

# Mental health, employment and the social care workforce

By Linda Seymour, Pete Fleischmann, Paul D S Ross, Bob Grove and Angela Sweeney

## Key messages

- Mental health problems are widespread in the working-age population.
- Mental health stigma and discrimination remain common in the workplace.
- Employers are largely unaware of the levels of mental health need among employees, line managers lack confidence in supporting people with mental health problems and co-workers have mixed views about mental health.
- Policy on mental health and employment does not provide a coherent framework to support the recruitment and retention of people with mental health problems.
- People with mental health problems do not have to be completely recovered to remain in or return to work.
- Good practice means collaboration between professionals, practitioners and employees.
- There is sufficient evidence to inform the development of services and interventions so that people with mental health problems can find and keep work in social care.

## Introduction

This briefing addresses two principal research questions about mental health and employment:

- What is the evidence about discriminatory practice – at recruitment as well as during employment – against people with mental health problems?
- What is the evidence about recruitment and retention practices that can enable these groups of people to secure and retain employment in the social care workforce?

A number of drivers account for the continued interest in mental health and employment. High levels of poor mental health in the working-age population combine with persistent stigmatising attitudes to prevent people from asking for and getting help when they need it. Public attitudes about mental health continue to be mixed and there are low levels of awareness among employers about the extent of mental health need in the workforce. Taken together, these factors are associated with low levels of employment for people with mental health problems.

A range of initiatives underline the significance of mental health and employment on the policy

agenda. The common goal of these programmes and approaches is to make it possible for working-age adults to gain and retain competitive employment that utilises their skills and knowledge, regardless of mental health problems.

This briefing describes the findings from narrative and intervention studies, reviews, guidance and policy that have been systematically identified. Its purpose is to inform the policy, practice and research agendas on mental health, employment and the social care workforce.

The descriptor *mental health problems* is used throughout to represent all mental disorders or illnesses.

### What is the issue?

Mental health problems such as depression or anxiety are extensive and disabling in the working-age population. At any one time, nearly one worker in six will be experiencing such problems and incidence increases to one in five when drug or alcohol dependence are included.<sup>1,2</sup>

Socioeconomically deprived employees are at heightened risk of mental health problems associated with lower occupational or educational standing, poorer quality of work and less secure employment.<sup>3</sup>

People who return to work after absence with depression do not always receive the levels of support required to ensure a smooth re-entry to employment.<sup>4</sup> Retention is jeopardised by scant regard for relevant policies, poor communication and line managers' lack of competence in managing the return to work.

Far fewer people have more severe mental health problems and approximately one per cent of the working-age population has a diagnosis such as schizophrenia, bipolar disorder or severe depression.<sup>5</sup> Best estimates are that between 10 and 20 per cent of this group are in paid employment.<sup>6</sup>

### Why is it important?

People with mental health problems who do find work are more likely to be underemployed, employed in low-status or low-waged jobs or employed in roles which are not commensurate with their skills or level of education.<sup>7</sup> They are over-represented in the secondary labour market that consists almost entirely of part-time temporary jobs, which although they might offer flexibility, are often unstable, poorly remunerated, open to exploitation and offer limited opportunities for training and career development.<sup>5</sup>

Mental health problems at work have economic consequences. The average employee takes seven days off sick each year, and of these days, 40 per cent are taken as a result of mental health problems. However, reduced productivity while at work – known as 'presenteeism' – accounts for 1.5 times as much working time lost as absenteeism. In addition, mental health problems, including stress, can account for up to five per cent of staff turnover.<sup>2</sup> The total cost of mental ill health in England in 2009–2010 was £105.2 billion, of which almost 30 per cent (£30.3 billion) was in lost economic output.<sup>8</sup>

### What does the research show?

#### Policy and statute relevant to mental health and employment

There have been a range of different policy and practice initiatives pertinent to mental health and employment.

The National Health Service (NHS)<sup>9</sup> has set out core principles that not only condemn stigma and discrimination at work against people with mental health problems, but also the refusal or termination of employment on mental health grounds. NHS employers are urged to base recruitment solely on merit and to lead by example in recruiting employees with mental health problems.

*Working our way to better mental health: a framework for action*<sup>10</sup> was commissioned by the previous Labour government and produced by Health, Work and Well-being (HWWB), a cross-government mental health and employment strategy that addresses wellbeing at work for everyone, and better employment outcomes for people with mental health problems, whether they are currently in work or not. A range of complementary schemes are run under the aegis of HWWB such as the Fit for Work Service, HWWB coordinators in each of the English regions, Wales and Scotland, and an occupational health advice line for small businesses and general practitioners (GPs) (see [www.dwp.gov.uk/health-work-and-well-being](http://www.dwp.gov.uk/health-work-and-well-being)).

A review on the health and wellbeing of NHS staff was undertaken as part of the HWWB framework for action.<sup>11</sup> NHS organisations were encouraged to provide staff health and wellbeing services centred on prevention and fully aligned with wider public health policies and initiatives. These services were seen as a real and tangible benefit of working in the NHS. High priority was given to ensuring that managers have the skills and tools to support staff with mental health problems.

The Improving Access to Psychological Therapies (IAPT) programme offers treatment for depression and anxiety disorders, combined, where appropriate, with medication. The economic case has demonstrated that talking therapies can help people come off sick pay and benefits and stay in or return to work (see [www.iapt.nhs.uk](http://www.iapt.nhs.uk)). An action plan on IAPT for the current Parliament reiterates a key goal of improving social and economic participation, including employment, for working-age people.<sup>12</sup>

There is a cross-government mental health outcomes strategy for people of all ages entitled *No health without mental health*.<sup>13</sup> This policy document highlights the interconnections between mental health, housing, employment

and the criminal justice system. One of the six shared objectives focuses on quality of life for people with mental health problems, including improved employment rates.

The Equality Act 2010 superseded the Disability Discrimination Act in October that year. Since April 2011 there has been a public sector equality duty in place (see [www.equalityhumanrights.com](http://www.equalityhumanrights.com)). Employers are not allowed, as part of the application process or during an interview, to ask any job applicant about their health or any disability until the person has either been offered a job outright, or on conditions, or has been included in a pool of successful candidates to be offered a job when a position becomes available. People with mental health problems are covered under the Act's 'protected characteristic' of disability, which is defined as: 'a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities'.

## Mental health and the social care workplace

The adult and children's social care workforce consists of almost two million, mainly female, employees.<sup>14,15</sup> There is evidence of psychological distress in the statutory social care workforce associated with abuse and violence at work, stress in the workplace, staff experience of racism and discrimination, and gender issues.<sup>16</sup> Employees in social care may be at a high risk of poor mental health because of the demands of their challenging roles and their increased tendency to empathy and self-selection into the job, as has been shown for health care professionals.<sup>17</sup>

Interviews with social workers found that more than a quarter of the 50 participants had experienced between one and three months of sickness absence associated with depression and just under a quarter had been off work for between four and six months.<sup>18</sup> Identified causes included

heavy workload, lack of control, absence of boundaries and the demanding nature of the work.

“There was a huge pressure of turnaround and lack of resources, no control over workload. It was relentless”

Aspects of the work environment such as patterns of constant change, and management responses that could sometimes come across as intolerant or bullying, were also contributory factors.

“Management support. The first time there was bullying big-style. They threatened my career”

A study that explored working conditions and quality of life in two social services departments in the UK<sup>19</sup> identified determinants of distress as including organisational culture and function, control, lack of resources, responsibility for people and the rate and pace of change.

“Our initial assessments are supposed to be brief, but you’re frightened in case you miss any information. You miss any information and then something happens and it’s: “why didn’t you put that in your initial assessment?””

A survey of 500 social workers explored their views on what was most helpful in managing their depression and in maintaining or returning to employment.<sup>20</sup> Psychotherapy or counselling, independent of the workplace, were established to be the most effective forms of treatment.

