people [with mental health conditions] because I know you can't help, without any help, all it's going to be at the end of the day is detrimental to the business.*

(Owner and manager, small employer, catering sector)

A manager at a large healthcare employer was wary of recruiting people with mental health conditions and worried about the impact on others in the workplace.

This stemmed from an experience of working with an employee with a bipolar disorder who had been disruptive and abusive towards other staff and patients at her hospital. This example illustrates how previous experience can be pivotal in shaping views and may lead to a general reluctance to employ people with mental health conditions.

### 5.3 Conclusion

One of the aims of this research project was to learn from the experiences of people who had successfully made the transition from a period on benefits to finding employment. From these experiences, and from the 'success stories' of employers, it was hoped that lessons for policy makers would be generated.

It has been interesting therefore that one of the key contributors to getting into work identified in this study was an improvement in mental health (or 'feeling better') to the extent that an individual felt ready and able to do some form of work again. Most people in the study who had found work therefore did not mention their mental health during the recruitment and appointment processes. For these people, their period of mental ill health had ceased to be a relevant or necessary piece of information to make known to a prospective employer. In some cases, people explained that their decision not to tell an employer was reinforced by their expectation that, if they had, then their chances of getting a job would be reduced or disappear.

Some people in the study group were critical of the lack of support in looking for work from mainstream Jobcentre Plus advisers. In contrast, DDAs were found to be much more helpful. It must be remembered that this study was undertaken in areas without Pathways to Work provision so that benefit recipients would normally have little input from advisers. We might interpret this finding therefore as being an endorsement of the Pathways rationale of providing a service of personal adviser support to benefit recipients with health conditions.

It might have been expected that employers in the study would have argued strongly for knowing about people's mental health (current and previous) before they made appointments. However, the evidence here was very mixed. We identified a range of views, from those employers who did not expect people to provide information about their mental health and who saw limited value in making much effort to find out (for example by using pre-employment health questionnaires), to those who thought that being 'upfront' and 'honest' was more constructive in the long term. There were also some employers who said the nature of their business would make them very cautious in recruiting someone with a mental health condition to certain positions, for example if the work was pressured or stressful, where health and safety was a concern or where the job involved working with vulnerable groups.

Few employers in the study had seemingly given much thought to how their recruitment and selection processes might be adjusted to accommodate people with mental health conditions, and few had sought any advice and guidance from external specialist organisations. This contrasted with their descriptions of what could be done to help people with physical disabilities or learning difficulties.

The final observation to make from the analysis in this chapter is on people's experiences of telling a new employer about mental health conditions. When people did tell their new employer about their mental health, either during recruitment or upon taking up a post, they were mostly met with constructive responses, and that any fears about negative or prejudicial reactions proved to be unfounded. We will reflect further on this and other findings in Chapter 7.



## 6 Attachment to work

In this chapter, the focus moves away from people's transitions into or out of specific jobs and considers broader questions of 'attachment' to work, including people's overall feelings about being in work, the importance they place on it and the benefits (or otherwise) which they perceive as stemming from employment. The chapter goes on to discuss people's employment expectations and aspirations for the future and, for people who were not currently in work, the changes, actions or supports that they felt would be necessary for them to become 'reattached' to work.

### 6.1 The meaning and value of work

In the research interviews, study participants were asked about whether their work was or had been important to them and to give their opinion on the viewpoint that 'work is good for you'. Responses to these two areas of inquiry demonstrated that a majority of people in the study group saw work as beneficial in a range of ways.

People varied in how strongly they felt about their specific job or profession.<sup>18</sup> Some people described their work as a 'passion' or talked enthusiastically about their commitment to their job or their clients. Some people emphasised that it was important to them to do a meaningful and worthwhile job that involved helping others, or to feel a sense of identification with the company they worked for. On the other hand, for some people, work was more of a 'means to an end'. Reflecting on their work histories, some people felt that they had never been particularly ambitious or career-minded, but had worked primarily in order to support their family and life outside of work. There were also people who felt that current or recent jobs had not been particularly engaging or connected to

---

<sup>18</sup> The diversity among the study group means it is difficult to make any general comments about people's employment histories. Given the range of ages among participants (18 to 64) the length of people's working lives varied substantially. The education and subsequent employment pathways people had taken over their years in the labour market also varied greatly.

their longer term career plans, but they had nevertheless 'taken it seriously' and enjoyed work on a day-to-day basis.

Among the study group overall, there was much evidence that people placed a great deal of importance on being in rather than out of work, regardless of the level of personal meaning they attributed to their particular occupation. Where there had been significant gaps in people's employment, the main reasons given were time off while caring for young children and previous periods out of employment due to the effects of mental health conditions, which for a minority of people included time in residential settings. There were also a small number of people who had spent time in prison. Although a number of people had some experience of claiming Jobseeker's Allowance (JSA), there were few accounts of long-term unemployment.

The strength of people's desire to be in work was evident in a number of ways, including: the length of time that some people 'struggled on' in work despite experiencing mental ill health; the actions of people who had left work due to a mental health condition but taken up another position prior to claiming Incapacity Benefit (IB); voluntary moves off IB to JSA when people felt able to work; and the continued jobsearch activities of some people who said they had never really stopped thinking about work while on IB. As noted in Chapter 3, there was also much evidence that people saw work as being the normal, expected and desirable status and way of supporting oneself:

*I'm a person who supports myself, I have responsibilities out there. I have my needs, I have my standards and that entails work.*

(Male, 30s)

*I was brought up in the situation where everybody worked, and worked hard at whatever they were doing, and it's just not in our psyche not to work.*

(Female, 50s)

It was very clear from most people's comments that they did not like to be inactive, and so long as they were feeling well enough, they wanted to be in work. Notwithstanding their periods of struggling in work due to mental ill health, most people said that they enjoyed being in work and there was widespread general agreement with the proposition that 'work is good for you'. Several common themes emerged as people elaborated on what they saw as the benefits of being in employment.

One important benefit was that work kept people 'active' and 'occupied', giving them 'something to do' or 'something to get up for'. The routine and structure provided by work was also seen as beneficial in providing 'stability' and 'keeping you going'. For some people who had experienced depression or drug addiction, keeping busy and 'distracted' through work was cited as particularly important in avoiding boredom or excessive time to 'dwell on' things, which could trigger or exacerbate their mental health condition:

*Since I've been back in work now, I feel a lot more alive with myself ... When I was on the Incapacity there was nothing to do, you just sit around and it wasn't really helping me in any way really. ... It's like digging a hole and burying yourself really. You sit around doing nothing and the hole just keeps on getting bigger and I didn't feel it helped in any way.*

(Male, 20s)

*Working's very good for people. It keeps them motivated, it keeps them concentrated, it keeps them a decent person, and it keeps them a more practical person, more to life, you know.*

(Male, 20s)

Linked to this theme of activity and mental stimulation, people noted the social benefits of employment. Work got people 'out and about' interacting and engaging with others, which was again noted as important in reducing the isolation that could exacerbate depression. Furthermore, for some people, work was a source of 'camaraderie' and an environment where they had built strong friendships.

Having a job was seen to provide psychological benefits of 'pride', 'dignity' and 'self-esteem'. There were also references to the 'persona' and 'respect' that accompanied the positions that some people had held in the past. People also talked about the satisfaction they got from doing their job well, from being 'appreciated' and from feeling they had a 'meaningful' or 'useful' role. Some people specifically felt that it was important to make a 'contribution to society'. Work was also valued for enabling financial independence from a partner or parents, and for some people was also valued for providing a separate identity from their domestic and parenting role. There were also comments that work was central to 'getting somewhere' in life and 'having a standing of your own'. Increased confidence was also a benefit that some people said they gained through their work.

There was also recognition that work had a key role in providing an income. As already noted, some people took a fairly instrumental approach to work and saw an income as their principal motivation. Fulfilling a 'provider' role for their family was important to some people. Others noted how, at certain times of life, income levels became a more central concern, for example, when starting a family or supporting children through university. However, when asked about the importance of work, financial gains were not among the most common spontaneous responses. Some people specifically stated that money was not foremost among the benefits they gained from work and that the social engagement or personal fulfilment was of greater value to them.

