Mental health, employment and the social care workforce

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About this report

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.

Research briefing methodology
SCIE research briefing methodology was followed throughout (inclusion criteria; material not comprehensively quality assured; evidence synthesised and key messages formulated by author). See research briefing methodology for a full description.

Stakeholder involvement
A range of experts were consulted, including service users, practitioners and national organisations. The authors are topic experts, and 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.

Key messages

- The right to work is universal. The Equality Act 2010 and Public Sector duty protects people with mental health problems against employment discrimination. The Government includes improved employment rates for people with mental health problems in their key objectives for mental health and wellbeing.
- Working generally benefits and protects mental health (though stressful work in physically or emotionally unhealthy work environments can cause or worsen mental health problems).
- Employees in social care may be at high risk of poor mental health due to work pressures, however most people in social care say they like their work and find it fulfilling.
- People with mental health problems are more likely than other groups of disabled people to be unemployed. Yet most would like to work, and can do so given suitable job opportunities and reasonable adjustments where needed. They do not have to be fully recovered before returning to work.
- Reasonable adjustment can include flexible work times, working from home, gradual return to work after ill health, part-time working or job shares, a change of tasks, informal mentoring, and involvement in planning one's workload.
- Social care can benefit from employing more people with mental health problems, who may have a lot to offer as employees. Some social care jobs make personal experience a valued background.
- Programmes to promote health and wellbeing at work can support staff efforts to protect existing employees' mental health and make it easier to retain and regain staff with mental health problems.
- Long-term absence due to mental health problems can be prevented or helped by early intervention. Successful interventions include telephone support and talking therapies.
- Employment advisors and individual work placement with ongoing support have been found helpful for people who have not worked for some time due to severe mental health problems,
- Interventions must fit the individual, and are more successful with people who are keen to return to work or retain their jobs.
- Employment strategies based on changing individual behaviour need balancing with strategies to improve accessibility of work and healthy work conditions.
- Occupational health staff, human resources staff and line managers are vital in helping to retain and regain staff with mental health problems, and to enable people with longer term mental health problems to become employed.
- Evidence shows that line managers benefit from training in mental health awareness, and from increasing their skills and confidence to engage with employees about their mental health. Training can help staff gain more knowledge about employment rights, reasonable adjustment, and available help and resources to which people can be referred.

1 Introduction

'Employment rates vary greatly according to the type of impairment a person has; only 20 per cent of people with mental health problems are in employment' [2]

This guide addresses two main 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?

Government policy states a firm intention 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 DWP DH [1] and the cross-Government Health, Work and Well-being programme of work is overseeing a range of initiatives to support this policy (see Law, policy and guidance).

This guide sets out the main 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 in the context of the social care workforce.

It sets out some conclusions and recommendations drawn from this research to inform staff in occupational health, human resources and line managers in the social care field of what helps retain employees with mental health problems and enable people with mental health problems to succeed in gaining or regaining employment in social care.

Some facts about mental health and employment

- The adult and children's social care workforce consists of almost two million, mainly female employees [3, 4]
- Among the working age population, nearly one in six people will be experiencing mental health problems such depression or anxiety at any time. If drug or alcohol dependence are included, this frequency increases to one in five [5] [6]
- Far fewer people have more severe mental health problems. Approximately one per cent of the working age population has a diagnosis such as schizophrenia, bipolar disorder or severe depression [7].
- Best estimates are that between 10 and 20 per cent of people with severe mental health problems are in paid employment [6.]
- Mental health problems including stress could account for up to five per cent in staff turnover. [6]
- The total cost of mental ill health in England in 2009 - 10 is estimated as £105.2 billion – including an estimated £53.6 billion representing the negative

impact on life quality. Of this total, almost 30 per cent - £30.3 billion - was in lost economic output, and £21.3 billion was spent on health and social care [13].