An examination of statistical evidence about the length of working life found that the expected

working life of social workers and social care workers is considerably shorter than comparable professionals and that gender differences are less apparent. Working life is defined as the length of time someone uses their qualification. Social workers’ length of working life is eight years and social care workers 13 years. Previous work has estimated that the expected working life of a doctor is 25 years compared with 15 years for nurses and 28 years for pharmacists. Workplace stress maybe a factor in the early exit of social workers to other occupations. However the paper concludes that further research is needed to identify the extent of this and underlying reasons why this should be the case.<sup>83</sup>

### Positive aspects of work for mental health

Despite the negative elements of some aspects of employment, appropriate work is generally good for people.<sup>21</sup> In an attitude survey on health, work and wellbeing, more than 8 in 10 employees agreed that ‘taking everything into account, paid work is very good or good for mental health’.<sup>22</sup>

Research in social care has found that the vast majority of staff enjoy spending time with clients and developing relationships with them, along with the sense of camaraderie of working in a team with friendly colleagues.<sup>19</sup>

“I love my job as a carer. I find it very fulfilling”

Other findings describe how working with people in a caring situation, together with the satisfaction of seeing improvements in clients, were sources of job satisfaction among local authority residential care workers in the north-west of England.<sup>23</sup> Work not only has a positive influence on health and wellbeing, but is also associated with less chance of a mental health issue recurring.

‘Whilst working in a busy store and having so many customers to serve I wasn’t reflecting on my thoughts and becoming paranoid about my problems’<sup>24</sup>

Besides an income, positive outcomes of work include a reduction of anxiety and depression and improvement in health and psychosocial status.<sup>25</sup>

‘Ultimately work is a very positive thing in my life as it gives me something to get up for in the morning’<sup>26</sup>

Qualitative research with people with mental health problems in Scotland endorses this premise.<sup>27</sup>

‘I feel as if, very slowly and very surely, there’s a confidence coming back, especially when I got accepted into the organisation, it’s boosted my confidence immensely’

### Contribution of people with mental health problems to the workplace

Many people who work in social care services have mental health problems. Such employees believe that their own experiences are of value to their employer and to performing their role with insight and skill.

‘I work in the mental health sector where my experience is valued’<sup>28</sup>

Qualitative research with people experiencing mental health problems makes it clear that they have something positive to contribute to the workforce, not least because their eagerness to prove themselves makes them better employees.

‘I would like to inform them [employers] that they are missing out on a great opportunity. There are a large group of people who are willing and able’<sup>27</sup>

The importance of including the expertise of lived experience in the workforce, alongside professional competencies, has been acknowledged by professionals themselves.<sup>29</sup> A nurse consultant working with a peer support programme said:

‘Peer support offers something that can go beyond the professional support and therapy offered to people during crisis’

### Mental health and equalities groups

The Equality Act 2010 protects people from discrimination on the grounds of disability, age, gender, pregnancy, maternity, marriage, civil partnership, gender reassignment, race, religion or belief and sexual orientation. Some people may experience discrimination in the workplace because they have mental health issues. Some people may also experience discrimination related to one or more of the other protected characteristics which in turn may impact on their mental health and their work. The interface between mental health issues and some of the other protected characteristics is described next.

#### Age

By 2020, one in five people in the UK will be aged 65 and over and nearly two in five will be aged 50 and over.<sup>30</sup> At the same time, the number of young people in the population is decreasing. As a result there will be pressure to retain older people in the workforce. Mental health problems linked more commonly to later life include depression, associated with chronic physical ill health or social isolation. About 20 per cent of older people have reported being depressed.<sup>31</sup>

### Race

There are particular hazards for the mental health of employees from ethnic minority groups, especially among individuals reporting unfair treatment at work.<sup>32</sup> The experiences of discrimination of people from these communities is seen as a source of ill health.<sup>33</sup> For example, the insults and accompanying humiliation to which these groups are exposed are known to be risk factors for depression.<sup>34</sup>

### Gender

A recent review of the mental health of girls and women in England and Wales concluded that almost two-thirds have been affected by mental health problems triggered by bullying, physical or emotional abuse, bereavement or unemployment.<sup>35</sup> The review described how more than 1 in 10 women experiencing mental health problems had quit a job. More than two in five had taken related time off work and more than a quarter had been off work for at least a week.

### Sexual orientation

The mental health of lesbian, gay, bisexual and transgender (LGBT) people is affected by the stressors associated with discrimination, negative messages about identity and difficult familial interactions.<sup>36</sup> A qualitative study of LGBT experiences in the workplace suggests issues similar to those for mental health in relation to stigma, risk and disclosure.<sup>37</sup>

## Mental health stigma and discrimination in the workplace

There is evidence of stigma and discriminatory behaviour faced by people with mental health problems when trying to find work or retain their jobs, and their low workforce participation offers demonstrable proof of its negative impact.<sup>24,38,39,40</sup>

A clear majority of people experiencing depression and anxiety are in work. However, only just over one in five people with a severe and enduring mental health problem are employed

compared with almost three-quarters of the overall working-age population. Employment rates for people with more serious issues have fallen steadily since the 1970s.<sup>41,42</sup> These figures belie the fact that people with mental health problems have the highest 'want to work' rates of all disabled groups<sup>24</sup> and that research has shown they do not have to be completely recovered to remain in or return to work.<sup>2,43</sup> A persistent fallacy – that people with mental health problems are incapable of work – is still widespread and impedes employment opportunities. As a rule, health and social services have not considered employment, and its role in maintaining mental wellbeing, as part of their remit. As a consequence they have often failed to address the employment needs of the people with whom they work, implicitly or explicitly counselling against it.<sup>24</sup>

“In 14 years as a service user, mental health professionals have never offered me help with working towards getting back to work”

“My doctor told me I would never work again”

For some people with mental health problems, discrimination in the workplace is greater than in any other part of their lives. A qualitative study that explored first-hand experiences of discrimination associated with mental health problems confirms this to be so.<sup>44</sup> Difficulties at the recruitment stage were also described.

“I am always careful how I describe my health problems if I am going to an interview ... Depression has become more acceptable so I often use that label”

Returning to work following a period of mental health-related sickness absence also poses problems. Participants described a variety of negative responses such as pressure to take early retirement, the necessity to appeal against threatened termination, and being moved and downgraded within the organisation.<sup>44</sup>

One study found that almost half of those people with physical health problems experienced mild to moderate depression but were more worried about telling their employer about their mental health problems.<sup>4</sup>

‘... after the cancer, it wasn’t so bad ... but I think I was much more frightened going back after last year’s bout of depression ... maybe my overall boss wouldn’t be very sympathetic if I took time off’

Employees with mental health problems can feel isolated and ostracised by colleagues who do not know how to support them and may be unsure how to react, or whether to acknowledge a mental health issue.<sup>28</sup>

‘I came back to work after a bout of depression, people didn’t even ask how I was. No one visited or sent a get-well card – things that always happen if people have a physical illness’

### Employers’ attitudes

Employers’ attitudes to mental health were surveyed in approximately 300 small companies (1–50 employees) and 200 medium/large companies (more than 50 employees).<sup>26</sup> Of the sample, two in five respondents agreed that

workers with a mental health problem could pose a significant risk. Just over a quarter of employers acknowledged that a person might experience a mental health issue at some point in their lives and more than 3 in 10 thought that more than a quarter of the population could be affected.

However, despite these levels of awareness, more than 7 in 10 workplaces had no formal policy on mental health and wellbeing. Smaller businesses and employers with no human resources responsibilities in the survey were more likely to answer ‘don’t know’ when asked about how they would describe mental health problems in the workplace.<sup>47</sup>

Other research has demonstrated that even though employment agencies will consider putting forward individuals with previous mental health problems to employers, the latter had high levels of concern in employing them.<sup>48</sup>

‘We [the recruitment agency] are the middle person, so I’m not the ultimate decision maker [for recruiting the person], all I do is present a selection of candidates to a client and they decide who they want to take and who they don’t want to take’

Some clients using an employment adviser scheme described the lack of support they received from their employer, despite confiding in them about their mental health problems before taking sick leave.<sup>49</sup>

‘I did tell my manager probably two months before I was off that if it carried on I would have to leave because I couldn’t put up with it; nobody listened’

Employers' reluctance to engage with the issue of mental health problems has been demonstrated in other research. A survey of progress against key indicators on health and work examined employers' attitudes to their role in promoting and protecting their employees' health and wellbeing.<sup>22</sup> The majority of employers in the sample agreed that there is a link between work and the health and wellbeing of their employees and that they have a responsibility to encourage employees to be physically and mentally healthy. However, more than half the sample agreed that 'in general, your employees do not want you to intervene in terms of their physical and mental health'.