Although everybody in the study group viewed work as beneficial in principle, it is important to note that a small number of people, namely those who were experiencing a period of acute mental ill health at the time of the research interview, felt that work would not be good for them at the moment. Recalling the discussion in the previous chapter, a number of people felt that, at the time their mental health condition was at its most severe, they too could not have stayed

in work in the short term. Finally, some people who had experienced anxiety or depression noted that it was important to be in a job that they enjoyed. One person explained that when experiencing depression 'everything's a struggle' and so a job that was not enjoyable only made life harder, while another said that work was good for you if you were happy at work, but not if you were 'miserable and coming home stressed'.

## 6.2 Looking to the future

At the time of the research interviews, the study group included people who:

- were currently in work having moved off IB;
- had returned to work for a time but were not currently in employment and were now claiming JSA, or had reclaimed IB, or were being supported through another source of income;
- were still on IB with no return to work;
- had moved off IB (voluntarily or following a medical assessment) but had not yet returned to work and were claiming JSA or being supported through another source of income.

Among those who were in employment at the time of interview, most people were glad to be back in work and, overall, were enjoying their current job and feeling positive about the future. In describing the aspects of work that they enjoyed, people's comments reflected the benefits of work that have been outlined above, such as social contact, activity and occupation. Some people noted certain aspects of their new job that they struggled with, but these were generally unrelated to, and were not described as impacting on, their mental health. Some people, particularly among the older members of the study group, hoped to stay in their current jobs for the foreseeable future, perhaps until retirement. Several of the younger people had plans to return to education or training, to gain vocational or academic qualifications which would allow them to set out on or to make a more radical change to their career path.

Some people also talked about a realisation that the type of work they were in was not very well suited to them, given the effects of their mental health condition. For example, a person who experienced depression and who worked on a freelance basis, which inherently involved uncertainty about workflow, felt it would be beneficial to find work that was more consistent and predictable. Another individual felt that his experience of depression due to 'job stress' had been valuable in a way, because it had helped him to identify the alternative career path that he did want to pursue.

A small number of people described continuing difficulties in work which they linked to their mental health condition. Two people explained that they were currently struggling to manage in work, one of whom was off sick at the time of the research interview and was not planning to return to her job. One person had

changed jobs because he had found his role detrimental to his mental health, and another was thinking about changing jobs within the next few months, though this was in part due to physical health constraints. However, these few people who were looking to change jobs because of the effect their current work was having on their mental health maintained that they did want to work and felt able to work, given more suitable job conditions, for example, part-time hours.

Among the study participants who had not yet returned to work at the time of the research interviews, some people who were still on IB felt that, at the present time, they were not ready for work and needed to spend longer addressing their mental health problem. However, almost everybody hoped to return to work at some point in the future. Only a very small of people number were in a position where their ongoing experiences of mental ill health made it difficult to think about work at all. Rather, most people talked in some detail about their plans and ideas for work in the future. As with people who had returned to work, a number of people talked about plans to take up or return to education, in order to improve their prospects or work towards long-term career goals. Some people, not only younger members of the study group, were already engaged in vocational or basic skills training, either initiated independently or with support from Jobcentre Plus.

Moreover, some of the people who had moved onto JSA, and indeed some people still on IB, said that they were feeling much better or at least well enough to return to work. Reasons underpinning such feelings included effective medical treatment, improvements in the personal circumstances that had triggered mental health conditions, time to overcome traumatic events, or the passing of a low ebb in a fluctuating condition. Thus, the current positions of these people closely reflect the accounts of feeling ready for work that were given by study participants who had already returned to employment.

Despite widespread desires to be in work, however, some people's expectations or aspirations for work in the future had altered somewhat, in light of their experiences of mental ill health while in work. Other than the few people who had already done so, nobody expressed a wish to return to their previous job, including the two individuals who were still under contract or 'on the books' with their most recent employer. Moreover, some people's experiences had made them feel that they could not return to their previous type of employment, because of the negative emotions or high levels of anxiety that were associated with it. For some people, this meant seeking a new direction after several years in an established career, for example, teaching, nursing or administration.

As noted in Chapter 5, some people who had returned to work were not seeking to obtain as senior or responsible a position as they had held previously and this view was echoed among some of the study participants who were still in receipt of IB. The experience of 'breaking down' under the pressure of work had led some people to be cautious about the kind of work they took on in the future. Although people frequently discussed a range of possibilities for alternative work, one person, who did not feel able to return to her previous profession explained that she was now feeling 'a little bit lost' and in need of some guidance in finding a new career path.

The experience of mental ill health had also led some people to reassess the priority they placed on work among other aspects of their lives. One person in the study group who had earned a particularly high income prior to becoming unwell explained how, through the experiences that had triggered his mental health condition, he had come to place far greater value on spiritual and emotional rather than material wealth. There were also people who had been very career-driven in the past, who felt that in future they would seek to achieve a better work-life balance for the benefit of their mental health, accepting some trade-off with income levels. Finally, there were isolated examples of people who felt that, in part due to their mental health condition, they would prefer a way of life that was somewhat outside of mainstream society, for example, living a subsistence lifestyle in a rural area.

Mental health conditions aside, people's comments also reflected the way that work plans and aspirations change over the life course. While there were younger people seeking to start building a career that enabled them to support a family or advance in life, there were also older people who were thinking about their final years in employment and looking towards retirement. In discussing their changing views on work-life balance, some people in part attributed their decision to take on a less prestigious or senior role to advancing age, feeling that they were past the stage of 'chasing money'. There were also some older people who, while actively seeking work, said that they were looking for 'a job, not a career' at this stage, which would 'tide them over' until they were able to receive their pension.

### 6.3 Challenges and support needs in returning to work

This section considers what might be done to help people who have experienced mental ill health to return to and remain in employment. Study participants who had not yet returned to work were asked what actions or circumstances they felt would be necessary in order for them to get back into employment. A range of barriers and challenges were also highlighted in this context, as well as suggestions about the support that would be helpful. People who had returned to work were also asked to comment on what would have been helpful in enabling them to return to work more quickly. Some of factors identified were directly related to people's mental health condition, while others were indirectly linked, or were more general issues faced by jobseekers of all types. These factors, discussed in more detail ahead, included:

- Addressing mental ill health.
- Finding work that is suitable.
- An employer who is understanding about mental ill health and related gaps in employment.

- Support for qualifications and training.
- Transitional support in moving off IB.
- Meeting housing needs.
- Addressing broader employment constraints.

### **Addressing mental ill health**

As previously noted, some people who were currently on IB felt that their mental health condition was still a key barrier to work and that more time to address this through medical treatment or counselling was necessary before they could think about going back into employment. This view echoes the finding reported in Chapter 5 that feeling 'better' was central to people's readiness to return to work. One person who had returned to work felt that, had she received counselling sooner, she could have returned to work more quickly. Among the study group, there were experiences of hypnotherapy, cognitive behavioural therapy, other forms of counselling (both individual and in a group setting), various types of medication for depression, anxiety, psychosis and drug rehabilitation, attendance at therapeutic groups and also, for a small number people, time in a residential setting for mental health intervention.

From people's comments on the medical or therapeutic interventions they had received, it was evident that different people had gained differing levels of benefit from various types of treatment. For example, while some people had found counselling to be very effective in improving their mental health, others felt that counselling was not a very 'constructive' form of support or caused them to reflect on past events in a way that they did not find helpful. People also had differing perspectives on medications. Some people described them as a valuable support in stabilising their mental health, but there were also a notable number of people, particularly those who had been prescribed anti-depressants, who said they had voluntarily 'weaned' themselves off medication or had chosen not to take the drugs they had been prescribed at all. Talking to other people who had been through similar experiences, either in support group meetings or through informal personal contacts, had been particularly helpful for some people. Among other people who had not had this opportunity, there were also comments that 'peer' support would be something that they would find useful.