- The average employee takes seven days off sick a year, of which 40 per cent are for mental health problems [6]
- Estimates of economic costs per annum from absenteeism (people being off work from mental health problems) are £8.4 billion, while presenteeism (lack of productivity due to mental health problems) is estimated at £15.1 billion [8]. Presenteeism is difficult to measure and can include people who are less productive than usual following a managed phase or reduced work pattern
- Some research challenges traditional systems of measuring absenteeism, suggesting they are do not take into account 'extensionism' - the fact that in flexible modern work situations (as opposed to those where employees clock on and off), many workers extend their hours to make up time lost, in order to achieve their work goals [9].

Structure of this report

This report summarises evidence and provides links to further information relevant to those working in social care who have responsibility for the mental health and wellbeing of employees in their organisations (i.e. line managers and people working in occupational health and human resources). It contains the following sections:

- The importance of mental health in employment
- What keeps people with mental health problems from working in social care?
- Law, policy and guidance related to mental health and employment
- The social care workplace and mental health
- What helps people with mental health problems gain and regain employment?
- Who helps people with mental health problems gain and regain employment?
- Additional online resources.

2 The importance of mental health in employment

'Employment rates vary greatly according to the type of impairment a person has; only 20 per cent of people with mental health problems are in employment'[2]

This section sets out the main reasons why mental health is an important issue in social care employment (as well as in employment generally).

It shows the findings from research which looks at social justice and rights, economic costs and benefits, the value of work to people with mental issues, and what they can offer to employers and organisations.

Social justice and rights

Socio-economically 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[10].

People with mental health problems who find work are more likely to be underemployed, employed in low status or low-paid jobs or employed in roles which do not reflect their skills or level of education [12]

This group 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 [7].

Economic and social costs of mental health and work

Mental health problems at work are known to have economic and social consequences, though these can be hard to separate from each other in research terms. The Centre for Mental Health figures for the total cost of mental ill health in England in 2009-10 are £105.2 billion, which is a substantial increase since the 2002/2003 figures of £77.4 billion [13].

However, of 2009-10 total, only 30 per cent - £30.3 billion - was attributed to lost economic output, while £21.3 was spent on health and social care. The largest amount, £53.6 billion, is an estimated figure representing the negative impact on life quality for those personally affected by mental health problems. This figure is based on QALYs (quality-adjusted life years) [14]. The human costs fall on those who suffer from mental health problems, together with their families.

Sickness absence is easy to measure but 'presenteeism' (reduced productivity while at work) is not, and for this reason is often ignored. For example reduced productivity can be a feature of a phased or managed work recovery plan. Researchers suggest there should be performance measures able to pick up significant change in

individual performance, with occasional use of specific measures such as the WHO Health and Work Performance Questionnaire. [15] [8].

Other researchers suggest that although psychological distress does lead to increased absenteeism, in contemporary workplaces, staff often work evenings and weekends to make up time, and if these additional hours are calculated, psychological distress has lower impact on productivity [9].

Two way benefits of retaining and regaining people with mental health problems

Work not only has a positive influence on health and wellbeing, but also is associated with less chance of a mental health issue recurring. According to evidence, the majority of people with mental health problems say that they want to work [17] and have a lot to contribute, despite ongoing problems, and sometimes because of the life experience gained in overcoming mental distress:

'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' [18].

Besides an income, positive outcomes include reduction in anxiety and depression and improvement in health and psychosocial status [7]

Although stressful work situations have been reported to cause mental health problems, including for those working in social care[19], suitable work in a safe and healthy workplace is generally good for people[20] In an attitude survey on health, work and wellbeing, more than eight in ten employees agreed that:

'...taking everything into account, paid work is very good or good for mental health'[22].

Qualitative research with people with mental health problems in Scotland endorses this premise:

 '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' [22].

Qualitative research with people with mental health problems makes plain that they have something positive to contribute to the workforce, not least because they are keen to be back at work and to prove themselves as 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' [22].