### Disclosing mental health problems

Employers' attitudes, as described above, underpin an unwillingness to disclose mental health problems at recruitment or once employed – fewer than 40 per cent of people would disclose any mental health problems to an employer.<sup>50</sup>

A Mind survey to mark Stress Awareness Day found that almost one-fifth of the 30 million adult working-age population admitted to having called in sick because of stress, but had lied about the reason.<sup>51</sup> Instead they cited stomach upsets, housing problems and the illness of a loved one.

People's fears of disclosing mental health problems are not groundless and research describes how people have lost employment as a result.

“My teaching work was a vocation for which I trained five years. Losing work which has seemed “meant to be” is very confusing.”<sup>52</sup>

One of the recommendations of The Beverly Allitt Inquiry has had serious implications for people who have, or have had, mental health problems and wish to work in health or social

care services.<sup>45</sup> A recommendation of the Inquiry was that no applicant for a post in the NHS, who had a previous mental health issue, should be accepted for employment unless they had been free of drugs and other support for at least two years. Guidance now recommends that the “two-year rule” should no longer to be used in the NHS.<sup>9</sup> The rule is not part of regulators' professional standards. However the rule may still have an enduring effect on attitudes and may still have an impact on the behaviour of some employers and occupational health advisors.

A social worker described his feelings following disclosure of experience of mental health problems:

*‘I decided to be open with the GSCC about my mental health problems ... they have made me feel as though I have something to be ashamed of and punished for, rather than recognising the additional expertise my experience gives me as a practitioner.’<sup>\*47</sup>*

Even if a decision to disclose is made, employees with mental health problems will often wait until they have made a good impression in the hope that their performance will offset any negative views.<sup>27</sup>

### Interpretations of risk

Regulation of social care is critical for the protection of the public. However, there are over 70 separate pieces of legislation and statutory guidance in social care as well as nursing and teaching, many of which contain ambiguous requirements for ‘good health’ or ‘physical and mental fitness’ and are therefore at odds with equality legislation.<sup>45</sup> These ‘standards’ hinder disabled people’s access to the social care professions and can lead to

---

\* It is important to note that in this case unlawful discrimination was not formally established.

discrimination and exclusion of people with mental health problems.

The Equality Act 2010 makes the use of routine pre-employment screening questionnaires illegal and the spirit of the Act is to prevent discrimination. However, even the knowledge that an employer might ask health questions before final job offer can discourage some people with mental health problems from applying.

### Workplace adjustments for people with mental health problems

The Equality Act 2010 requires employers to make reasonable adjustments when their practices or premises put a disabled employee at a substantial disadvantage in comparison to a comparator without the same particular disability. The purpose of the reasonable adjustments is to eliminate the substantial disadvantage. What adjustments are reasonable depends on the circumstances.

Work resumption and a change in work tasks, as well as other adaptations – such as flexible work times, working from home, gradual return to work after ill health, part-time working or job share – have been shown to be effective in enabling employees with mental health problems to remain in work.<sup>24,53,54</sup> Each person's skills and the challenges they may face at work will differ, so adjustments should be bespoke rather than 'off the shelf'.

#### Practical help

The Access to Work scheme can help people if their health or disability affects the way they do their job. It gives employees and employers advice and support with extra costs which may arise because of health or disability issues. Access to Work is more commonly associated with physically disabled people, however the scheme may be appropriate for some people with mental health problems. For example, the fund might contribute to the cost of a support worker or specialised equipment at work. It may also

contribute towards the cost of getting to work if a person cannot use public transport (see [www.direct.gov.uk](http://www.direct.gov.uk) for further details).

Mind has produced joint guidance with the Federation of Small Businesses (FSB) on reasonable adjustments for employees with mental health problems.<sup>55</sup> Actions include good communication, especially with staff working in isolation, informal mentoring for new staff and involving employees, wherever possible, in planning their own workload and setting reasonable agreed deadlines. These guidelines are particularly relevant to the small businesses that comprise the majority of social care workplaces.<sup>15,56</sup>

### Supporting the mental health of the workforce

A range of interventions that can support employees with mental health problems in securing and retaining employment have been identified for this review.

#### Preventative interventions

Preventative interventions aim to create workplace systems, structures and processes that can support employees' mental health regardless of any specific issues they might bring with them into the workplace.

#### Organisational approaches

In 2009 the National Institute for Health and Clinical Excellence (NICE) published a review of different types of evidence to assess whether healthy and productive working conditions might promote mental wellbeing among employees.<sup>56</sup> The review findings informed guidance on mental health and work.<sup>57</sup> Employers and trade unions were encouraged to develop a strategic and coordinated approach that assessed opportunities for promoting employees' mental wellbeing. Line managers were urged to respond with sensitivity to employees' emotional concerns and when necessary to signpost an employee on to appropriate services.

Key partners for small and medium-sized enterprises (SMEs), such as primary care trusts and the FSB, were prompted to offer a range of support such as occupational health services, counselling or stress management training.

### **Training for managers**

A review of workplace interventions for employees with mental health problems identified underdeveloped capabilities among line managers in dealing with employees with sickness absence related to mental ill health.<sup>58</sup> Lack of appropriate training in relevant skills and mental health awareness were specifically highlighted. Improving mental health literacy and awareness at work is something that people with mental health problems have identified as critical.<sup>59,60</sup>

An active listening intervention by line managers for approximately 2,000 employees in a Japanese manufacturing company appeared to result in a decrease in job stressors, stress reactions and workers' sick leave due to mental health problems.<sup>61</sup> Managers learned active listening skills to improve their communication with and support for their employees.

A UK training intervention for line managers on mental health problems demonstrated a significant effect, sustained at eight-month follow-up, on knowledge, attitudes, willingness to engage and self-reported confidence levels.<sup>62,63</sup> The training emphasised recognition of very early signs of mental health problems at work, useful approaches to colleagues about whom managers are concerned and information on the range of professional support and treatments available.

### **Early identification and signposting**

A range of different interventions have been identified that emphasise the benefits of early identification of employees with mental health problems so that suitable support or signposting to appropriate treatment can be enabled as quickly as possible.

### **Postal intervention**

A randomised controlled trial (RCT) that included a one-year follow-up was carried out on a minimal postal intervention offered within two weeks of the start of sickness absence.<sup>64</sup>

Participants were sent a letter offering return to work in a modified form, in combination with sickness benefits; a questionnaire about sick leave; and a consent form. The trial demonstrated a significant reduction in length of sick leave. Critical success factors included early intervention, within one month of the start of sick leave, and also a focus on return to work regardless of mental health problems.

### **Telephone intervention**

An RCT of a telephone screening, outreach and care management intervention for depressed workers in the USA demonstrated a positive impact on clinical and work productivity outcomes.<sup>65</sup> The intervention was delivered by care managers and depression severity and work performance were the outcomes measured. At the end of the trial, the intervention group had significantly lower self-reported depression scores, higher job retention and more hours worked.

### **Rehabilitation including third-party case management**

Rehabilitation back into employment after absence associated with mental health problems can be effectively facilitated by third-party specialists and case managers.

### **The retain/regain intervention**

An intervention in Cambridgeshire, England, assessed the impact of GP referrals to case managers and demonstrated positive employment outcomes.<sup>49</sup> The employment advisers (EAs) worked in three localities alongside or within various GP surgeries. They received referrals for people with mental health problems who were in work or off sick ('retain' clients), or unemployed due to their mental health problems ('regain' clients). Tailored brief interventions were

offered either face to face or via telephone or email. These included careers guidance and skills to negotiate with employers for the retain clients, or practical assistance with job searches, CV writing, interview technique, careers guidance and assertiveness training for the regain group.