### **Finding work that is suitable**

Although improvements in mental health were seen as a crucial factor, people did not always perceive that a full 'recovery' was necessary before thinking about work. As noted in Chapter 5, feeling 'better' could be relative and some people felt able to return to some sort of work, despite still experiencing the effects of their mental health condition at times. As such, people commented that finding a suitable or manageable job would help them to return to work. A number of people felt that part-time work would be most appropriate for them and for some people, finding a job that was not 'stressful' was of key importance. The possibility

of flexible hours, to fit work around a fluctuating condition, was also cited as being very important. Chapter 3 highlighted examples of people for whom flexibility in their work had been crucial to sustaining their return to work. Another person made the overall observation that most people with mental health conditions do want to work and that, for people with fluctuating conditions like her own, the main obstacle faced was the inflexibility of most employment options. An ideal job, she felt, would be one that allowed her to work to her own timetable, matching work hours to times when she was feeling better:

*People with mental health issues don't necessarily want to sit at home, you know, we do want to work, we just can't work sometimes, our energy levels are different. Some days we have lots of energy and some days we don't. If there was a job that was flexible to allow you to work when you could and not work when you couldn't then it would be perfect. ... A lot of us do want to work, you know, we want to earn our own money and be independent, we don't want to be on benefits and we want to feel like we're contributing to society.*

(Female, 30s)

### **An employer who is understanding about mental ill health and related gaps in employment**

Reflecting on the recruitment stage, a number of people noted the challenge they faced because of the gaps in their employment record, due to mental ill health itself or the underlying personal circumstances. Such gaps could be a barrier in themselves, but could become a greater issue if they had to be explained to employers who held prejudiced views about the employability of people with experience of a mental health condition. As such, some people highlighted the importance of finding an employer who was understanding and supportive of their past or ongoing experiences of mental ill health. For some people, in particular those who had experienced drug addiction, an employer who was willing to consider applicants with criminal convictions was also important. One person felt that the application form stage was the biggest obstacle for people whose circumstances had led to substantial gaps in employment. She suggested that it would be helpful if people who did not have a comprehensive CV, but who felt they were able to do the job, could bypass the written application stage and make their initial presentation in person:

*For people in my situation and people that have had a disruptive sort of life ... I think, you know, if you went and explained your circumstances face-to-face with somebody, you might get more chance of having a, getting a job ... [because] on paper you don't look very good at all. ... How can you say you're gonna try on a bit of [paper], you know, 'I've never done all this but I will try'. They don't want to know, why would they? They just take someone else.*

(Female, 50s)



## **Support for qualifications and training**

Lack of qualifications was a challenge facing some people. In some cases, people related their difficulties in obtaining qualifications when at school to their early experiences of mental ill health, while other people said they had simply not achieved very highly at school. Skills or qualifications were also important for people who had come to change their views on what area or type of work was most appropriate for them. Some people needed to retrain in order to enter a new field of work and there were also individuals who, having found themselves unexpectedly in the role of jobseeker, now needed to gain new skills (for example, computer literacy) that had not been required when they first started their working life. There were also people who explained that they had substantial experience in particular professions but were without the formal qualifications to support this when making job applications.

As noted in Chapter 5, few people in the study group had received training support from Jobcentre Plus, either financial or practical. A small number of people had been in contact with a range of New Deal Job Brokers and training providers but these tended to be people who had spent time on JSA since leaving IB. As with people who had returned to work, some people who had not yet taken up employment had found that their particular aspirations for retraining could not be supported through Jobcentre Plus. One person commented that it would be helpful if there were more organisations reaching out and 'trying to build some bridges' for people who had lost their connection to employment, particularly those whose mental health conditions made it challenging for them to initiate the first steps. It should also be noted, however, that there were a number of cases among the study group of younger people who had made successful applications for further or higher education independently of Jobcentre Plus and had begun college courses or secured places for the next intake.

## **Transitional support in moving off Incapacity Benefit**

The benefits system itself was also reported as a barrier to moving into work. Some people talked about the worry of moving off benefits but then finding that you could not manage in work, given the complexities, uncertainties and delays often involved in reclaiming IB and, as applicable, Housing and Council Tax Benefits. There were suggestions of an arrangement whereby people could make a gradual return to work with tapering benefit payments, or have a transitional period where they retained their entitlement to return directly to Incapacity Benefit if they had to stop work. While one person making such a suggestion felt it would probably be perceived as 'crazy', it was notable that these ideas bear close resemblance to the existing permitted work and benefit linking rules. This suggests that there are knowledge and information gaps among some Incapacity Benefit recipients, with implications for communication and awareness-raising. There were also comments that once a person moved into work, they were 'dropped' by Jobcentre Plus, without any continuity of support, and that more transitional support would be beneficial:

*The minute you get the job, they do seem to drop you immediately. They wipe their hands of you, think 'Good, we've got rid of one'. But I think they would get rid of a lot more if they helped them, if people knew they weren't just gonna be dropped. ... It would be so beneficial to people, because it's the fear, it's the fear of making that move and losing all support that would scare people.*

(Female, 50s)

Relating to this point, one person who had moved between jobs several times since coming off IB, sometimes due to negative impacts on his mental health, described how his GP had been helpful in confirming to Jobcentre Plus that he had left for medical reasons, as opposed to 'voluntary unemployment', thus enabling him to reclaim JSA without delay.

Reflecting the relative and subjective nature of 'wellness' or 'feeling better' a particularly noteworthy scenario had developed for two people in the study group, where they had been deemed no longer eligible for IB at a DWP medical assessment but were being advised by other medical practitioners that work would not be good for them at this stage. One of these individuals was involved with a residential alcohol rehabilitation programme, where it was not recommended that people engage in paid work until they had completed the course of therapeutic activities. This person had moved onto JSA and felt he could manage work, but explained that if he took up paid work, he would lose his supported accommodation. The other person was about to begin a comprehensive vocational rehabilitation programme to address post-traumatic stress disorder that had been triggered by a serious physical accident. She felt that it would be difficult to take up work while undertaking this time-intensive treatment programme.

### **Meeting housing needs**

Looking at people's circumstances more broadly, a small number of people explained that their current housing arrangements were a barrier to feeling able to think about work. One person was in temporary accommodation and another described how the area in which he lived was closely tied in to his anxiety condition. Among people who had returned to work, there was again evidence that being in temporary or insecure housing could be a barrier to settling into a job.

### **Addressing broader employment constraints**

Some people also cited barriers or challenges to obtaining work or achieving their job aspirations that were not related to their mental health condition, and might be shared by anyone seeking to enter employment. These included age barriers (cited mainly by people in their late 50s) and physical health conditions that needed to be addressed before work was a possibility.<sup>19</sup> Finding work that left them better

---

<sup>19</sup> At the time of the research interviews, some people explained that their current Incapacity Benefit claim was in respect of both physical and mental health conditions.

off than on benefits, given age, skills and labour market opportunities, was also highlighted as a challenge by one study participant.

## 6.4 Conclusion

This chapter has considered people's broader views on being in work, their aspirations for future employment, and their perceived support needs in achieving this. We found strong evidence that people in the study group wanted to be in work and that they gained a range of benefits from being in employment, not only financial, but also social and emotional. By definition, study participants had, at some point, found themselves unable to work because of a period of acute mental ill health. However, there was recognition that being in work could be beneficial to mental health and a view that, given appropriate employment conditions, work could be manageable alongside some of the symptoms or effects of a mental health condition. Some people's career aspirations or goals had altered in light of their experiences of mental ill health, but almost all participants viewed themselves as being in employment in the future.

Participants' experiences or perceptions of moving from benefits to employment indicated a number of areas where the benefits system could be more supportive during this transition. Making the move off benefits and into work was seen as a 'risk' for some people, if work proved unmanageable. The opportunity to make a gradual transition to work, while retaining an entitlement to reclaim benefits quickly, was thought to be helpful. Recalling that this research was not carried out in Pathways to Work pilot areas, few people said they had received any training through Jobcentre Plus and there were people who felt that former IB recipients were 'dropped' by Jobcentre Plus as soon as they entered work. These experiences reinforce the need for job preparation and in-work support for people who have claimed IB, as piloted in the Pathways to Work areas.

Some people's situations highlighted the tensions that may exist between the opinions of health professionals, DWP practitioners and the rules operating around different benefits. Specifically, there were people who found they were deemed fit for work by one party but not by another, leading to conflicting or incompatible requirements set out by health and benefits agencies. There were also people for whom unstable housing was proving an obstacle to settling into work. These scenarios suggest the need for a more holistic consideration of people's capacity for work, in the context of their mental health and related personal circumstances.

Once in work, flexibility in one's job emerged as an important factor in making work manageable alongside a mental health condition. In particular, flexible hours that allowed a person to take breaks or time off when they were not feeling well was viewed as helpful. A few study participants had found work that allowed them to organise their time in this way, but there were also people who thought it would be difficult to find such flexible job opportunities in the current labour market. A job that was enjoyable and not stressful was also highlighted as important for people who have experienced anxiety or depression.