Some people felt that their experiences were valued by their workplace, and a number of respondents worked in the mental health field where personal experience of the issues was seen as a definite plus [19].

3 What keeps people with mental health problems from working in social care?

Too many people have been given the message, both by health professionals and society more generally, that work is not a realistic possibility for them[18]

There are some obstacles to working that are more general across all types of employment, but some are specifically an issue in social care and health, including legislation and guidance that is meant to protect the public from risk but which acts in a discriminatory way preventing people with mental health problems from getting work.

Evidence shows that stigma and discrimination towards people with mental health problems both in wider society and within the workplace still exists, despite efforts to eradicate this. Given this, it is difficult for people to disclose current or past problems with their mental health. Despite much evidence that work is beneficial for mental health, workplaces can be a cause of stress and mental health problems, or make problems worse, and there is often a lack of awareness among managers and staff about what support is needed. However, people do not have to be fully recovered from mental health problems to go back to work.

Stigma and discrimination

The term stigma refers to problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination) [23]. Stigma (in relation to mental health problems) can be defined narrowly as a prejudiced attitude towards people with mental illness labels, or more broadly as a social process including attitudes, behaviours and structures that create and perpetuate inequalities [24].

Stigmatising attitudes in society can stop people from asking for and getting help when they need it. Public attitudes about mental health show some positive changes in recent years, but continue to be mixed [25]. Anti-stigma campaigns such as Time to Change are raising awareness and increasing openness about mental health problems [26].

Many people with severe mental illness want to work and 30-50 per cent are capable of work, though only 10-20 per cent are working (20). Negative assumptions by doctors and medical staff play a significant role:

'My doctor told me I would never work again...' [18]

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 the impact of stigma [18, 27, 28, 29].

Employers' attitudes also show signs of stigma. Research shows that even though employment agencies would consider putting forward individuals with previous mental health needs to employers, the latter had high levels of concern in employing them [30].

Disclosure issues

A Mind survey found that almost one fifth of the 30m adult working age population admitted to having called in sick because of stress, but had lied about the reason. Instead they cited stomach upsets, housing problems and the illness of a loved one [31].

Although the Equality Act 2010 makes illegal the use of routine pre-employment screening questionnaires, and the spirit of the Act is to prevent discrimination, the knowledge that an employer might ask health questions before any final job offer could discourage people from applying.

For example a social worker described how openness was treated:
'I decided to be open … 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' [32].

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 [33][22].

The Clothier Inquiry recommended that no applicant for a post in the NHS with a previous mental health issue should be employed 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. The rule is not part of regulators'professional standards. However the rule may still have an enduring effect on attitudes. (see Law, policy and guidance).

A national survey [35] found more than seven in ten workplaces lacked a formal policy on mental health. Smaller businesses and employers with no human resources responsibilities were more likely to answer 'don't know' when asked their views on mental health problems in the workplace. Given this situation it is no surprise that less than two in five people said they would disclose any mental health problems to an employer.

Mentally or physically unsafe working environments

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Lack of needed supports

'In 14 years as a service user, mental health professionals have never offered me help with working towards getting back to work.'[18]

Some of the clients using an employment adviser scheme described the lack of support they received from their employer, despite confiding in them about their mental health difficulties before taking sick leave: '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.' [42].

Returning to work following a period of mental health related sickness absence also posed 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 [43].

One study found that almost half of people with physical health problems experienced mild to moderate depression but were more worried about telling their employer about their mental health problems:

'...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.' [44]

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. Retention is jeopardised by scant regard for relevant policies, poor communication and line managers' lack of competence in managing return to work [44].

Employees with mental health problems can feel isolated and ostracised by colleagues who do not know how to support them and might be unsure how to react or whether to acknowledge a mental health issue:

'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' [19].

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 [18].

4 Law, policy and guidance

'Mental health problems are now the most common reason for long-term sickness absence... As a result work and psychiatric disorders is a high priority for policymakers'[45].