### **Cognitive behaviour therapy focused on return to work**

An RCT in the Netherlands assessed a brief intervention that began two or three weeks after the start of sick leave and was based on cognitive behaviour therapy (CBT) principles combined with graded activity and a phased return to work.<sup>66</sup> Those who received the intervention returned to either full- or part-time work within a shorter time than those in the comparison treatment group or the control group.

### **Return to work co-ordinators**

Another intervention in the Netherlands compared care as usual by occupational physicians with support from 'return to work co-ordinators' for those employees who had been off work for two to eight weeks suffering from 'distress'.<sup>67</sup> The co-ordinators acted as brokers between employees and their workplaces, holding separate one-to-one interviews with the employee and employer, and then arranging a joint meeting for all parties.

The intervention had a positive effect for those employees who intended to return to work at baseline, despite any psychological symptoms, but was less effective for those employees who did not intend to return to work at baseline. Cost effectiveness mirrored overall effectiveness; for the sub-group of employees who intended to return to work at baseline there was an economic benefit over and above care as usual.<sup>68</sup>

### **Occupational health services**

Occupational health practitioners (OHPs) have a significant role to play in supporting employees with mental health problems, but there is limited evidence on the efficacy of interventions delivered by them.

An RCT in the Netherlands compared a CBT-based intervention delivered by OHPs with care as usual on a range of work outcomes such as absenteeism, full and partial return to work and recurrence rates.<sup>69</sup> The CBT intervention used this form of therapy to encourage employees to think about the causes of their mental distress, develop strategies for managing stressors, and practice and embed their learning. At three months the intervention group had significantly higher return to work rates as well as shorter periods of sickness absence.

An audit has been carried out in the UK into the way in which OHPs are applying evidence-based guidance on depression and the management of long-term sickness absence.<sup>70,71</sup> The audit examined whether occupational health doctors and nurses were taking depression into account as an influence on periods of sickness absence. It also explored barriers to return to work and the use of psychological and physical therapies provided by the employer. The results provide useful guidance for occupational health on how mental health problems should be assessed and included as an obstacle to returning to work.

### **Individual placement and support for serious mental health problems**

There is now a body of evidence to support the efficacy of 'place then train' models – rather than traditional approaches such as vocational training and sheltered work – in successfully getting people with severe mental health problems into work.<sup>6,72,73,74,75,76</sup> Key aspects of this individual placement and support (IPS) approach include rapid job search based on individual preference and ongoing support for individuals and employers from an employment adviser working within mental health services. Complete recovery from mental health problems is not a prerequisite as long as a job-seeker wants to work and is confident they can do so.

These types of service can work equally well for people from ethnic minority communities,

as long as employment advisers are skilled and confident in addressing issues associated with racism.<sup>77</sup>

### Assessment of the intervention studies

The intervention studies on mental health and employment cover a range of different approaches, delivered by varying types of practitioner, to participants with a wide spectrum of mental health problems.

#### Strengths

The interventions reviewed in this briefing have a focus on work, rather than merely clinical, outcomes. In other words, they support the principle that people with mental health problems do not have to be completely recovered to be in or return to work. Several of the interventions have been undertaken in the UK and offer the possibility of applying these research findings without further testing to practice in social care workplaces.

#### Weaknesses

The data set is diverse in character with the accompanying limitations in terms of drawing firm and universally applicable conclusions. As a rule, participant sample sizes are small and follow-up on the effects of the interventions is usually of short duration. Attrition at these points is common, resulting in even smaller sample sizes.

None of the studies showed evidence of the involvement of people with mental health problems in their design and delivery. People with mental health problems were the subject of the research, not the authors, even though their needs and experiences are the pivot around which the interventions revolve.

#### Economic evaluations

Only one of the intervention studies in this review included an economic evaluation. It showed that there was an economic benefit,

over and above care as usual, for those employees who benefited from the intervention.<sup>68</sup> An assessment of the economic case for mental health promotion and mental illness prevention, separate from this review, provides two examples of the cost effectiveness of workplace interventions for mental health problems.<sup>65</sup> The first example uses the telephone intervention included in this review.<sup>70</sup> The authors conclude that the intervention is cost-saving from a business and health perspective, as long as all costs are borne by business. Intervention costs are more than outweighed by gains to business because presenteeism and absenteeism both reduce. Public sector employers could benefit from investing in such a universal screening intervention.

The second example focused on promoting mental wellbeing at work and mirrored the recommendations in the NICE review on organisational approaches, also discussed in this research briefing.<sup>57</sup> The authors judge that a strong case can be made to businesses that workplace wellbeing interventions can be significantly cost-saving in the short term. The public sector could benefit as an employer from improved investment in workplace wellbeing programmes. Smaller companies and organisations may need public support to implement such schemes.

### Implications from the research

The research base relevant to social care was of mixed quality in this review. Some of the narrative and qualitative studies describing personal experience of stigma and discrimination did include employees from social care, however none of the intervention studies were conducted in social care, even though their findings are relevant for that sector.

Several of the key interventions, such as those on line manager training, employment advisers,

occupational health audit of NICE guidance and IPS have all been conducted and implemented in the UK. Evaluation of their implementation in social care workforces would fill knowledge gaps about how best to recruit and retain employees with mental health problems in social care.

The two research questions that underpin this review addressed themselves to identifying evidence of mental health discrimination in employment, and recruitment and retention practices that might improve social care workforce participation by people with mental health problems. The findings have implications for related policy, social care workforce practice and also further research into relevant questions.

### For the policy community

Key tensions must be addressed by policy-makers and those who frame and monitor legislation to remove obstacles to employment for people with mental health problems.

The Equality Act 2010 makes it illegal for employers to require candidates to disclose a disability at the recruitment stage of securing work. However, once a job offer has been made, employers can lawfully make such a request. The legislation emphasises that employers must be able to demonstrate, having asked for this information, that they have made every attempt to put reasonable adjustments in place that will allow the candidate to take up the post and perform to the best of their ability.

The evidence that people with mental health problems still experience stigma and discrimination sits at odds with both the policy and the law. Policy on mental health and employment must be joined up, made coherent across the different responsible government departments and positively welcome people with mental health problems into work.

### For practitioners

The interventions in our identified studies have important ramifications for all those with responsibility for mental health and employment as well as for those employees with mental health issues.

Within the workplace, line managers, human resource professionals and OHPs all occupy central positions to support employees with mental health problems. Training on mental health awareness for line managers seems to show promise for the successful support of mental health problems among employees. Enhancing managers' skills, confidence and knowledge gives them the ability to intervene early and appropriately so that employees with mental health problems can remain at work. Training like this can dispel employers' fears about engaging with mental health problems and it remains a pressing need. More than half of those employees who reported that they were line managers said that they had never received information, help or advice on how to manage stress among the employees for whom they were responsible.<sup>22</sup>

None of the identified research for this briefing was conducted with human resources professionals, but they are central to the delivery or initiation of many of the interventions. In social care workplaces such as local authorities, human resource functions are either located in service departments, such as adult social care, or increasingly as corporate functions with specific departmental links or teams.<sup>79</sup> In many of the smaller social care businesses, managers or owners often take responsibility for human resource duties themselves. They can access help from umbrella organisations that provide infrastructure support to the sector, such as courses and training in relevant knowledge and skills on recruitment procedures, support for vulnerable people and training on the impact of the Equality Act 2010. However, only about a third of providers are registered with an umbrella organisation.<sup>80</sup> Training for line managers is

relevant for human resource practitioners, many of whom will have management responsibilities. Some of the low-cost interventions reviewed, such as those delivered by post or telephone, could be promoted by human resources.

Evidence for occupational health interventions was limited and perhaps reflects the varying levels of occupational health provision in the UK. In local authorities, occupational health is a discrete corporate function and operates council-wide. The more usual SME social care establishments access occupational health in different ways: they invest in relevant services from independent practitioners or the local authority, contract with companies providing occupational health services, or purchase relevant skills as necessary from primary care practitioners. They might also turn to their insurers for advice, guidance and support in occupational health matters.<sup>80</sup>

The audit of NICE guidance on long-term conditions, with an emphasis on detection of depression and support for those employees offers a blueprint for occupational health practitioners in social care.