## 7 Conclusion and policy implications

This final chapter is divided into two main parts. In the first part we draw together the main findings from the study which, as set out in Chapter 1, aimed to contribute to a greater understanding of the employment experiences of people with mental health conditions and of employers in recruiting and employing people with mental health conditions. To do this we carried out qualitative interviews with 60 current and former recipients of Incapacity Benefit (IB) and 52 people in 40 private, public and voluntary sector employers. Around half of the IB recipients had recently made the transition from benefits to work, and half had made a recent new claim for IB. These 60 individuals were recorded as having a mental health condition as the main disabling condition on their benefit claim. The 40 employers comprised a randomly-selected sample of large, medium and small employers, and a purposively selected group of 'engaged' employers believed to have a positive, pro-active, or innovative approach to recruiting and employing people with mental health conditions.

The purpose of the research study was to inform the development of employment policies aimed at helping people move into work and policies aimed at job retention. In the second part of the chapter therefore we discuss a number of policy implications from the study for government and employers. We have restricted our discussions of policy implications to those which emerge specifically from the evidence collected in this study. We acknowledge that there are other aspects of mental health and employment that were not included in our terms of reference but are covered elsewhere in the literature (see, for example, Mental Health Foundation 2002; British Occupational Health Research Foundation 2005; Grove *et al.* 2005).

## 7.1 Summary of main findings

The summary of findings ahead is presented under four headings:

- Knowledge and understanding of mental health.
- Mental ill health in work.
- Mental health and transitions out of work.
- Transitions into work.

### 7.1.1 Knowledge and understanding about mental health

The employers and individuals interviewed for this study showed a wide diversity in their knowledge and understanding of mental health conditions.

Some employers in the study sample had become well-informed about mental health through their own experiences and by proactively accumulating knowledge. These employers tended to be large and to have their own, or good links to, occupational health specialists. Other employers, particularly the smaller ones, tended to have much more limited knowledge and experience and have more limited access to sources of advice and expertise. Among the smaller employers, the more severe and enduring conditions, such as schizophrenia and bipolar disorder, appeared to have greater prominence in people's minds when reflecting on what they understood by the term 'mental health condition'.

How people viewed their own experience of mental ill health was partly influenced by when their condition emerged in their lives, what they perceived as the origins or 'triggers' of their condition, and whether they had recurrent or single episodes of mental ill health. Many people had powerful subjective and normative feelings about their own condition and how they thought others saw them. Themes of 'stigma', 'strength' and 'weakness' were common and these influenced the extent to which people were willing to talk about mental ill health with their employer or their family and friends.

### 7.1.2 Mental ill health in work

People's accounts of their experiences of mental ill health at work highlighted diversity in the extent to which they told their employer about their condition. Some had never told their employer for a range of reasons including lack of personal insight, feelings of shame or weakness associated with mental ill health, or the expectation of stigma or discrimination by employers and colleagues. Others said that the reason they had not mentioned their condition to anybody was that their mental health had no bearing on their work.

The data also indicated that colleagues and employers could be similarly reluctant to raise the possibility that a person was experiencing some episode of mental distress, even when there was sometimes a compelling reason for thinking so. A fear of making things worse, of being wrong or of not knowing how to broach the subject could all act to prevent people from taking any sort of action.

There were few examples from the employee data of adjustments being made to their role at a time when their mental health condition began to affect them in work. A few people reported constructive responses where some adjustments had been made, such as changes to shift patterns or workloads. However, a perception that adjustments were not possible or not likely to be made – coupled with a reluctance to talk about their difficulties – had led some people to ‘struggle on’ in work without asking for support. In contrast, employers gave a wider range of examples of adjustments that they had either made for individual employees or would consider appropriate in some circumstances. The larger employers had access to far greater resources (such as human resources and occupational health staff) than smaller employers and this was reflected in the options open to them, although more ‘informal’ support arrangements involving only line managers or close colleagues were noted as being potentially very effective. Knowledge about how to respond, and who might be available to offer support, was much less in evidence among the medium and small employers in the sample. Several employers talked about the difficulties for them balancing the needs of an employee with a mental health condition and other staff.

Awareness of the Disability Discrimination Act (DDA) and its application to mental health conditions was mixed among employers and very limited among the employee sample. Employers who were aware of the DDA (in relation to mental health) tended to view this as underpinning good practice, rather than their central reason for facilitating adjustments.

General Practitioners (GPs) played a limited role in the relationship between people with mental ill health and their employers beyond the initial and continued provision of sickness certificates. There were relatively few examples of employees, employers and GPs working collaboratively to manage someone’s job retention, sickness absence or return to work, although some employers expressed the opinion that they would welcome closer collaboration.

### **7.1.3 Mental health and transitions out of work**

We identified various routes by which people left their employment because of a mental health condition. For some people, there was a sudden and acute change in mental health that led them to stop their work immediately, while others had an extended period of ‘struggling on’ before reaching some ‘crisis point’. At the point at which they felt they could no longer be at work, some people left their jobs directly, but others had a period of sick leave before their employment ended permanently. People who had left suddenly effectively removed any possibility of job retention. For many in the sample who had had a period off sick there was little contact with employers and little discussion with GPs and other health professionals about returning to work.

Some accounts of leaving work indicated that it had been the employee’s independent decision, while others described a ‘mutual’ agreement that leaving work was the right outcome. Some people explained that leaving work had been a constructive decision for them. However, there were also examples where an

employee had been dismissed, though this was generally viewed by employers as a last resort.

Although the larger and particularly the 'engaged' employers described a range of ways in which they might attempt to retain a member of staff experiencing mental ill health, many employers emphasised the challenges faced when it seemed that an employee was either not aware of, or was ignoring, their condition. Some employers said they found it difficult to respond to people with a mental health condition, feeling ill-equipped, lacking in knowledge or isolated.

The DDA was virtually absent from employers' and individuals' accounts of leaving employment, suggesting that the Act currently has little salience in the employment experiences of people with mental health conditions and in the actions of employers towards this group.

#### **7.1.4 Transitions into work**

We found strong evidence that people in the study group wanted to be in work and that they gained a range of benefits from being in employment, not only financial, but also social and emotional.

One of the key findings from people's accounts of moving into work after a time on IB was that a major contributing factor was an improvement in their mental health (often described as 'feeling better'). Hence, most people in the study did not mention their mental health during recruitment and appointment processes because they felt it was not relevant at this time. Some people also explained that they did not tell an employer because of the fear that their chances of getting a job would be reduced.

Some people in the study group were critical of the lack of support in looking for work from mainstream Jobcentre Plus advisers. In contrast, Disability Employment Advisers (DEA) were found to be much more helpful. (It must be remembered however that the research was conducted in areas without Pathways to Work provision.)

Employers expressed a range of views about whether it would be helpful to know about an applicant's mental health during the recruitment process, something which was not common in their current experience. Some did not expect people to provide information about their mental health and saw limited value in devoting resources to collecting such information at the recruitment or appointment stages (for example by using pre-employment health questionnaires). Others felt that being 'upfront' and 'honest' was more constructive in the long term, though there was some evidence that employers faced tensions between showing due regard for confidentiality and equality of opportunity and gathering specific information about applicants' mental health. Although there was general openness to employing people with mental health conditions, some employers felt that certain mental health conditions would be difficult to accommodate in some job roles, for example, where the safety of the employee or others might be put at risk.



A range of factors was identified that contributed to people making the move from IB to work, including finding suitable work that was flexible enough during possible periods of mental ill health, having an employer who was understanding about mental ill health and related gaps in employment, the possibility of pursuing qualifications and training, financial support after the cessation of benefit receipt, and the concurrent addressing of other needs and barriers (such as housing or age discrimination).

## 7.2 Policy implications

The overall purpose of the study was to generate policy lessons, mainly for government and employers, for helping people with mental health conditions to enter or to stay in work. As perhaps was to be expected we found a great diversity in the experiences of employers and people who had made the transition either into or out of work on which to base policy implications. For many people in the study the most salient aspects of their experiences did not necessarily involve their employer, the benefits system, or contacts with Jobcentre Plus.

This final section therefore extends beyond policy implications for the Department for Work and Pensions (DWP) and employers. We cover also a discussion of general 'mental health literacy' in the UK, the role of mental health services, and the role of GPs. We have restricted this section to policy implications specifically related to mental health rather than other health conditions or the employment and benefit systems more generally.