A series of government reforms since the mid 1990s have aimed to reduce the numbers of people on incapacity-related benefits. Programmes including the ONE Advisory Service, New Deal for Disabled People, and Pathways to Work have focused on encouraging people to seek work by providing incentives to work and disincentives to remain on benefits. However, these reforms have been shown to have limited success in increasing the employment of people with long term and complex problems, especially those with mental health problems. Alongside these measures is a need to address the barriers to employment of people with mental health issues [41].

Since the turn of the century governments have aimed to reduce health inequalities and social exclusion by demonstrating the contribution of employment to personal health and wellbeing. This has been reinforced by legislation which outlaws employment discrimination [28, 46]. A major report by Dame Carol Black provided an evidence base for this [47]. Action to improve health and work and reduce sickness absence and avoidable job loss is being taken forward by the Health, Work and Wellbeing initiative (HWWB), run by a cross departmental group (Department for Work and Pensions, the Department of Health, the Health and Safety Executive, the Scottish Executive and the Welsh Assembly Government).

HWWB has established a national agenda to improve awareness of health and wellbeing at work, and developed evidence-based methods to enable people to remain in work or get back to work more quickly after a health problem [48, 47, 1, 49, 21]. Since mental health problems, such as anxiety or depression are one of the leading health problems among people of working age[45], strategies for enabling people with mental health problems to retain or regain work are an essential part of this plan [49, 50].

Current Government mental health policy (51) highlights the importance of improved employment rates for people with mental health problems as one of their key objectives in promoting mental health and wellbeing.

Equalities law

The Equality Act 2010 [46] superseded the Disability Discrimination Act in October 2010. Since April 2011 there has been a public sector equality duty in place [52].

The Public Sector Duty [52] 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 job and perform to the best of their ability.

People with mental health problems are covered under the Act's 'protected characteristic' of disability, which is defined as:

"... a disability if s/he has 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."

The Equality Act 2010 sets out nine protected characteristics that employers need to take into account. Disability is one of these and incorporates mental health problems. Some people may experience mental issues and one of the other protected characteristics. This may impact on their mental health and/or be another source of discrimination within employment. (See example below)

The interface between mental health problems and some of the other protected characteristics under equalities law

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 [53] At the same time, the numbers of young people in the population are 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 [54].

Race

There are particular hazards for the mental health of employees from ethnic minority groups, especially among individuals reporting unfair treatment at work [37] The daily discrimination experiences of people from these communities have been seen as the source of ill health [55] For example, the insults and accompanying humiliation to which these groups are exposed are known to be risk factors for depression [56]

Gender

A recent review of the mental health of girls and women in England and Wales has concluded that almost two-thirds have been affected by mental health problems triggered by bullying, physical or emotional abuse, bereavement or unemployment [57]. The review described how more than one in ten 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 people (LGBT) is affected by the stressors associated with their sexuality, discrimination, negative messages about identity and difficult familial interactions [58]. A qualitative study of LGB experiences in the workplace suggested issues similar to those for mental health, on stigma, risk and disclosure [59].

5 Mental health and social care work

'Employers in all sectors, including the public sector, can play an important role in supporting the health and wellbeing of their staff by providing healthy workplaces which support their employees' mental health and wellbeing'[51].

Social care is a major source of employment in England. The adult and children's social care workforce consists of almost two million, mainly female, employees [3], [4], [63]. Data suggests that 17 per cent of the independent sector social care workforce in England is black and minority ethnic and around 13 per cent of social care workers have a non-European Economic Area nationality.

Several studies have looked at issues of workplace stress in the social care workforce, finding high risk of mental health problems due to factors including abuse and violence at work, staff experiences of racism, discrimination and gender issues, and demanding roles. However, evidence shows the majority enjoy working on social care, and find their jobs fulfilling.