Third-party specialists, variously described as 'return to work co-ordinators', 'employment advisers' or 'labour experts' have emerged from the research as having an effective role to play in retention and return to work for employees with mental health problems.

### For primary care

Primary care can play a vital role in the rehabilitation of people with mental health problems into work, enabling them to remain in work even if they are receiving treatment. In fact, 8 out of 10 of people say they would consult their GP first for treatment if they thought they had a mental health issue.<sup>50</sup>

Primary care emerges as a key lynchpin in supporting people with mental health problems

to achieve their employment goals. GPs can use their unique position to assist people back to work through flexible application of the 'fit note' and referrals to employment advisers, who are now likely to be integrated with local IAPT programmes.

### For employees

The research supported the principle that people with mental health problems do not have to be fully recovered to be employed. However, there were also many vivid descriptions of the lived experience of stigma and discrimination during working life – at recruitment, during sickness absence and on return to work.

One of the most important improvements that could be made at work is to open up discussions about mental health problems and ensure that line managers receive appropriate training. For example, the 'double tick' symbol used by those organisations signed up to Mindful Employer ([www.mindfulemployer.net](http://www.mindfulemployer.net)) enables job applicants to have confidence in the company's levels of mental health awareness.<sup>27</sup>

### For talking therapies

A common feature of many of the interventions is a CBT approach, with a focus on return to work rather than merely trying to improve mental health problems. Talking therapies such as CBT have been widely recognised as helpful treatments for mild to moderate mental health problems such as depression or anxiety.<sup>81,82</sup> Government commitment to extending the range of and access to talking therapies should benefit those with mental health problems who want to work.

## Conclusions

This briefing has identified evidence to support the existence of discriminatory practice, at recruitment as well as during employment, against people with mental health problems and

the kinds of intervention that could enable these groups to secure and retain employment in the social care workforce.

Mental health problems are widespread and debilitating and are the dominant health problem in working age.<sup>10</sup> Given the size of the social care workforce, many of these employees will, along with the general adult population, have a mental health problem at some point in their working lives.

Even though mental health problems are so common, the stigma and discrimination surrounding them is still extensive, presenting a special set of dilemmas for employees suffering such problems. Under the terms of equalities legislation they are entitled to reasonable adjustments by their employer to enable them to work effectively. To gain access to these adjustments, disclosure of mental health problems is necessary, and yet the implications of disclosure have too often been detrimental. Many people have lost their jobs, been forced into redundancy or early retirement, been downgraded in their current job, or sidelined through lack of training and development opportunities. Bullying and marginalisation are also not unknown. Employers' low levels of understanding and awareness have not helped to ease these circumstances.

The key ingredient in knitting these elements together is mental health awareness training for line managers and ideally for workplaces as a whole. Giving managers the confidence and skills to support employees with mental health problems has been shown to be

effective. They are more prepared to intervene early, a hallmark of effective schemes, approaching an employee after noticing changes in behaviour and having a conversation about relevant issues, signposting individuals for treatment and providing ongoing support at work including making reasonable adjustments.

Mental health literacy in the workplace is the backdrop against which almost any of the interventions identified in this review will have a meaningful effect. Most focus on the individual employee with mental health problems. Quite rightly, they emphasise return to work rather than just 'getting better'. However, if people with mental health problems return to or take up work, the ethos and context of the workplace is critical to the success of their employment.

Social care workplaces can take advantage of a range of partnerships as they move forward on this important public health issue. There are many key collaborators within such workplaces, as well as in local and national health and third-sector organisations. In particular, the rapidly developing role of employment advisers holds immense promise for employees with mental health problems in social care.

Uniquely, there is evidence from the UK on interventions that are transferable to social care and could be implemented with few changes. Future research would however benefit from economic evaluations and the contribution of people with mental health problems into its design and delivery.

## Useful links

### Advisory, Conciliation and Arbitration Service (ACAS)

Aims to improve organisations and working life through better employment relations.

[www.acas.org.uk/publications](http://www.acas.org.uk/publications)

### Black Mental Health UK

[www.blackmentalhealth.org.uk](http://www.blackmentalhealth.org.uk)

### British Association and College of Occupational Therapists

Occupational therapists and support workers help people engage as independently as possible in the activities (occupations) which enhance their health and wellbeing. [www.cot.co.uk](http://www.cot.co.uk)

### Centre for Mental Health

Aims to help to create a society in which people with mental health problems enjoy equal chances in life to those without such problems.

[www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

### Department for Work and Pensions

[www.dwp.gov.uk](http://www.dwp.gov.uk)

### Employers Forum on Disability

Enables companies to become 'disability confident' by making it easier to recruit and retain disabled employees and to serve disabled customers.

[www.efd.org.uk](http://www.efd.org.uk)

### Equality and Human Rights Commission

Provides detailed guidance for employers and workers on the impact, implementation and use of the Equality Act 2010 in the workplace.

[www.equalityhumanrights.com](http://www.equalityhumanrights.com)

### Health, Work and Well-being (HWWB)

Embraces a range of support such as the Fit for Work Service, HWWB coordinators in each of the English regions, Wales and Scotland and an occupational health advice line for small businesses and GPs.

[www.dwp.gov.uk/health-work-and-well-being](http://www.dwp.gov.uk/health-work-and-well-being)

### HSE Management Standards for Work-Related Stress

Contains information about the prevention of mental health problems and has useful guidance

on preventing work related stress and complying with the law. [www.hse.gov.uk/stress](http://www.hse.gov.uk/stress)

### Institution of Occupational Safety and Health (IOSH)

The chartered body for health and safety professionals. [www.iosh.co.uk](http://www.iosh.co.uk)

### Mental Health and Work

[www.direct.gov.uk/en/DisabledPeople/HealthAndSupport/MentalHealth](http://www.direct.gov.uk/en/DisabledPeople/HealthAndSupport/MentalHealth)

### Mental Health Foundation

[www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

### Mind

Helps people take control of their mental health and offers a range of resources and support for mental health and wellbeing at work. There is a particularly useful guide on surviving working life.

[www.mind.org.uk/employment](http://www.mind.org.uk/employment)

### Mindful Employer

This initiative is led and supported by employers to increase awareness of mental health at work and provide support for businesses in recruiting and retaining staff.

[www.mindfulemployer.net](http://www.mindfulemployer.net)

### NHS Plus

The NHS occupational health service for staff and the broader community.

[www.nhsplus.nhs.uk](http://www.nhsplus.nhs.uk)

### National Institute for Health and Clinical Excellence (NICE)

Provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health.

[www.nice.org.uk](http://www.nice.org.uk)

### National Mental Health Development Unit (NMH DU)

Working across all age ranges and all aspects of mental health. NMH DU closed on 31 March 2011, however, all publications and resources produced remain available on the website.

[www.nmhdu.org.uk](http://www.nmhdu.org.uk)

### PACE

[www.pacehealth.org.uk](http://www.pacehealth.org.uk)

### Rethink

Aims to assist anyone affected by severe mental illness such as schizophrenia, bipolar disorder and depression. They also have guidance specifically for line managers. [www.rethink.org](http://www.rethink.org)

### Shaw Trust

Works in partnership with public sector organisations to develop and deliver effective social care services which empower people to live more independent lives.

[www.shaw-trust.org.uk/home](http://www.shaw-trust.org.uk/home)

### The HUB

Structured to provide information and dedicated links to resources; also a communication tool for people to discuss mental health in the workplace.

[www.workplacementalhealth.co.uk/](http://www.workplacementalhealth.co.uk/)

### Time to Change

England's biggest ever attempt to end the stigma and discrimination that faces people with mental health problems.

[www.time-to-change.org.uk/home](http://www.time-to-change.org.uk/home)

### YourWorkHealth website

Support people to stay in or return to work with a chronic or fluctuating health condition.