### 7.2.1 Mental health literacy – increasing knowledge and understanding

There is a growing literature on 'mental health literacy' which can be defined as 'the knowledge and beliefs about mental disorders which aid their recognition, management and prevention' (Goldney *et al.*, 2001). Low levels of mental health literacy have been argued to be detrimental to the identification, acceptance and treatment of mental ill health (Jorm, 2000). It is possible from this study to suggest that low mental health literacy among employers and people with mental health conditions themselves contributed to some of their negative experiences.

One of the striking and consistent findings from many of the study participants was the reluctance to engage with others about mental health. We have seen how people choose not to tell employers (at recruitment or when already in work) about a mental health condition and how employers may feel ill-equipped to respond to a member of staff whose attendance, performance or behaviour suggests that a problem might exist. Concerns about provoking an adverse reaction can effectively prevent employers and employees from even raising the subject and, in the cases where people leave their employment suddenly any possibility of job retention is lost. Although there were exceptions in this study, there were also examples of people receiving sympathetic and constructive responses from employers and colleagues when they did tell someone. Increasing mental health literacy among

both employers and their staff can be seen therefore as a crucial step in addressing the uncertainty, reticence, secrecy and silence that frequently surrounds mental health conditions.

This study has also reinforced the increasingly prevalent, yet complex, position of 'stress' in relation to managing mental health at work, and the need for responses which take a holistic view of the multiple personal, domestic and workplace factors which may, at times, impact on an individual's mental wellbeing. The data highlight the dual importance of improving medical responses to the treatment of mental ill health but also broader responses to social causes of mental distress.

The need to increase knowledge and understanding of mental health conditions, among employers and particularly those with line management responsibilities, has already been recognised by government in a number of ways. For example, the Department of Health led initiative on 'Action on Stigma' has produced practical guidance and an online resource for line managers (Department of Health *et al.*, 2007), whilst the National Institute for Health and Clinical Excellence is currently in consultation with stakeholders to develop guidance for employers on promoting mental wellbeing in the workplace. Following the large-scale review of the health of Britain's working age population (led by Dame Carol Black and published in March 2008) the development of a National Strategy for Mental Health and Work is also expected. The findings from this study underline the necessity of these initiatives.

### **7.2.2 Enhancing the role of employers in job retention**

In the course of this study we have identified from the accounts of the employers interviewed, particularly the 'engaged' employers, many examples of policy and practice that seem well suited to promoting the recruitment and retention of people with mental health conditions. We have less data from the sample of former and current IB recipients about effective retention practices but this is largely due to the sampling approach taken in this study that focused on people making transitions into or out of work.

What is clear from the experiences of the people who took part in this study is that, alongside conditions which are understood to have biological or 'biopsychosocial' origins, people are susceptible to negative impacts on their mental wellbeing, stemming from a wide range of circumstances in family life, relationships and the workplace, often in complex combination. The study cannot provide a simple answer to the question of what employers should do in order to prevent the loss of employees who experience mental ill health. However, the solution would seem to involve a combination of formal employment conditions that support staff retention (such as contracted employment with entitlement to sick pay), flexibility and the facilitation of adjustments to enable the employee to be at work and to carry out their role alongside the day-to-day effects of their condition, but also a degree of concern and empathy for the personal circumstances that may underlie an individual's mental ill health. This implies a need to take a broad understanding

of mental health that encompasses both social and medical influences and the concept of 'emotional wellbeing'.

We have also seen that work, rather than personal circumstances, can sometimes be the sole trigger for the onset of mental ill health or the source of stress that eventually leads to a mental health condition. Again, the recognition of the health and economic benefits of 'healthy' workplaces has been accepted in recent years and has been the focus of policy development (for example by the Health and Safety Executive). With a view to reducing the risk of mental ill health arising from within the workplace, it could be argued that greater provision of flexible working arrangements for all employees as a matter of course, allowing more control for the individual over their working patterns and work locations, might be of benefit in preventing the emergence of work-related stress and promoting general wellbeing among staff.

Chapter 2 described how the larger employers in the study had introduced awareness and other training aimed at improving the management of mental ill health in their organisations. The policy implication is to identify and implement ways of replicating this good practice in other employers, particularly those without the training and development resources of large employers.

One of the possibly self-evident lessons from this study is that employers can only engage with an employee once a mental health condition has been recognised and acknowledged between them. Some people in this study have reflected, for example, that they wished they had talked earlier to their employer. We have already suggested that better mental health literacy could create more confidence in workers to talk about mental health. Employers might also be able to develop procedures aimed at identifying mental health problems before they become severe. For example, managers, particularly supervisors and line managers, could be trained in the early identification of emerging mental ill health, such that changes in behaviour, performance or attendance are not ignored when they could be manifestations of mental ill health. Absence management could be more proactive and recognise that reasons given for absence might be partial or conceal a mental health problem. Importantly, employers should equip appropriate staff with knowledge about how to respond to someone who has a mental health condition. We have seen how sometimes seemingly modest and minor changes to people's work or hours or tolerance for reduced performance in order to reduce the stressors on people can be important in helping someone with a mental health condition continue in work.

There are already resources in existence that give advice on recognising the signs of stress or more acute mental ill health in employees, for example, the line managers' resource produced by the Shift initiative (Department of Health *et al.*, 2007), and the good practice guidance published online by the Health and Safety Executive (<http://www.hse.gov.uk/stress>). A systematic campaign to bring such resources to the attention of small and medium-sized employers in particular might increase knowledge and confidence of managers who are working within a small organisation.

Managers in large organisations often have the benefit of human resources and specialist occupational health staff to advise them and to contribute to the management of people with mental health conditions. Evidence on the value of such expertise to other staff has been presented earlier. The case for extending access to occupational health support to other employers has been made by government in, for example, the cross-department policy paper *Health, work and well-being – Caring for our future*, published in 2005. The implementation of the plans to increase the supply of occupational health services particularly through innovative channels that will make them available to medium and small employers can be expected to improve the job retention rates of people with mental health conditions.

In this section, we have discussed a range of ideas that might seem a large set of demands to place on employers and the findings of this study highlight that such approaches and responses to mental ill health in the workplace may be more challenging for smaller organisations. But at the same time, there are suggestions that relatively simple adjustments, alongside a sense that there is genuine sympathy and concern from their employer and colleagues, may make an employee feel that it is possible to remain in their job.

### **7.2.3 Mental health treatment services**

We have reported the finding above that many people return to work only when they feel 'better' either in the sense that their period of mental ill health is over or they are well enough to consider working again. The route by which people reach this position of being better was varied but some spoke positively of the input from various psychological therapists, including cognitive behavioural therapists. Some people mentioned having to wait for help, and that they felt they could have returned to work earlier had they had quicker treatment.

The urgent need for more psychological therapists has been strongly argued in recent years (for example, Layard, 2006) and the government has committed itself to increase their numbers over the period to 2010-11 (Department of Health, 2008b). For those people whose main or only reason for being out of work is their mental health, easier and quicker access to psychological therapy may be the most significant and effective step in enabling them to return to work.

### **7.2.4 The role of GPs**

We have found little evidence in this study of GPs having much involvement in people's return to work from being on sick leave or after a period on benefit. Few people had discussed work with their GP and few employers had contacted GPs about their patients (those who had were larger employers with access to occupational health specialists). Again, our findings here do not enter a policy vacuum; the debate about the role of GPs in the management of sickness absence is long-standing and ongoing (see for example, Department of Health, 2008a).

What emerges from this project is an indication of the role that GPs could play i.e. in discussing work not only with their patients but co-operating with the employer to facilitate a return to work, but in the experiences of most people we interviewed did not happen. We know from a recent research project on a pilot scheme locating employment advisers in GP surgeries (the Pathways Advisory Service), that many GPs feel ill-equipped (in knowledge and time) to have an involvement in their patients' work plans (Sainsbury *et al.*, 2008). However, the model of an employment adviser from Jobcentre Plus in surgeries might form the basis of thinking about how to provide similar support to people with mental health conditions who want to stay in or return to work.

### **7.2.5 The role of Jobcentre Plus**

As we have explained in Chapter 1, this research study was carried out in areas without Pathways to Work provision. Unsurprisingly therefore we found little evidence of input from Jobcentre Plus mainstream advisers, but reassuringly heard positive reports of contributions from DEA. Pathways to Work is planned to cover the whole of Great Britain by the end of 2008.