There have been efforts to bring more people into specific peer support roles and there are good reasons for actively trying to include more people with lived experience of mental distress as well as improving mental health support for the existing workforce.

What aspects of social care work are valued?

Research in social care found that the vast majority of staff enjoyed spending time with clients and developing relationships with them; and the sense of camaraderie of working in a team with friendly colleagues [65], [64].

'I love my job as a carer. I find it very fulfilling''Camaraderie between colleagues...supportive colleagues'

Other findings describe how working with people in a caring situation, together with the satisfaction of making a difference and helping their clients were sources of job satisfaction among care workers in the northwest of England [66], and in a national survey [64].

What aspects of social care work can be difficult?

Studies have shown that employees in social care may be at high risk of poor mental health because of their challenging and demanding roles [67], [68].

Residential care workers in a study in the North-West said that they routinely did unpaid overtime to get the job done satisfactorily[66]. Workers may have a heavy workload and feel a lack of control or absence of boundaries in their work[67].

Work patterns of constant change, and management responses that could sometimes come across as intolerant or bullying were also contributory factors to mental health problems [67].

Work insecurity was demoralising issue for residential care workers who believed that to save money, local authorities were freezing posts, shifting to part-time contracts with inferior conditions of service, re-organising shift systems and relying more on casual staff [66].

A study that explored working conditions and quality of life in two social services departments in the UK came to similar conclusions. Determinants of distress included organisational culture and function; lack of time and rigid timescales; lack of resources; responsibility for people; the rate and pace of change, and poor communication:

'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?' [65].

Staff sometimes feel undervalued by their own hierarchy, poorly paid, and misunderstood by the public [64, 65]

Staff can experience violence and verbal abuse in the course of their work) [66] [69]. Staff may experience racism, discrimination and gender issues [69].

Social workers who experience mental health problems

Interviews with social workers found that more than a quarter of the fifty participants had had between one and three months sickness absence associated with depression; and just under a quarter had been off for between four and six months [67].

Regulation of social care is critical for the protection of the public. However there are over seventy separate pieces of legislation and statutory guidance, much of it at odds with equality legislation. These set out unclear requirements for 'good health' or 'physical and mental fitness' in social care as well as nursing and teaching [70]. These standards hinder disabled people's access to social care professions and can lead to discrimination and exclusion of people with mental health problems (see Law, policy and guidance).

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 confirmed this to be so [43].

Why social care would benefit from employing more people with personal experience

Many people who use social care services themselves have mental health problems. Employees perceived that their own experiences were 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' [19].
Qualitative research with people with mental health problems makes plain that they have something positive to contribute to the workforce, not least because of their keenness to prove themselves in the workplace:

'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' [22].

The importance of including the expertise of lived experience in the workforce, alongside professional competencies is now widely acknowledged. 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' [71].

An evaluation of peer support in mental health found that the best approach was to base new peer support workers in teams that were beginning to implement a recovery approach. However:
'Peer support workers thrived and had positive impacts on service users and culture in a range of settings' [72].

Case study

Support, Time and Recovery (STR) worker roles were created with the intention that people with direct experience as service users could bring something valuable to the role of supporting others to recover. An evaluation of three pilot STR programmes found this had worked best where there had been a good consultation process with everyone involved from the outset:

'we didn't really know the best way to [recruit service users] so we set up a working group with service users, HR, unions, vocational health, STR workers, managers and some providers, and really kind of a blank form really - how can we address that?

' On our job description we said that it was desirable to have experience of mental health distress, either as a worker, carer or a service user, and that covers the three criteria. On our covering letters we had signposted people to support through the application process, so like Rethink, job net, the Job Centre'.

'My main qualification for the job was having been a service user . Got good support. 2hr supervision once every month and manager knows my background, am well supported.'