[www.yourworkhealth.com](http://www.yourworkhealth.com)

## Related SCIE publications

*Whose recovery is it anyway?* (2007)

Knowledge review 21: *Supporting people in accessing meaningful work: recovery approaches in community-based adult mental health services* (2008)

Research briefing 26: *Mental health and social work* (2008)

Report 27: *Leadership for personalisation and social inclusion in mental health* (2009)

Research briefing 33: *The contribution of social work and social care to the reduction of health inequalities: four case studies* (2010)

## References

1. Deverill C. and King M (2009) 'Common mental disorders', in S. McManus et al. (eds) *Adult psychiatric morbidity in England: results of a household survey*, [www.ic.nhs.uk/pubs/psychiatric\\_morbidity07](http://www.ic.nhs.uk/pubs/psychiatric_morbidity07)
2. Sainsbury Centre (2007) *Mental health at work: developing the business case*, policy paper 8, London: SCMH, [www.centreformentalhealth.org.uk/publications/MH\\_at\\_work.aspx?ID=575](http://www.centreformentalhealth.org.uk/publications/MH_at_work.aspx?ID=575)
3. Siegrist, J. and Menni, C. (2009) 'Work stress and health in the context of social inequality', in A.S.G. Antoniou et al. (eds) *Handbook of managerial behaviour and occupational health*, Northampton, MA: Edward Elgar.
4. Munir, F. et al. (2009) *Returning to work: the role of depression*, London: Mental Health Foundation. [www.mentalhealth.org.uk/content/assets/PDF/publications/returning\\_to\\_work.pdf](http://www.mentalhealth.org.uk/content/assets/PDF/publications/returning_to_work.pdf)
5. Royal College of Psychiatrists (2008) *Mental health and work*, [www.dwp.gov.uk/docs/hwwb-mental-health-and-work.pdf](http://www.dwp.gov.uk/docs/hwwb-mental-health-and-work.pdf)
6. Sainsbury Centre (2009) *Doing what works: individual placement and support into employment*, [www.centreformentalhealth.org.uk/publications/doing\\_what\\_works.aspx?ID=592](http://www.centreformentalhealth.org.uk/publications/doing_what_works.aspx?ID=592)
7. Stuart, S. (2006) 'Mental illness and employment discrimination', *Current Opinion in Psychiatry*, no 19 pp 522–526.
8. Centre for Mental Health (2010) *The economic and social costs of mental health problems in 2009/10*, London: Centre for Mental Health, [www.centreformentalhealth.org.uk/publications/economic\\_social\\_costs\\_2010.aspx?ID=622](http://www.centreformentalhealth.org.uk/publications/economic_social_costs_2010.aspx?ID=622)

9. Department of Health (DH) (2002) *Mental health and employment in the NHS*, London: DH, [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4008361](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008361)
10. Health, Work and Wellbeing (2009) *Working our way to better mental health: a framework for action*, [www.official-documents.gov.uk/document/cm77/7756/7756.pdf](http://www.official-documents.gov.uk/document/cm77/7756/7756.pdf)
11. Boorman, S. (2009) *NHS health and wellbeing: final report*, [www.nhshealthandwellbeing.org/FinalReport.html](http://www.nhshealthandwellbeing.org/FinalReport.html)
12. Department of Health (DH) (2011) *Talking therapies: a four year plan of action*, London: DH. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123759](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123759)
13. Department of Health (DH) (2011) *No health without mental health: delivering better mental health outcomes for people of all ages*, London: DH, [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123766](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766)
14. Children's Workforce Development Council (2009) *The state of the children's social care workforce 2008: summary report – a profile of the children's social care workforce in England*, [www.cwdcouncil.org.uk/research/projects/state-of-the-childrens-social-care-workforce](http://www.cwdcouncil.org.uk/research/projects/state-of-the-childrens-social-care-workforce)
15. Eborall, C., Fenton, W. and Woodrow, S. (2010) *The state of the adult social care workforce in England 2010*, Leeds: Skills for Care, [www.skillsforcare.org.uk/research/research\\_reports/state\\_of\\_the\\_adult\\_social\\_care\\_workforce\\_reports.aspx](http://www.skillsforcare.org.uk/research/research_reports/state_of_the_adult_social_care_workforce_reports.aspx)
16. Balloch S, McLean J and Fisher M (1999) *Social services: working under pressure*, Bristol/London: Policy Press/National Institute of Social Work.
17. Harvey, S.B., Laird, B., Henderson, M. and Hotopf, M. (2009) *The mental health of health care professionals: a review for the Department of Health*, London: King's College London Institute of Psychiatry, [www.swdc.org.uk/silo/files/the-mental-health-of-health-care-professionals.pdf](http://www.swdc.org.uk/silo/files/the-mental-health-of-health-care-professionals.pdf)
18. Stanley, N.J., Manthorpe, J. and White, M. (2007) 'Depression in the profession: social workers' experiences and perceptions', *British Journal of Social Work*, vol 37, no 2, pp 281–298.
19. Coffey, M., Dugdill, L. and Tattersall, A. (2009) 'Working in the public sector: a case study of social services', *Journal of Social Work*, vol 9, no 4, pp 420–442.
20. Caan, W., Stanley, N. and Manthorpe, J. (2006) 'Depression and persistent effects on work: an "expert patient" survey of 500 social workers', *Journal of Public Mental Health*, vol 5, no 4, pp 38–44.
21. Waddell, G. and Burton, A.K. (2006) *Is work good for your health and wellbeing?* Norwich: The Stationery Office. [www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf](http://www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf)
22. Health, Work and Wellbeing (2010) *Health, work and wellbeing: baseline Indicators report*, [www.dwp.gov.uk/health-work-and-well-being/resources](http://www.dwp.gov.uk/health-work-and-well-being/resources)
23. Penna, S., Paylor, I. and Sparkes, T.J. (1995) *Job satisfaction and dissatisfaction: a study of residential care work*, London: National Institute for Social Work.
24. Perkins, R., Farmer, P. and Litchfield, P. (2009) *Realising ambitions: better employment support for people with a mental health condition*, London: DWP. [www.dwp.gov.uk/docs/realising-ambitions.pdf](http://www.dwp.gov.uk/docs/realising-ambitions.pdf)
25. Royal College of Psychiatrists (2008) *Mental health and work*.

- [www.dwp.gov.uk/health-work-and-well-being/resources](http://www.dwp.gov.uk/health-work-and-well-being/resources)
26. Shaw Trust (2010) *Mental health: still the last workplace taboo?*  
[www.tacklementalhealth.org.uk](http://www.tacklementalhealth.org.uk)
  27. Arthur, B., Knifton, L., Park, M. and Doherty, E. (2008) "Cutting the dash" – experiences of mental health and employment', *Journal of Public Mental Health*, vol 7, no 4, pp 51–59.
  28. Mental Health Foundation (2002) *Out at work: a survey of the experiences of people with mental health problems within the workplace*, London: Mental Health Foundation.  
[www.mentalhealth.org.uk/publications/out-at-work](http://www.mentalhealth.org.uk/publications/out-at-work)
  29. Basset, T., Faulkner, A., Repper, J. and Stamou, E. (2010) *Lived experience leading the way: peer support in mental health*, [www.together-uk.org/about-us/who-we-are/peer-support-report](http://www.together-uk.org/about-us/who-we-are/peer-support-report)
  30. Lee, M. (2006) *Promoting mental health and wellbeing in later life: a first report from the UK Inquiry into mental health and well-being in later life*, London: Age Concern/Mental Health Foundation,  
[www.nationalcareforum.org.uk/content/Inquiry%20report%20Promoting%20mental%20health%20and%20well-being%20in%20later%20life%20-%20Executive%20Summary%20and%20Recommendations.pdf](http://www.nationalcareforum.org.uk/content/Inquiry%20report%20Promoting%20mental%20health%20and%20well-being%20in%20later%20life%20-%20Executive%20Summary%20and%20Recommendations.pdf)
  31. Mental Health Foundation (2007) *Fundamental facts*, London: Mental Health Foundation.
  32. Bhui, K., Stensfeld, S., McKenzie, K., Karlsen, S., Nazi, J. and Weich, S. (2005) 'Racial/ethnic discrimination and common mental disorders among workers: findings from the EMPIRIC study of ethnic minority groups in the United Kingdom', *American Journal of Public Health*, vol 95, no 3, pp 496–501.
  33. Meyer, I.H. (2003) 'Prejudice as stress: conceptual and measurement problems', *American Journal of Public Health*, no 93, pp 262–265.
  34. Brown, G.W. and Moran, P.M. (1997) 'Single mothers, poverty and depression', *Psychological Medicine*, no 27, pp 21–33.
  35. Platform 51 (2011) *Women like me: supporting wellbeing in girls and women*, [www.platform51.org/downloads/resources/reports/mentalhealthreport.pdf](http://www.platform51.org/downloads/resources/reports/mentalhealthreport.pdf)
  36. Chakraborty, A., McManus, S., Brugha, T.S., Bebbington, P. and King, M. (2011) 'Mental health of the non-heterosexual population of England', *The British Journal of Psychiatry*, no 198, pp 143–148.
  37. Guasp, A. and Balfour, J. (2008) *Peak performance: gay people and productivity*, [www.stonewall.org.uk/documents/productivity.pdf](http://www.stonewall.org.uk/documents/productivity.pdf)
  38. Thornicroft, G. (2006) *Actions speak louder: tackling discrimination against people with mental illness*, [www.mentalhealth.org.uk/publications/actions-speak-louder](http://www.mentalhealth.org.uk/publications/actions-speak-louder)
  39. Social Exclusion Unit (2003) *Mental health and social exclusion*, London: Office of the Deputy Prime Minister.  
[www.socialinclusion.org.uk/publications/SEU.pdf](http://www.socialinclusion.org.uk/publications/SEU.pdf)
  40. Corry, P. (2008) *Stigma shout: service user and carer experiences of stigma and discrimination*, London: Time to Change.  
[www.time-to-change.org.uk/about/stigma-and-discrimination-0](http://www.time-to-change.org.uk/about/stigma-and-discrimination-0)
  41. Marwaha, S. and Johnson, S. (2004) 'Schizophrenia and employment: a review', *Social Psychiatry and Psychiatry Epidemiology*, no 39, pp 337–349.
  42. Perkins, R. and Rinaldi, M. (2002) 'Unemployment rates among patients with long term mental health problems: a decade