These findings provide an indirect, implicit endorsement of the Pathways model of delivery, i.e. a regime of compulsory work-focused interviews with specially-trained advisers. However, one lesson from this study that could be used to inform Pathways implementation is that for many people who are out of work because of mental ill health, there is often a period of time when they are not ready mentally to enter into discussions about a return to work. Only when people feel 'better' do they make (often rapid) progress towards work. Under the current Pathways arrangements personal advisers can defer monthly interviews when appropriate and continue to see claimants (as voluntary participants) after the six mandatory interviews. Flexibility therefore already exists for personal advisers. This flexibility needs to be used sensitively for IB claimants with mental health conditions in order to prevent additional pressure being experienced by them.

## **7.3 Final comments**

The individual experiences reported in this study, from a sample of 60 IB claimants and 40 employers, demonstrate that the policy area of mental health and employment is diverse and complex. The evidence has been clear for many years that people with mental health conditions have lower employment rates than almost every other group in society despite the passing of the original DDA in 1995 and over ten years of active benefit and employment policies, and despite the evidence that large numbers of people with mental health conditions want to work. In this report we have tried to identify where the government, employers and health services can contribute to increasing employment and retention rates and there are clearly constructive policies and practices among some large employers in particular that indicate what is possible. We appear therefore to have something of a paradox.

The heart of this paradox probably lies in the continuing lack of knowledge and understanding about mental health (which often crosses the line into stigma and prejudice) that permeates much of the public's, as well as many employers', perceptions and attitudes. The observable outcome in this study has been the cautious and fearful responses from employees and employers when mental health conditions manifest themselves and the overall lack of confidence to raise and discuss them. For some people, a mental health condition will be a part of their experience throughout their life and may require ongoing treatment and adjustments. However, some people's accounts highlighted that mental ill health can also be triggered by specific life events and the way in which these are responded to by the individual and others around them can affect how severe and how prolonged an effect there is on the individual's mental wellbeing.

While constructive legislation and employer policies and a more proactive approach from GPs and other health professionals are undoubtedly part of the way forward in improving the employment experiences of people with mental health conditions, long-term progress possibly lies in changing attitudes towards mental health across all groups in society. This reflection was well put (in Chapter 3) by one of the people interviewed for this study who had a depressive illness when he said that:

*... development lies in the way that this society understands depression as an illness.*

Although this respondent referred only to depression, his sentiment could apply equally to all types of mental health condition. Shifting public attitudes will not be easy or quick but is likely to be essential to solving the paradox impeding progress on mental health and employment.

# Appendix

## Recent claimants of Incapacity Benefit with mental health conditions

Peter A. Kemp

University of Oxford

### 1 Introduction

This brief note describes some key characteristics and circumstances of people with mental health conditions that have recently claimed Incapacity Benefit (IB) and compares them with claimants that do not report having mental health conditions. As explained in Chapter 1, it was produced in order to help inform the qualitative research on mental health and employment.

The data presented in this note are from a face-to-face survey of a nationally representative sample of 1,843 recent claimants of IB. The research was conducted by the University of Oxford in collaboration with SPRU for a Department for Work and Pensions (DWP) project on Routes onto IB (Kemp and Davidson, 2008). The fieldwork was undertaken by Ipsos-MORI between September 2006 and January 2007, approximately six months after the respondents' recent claim.

All differences described in the text are statistically significant at the 95 per cent confidence level ( $p < 0.05$ ).

### 2 Prevalence of mental health conditions

Of the 1,843 respondents that were interviewed, 96 per cent said they currently, or in the past 12 months, had a health condition or disability that affected their

everyday activities (Table A1). When asked what health conditions or disabilities they had at the time of their claim for IB, two-fifths reported having mental health conditions, including stress, anxiety and depression.

**Table A1 Type of health condition now or in past 12 months**

Type of condition	% of total	% with health conditions
Mental health sole condition	8	8
Mental health main condition	17	18
Mental health not main condition	18	18
Physical health condition(s) only	54	56
No health conditions	4	
Total	100	100
(Base)	(1,843)	(1,776)

Base: (1) all respondents and (2) respondents with a health problem.

Note: columns may not sum to exactly 100 due to rounding.

However, only a small minority reported that they only had mental health conditions at the time of their claim. It was much more common for them to say that they had both physical and mental health problems. A third of all new claimants had physical and mental health problems or disabilities, divided equally between those who described mental health as their main condition and those who said it was not their main condition (Table A1). Among claimants for whom some form of mental ill-health was their main condition, about half reported that it was depression and another third that it was stress or anxiety (Table A2).

**Table A2 Type of main health condition**

Type of main condition	% with health conditions	% with mental health conditions
Stress or anxiety	9	34
Depression	14	53
Other mental health condition	4	13
Physical health condition	72	
Total	100	100
(Base)	(1,776)	(463)

Base: all respondents with a health problem now or in past 12 months.

Note: columns may not sum to exactly 100 due to rounding.



New IB claimants with a mental health condition were more likely to report that it fluctuated - that is, got better or worse - over time than were those with only physical conditions or disabilities. This was especially true of claimants that only had mental health problems, among whom 71 per cent said their condition fluctuated over time (Table A3). New claimants for whom mental health was their main condition were more likely to report having a fluctuating condition than those for whom it was only a secondary condition (65 per cent compared with 52 per cent).

**Table A3 Whether health condition is constant or fluctuates over time**

Type of condition	Fluctuates %	Constant %
Mental health sole condition	11	5
Mental health main condition	24	13
Mental health not main condition	19	17
Physical health condition(s) only	46	65
Total	100	100
(Base)	(861)	(878)

Base: all respondents who knew whether their health problem fluctuated or not.

Note: columns may not sum to exactly 100 due to rounding.

### 3 Socio-demographic characteristics

Two out of five new IB claimants were women. Women were more likely than men to report having mental health problems (54 per cent compared with 38 per cent). New claimants aged 55 and over were significantly more likely than younger people to have only physical health conditions or disabilities. Indeed, only a third (33 per cent) of these older claimants had mental health problems, either solely or in combination with physical health conditions, compared with two-fifths (44 per cent) among the new claimants as a whole. The ethnic background of the two groups of new claimants was similar (Table A4).

New claimants of IB that had mental health problems were more likely than those that did not, to be living alone in their accommodation. Thus, whereas a quarter of people with mental health problems lived alone, only a sixth of claimants with only physical health problems or disabilities did so. New claimants whose conditions included mental health problems were also more likely to be single but living with other adults or to be lone parents. They were less likely to be living as part of a couple, whether childless or not, than people with only physical disabilities or health conditions (Table A4).

**Table A4** Socio-demographic characteristics

	Physical health only %	Mental health %
<b>Gender</b>		
Male	66	51
Female	34	49
<b>Age</b>		
16 to 24	13	14
25 to 34	12	19
35 to 44	20	24
45 to 54	27	26
54 to 64*	29	17
<b>Household type</b>		
Single and lives alone	18	26
Single but not alone	14	17
Lone parent with children	15	18
Couple without children	31	21
Couple with children	22	19
<b>Ethnic background</b>		
White	91	93
Mixed	<1	1
Asian or Asian British	6	5
Black or Black British	2	1
Other+	1	<1
<b>Housing tenure</b>		
Owner-occupier	47	37
Social tenant	37	42
Private tenant	13	15
Other+	4	6
(Base)	(991)	(786)

\* One respondent said they were aged 65 and two that they were 67.

+ 'Other' includes 'don't know' and 'refused to say'. For housing tenure it also includes people living in hostel and other forms of institutional accommodation.

Note: columns may not sum to exactly 100 due to rounding.

Compared with the general population, new IB claimants were much less likely to be homeowners and more likely to be renting their accommodation. However, claimants whose condition included mental health problems were more likely to rent their home – either from private or social housing landlords – than people that had only physical health problems or disabilities (Table A4).

There were significant differences in employment history between claimants with mental health problems and those with only physical conditions, with the former more likely than the latter to have a chequered work history. Thus, new IB claimants with mental health problems were less likely than those with only physical health problems or disabilities to report having spent most of their working life in steady jobs or self-employment. Claimants with mental ill-health were more likely to say they had been in and out of work several times or that they had spent a lot of their adult life looking after the family or home (Table A5).

New IB claimants with only physical health conditions were more likely than those that had mental ill-health to be currently working at the time of the interview or to have a job to go back to. Compared with claimants with only physical conditions, people with mental health conditions were twice as likely to report that they would require help, rehabilitation or training before they could return to work (Table A6).