> 'have been a service user, then became a service user co-ordinator then into STR. User perspective brings another aspect to the job' [73]

6 What helps people with mental health problems gain and retain employment?

[There is a] need for management priorities that value worker wellbeing with a balance between productivity and a healthy work climate [74]

NICE commissioned an evidence review to find out whether healthy and productive working conditions promote mental wellbeing among employees [73]. This review informed NICE guidance on mental health and work [36]. The Health and Safety Executive also produce standards to help management promote healthy workplaces [62] (see Law, policy and guidance).

There are a number of programmes and interventions designed help people of working age to gain and retain competitive employment that utilises their skills and knowledge, regardless of mental health problems. These types of services can work equally well for people from ethnic minority communities, as long as employment staff are skilled and confident in addressing issues associated with racism [75]

Reasonable adjustment

The public sector duty of the Equality Act 2010 provides legal safeguards for employees with mental health problems. Employers must demonstrate that they have introduced adjustments that allow disabled employees to do their job [76]

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 or part-time working or job shares, have been shown as effective in enabling employees with mental health problems to remain in work [77], [78], [18]

Each person's skills and the challenges they might face at work will differ, so any adjustments should fit the individual's needs, not be standardised.

The mental health charity Mind has produced joint guidance with the Federation of Small Businesses on reasonable adjustments for employees with mental health problems [79]

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 [4]

Interventions to support mental health at work

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.

A common feature of many of the preventive interventions is a cognitive behavioural therapy (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 [36, 80] Government commitment to extending the range of and access to talking therapies should benefit those with mental health problems who want to work [81].

Case studies

The health and wellbeing of NHS staff was reviewed as part of the Health, Work and Wellbeing Programme [49].

The review encourages NHS organisations to provide staff health and well-being services centred on prevention, fully aligned with wider public health policies and initiatives. It states that these services should be seen as a real and tangible benefit of working in the NHS, and managers should be given the skills and tools to support staff with mental health problems.

The report includes ac case study of an initiative to promote health and wellbeing among staff at Cambridge University Hospitals NHS Foundation Trust through a varied programme of physical and non-physical activities, social events and clubs:

'Staff enjoy physical health activities, including: a staff inter-departmental football tournament, supported by Cambridge United Football Club; Walk to Work, sponsored by Stagecoach and Cambridgeshire County Council; free stretch and Pilates classes for staff alongside a campaign to increase staff activity and exercise levels; and monthly de-stress days where, in partnership with Cambridge Regional College, staff can receive either a 20-minute manicure and hand massage or a relaxing back massage' p.9

The Increasing 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 could help people come off sick pay and benefits and stay in or return to work.
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 [81].

Individual placement and support (IPS) for serious mental health problems

There is now strong evidence that IPS models (which place people in jobs and then train and support them while working) have better success rates than more traditional approaches such as vocational training and sheltered work, in getting people with severe mental health problems into paid jobs. [82], [83], [84], [85], [86]

Key aspects of this Individual Placement and Support (IPS) approach include rapid job search based on individual preference, and ongoing support by an employment adviser, working within mental health services, to individuals and employers. 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.

Early intervention initiatives

There are a number of studies that look at early intervention. Researchers looked at how to identify employees with mental health problems so that suitable support or signposting to appropriate treatment could begin as soon as practicable.

Case studies

Postal intervention:

Researchers (87) looked at the results of sending letters to people within two weeks of the start of sickness absence. Participants in the trial were sent a letter offering return to work with adjusted job on sickness benefits; a questionnaire about sick leave; and a consent form.

This randomised controlled trial (RCT) included a one-year follow-up, and showed 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 screening:

A randomised controlled trial (RCT) of a telephone screening, outreach and care management intervention in the United States for depressed workers showed a positive impact on clinical and work productivity outcomes. Employees of a large company were surveyed and those who had symptoms of depression were invited to join the study, then randomly assigned to a telephone intervention group or a non intervention group.