- of rising unemployment', *Psychiatric Bulletin*, no 26, pp 295–298.
43. Sainsbury Centre (2009) *Removing barriers: the facts about employment and mental health*, briefing 40, London: SCMH, [www.centreformentalhealth.org.uk/pdfs/briefing40\\_Removing\\_barriers\\_employment\\_mental\\_health.pdf](http://www.centreformentalhealth.org.uk/pdfs/briefing40_Removing_barriers_employment_mental_health.pdf)
  44. Lyons, C., Hopley, P. and Horrocks, J. (2009) 'A decade of stigma and discrimination in mental health: plus ça change, plus c'est la même chose (the more things change, the more they stay the same)', *Journal of Psychiatric & Mental Health Nursing*, no 16, pp 501–507.
  45. Disability Rights Commission (2007) *Maintaining standards, promoting equality: professional regulation within nursing, teaching and social work and disabled people's access to these professions*, [www.leeds.ac.uk/disability-studies/archiveuk/DRC/Maintaining\\_Standards\\_Summary\\_Report.pdf](http://www.leeds.ac.uk/disability-studies/archiveuk/DRC/Maintaining_Standards_Summary_Report.pdf)
  46. Department of Health (DH) (1994) *The Allitt Inquiry: independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991*, London: HMSO.
  47. Stanley, N.J., Ridley, J., Manthorpe, J., Harris, J. and Hurst, A. (2007) *Disclosing disability: disabled students and practitioners in social work, nursing and teaching – a research study to inform the Disability Rights Commission's formal investigation into fitness standards*, [www.leeds.ac.uk/disability-studies/archiveuk/Hurst%20Alan/Disclosing DisabilityReport07.pdf](http://www.leeds.ac.uk/disability-studies/archiveuk/Hurst%20Alan/Disclosing%20DisabilityReport07.pdf)
  48. Biggs, D., Hovey, N., Tyson, P.J. and MacDonald, S. (2010) Employer and employment agency attitudes towards employing individuals with mental health needs, *Journal of Mental Health*, vol 19, no 6, pp 509–516.
  49. Pittam, G., Boyce, M., Secker, J., Lockett, H. and Samele, C. (2010) 'Employment advice in primary care: a realistic evaluation', *Health and Social Care in the Community*, vol 18, no 6, pp 598–606.
  50. National Statistics (2010) *Attitudes to mental illness 2010*, London. TNS-BMRB.
  51. Mind (2010) *The final taboo: millions of employees forced to lie about stress*, [www.mind.org.uk/news/filter/employment](http://www.mind.org.uk/news/filter/employment)
  52. Bodman, R., Davies, R., Frankel, N., Minton, L., Mitchell, L., Pace, C., Sayers, R., Tibbs, N., Tovey, Z. and Unger, E. (2003) *Life's labours lost: a study of the experiences of people who have lost their occupation following mental health problems*, [www.bristolmind.org.uk/files/docs/research/lifes-labours-lost-report.pdf](http://www.bristolmind.org.uk/files/docs/research/lifes-labours-lost-report.pdf)
  53. Brenninkmeijer, V., Houtman, I. and Blonk, R. (2008) 'Depressed and absent from work: predicting prolonged depressive symptomatology among employees', *Occupational Medicine*, vol 58, no 4, pp 295–301.
  54. Waddell, G., Burton, A.K. and Kendall, N.A.S. (2008) *Vocational rehabilitation: what works, for whom, and when?* London: TSO. [www.dwp.gov.uk/docs/hwwb-vocational-rehabilitation.pdf](http://www.dwp.gov.uk/docs/hwwb-vocational-rehabilitation.pdf)
  55. Mind and Federation of Small Businesses (2011) *Taking care of business*, [www.fsb.org.uk/policy/images/taking\\_care\\_of\\_business%5B1%5D.pdf](http://www.fsb.org.uk/policy/images/taking_care_of_business%5B1%5D.pdf)
  56. Baxter S., Goodyear, L., Herrmann, K., Pickvance, S. and Chilcott, J. (2009) *Mental well-being through productive and healthy working conditions (promoting well-being at work)*, Sheffield: School of Health and Related Research (ScHaRR), [www.nice.org.uk/nicemedia/pdf/PH22\\_Guidance.pdf](http://www.nice.org.uk/nicemedia/pdf/PH22_Guidance.pdf)
  57. National Institute for Health and Clinical Excellence (NICE) (2009) *Promoting mental wellbeing through productive and healthy*