## 4 Responses to health conditions or disabilities

### 4.1 The role of the employer

People who were employees in paid work or on sick pay immediately prior to their recent claim – described here as ‘employees’ for convenience – and who had at least one health condition that affected their ability to do their job, were asked whether they discussed it with their employer. In total, seven out of ten had discussed their health condition or disability with their employer at some point. This was equally as true of people with only physical health conditions as of those who had mental health problems (Table A7).

Among those who had discussed it, the most common time at which they did so was after they had started the job, but as soon as the condition had become a problem. This was the case with half (50 per cent) of employees who had discussed their health or disability with their employer. Meanwhile, 12 per cent discussed it with their employer before they started the job, 20 per cent after they started the job but sometime after the condition became a problem and 18 per cent after they started the job but not until the problem had got worse (Table A7).

In summary, three out ten (30 per cent) employees had not discussed the problem with their employer. Meanwhile, a quarter (27 per cent) had ‘struggled on’ (Sainsbury and Davidson, 2006) with their condition before discussing it with their employer, either until sometime after it had become a problem or once it had got worse.

**Table A5 Work history**

<b>Overall work history</b>	<b>Physical health only</b> %	<b>Mental health</b> %
I have spent most of my life in steady jobs	70	59
I have spent most of my life self-employed	7	4
I have been in and out of work several times	10	15
I have mainly done casual or short-term work	4	4
I have spent more time unemployed than in work	3	4
I have spent a lot of time out of work because of sickness or injury	2	4
I have spent a lot of my adult life looking after family or the home	4	9
None of these apply to me	1	1
Total	100	100
(Base)	(814)	(597)

Base: all respondents who have been in paid work.

Note: columns may not sum to exactly 100 due to rounding.

**Table A6 Work situation or expectations**

	<b>Physical health only</b> %	<b>Mental health</b> %
I am currently working	17	10
I have a job to go back to	11	6
I am waiting to start my new job	2	2
I am looking for work, but have not found a suitable job	11	10
I was looking for work, but stopped because I can't find a suitable job	1	1
I was looking for work, but stopped because my health has deteriorated	7	8
I hope to do a job in the future, but have not started looking yet	15	19
I would need help, rehabilitation or training before I could consider working	6	14
I do not expect to work in the future	14	12
I am permanently unable to work because of my health condition or disability	14	14
Total	100	100
(Base)	(991)	(786)

Base: all respondents with a health problem now or in past 12 months.

Note: columns may not sum to exactly 100 due to rounding.

**Table A7 Whether and when employees discussed their condition with their employer after it began to affect their ability to do the job**

	Physical health only %	Mental health %
Did not discuss it with employer	30	32
Before started the job	6	11
After started the job but as soon as it became a problem	39	31
After started the job but not until sometime after it became a problem	13	17
Not until the condition became worse	14	13
Total	100	100
(Base)	(424)	(319)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job.

Note: columns may not sum to exactly 100 due to rounding.

There was a wide variety of reasons why employees had not discussed their health condition with their employer, even though it had affected their ability to do the job. The most commonly mentioned reason, cited by 12 per cent of employees who had not discussed their condition with their employer, was that it was 'personal' and they did not wish to discuss it. Other responses included feeling it was not relevant or that there was no need to discuss it (eight per cent), that they had not realised it was a problem (seven per cent), that it came on suddenly (three per cent), that it would have jeopardised their job (three per cent), that they had been made redundant (three per cent), or that they would not have taken them on if the employer had known it was a problem (two per cent).

## 4.2 Helpfulness of employer

Employees that had discussed their condition were asked how helpful, if at all, their employer had been. In total, two-thirds of employees that had discussed it, said that their employer had been either fairly or very helpful. Three out of ten felt that their employer had been either very or fairly unhelpful. Employees whose condition(s) included mental health were about twice as likely as those with only physical conditions or disability to say that their employer was unhelpful (Table A8).

**Table A8 Helpfulness of employer**

	Physical health only %	Mental health %
Very helpful	51	40
Fairly helpful	23	16
Fairly unhelpful	7	15
Very unhelpful	15	26
Don't know/can't remember	4	3
Total	100	100
(Base)	(297)	(216)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job and who discussed the problem with their employer.

Note: columns may not sum to exactly 100 due to rounding.

### 4.3 Occupational health

New IB claimants that were employees – that is, were either in paid employment or on sick pay immediately prior to their claim – and that had at least one condition that affected their ability to do the job, were asked if they had access to occupational health services through their employer. In total, 27 per cent of them reported that they did have such access, 71 per cent that they did not, and two per cent that they did not know whether or not they did. There were no statistically significant differences in this respect between employees whose condition(s) included mental health and those who had only physical conditions (Table A9).

**Table A9 Whether employees had access to occupational health services via employer**

	Physical health only %	Mental health %
Yes	26	30
No	73	69
Don't know	2	1
Total	100	100
(Base)	(424)	(319)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job.

Note: columns may not sum to exactly 100 due to rounding.

Employees that had access to occupational health through their employer were asked if they discussed their condition(s) with the service. Seven out of ten (71 per cent) had discussed it with occupational health and the remainder (29 per cent) had not. The differences in this respect between employees whose condition(s) included mental health and those with only physical condition(s) were not statistically significant (Table A.10).

**Table A.10 Whether employees discussed their condition with the occupational health service**

	Physical health only %	Mental health %
Yes	76	65
No	24	35
Total	100	100
(Base)	(108)	(95)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job and access to occupational health service via their employer.

Note: columns may not sum to exactly 100 due to rounding.

In total, about eight out of ten employees that had discussed their health condition or disability with occupational health found it either fairly (24 per cent) or very (55 per cent) helpful. Again, the differences in this respect between employees with and without mental health conditions were not statistically significant.

#### 4.4 Changes to working conditions

Only one in six (16 per cent) employees whose health or disability affected their ability to do their work reported that any changes had been made to their job or working arrangements to help accommodate their condition. Instead, the great majority (83 per cent) reported that no changes of that kind had been made. The differences here between people with mental health problems and those whose condition(s) were only physical were not statistically significant (Table A.11).

**Table A.11 Whether changes were made at work to help accommodate employees' health condition or disability**

	Physical health only %	Mental health %
Yes	14	18
No	84	81
Don't know/can't remember	1	1
Total	100	100
(Base)	(424)	(319)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job.

Note: columns may not sum to exactly 100 due to rounding.

Among those employees who reported that changes had been made, about a third (35 per cent) said that their duties had been altered and another third (33 per cent) that the number or pattern of their working hours had been adjusted. Other changes included adaptations or the provision of special equipment

(14 per cent) and being allowed to take emergency leave (seven per cent). People with mental health problems were less likely than claimants with only physical conditions or disabilities to say that their duties had been changed and more likely to report that their working hours had been altered in some way.

A third (34 per cent) of employees who reported that changes had been made to their working conditions said the alterations were made after they discussed their health condition or disability with their employer. Nearly three out of ten (29 per cent) said the changes were made as soon as the condition started and about a quarter (23 per cent) after they had taken time off work. About one in ten (nine per cent) reported that the changes were made after discussing the problem with the occupational health service. Compared with employees with only physical conditions or disabilities, people with mental health conditions were less likely to say that the changes were made when the condition started and more likely to say it was after they spoke with occupation health.

Three-quarters (75 per cent) of employees who reported that changes had been made to their working conditions to accommodate their health problem or disability said that it had helped them to keep working longer than might otherwise have been possible. This was equally true of people with mental health problems as those with only physical conditions.

#### 4.5 Changes that could have helped

One in five employees said that other changes could have helped them to stay in work for longer, if they had been made. This was especially so among people with mental health conditions compared with those with only physical conditions (Table A.12).

**Table A.12 Whether other changes could have helped employees to keep working longer than might otherwise have been possible**

	Physical health only %	Mental health %
Yes	14	26
No	82	68
Don't know/can't remember	5	6
Total	100	100
(Base)	(424)	(319)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job.

Note: columns may not sum to exactly 100 due to rounding.



The most commonly mentioned changes that would have helped were changes in duties (39 per cent) and changes in the number (16 per cent) or the pattern of hours (seven per cent) of work, or the provision of equipment or making of adaptations (12 per cent). People with mental ill-health were less likely to say that changes in their duties would have helped and more likely to mention changes in the number or the pattern of their hours, when compared with employees with only physical disabilities or health problems. Three-fifths (57 per cent) of employees did in fact ask their employer to make such changes, but this was somewhat less true of people with mental health (54 per cent) than those with physical disabilities or conditions (63 per cent).