The intervention group were telephoned by qualified mental health clinicians who assessed their needs and recommended suitable treatment (or offered to talk to them on the phone if treatment was refused). 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.[88]

Getting back to work initiatives

CBT focused on Return to Work
A randomised controlled trial (RCT) in the Netherlands assessed a brief intervention, that started 2-3 weeks after start of sick leave and was based on cognitive behavioural therapy (CBT) principles combined with graded activity and a phased return to work.

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 [89]

Return to Work Co-Ordinators
Intervention by Return to Work co-ordinators study were compared with care as usual by occupational physicians in a Netherlands study. The Return to Work coordinators offered support to employees who had been off work for 2-8 weeks with distress. They 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 [90].

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 similarly showed a benefit (cost savings) for the subgroup of employees who intended to return to work at baseline, over and above care as usual, though no overall cost savings for the whole group [91].

The Retain/Regain Service
Intervention by employment advisers (EAs) was researched in Cambridgeshire, England and found to improve employment outcomes. The EAs worked in three localities alongside or within various GP surgeries. GPs could refer to the EAs anyone with mental health problems whether in work or off sick (Retain clients) or unemployed due to mental health problems (Regain clients). Tailored brief interventions were offered either face-to-face or via telephone or email contact. They included careers guidance and skills to negotiate with employers for the Retain clients; or practical assistance in job search, CV writing and interview technique; careers guidance; and assertiveness training for the Regain group [42].

Assessing what works

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

Some of the narrative and qualitative studies describing personal experience of stigma and discrimination included include employees from social care, but none of

the intervention studies were conducted in social care, even though their findings are relevant for that sector.

Some important studies, such as those on line manager training, employment advisers, OH audit of NICE guidance and IPS, have been conducted and implemented in the UK. It would help if the implementation of these studies in social care could be evaluated, fill knowledge gaps about how best to recruit and retain employees with mental health problems in social care.

Strengths
The interventions reviewed in this briefing focus on work outcomes, not just clinical improvement. In other words they supported the principle that people with mental health problems do not have to be completely recovered to be in or to return to work.

Several of the interventions reported in this review have been undertaken in the UK. They offer the possibility of applying these research findings to practice in social care workplaces.

Weaknesses
It is hard to compare data from the various studies as the participants are from a wide range of groups and backgrounds. As a rule participant sample sizes are small and follow-up on interventions' effects are usually of short duration, and may have a high drop-out rate, resulting in even smaller sample sizes on which to base conclusions.

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 evaluation of what works

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[91].
An assessment of the economic case for mental health promotion and mental illness prevention [92,] gives two examples of the potential cost effectiveness of workplace interventions for mental health problems. Their first example refers to the telephone intervention included in this review [88.]

The authors conclude that this type of intervention would be 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 [92].

Their second example is a model intervention on promoting mental wellbeing at work, mirroring the recommendations in the NICE guidance [36]. The authors argue that workplace well-being interventions can be significantly cost-saving in the short term. The public sector could benefit as an employer from improved investment in

workplace well-being programmes. Smaller companies and organisations may need public support to implement such schemes [92].

7 Who helps people with mental health problems gain and regain employment?

'The majority of employers 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' [21].

This section looks at research about the roles of those who can or potentially could help people already in the workforce to deal with mental health problems and retain their jobs, and help people with mental health problems to gain or regain social care employment. This includes GPs and other staff in primary care, those working in occupational health (OH) and human resources (HR), and line managers.

There is a surprising lack of research in this area, particularly in relation to the role of human resources, though much that applies to line managers is also relevant to HR.

The research shows a need for more training for all relevant professionals which would enable earlier identification of problems experienced by existing staff, and more confidence in employing or re-employing people with mental health problems.

Primary care

Primary care can play a vital role in the rehabilitation of people with mental health problems back into work, enabling them to remain in work even if they are receiving treatment. In fact eight out of ten of people say they would consult their GP first for treatment if they thought they had a mental health issue [93].