- working conditions: guidance for employers*, [www.nice.org.uk/PH22](http://www.nice.org.uk/PH22)
58. Seymour, L. and Grove, B. (2005) *Workplace interventions for people with common mental health problems*, London: British Occupational Health Research Foundation, [www.bohrf.org.uk/downloads/cmh\\_rev.pdf](http://www.bohrf.org.uk/downloads/cmh_rev.pdf); summary reports can be found at [www.bohrf.org.uk/downloads/cmh\\_hp.pdf](http://www.bohrf.org.uk/downloads/cmh_hp.pdf), [www.bohrf.org.uk/downloads/cmh\\_emp.pdf](http://www.bohrf.org.uk/downloads/cmh_emp.pdf)
  59. Sainsbury, R., Irvine, A., Aston, J., Wilson, S., Williams, C. and Sinclair, A. (2008) *Mental health and employment*, research report no 513, London: DWP.
  60. Irvine, A. (2008) *Managing mental health and employment*, research report no 537, London: DWP. <http://php.york.ac.uk/inst/spru/pubs/ipp.php?id=1137>
  61. Ikegami, K., Tahara, H., Yamada, T., Mafune, K., Hiro, H. and Nagata, S. (2010) 'Effects of a mental training program for manufacturing company managers', *Journal of UOEH*, vol 32, no 2, pp 141–153.
  62. Lockett, H. and Grove, B. (2010) 'Responding to mental distress at work: part 1, can training managers in how to respond to mental distress in the workforce make an impact?' *Occupational Health at Work*, vol 7, no 2, pp 24–27.
  63. Lockett, H. and Grove, B. (2010) Responding to mental distress at work: part 2, does workplace mental health training have a lasting impact? *Occupational Wealth at Work*, vol 7, no 3, pp 20–23.
  64. Fleten, N. and Johnsen, R. (2006) 'Reducing sick leave by minimal postal intervention: a randomised, controlled intervention study', *Occupational Environmental Medicine*, no 63, pp 676–682.
  65. Wang, P.S., Simon, G.e., Avorn, J., Azocar, F., Ludman, E.J., McCulloch, J., Petukhova, M.Z. and Kessler, R.C. (2007) 'Telephone screening, outreach and care management for depressed workers and impact on clinical and work productivity outcomes: a randomized controlled trial', *Journal of the American Medical Association*, vol 298, no 12, pp 1401–1411.
  66. Blonk, R.W.B., Brenninkmeijer, V., Lagerveld, S.E. and Houtman, I.L.D. (2006) 'Return to work: a comparison of two cognitive behavioural interventions in cases of work-related psychological complaints among the self-employed', *Work & Stress*, vol 20, no 2, pp 129–144.
  67. van Oostrom, S.H., van Mechelen, W., Terluin, B., de Vet, H.C.W., Knol, D.L. and Anema, J.R. (2010) 'A workplace intervention for sick-listed employees with distress: results of a randomised controlled trial', *Occupational and Environmental Medicine*, doi 10.1136/oem.2009.050849.
  68. van Oostrom, S.H., Heymans, M.W., de Vet, H.C.W., van Tulder, M.W., van Mechelen, W. and Anema, J.R. (2010) 'Economic evaluation of a workplace intervention for sick-listed employees with distress', *Occupational and Environmental Medicine*, 67: 603–610.
  69. van der Klink, J.J.L., Blonk, R.W.B., Schene, A.H. and van Dijk, F.J.H. (2003) 'Reducing long term sickness absence by an activating intervention in adjustment disorders: a cluster randomised controlled design', *Occupational & Environmental Medicine*, vol 60, no 6, pp. 429–437.
  70. National Institute for Health and Clinical Excellence (NICE) (2009) *Managing long-term sickness absence and incapacity for work*, <http://guidance.nice.org.uk/PH19/Guidance/pdf/English>
  71. Henderson, M., Harvey, S., Williams, S., Thompson, A., Lowe, D., Jones, S. and Peel, P. (2010) *Depression detection and*

*management of staff on long term sickness absence: occupational health practice in the NHS in England, a national clinical audit: round 2*, London: Health and Work Development Unit.

72. Burns T., Catty, J., Becker, T., Drake, R.E., Fioritti, A., Knapp, M., Lauber, C., Rossler, W., Tomov, T., van Busschbach, J., White, S. and Wiersma, D. (2007) 'The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial', *The Lancet*, no 370, pp 1146–1152.
73. Rinaldi, M. and Perkins, R. (2007) 'Implementing evidence-based supported employment', *Psychiatric Bulletin*, 31: 244–249.
74. Rinaldi, M. and Perkins, R. (2007) 'Comparing employment outcomes for two vocational services: individual placement and support and non-integrated pre-vocational services in the UK', *Journal of Vocational Rehabilitation*, no 27, pp 21–27.
75. Crowther, R.E., Marshall, M., Bond, G.R. and Huxley, P. (2001) 'Helping people with severe mental illness to obtain work: systematic review', *British Medical Journal*, 322: 204–208.
76. Twamley, E.W., Jeste, D.V. and Lehman, A.F. (2003) 'Vocational rehabilitation in schizophrenia and other psychotic disorders: a literature review and meta-analysis of randomised controlled trials', *Journal of Nervous and Mental Disorders*, no 191, pp 515–523.
77. Seebohm, P. (2008) *Evening the odds: employment support, mental health and the black and minority ethnic communities*, London: Sainsbury Centre for Mental Health.  
[www.centreformentalhealth.org.uk/pdfs/Briefing35\\_Evening\\_the\\_Odds.pdf](http://www.centreformentalhealth.org.uk/pdfs/Briefing35_Evening_the_Odds.pdf)
78. Knapp, M., McDaid, D. and Parsonage, M. (eds) (2011) *Mental health promotion and mental illness prevention: the economic case*, London: Personal Social Services Research Unit, London School of Economics and Political Science,  
[www.lse.ac.uk/LSEHealthAndSocialCare/PSSRU/pdf/MHPP%20The%20Economic%20Case.pdf](http://www.lse.ac.uk/LSEHealthAndSocialCare/PSSRU/pdf/MHPP%20The%20Economic%20Case.pdf)
79. Personal communication, director of adult social services.
80. Personal communication, chair of third sector infrastructure organisation.
81. National Institute for Health and Clinical Excellence (NICE) (2009) *Depression: the treatment and management of depression in adults*,  
[www.nice.org.uk/CG90](http://www.nice.org.uk/CG90)
82. National Institute for Health and Clinical Excellence (NICE) (2011) *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care*,  
<http://guidance.nice.org.uk/CG113/NICEGuidance/pdf/English>
83. Curtis, L., Moriarty, J. and Netten, A. (2010) 'A different angle on statistics is the measure of length of working life: The Expected Working Life of a Social Worker' in *British Journal of Social Work* 40 (5): 1628–1643.

## About the development of this product

### Scoping and searching

A scope of the broad mental health and employment literature was carried out between September and November 2010. Further searching took place between November and December 2010.

### Stakeholder involvement

A range of experts were consulted, including service users, practitioners and national organisations. The topic experts, Angela Sweeney and Pete Fleischmann identify as mental health survivors.

### Peer review and testing

The final research briefing was peer reviewed by three external subject experts, including two mental health service users.

### About SCIE research briefings

SCIE research briefings provide a concise summary of recent research into a particular topic and signpost routes to further information. They are designed to provide research evidence in an accessible format to a varied audience, including health and social care practitioners, students, managers and policy-makers. They have been undertaken using methodology developed by SCIE. The information on which the briefings are based is drawn from relevant electronic databases, journals and texts, and where appropriate, from alternative sources, such as inspection reports and annual reviews as identified by the authors. The briefings do not provide a definitive statement of all evidence on a particular issue. SCIE research briefing methodology was followed throughout (inclusion criteria; material not comprehensively quality assured; evidence synthesised and key messages formulated by author): for full details, see [www.scie.org.uk/publications/briefings/methodology.asp](http://www.scie.org.uk/publications/briefings/methodology.asp)

SCIE research briefings are designed to be used online, with links to documents and other organisations' websites. To access this research briefing in full, and to find other publications, visit [www.scie.org.uk/publications/briefings/](http://www.scie.org.uk/publications/briefings/)

## Latest SCIE research briefings

- 20 The implementation of individual budget schemes in adult social care
- 21 Identification of deafblind dual sensory impairment in older people
- 22 Obstacles to using and providing rural social care
- 23 Stress and resilience factors in parents with mental health problems and their children
- 24 Experiences of children and young people caring for a parent with a mental health problem
- 25 Children's and young people's experiences of domestic violence involving adults in a parenting role
- 26 Mental health and social work
- 27 Factors that assist early identification of children in need in integrated or inter-agency settings
- 28 Assistive technology and older people
- 29 Black and minority ethnic parents with mental health problems and their children
- 30 The relationship between dual diagnosis: substance misuse and dealing with mental health issues
- 31 Co-production: an emerging evidence base for adult social care transformation
- 32 Access to social care and support for adults with autistic spectrum conditions (ASC)
- 33 The contribution of social work and social care to the reduction of health inequalities: four case studies
- 34 Communication training for care home workers: outcomes for older people, staff, families and friends
- 35 Black and minority ethnic people with dementia and their access to support and services
- 36 Reablement: a cost-effective route to better outcomes
- 37 Mental health service transitions for young people
- 38 Mental health, employment and the social care workforce

---

A full list of SCIE research briefings can be found at [www.scie.org.uk/publications](http://www.scie.org.uk/publications)

### Social Care Institute for Excellence

Fifth floor  
2–4 Cockspur Street  
London  
SW1Y 5BH

tel: 020 7024 7650  
fax: 020 7024 7651  
[www.scie.org.uk](http://www.scie.org.uk)