## 4.6 Consulting others

Two-thirds of employees consulted other people beside their employer about the effect of their disability or health condition on their ability to do their job. People with mental health conditions were rather more likely than other employees to have consulted with other people or organisations (Table A.13).

Most commonly, people had consulted their General Practitioners (GPs). Just over half of employees had been to see their doctor, a proportion that was the same both for people with mental ill-health and employees with only physical disabilities or health conditions. Relatively few had consulted trade union officials. People with mental health conditions were somewhat less likely than those with physical conditions to report having seen another health professional (22 per cent compared with 27 per cent) and more likely to have spoken to a relative or friend (12 per cent compared with five per cent).

**Table A.13 Whether employees consulted anyone apart from the employer about the effect of their condition(s) on their ability to do their job**

	Physical health only %	Mental health %
Yes	65	72
No	35	26
Don't know/can't remember	<1	2
Total	100	100
(Base)	(424)	(319)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job.

Note: columns may not sum to exactly 100 due to rounding.

## 4.7 Sick pay and time off work

Three-fifths (63 per cent) of employees said that they were entitled to sick pay, but around a third (34 per cent) said they were not entitled and a few (three per cent) did not know either way. The responses of people with mental health conditions were the similar to employees with physical conditions (Table A.14).

**Table A.14 Whether employees were entitled to sick pay from their employer**

	Physical health only	Mental health
	%	%
Yes	63	62
No	34	35
Don't know	3	3
Total	100	100
(Base)	(424)	(319)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job.

Note: columns may not sum to exactly 100 due to rounding.

About three-quarters of both groups of employees reported that they had taken time off work because of their health condition. Three-fifths of them said they had discussed returning to work with their employer, a proportion that was also the same for both groups of employee (Table A.15). While seven out of ten (69 per cent) of those who had discussed returning to work said their employer was either fairly or very helpful, people with mental ill-health were less likely to report that than employees with only physical conditions (59 per cent compared with 78 per cent).

**Table A.15 Whether employees discussed returning to work with their employer while they were off sick**

	Physical health only	Mental health
	%	%
Yes	60	63
No	40	37
Total	100	100
(Base)	(310)	(239)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job and had taken time off work because of their condition.

Note: columns may not sum to exactly 100 due to rounding.

Eight out of ten employees that had taken time off because of their condition had discussed returning to work with other people, most commonly their GP (59 per cent) or both their GP and another health professional (16 per cent).

Almost all (97 per cent) of these employees felt that discussing return to work with their GP was helpful and a similar proportion (93 per cent) said it was helpful discussing return to work with a health professional. There were no differences in either respect between employees that had mental health problems and those that do not (Table A.16).

**Table A.16 Whether employees discussed returning to work with their GP or other health professional while they were off sick**

	Physical health only %	Mental health %
Yes, with GP	58	59
Yes, with other health professional	7	7
Yes, with both	17	16
No	18	18
Don't know/can't remember	<1	1
Total	100	100
(Base) check	(274)	(219)

Base: all employees in paid work or sick pay immediately prior to their IB claim that had at least one condition that affected their ability to do their job and had taken time off work because of their condition.

Note: columns may not sum to exactly 100 due to rounding.

## 5 Health trajectory

All new IB claimants were asked whether, overall, their health was getting better or worse. The most common response, made by 31 per cent of claimants, was that their health was staying the same. Meanwhile, 28 per cent said it was getting worse, 24 per cent that it was getting better, and 18 per cent that it was changeable over time. The main differences between claimants that had mental health problems and those with only physical conditions were that the former were about twice as likely as the latter to say it was changeable and somewhat less likely to say it stayed the same (Table A.17).

**Table A.17 Whether claimants felt their health was getting better or worse**

	Physical health only %	Mental health %
Getting better	25	22
Getting worse	29	26
Staying the same	33	27
Changeable over time	13	25
Total	100	100
(Base) check	(990)	(785)

Base: all respondents with a health problem now or in past 12 months.

Note: columns may not sum to exactly 100 due to rounding.

Finally, about two-fifths of new claimants reported that they were currently on a waiting list for treatment. This was equally as true for people who only had physical conditions as for those that had both physical and mental health conditions. However, only a quarter (25 per cent) of claimants that only had mental health conditions said they were currently on a waiting list for medical treatment (Table A.18).

**Table A.18 Whether claimants were on a waiting list for medical treatment**

	Physical health only %	Mental and physical health %	Mental health only %
Yes	39	41	25
No	59	57	75
Don't know/ can't remember	1	2	0
Total	100	100	100
(Base)	(991)	(644)	(142)

Base: all respondents with a health problem now or in past 12 months.

Note: columns may not sum to exactly 100 due to rounding.

# References

Anderson, R. (2004), *'Stress and mental health'*, Journal of the Royal Society for the Promotion of Health, 124, 3, 112-13.

Aston, J., Willison, R., Davis, S. and Barkworth, R. (2005), *Employers and the New Deal for Disabled People: Qualitative research, wave 2*, DWP Research Report No. 231, Leeds: Corporate Document Services.

Bailey, R., Hales, J., Hayllar, O. and Wood, M. (2007), *Pathways to Work: Customer experience and outcomes*, DWP Research Report No. 456, Leeds: Corporate Document Services.

Bewley, H., Dorsett, R. and Haile, G. (2007), *The Impact of Pathways to Work*, DWP Research Report No. 435, Leeds: Corporate Document Services.

Bewley, H., Dorsett, R. and Ratto, M. (2008), *Evidence of the Effect of Pathways to Work on Existing Claimants*, DWP Research Report, Leeds: Corporate Document Services.

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

British Occupational Health Research Foundation (2005), *Workplace Interventions for People with Common Mental Health Problems: Evidence review and recommendations*, London: British Occupational Health Research Foundation.

Department of Health, Health and Safety Executive and Department for Work and Pensions (Shift initiative) (2007), *Line Managers' Resource. A practical guide to managing and supporting people with mental health problems in the workplace*, London: Shift.

Department of Health (2008a), *Johnson Calls for New Focus on Work-Health Balance*, Press Release, 20 February.

Department of Health (2008b), *Expanding the Psychological Therapies Workforce*, Press Release, 26 February.

Department for Work and Pensions (2007a), *In Work, Better Off: Next steps to full employment*, DWP, London: The Stationery Office.

- Department for Work and Pensions (2007b), *Ready for Work: Full employment in our generation*, DWP, London: The Stationery Office.
- Goldney, R., Fisher, L. and Wilson, D. (2001), *Mental health literacy: an impediment to the optimum treatment of major depression in the community*, *Journal of Affective Disorders*, 64, 277-84.
- Grove, B., Secker, J. and Seebohm, P. (eds) (2005), *New Thinking about Mental Health and Employment*, Oxford: Radcliffe Publishing.
- Irving, P., McKenna, K. and Brindley, Z. (2004), *Evaluation of the Adviser Discretionary Fund (ADF)* (online). Available: <http://www.dwp.gov.uk/jad/2004/185rep.pdf> [Accessed 7 August 2007].
- Jorm, A. (2000), Mental health literacy. *Public knowledge and beliefs about mental disorders*, *British Journal of Psychiatry*, 177, 396-401.
- Kemp, P. and Davidson, J. (2008), *Routes onto Incapacity Benefit: Findings from a survey of recent claimants*, DWP Research Report, Leeds: Corporate Document Services.
- Layard, R. (2006), *The Depression Report*, London: LSE.
- Mental Health Foundation (2002), *Out at Work. A survey of the experiences of people with mental health problems within the workplace*, London: The Mental Health Foundation.
- Sainsbury, R. and Davidson, J. (2006), *Routes onto Incapacity Benefits: Findings from qualitative research*, DWP Research Report 350, Leeds: Corporate Document Services.
- Sainsbury, R., Nice, K., Nevill, C., Wood, M., Dixon, J. and Mitchell, M. (2008, forthcoming), *The Pathways Advisory Service: Placing employment advisers in GP surgeries*.
- 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: Corporate Document Services.
- Social Exclusion Unit (2004), *Mental Health and Social Exclusion*, London: Office of the Deputy Prime Minister.
- Waddell, G. and Burton, K. (2006), *Is Work Good for Your Health and Well-being?*, London: The Stationery Office.