GPs can use their position as the first port of call to assist people back to work through flexible application of the fit note [60] (see Law, policy and guidance) and referrals to employment advisers, who are now likely to be integrated with local Improved Access to Psychological Therapies services [81].

Research looked at whether primary care physicians trained to deliver a minimal intervention for stress-related disorders were more effective than those delivering care as usual in enabling return to work among patients with sickness absence linked to mental health problems.

Occupational physicians trained primary care practitioners (PCPs) how to diagnose a stress-related mental health issue or to detect anxiety or depression; how to help the patient think about and plan for return to work; how to monitor patient engagement; and how to signpost on to more specialised services if the patient was not making expected progress.

The research looked at whether functional recovery was achieved within three meetings of doctor and patient. Even though the amount of sick leave taken was

unaffected, those diagnosed as having stress-related mental health problems seemed to return to work slightly more quickly than those in the usual care group [94].

Occupational health staff

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

This lack of research may be because of the variety of systems for providing OH interventions. While local authorities have OH as a council-wide corporate function, smaller and medium sized social care establishments access OH help from independent practitioners or the local authority; by contract with OH companies or by purchasing relevant skills as necessary from primary care practitioners. Some smaller organisations seek advice, guidance and support in OH matters from their insurers.

Identification of workplace factors that are perceived to have contributed to any depression is a key role of the OH professional [95]. There has been an audit in the UK [95] of how OH practitioners are applying evidence-based guidance on depression [96], and the management of long-term sickness absence. The audit examined whether OH 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. It recommended more effective systems for early referral to OH, and further development and improvement of early detection of depression. The results provide OH with a clear steer on supporting employees with mental health problems which may also be applicable to social care.

A trial 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.

OH practitioners used a CBT approach to encourage employees to think about causes for 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 as well as shorter periods of sickness absence.

Human resources staff

None of the identified research for this briefing was conducted with human resources professionals (HR), but they are central to the delivery or initiation of many of the interventions. In social care workplaces such as local authorities, HR functions are either located in service departments, such as adult social care, or increasingly as corporate functions with specific departmental links or teams.

In many of the smaller social care businesses, managers or owners often take responsibility for HR 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 or the impact of the Equality Act 2010 [78].

Training for line managers is relevant for HR practitioners, many of whom will have management responsibilities. Also some of the low-cost interventions reviewed, such as those delivered by post or telephone, could be promoted by HR.

Line managers

While employers are gradually recognising a duty of care towards their employees and the economic cost of absence due to mental health problems, there has been shown to be a pressing need for line managers to be better informed.

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 amongst the employees for whom they were responsible[21].

A review of workplace interventions for employees with mental health problems identified underdeveloped capabilities among line managers in dealing with employees with mental ill health related sickness absence [98]. Lack of appropriate training in relevant skills and mental health awareness was a particular gap. Improving mental health literacy and awareness at work is something that people with mental health problems have identified as critical [99] [16].

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 (See Additional online resources) enabled job applicants to have confidence in the company's levels of mental health awareness [22]. Training for managers has been shown to be effective (See boxe)

An active listening intervention by line managers for approximately 2000 employees in a Japanese manufacturing company seemed to demonstrate an effect on decreasing job stressors, stress reactions and workers' sick leave due to mental health problems. Managers learned active listening skills to improve their communication with and support for their employees. They became making them more willing to approach an employee after noticing changes in behaviour, to initiate a conversation on relevant issues, signpost individuals for treatment; and provide ongoing support at work including making reasonable adjustments [100].

A UK training intervention for line managers on mental health problems has demonstrated a significant effect, sustained at eight month follow-up, on knowledge, attitudes, willingness to engage and self-reported confidence levels. The training emphasised recognition of very early signs of mental health problems at work; useful approaches to colleagues or those you manage about whom you are concerned; and information on the range of professional support and treatments that are available [101] [102].

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